STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087196	A. BUILDING: _____ B. WING _____	05/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEACE OF MIND LLC II	223 N BURR OAK RD PO BOX 173 WICHITA, KS 67206

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS The following citations are the result of a Licensure Resurvey at the above named Home Plus Facility in Wichita, Kansas on 5/23/16, 5/24/16, and 5/25/16.	S 000		
S 140 SS=E	26-39-103 (i) Resident Right Privacy and Confidentiality (i) Privacy and confidentiality. The administrator or operator shall ensure that each resident is afforded the right to personal privacy and confidentiality of personal and clinical records. (1) The administrator or operator shall ensure that each resident is provided privacy during medical and nursing treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups. (2) The administrator or operator shall ensure that the personal and clinical records of the resident are maintained in a confidential manner. (3) The administrator or operator shall ensure that a release signed by the resident or the resident's legal representative is obtained before records are released to anyone outside the adult care home, except in the case of transfer to another health care institution or as required by law. This STANDARD is not met as evidenced by: KAR 26-39-103(i)(1) The census equalled eight the sample included three Residents. Based on interviews, observations, and reviews of records, for three of three sampled (#185, #187, and #189) and for all non-sampled Residents, the Operator failed to develop and implement policy and procedure to	S 140		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087196	A. BUILDING: _____ B. WING _____	05/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEACE OF MIND LLC II	223 N BURR OAK RD PO BOX 173 WICHITA, KS 67206

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 140	Continued From page 1	S 140		

ensure Residents afforded the right to privacy and confidentiality during medical and nursing treatment, personal care, visits, and meetings of family, related to the use of electronic monitors in Resident rooms that provided audible transmission to the open kitchen of facility.

Findings included:

- By interview on 5/23/16 at 12:30pm, during entrance tour, Facility Nurse #C stated "baby monitors (audible electronic monitors (AEM)) in all Resident rooms."

Observations during the entrance tour of facility beginning at 12:30pm on 5/23/16, revealed an active AEM in each Resident room, with transmission of all room sounds culminating in the open kitchen of facility.

By interview on 5/23/16 at 1:45pm, at the end of entrance tour, Facility Nurse #C stated not aware of facility policy and procedure related to the AEM... we use them in Resident rooms so we can hear Residents if they need anything... will ask Owner/Operator O/O #D.

By interview on 5/23/16 at 2:59pm, Facility Nurse #C and O/O #D confirmed no facility policies and procedures for the use of the AEM... stated the families know about the monitors and it is in the care plans they sign... no information available or given on how to turn off when having private conversations in the Resident rooms... confirmed the open kitchen end of AEM allowed potential for non staff persons in facility to hear transmissions from individual Resident rooms.

Record review revealed #185 admitted to facility 5/22/13. Current negotiated service agreement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087196	A. BUILDING: _____ B. WING _____	05/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEACE OF MIND LLC II	223 N BURR OAK RD PO BOX 173 WICHITA, KS 67206

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 140	Continued From page 2 (NSA) of 5/02/16 contained hand written note: "Baby monitor on at all times for staff assist." The back page contained signature of family member dated 5/05/16. Record review revealed #187 admitted to facility 11/28/14. Current NSA of 8/26/15 contained hand written note: "Baby monitor and sensor alarm to call for staff assist/prevent falls and notify staff when Resident getting up." The back page contained signature of family member dated 8/26/15. Record review revealed #189 admitted to facility 3/15/16. Current NSA of 3/15/16 contained hand written note: "Baby monitor, bed alarm - 3/17/16." The back page contained signature of family member dated 3/15/16. The absence of facility policy and procedure related to the use, placement, and operation of AEM (for example turning down or off when private visits or communications occurring), failed to ensure privacy and confidentiality maintained for each Resident during visits, and meetings of family. The culmination of the AEM transmissions in the open kitchen, failed to ensure privacy and confidentiality from non-staff persons in the facility who could hear transmissions from Resident rooms during medical and nursing treatment, or during personal care. The Operator failed to develop and implement policy and procedure to ensure Residents afforded the right to privacy and confidentiality during medical and nursing treatment, personal care, visits, and meetings of family, related to the use of electronic monitors in Resident rooms that provided audible transmission to the open kitchen of facility.	S 140		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087196	A. BUILDING: _____ B. WING _____	05/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEACE OF MIND LLC II	223 N BURR OAK RD PO BOX 173 WICHITA, KS 67206

