STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087042	A. BUILDING: _____ B. WING _____	03/07/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HOMESTEAD OF WICHITA	12221 W MAPLE ST WICHITA, KS 67235

(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 represent the findings of an abbreviated survey for the investigation of complaints #92991 and #94247 of the above assisted living facility on 2/25/16, 2/29/16, 3/1/16, 3/2/16, 3/10 and 3/14/2016	S 000		
S3026 SS=J	26-41-101 (f) (1) Staff Treatment of Residents ANE (f)The administrator or operator shall ensure that all of the following requirements are met: (1) No resident shall be subjected