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5127 SS=D	26-42-202 (i) NSA Services Received (i) Each administrator or operator shall ensure that each resident receives services according to the provisions of that resident ' s negotiated service agreement. This REQUIREMENT is not met as evidenced by: KAR 26-42-202(i) The census equalled eight the sample included three Residents. The facility identified all Residents in need of toileting assistance. Based on observations, interview, and reviews of records, for one non sampled in need of toileting assistance (#186), the Operator failed to ensure each Resident received services according to the provisions of that Resident's negotiated service agreement (NSA). Findings included: - Review of record revealed current functional capacity screen (FCS) of 10/29/15 assessed #186 in need of physical assistance (2) with bathing, dressing, toileting, transfers, and mobility; unable to perform (3) medication and treatment management. The 10/29/15 negotiated service agreement (NSA) documented #186 to use urinal at night and during the day PRN (as needed). The NSA documented for transfers #186 required one person assistance with gait belt. On 5/24/16 at 3:00pm, certified staff #L assisted #186 to toilet and shortly called out for help of	S5127		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087196	A. BUILDING: _____ B. WING _____	05/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEACE OF MIND LLC II	223 N BURR OAK RD PO BOX 173 WICHITA, KS 67206

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5127	Continued From page 4 other staff. By observation at 3:00pm in bathroom, #L holding onto #186 by back of pants attempting to keep him/her from going completely to the floor... #186 with knees against the roll in shower base... at this time certified staff #P entered bathroom... unable to assist #L in raising #186... Facility nurse #C entered bathroom and completed an initial assessment of #186... #P to a neighboring room and obtained a gait belt. The three staff raised #186 from knees and then placed the gait belt around #186 to complete the transfer back to wheelchair. Certified staff #P confirmed the gait belt not in use when #186 assisted with transfer in bathroom in accordance with the NSA. The Operator failed to ensure #186 received services according to the provisions of that Resident's NSA.	S5127		
S5130 SS=D	26-42-202 (j) NSA Outside Resources (j) If a resident's negotiated service agreement includes the use of outside resources, the designated staff shall perform the following: (1) Provide the resident, the resident's legal representative, the case manager, and, if agreed to by the resident or resident ' s legal representative, the resident ' s family, with a list of providers available to provide needed services; (2) assist the resident, if requested, in contacting outside resources for services; and (3) monitor the services provided by outside resources and act as an advocate for the resident if services do not meet professional standards of practice. This REQUIREMENT is not met as evidenced by:	S5130		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087196	A. BUILDING: _____ B. WING _____	05/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEACE OF MIND LLC II	223 N BURR OAK RD PO BOX 173 WICHITA, KS 67206

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5130	Continued From page 5 KAR 26-42-202 (i) The census equalled eight the sampled included three Residents. The facility identified four Residents receiving services by an outside provider, and three included in the sample. Based on interview and reviews of record, for one of three sampled (#189) with services by an outside provider, designated staff failed to monitor the services provided by an outside resource and act as an advocate for the Resident if serviced did not meet professional standards of practice. Findings included: - Review of record revealed #189 admitted to facility 3/15/16 with diagnoses of Encephalopathy, End stage renal disease (with dialysis), Gait abnormality, Atrial fibrillation, Heart failure, Hypertension, Anemia, Dementia, Cirrhosis of liver with ascites, and history of bladder neoplasm. The current functional capacity screen (FCS) of 3/15/16 assessed #189 in need of physical assistance (2) with bathing, dressing, toileting, transfers, mobility; unable to perform (3) medication and treatment management; with incontinence, impaired cognition, falls/unsteadiness, and impaired decision making. The negotiated service agreement (NSA) of 3/15/16 indicated facility staff to provide services to meet these identified needs. The NSA contained 3/17/16 notations of Home Health initiated to provide PT (physical therapy) and OT (occupational therapy). The NSA documented the last visits on 5/13/16. The medical record contained a 5/05/16	S5130		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087196	A. BUILDING: _____ B. WING _____	05/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEACE OF MIND LLC II	223 N BURR OAK RD PO BOX 173 WICHITA, KS 67206

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5130	Continued From page 6 documentation by OT: "Discontinue OT services, all goals met... HEP (home exercise plan) in place to increase strength." Medical record lacked any visit notes with exception of initial order to have PT and OT evaluations completed. Medical record lacked an HEP. NSA lacked an HEP. By interview on 5/24/16 at 3:57pm, when asked about HEP, Facility nurse #C stated I have never seen it... I have called... they (outside provider) said all they have is the therapy discharge but nothing in between the original order and the discharge notes." Facility nurse #C confirmed no method in place for this Resident to monitor the services of the outside provider. The Operator failed to ensure designated staff monitored the services provided to #189 by an outside resource, and to act as an advocate for the Resident if serviced did not meet professional standards of practice.	S5130		
S5155 SS=D	26-42-204 (a) Health Care Services (a) The administrator or operator in each home plus shall ensure that a licensed nurse provides or coordinates the provision of necessary health care services that meet the needs of each resident and are in accordance with the functional capacity screening and the negotiated service agreement. This REQUIREMENT is not met as evidenced by:	S5155		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087196	A. BUILDING: _____ B. WING _____	05/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEACE OF MIND LLC II	223 N BURR OAK RD PO BOX 173 WICHITA, KS 67206

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5155	Continued From page 7 KAR 26-42-204(a) The census equalled eight the sample included three Residents. The facility identified six Residents with bed rails and two included in the sample. Based on observation, interview, and reviews of record, for two of two sampled with bedrails on bed (#189 and #185), the Operator failed to ensure a Licensed nurse provided or coordinated the provision of necessary health care services that met the needs of each Resident, in regard to the appropriate assessment of bed rail use. Findings included: - By observation on 5/23/16 at 12:55pm, sampled Resident #189 in bed in room with bed rails in raised position. Review of record revealed #189 admitted to facility 3/15/16 with diagnoses of Encephalopathy, End stage renal disease (with dialysis), Gait abnormality, Atrial fibrillation, Heart failure, Hypertension, Anemia, Dementia, Cirrhosis of liver with ascites, and history of bladder neoplasm. The current functional capacity screen (FCS) of 3/15/16 assessed #189 in need of physical assistance (2) with bathing, dressing, toileting, transfers, mobility; unable to perform (3) medication and treatment management; with incontinence, impaired cognition, falls/unsteadiness, and impaired decision making. By review, the medical record contained a "Bed Rail Assessment" completed 4/14/16. The assessment documented bed rail indicated "to promote independence with bed mobility and	S5155		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087196	A. BUILDING: _____ B. WING _____	05/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEACE OF MIND LLC II	223 N BURR OAK RD PO BOX 173 WICHITA, KS 67206

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5155	Continued From page 8	S5155		

prevent falling out of bed."
This assessment failed to address #189's ability to bear weight, fluctuating cognitive status, body weight and size that may allow entrapment, ambulatory status, history of falls, ability to reposition in bed, safety awareness, Resident's desire to have or not have the bed rail.

The negotiated service agreement (NSA) of 3/15/16 indicated facility staff to provide services to meet these identified needs. The NSA lacked any mention of bedrails for this Resident.

By interview on 5/24/16 at 3:50pm, Facility nurse #C confirmed the bed rails not on the NSA... stated it is my understanding those were implemented when a hospital bed arrived on 3/17/16 after the Resident experienced a fall, and after the NSA signed by a family member on 3/15/16. Facility nurse #C confirmed he/she completed a "Bed Rail Assessment" 4/14/16... confirmed the assessment for bed rails lacked specific areas necessary to evaluate the safety for #189... #C confirmed assessment tool lacked the necessary components and he/she had not researched to obtain more thorough assessment form... stated he/she borrowed this assessment from another home plus facility...

The Operator failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services that met the needs of #189 in regard to the appropriate assessment of bed rail use for #189's bed.

- By observation on 5/23/16 at 1:05pmpm, sampled Resident #185 in bed in room with bed rails in raised position.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087196	A. BUILDING: _____ B. WING _____	05/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEACE OF MIND LLC II	223 N BURR OAK RD PO BOX 173 WICHITA, KS 67206

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5155	Continued From page 9	S5155		

Review of record revealed #185 admitted to facility 5/22/13 with diagnoses of Diabetes, Hypertension, Atrial fibrillation, Septic arthritis, Dementia, Hypothyroidism, Chronic obstructive pulmonary disease, and Hypercoagulable state.

The current 5/02/16 functional capacity screen (FCS) assessed #185 unable to perform (3) bathing, dressing, toileting, transfers, mobility, medication and treatment management; with incontinence, impaired cognition, impaired decision making, and in need of mechanical lift for transfers.

The 5/02/16 negotiated service agreement (NSA) documented #185 to receive services to meet these identified needs. The NSA contained an entry "side rails for turning/bed mobility."

Observation on 5/23/16 at 1:30pm revealed certified staff #M and #N turned and checked Resident for incontinence. Staff prompted and placed Resident's hand on rail as he/she was laying on left side for check of brief.

Observation on 5/24/16 at 3:00pm revealed #185 pushing back covers from lower extremities... stated "I am ready to get up..." When asked how he/she gets help if needed, #185 stated my neighbor told me if I wanted to climb up on a chair and dust, just call and she would come over..."

By review, the medical record contained a "Bed Rail Assessment" completed 4/14/16. The assessment documented bed rail indicated "Resident states makes me feel safe bed provided by Hospice comes with rails."
This assessment failed to address #185's ability to bear weight, fluctuating cognitive status, body weight and size that may allow entrapment,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087196	A. BUILDING: _____ B. WING _____	05/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEACE OF MIND LLC II	223 N BURR OAK RD PO BOX 173 WICHITA, KS 67206

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5155	Continued From page 10 ambulatory status, history of falls, ability to reposition in bed, and Resident's safety awareness. By interview on 5/24/16 at 3:50pm, Facility nurse #C confirmed he/she completed a "Bed Rail Assessment" 4/14/16... confirmed the assessment for bed rails lacked specific areas necessary to evaluate the safety for #189. The Operator failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services that met the needs of #185 in regard to the appropriate assessment of bed rail use for #185's bed.	S5155		
S5185 SS=E	26-42-206 (a) (b) (c) Dietary Services (a) The administrator or operator of each home plus shall ensure the provision or coordination of dietary services to residents as identified in each resident ' s negotiated service agreement. (b) The supervisory responsibility for dietetic services shall be assigned to one employee. (c) If a resident ' s negotiated service agreement includes the provision of a therapeutic diet, mechanically altered diet, or thickened consistency of liquids, a medical care provider ' s order shall be on file in the resident ' s clinical record, and the diet or liquids, or both, shall be prepared according to instructions from a medical care provider or licensed dietitian. This REQUIREMENT is not met as evidenced by: KAR 26-42-206 (c)	S5185		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087196	A. BUILDING: _____ B. WING _____	05/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEACE OF MIND LLC II	223 N BURR OAK RD PO BOX 173 WICHITA, KS 67206

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5185	Continued From page 11 The census equalled eight the sample included three Residents. All Residents received meal service. Based on interview and record review, for one of three sampled Residents with a therapeutic diet ordered (#189), the Operator failed to ensure the diet prepared according to written instructions from a medical care provider or licensed dietician in accordance with the NSA. Findings included: - Review of menus and facility dietary manual revealed typed suggestions for serving a variety of diets, but all lacked the signature of a dietician or physician. - By interview on 5/23/16 at 4:45pm, Facility nurse #C and Owner/Operator #D confirmed no directions for therapeutic diets signed by a physician or dietician... stated we have three Regular diets, four LCS (low concentrated sweets) diets, and one 2gm Na High Protein diet. - Review of record revealed #189 admitted to facility 3/15/16 with diagnoses of Encephalopathy, End stage renal disease (with dialysis), Gait abnormality, Atrial fibrillation, Heart failure, Hypertension, Anemia, Dementia, Cirrhosis of liver with ascites, and history of bladder neoplasm. The current functional capacity screen (FCS) of 3/15/16 assessed #189 in need of physical assistance (2) with bathing, dressing, toileting, transfers, mobility; independent with eating; unable to perform (3) medication and treatment management; with incontinence, impaired cognition, falls/unsteadiness, and impaired decision making.	S5185		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087196	A. BUILDING: _____ B. WING _____	05/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEACE OF MIND LLC II	223 N BURR OAK RD PO BOX 173 WICHITA, KS 67206

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5185	Continued From page 12 The negotiated service agreement (NSA) of 3/15/16 indicated facility staff to provide services to meet these identified needs. The medical record contained a 5/09/16 physician's diet order: 2 gm (gram) Na (sodium) High Protein diet The medical record contained a 5/17/16 physician's diet order: Extra protein portions. These diet orders were added to the current MAR (medication administration record), but not added to the NSA. By observation on 5/24/16 at 10:30am, #189 left facility for dialysis treatment with lunch. By interview of certified staff #K, contents of lunch included applesauce, fruit cup, tuna sandwich (approximately 600 to 800mg Na), bag of chips approximately 200mg of Na), and contained of Nepro liquid supplement drink (approximately 250mg Na). The Operator failed to ensure the diets for Residents with orders for therapeutic diets, accompanied by written instructions for preparation, signed by a physician or licensed dietician.	S5185		
S5300 SS=D	26-42-205 (d) (1-2) Facility Administration of Medications (d) Home administration of resident ' s medications. If a home is responsible for the administration of a resident ' s medications, the administrator or operator shall ensure that all medications and biologicals are administered to that resident in accordance with a medical care provider ' s written order, professional standards	S5300		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087196	A. BUILDING: _____ B. WING _____	05/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEACE OF MIND LLC II	223 N BURR OAK RD PO BOX 173 WICHITA, KS 67206

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5300	Continued From page 13 of practice, and each manufacturer ' s recommendations. The administrator or operator shall ensure that all of the following are met: (1) Only licensed nurses and medication aides shall administer and manage medications for which the home has responsibility. (2) Medication aides shall not administer medication through the parenteral route. This REQUIREMENT is not met as evidenced by: KAR 26-42-205(d) The census equalled eight the sample included three Residents. The Resident roster identified all Residents as receiving medication management. Based on interview and record review, for one of three sampled with medication management (#185), the Operator failed to ensure all medications and biologicals administered to Residents in accordance with written medical care provider orders, and in accordance with professional standards of practice. Findings included: - Record review revealed #185 admitted to facility 5/22/13 with diagnoses of Diabetes, Hypertension, Atrial fibrillation, Septic arthritis, Dementia, Hypothyroidism, Chronic obstructive pulmonary disease, and Hypercoagulable state. The current 5/02/16 functional capacity screen (FCS) assessed #185 unable to perform (3) medication and treatment management. The 5/02/16 negotiated service agreement (NSA) documented #185 to receive medication	S5300		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087196	A. BUILDING: _____ B. WING _____	05/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEACE OF MIND LLC II	223 N BURR OAK RD PO BOX 173 WICHITA, KS 67206

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5300	Continued From page 14 management by facility nurses and certified medication aides. Comparison of the May 15 - June 14, 2016 MAR (medication administration record) with signed medical care provider orders revealed a discrepancy: 5/11/16 order documented "Colace 100mg (milligrams) every day" According to MAR, Colace 100mg scheduled and documented as given twice daily at 0800 and 1700 each day 05/15/16 to 05/23/16. By interview on 5/23/16 at 6:10pm, Facility Nurse #C stated that order was changed on the previous MAR (April 15 - May 14, 2016) to the new order for daily. By review of previous MAR, the new Colace order was changed and documented correctly as daily, from 5/11/16 to 5/13/16. By interview, Facility Nurse #C stated the pharmacy usually sends us the new MAR's on the 7th or 8th of the month... I checked them all on the 9th... when the new order came on 5/11/16 I got it on the old MAR but missed putting it on the new MAR. The Operator failed to ensure #185 received all medications in accordance with written order and in accordance with professional standards of practice.	S5300		
S5335 SS=E	28-39-437 Construction (a) Each home-plus facility shall be designed, constructed, equipped, and maintained to protect	S5335		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087196	A. BUILDING: _____ B. WING _____	05/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEACE OF MIND LLC II	223 N BURR OAK RD PO BOX 173 WICHITA, KS 67206

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5335	Continued From page 15 the health and safety of residents, personnel, and the public. (b) All new construction, renovation, remodeling, and changes in building use in existing buildings shall comply with building and fire codes, ordinances, and regulations enforced by city, county, and state jurisdictions, including the state fire marshal. This REQUIREMENT is not met as evidenced by: KAR 28-39-437 The census equalled eight the sample include three Residents. The facility identified six with impaired cognitive status. Based on observations and interviews, for cognitively impaired Residents, family members, or visitors to facility, the Operator failed to ensure: Each home plus designed, constructed, equipped, and maintained to protect the health and safety of Residents, personnel, and the public, in regard to the locking mechanism of one of two front entry doors. Findings included: - During the entrance of facility on 5/23/16 at 12:00pm observed the front door of facility with locking outer door that did not automatically release with activation of the handle from the inside. The outer front door (plate glass), locked at the time of approach and entrance to facility, contained an interior handle and a grasp and twist button locking device. By observation and attempts to open this door from the inside, the handle did not function to release the door if pushed down in the typical manner, the handle	S5335		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087196	A. BUILDING: _____ B. WING _____	05/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEACE OF MIND LLC II	223 N BURR OAK RD PO BOX 173 WICHITA, KS 67206

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5335	Continued From page 16	S5335		

required an upward action. In addition an oval shaped grasp and twist locking mechanism above the handle required disengagement for the door to open.

The interior front door, locked from the outside at the time of approach and entrance to facility, contained a door knob on the inside, and door knob with a key hole on the outside. This door released from the inside automatically when the door knob turned in the typical fashion.

Upon entrance when staff answered the door bell, a mechanical alert announced loudly "front door" to alert staff the front interior door opened.

By interview on 5/23/16 at 12:22pm, Facility nurse #C confirmed the interior door always locked and automatically released the door for exiting when the door knob turned in the usual manner. Facility nurse #C confirmed the outside plate glass door did not release with the customary downward motion of the door handle, but required an upward motion, and in addition, one had to grasp and twist the oval locking mechanism, and then pull up on the handle in order to exit the building.

On 5/24/16 at 4:55pm, Owner/Operator #D confirmed the outer plate glass door did not automatically release with the customary downward motion of the door handle... stated we can remove the locking bolt part of that grasp and turn piece so door will still look nice, latch, but not lock... stated we were just trying to supplement safety features for our Residents by having two locking front doors instead of one.

The Operator failed to ensure the home plus designed, constructed, equipped, and maintained to protect the health and safety of Residents,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087196	A. BUILDING: _____ B. WING _____	05/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEACE OF MIND LLC II	223 N BURR OAK RD PO BOX 173 WICHITA, KS 67206

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5335	Continued From page 17 personnel, and the public, in regard to the locking mechanism of front outer plate glass entry door.	S5335		
S5380 SS=L	28-39-437 Plumbing and Piping Systems (i) Plumbing and piping systems. (1) Backflow prevention devices or vacuum breakers shall be installed on fixtures to which hoses or tubing can be attached. (2) Water distribution systems shall be arranged to provide hot water at hot water outlets at all times. The temperature of hot water shall range between 98° F and 120° F at showers, tubs, and lavatories accessible to residents. This REQUIREMENT is not met as evidenced by: KAR 28-39-437(i)(2) The census equalled eight, the sample included three Residents. The Owner/Operator identified one water heater used to supply the entire facility, including the four accessible hand wash sinks. Based on observation and interviews for 2 of the 8 (#184, #187) residents who were ambulatory and for 2 of 8 (#186, #189) capable of washing their own hands if placed in front of the sink, the Owner/Operator failed to ensure the water remained between 98 degrees Fahrenheit (F) and 120 degrees F at all times. The temperatures at time of entrance on 5/23/16 in the four sinks accessible to residents ranged from 145.7 degrees Fahrenheit (F) to 149 degrees F placing these residents in immediate jeopardy for harm or injury. The facility Resident Roster identified six Residents with Impaired Cognitive Status (#185,	S5380		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087196	A. BUILDING: _____ B. WING _____	05/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEACE OF MIND LLC II	223 N BURR OAK RD PO BOX 173 WICHITA, KS 67206

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5380	Continued From page 18 #182, #184, #186, #188, and, #189). The facility Resident Roster identified all eight Residents in need of toileting/bathing assistance. Facility staff identified two Residents able to ambulate facility independently with walker (#187 and #184). Facility staff identified two Residents able to wash own hands if placed in front of sink by staff (#186 and #189). Findings included: - During the entrance tour of facility on 5/23/16 at 12:20pm, accompanied by Facility Nurse #C, the following water temperatures were obtained: Resident bathroom attached to resident room #1A and #1B - 146.3 degrees Fahrenheit (F.) Resident hall bathroom with two sinks - Left sink 146.4 degrees F.; Right sink 145.7 degrees F. Kitchen sink - 149.0 F. Visitor/Staff bathroom near kitchen and laundry - 148.1 degrees F. These temperatures verified visually with Facility Nurse #C. Surveyor's thermometer compared with facility thermometer which revealed a five degree difference between the two - surveyor's thermometer at 147 degrees F. and facility thermometer at 142 degrees F. 5/23/16 at 12:55pm, Facility Nurse #C stated " the staff checks the water temperatures every night. " 5/23/16 at 12:55pm, by observation, when Facility Nurse #C checked the hot water with the facility thermometer, he/she failed to place the designated "notch" (temperature sensing area) of	S5380		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087196	A. BUILDING: _____ B. WING _____	05/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEACE OF MIND LLC II	223 N BURR OAK RD PO BOX 173 WICHITA, KS 67206

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5380	Continued From page 19	S5380		

stem in hot running water to register an accurate temperature.

By review of water temperature logs dated 01/05/16 to 5/22/16 documented all temperatures logged lower than the required 120 degrees F except on 2/14/16 when two temperatures recorded at 125 degrees and 126 degrees F. The 5/22/16 temperatures recorded as 110 and 112 degrees F.

5/23/16 at 1:45pm Owner/Operator (O/O) #D notified of elevated water temperatures. O/O #D and Facility Nurse #C confirmed no facility policy and procedure for hot water surveillance. O/O stated " I will have maintenance staff #G come to facility to correct the hot water situation. "

5/23/16 at 2:50pm Surveyor's thermometer calibrated with ice water and registered at 33 degrees F. (desired 32 degrees). O/O #D, and Facility Nurse #C not aware of thermometer calibration process.

5/23/16 at 3:12pm, Maintenance staff #G arrived and lowered water heater setting and began running water at sink faucets to lower tank temperature. #G was not aware of calibration process for thermometers. Facility thermometer open to room air registered 40 degrees F and when placed in ice water continued to registered 40 degrees F.

Re-check of resident hall bathroom with two sinks at 3:22pm revealed water temperatures of 118, 117, and 116 degrees F.

Random observations throughout 5/23/16 in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087196	A. BUILDING: _____ B. WING _____	05/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEACE OF MIND LLC II	223 N BURR OAK RD PO BOX 173 WICHITA, KS 67206

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5380	Continued From page 20	S5380		

general living areas revealed residents accompanied by staff when ambulating with walkers. No observations in general living ambulation of residents using hand sinks unattended by staff.

On 5/23/16 at 6:15pm, O/O #D provided written Water Temp Correction Statement: "Maintenance came and turned down on water heater. A thermometer will be placed in the line to the hot water heater to check daily water temperatures against. Staff will be educated on how to accurately check the temperature of the water. Staff will check water temperatures each night. If water temperatures are greater than 110 degrees staff will notify O/O #D, Facility Nurse #C, or Owner #F. The daily temperatures will be checked against the thermometer in the hot water heater line by the nurse to ensure accuracy."

On 5/24/16 at 8:45am, recheck of facility water temperatures revealed:

Resident bathroom attached to resident room #1A and #1B - 136.2 degrees Fahrenheit (F.)
Resident hall bathroom with two sinks - left sink 135.5 degrees F.
Kitchen sink - 134.2 F.
Visitor/Staff bathroom near kitchen and laundry - 133.3 degrees F.

5/24/16 at 9:10am, O/O #D and Owner #F notified of continued elevated hot water temperatures... stated will have maintenance staff #G return and lower temperature again.

5/24/16 at 12:30pm, recheck of facility water temperatures revealed:

Resident bathroom attached to resident room

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087196	A. BUILDING: _____ B. WING _____	05/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEACE OF MIND LLC II	223 N BURR OAK RD PO BOX 173 WICHITA, KS 67206

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5380	Continued From page 21 #1A and #1B - 134 degrees Fahrenheit (F.) Resident hall bathroom with two sinks - 134.4 degrees F. Kitchen sink - 130.6 degrees F. Visitor/Staff bathroom near kitchen and laundry - 133.5 degrees F. 5/24/16 at 12:30pm, O/O #D reported will have maintenance staff #G return to facility to lower water heater temperature. 5/24/16 at 2:12pm, no observed arrival of Maintenance staff #G to lower water heater temperature. Random observations throughout 5/24/16 in general living areas revealed staff accompanied residents when ambulating with walkers. No observations in general living area ambulation of Residents using hand sinks unattended by staff. 5/24/16 at 4:22pm, water temperature in Resident Hall Bathroom with two sinks remained at 132.8 degrees F. 5/24/16 at 4:30pm, O/O #D stated Owner #F reported maintenance staff #G at another job... still planning to come and turn it down. Surveyor requested a plan for safety of Residents. 5/24/16 at 5:00pm, O/O #D provided written plan: "Will first have the water temp adjusted again. Thereafter will have facility staff 1st and 3rd shift check every two hours. Also O/O #D and Facility Nurse #C will check to make sure temps [temperatures] are correct." According to Department policy and procedure, tissue destruction possible: at 149 degrees F. in 1 - 2 seconds;	S5380		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087196	A. BUILDING: _____ B. WING _____	05/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEACE OF MIND LLC II	223 N BURR OAK RD PO BOX 173 WICHITA, KS 67206

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5380	Continued From page 22 at 140 degrees F. in 5 seconds; at 133 degrees F. in 15 seconds; and at 131 degrees F. in 30 seconds. For 2 of the 8 (#184, #187) Residents who were ambulatory and for 2 of 8 (#186, #189) capable of washing their own hands if placed in front of the sink, the Owner/Operator failed to ensure the water remained between 98 degrees Fahrenheit (F) and 120 degrees F at all times. The temperatures at time of entrance on 5/23/16 in the four sinks accessible to residents ranged from 145.7 degrees Fahrenheit (F) to 149 degrees F placing these residents in immediate jeopardy for harm or injury. The jeopardy was corrected on 5/24/16 when the operator provided a plan to adjust the hot water temperature and institute ongoing monitoring.	S5380		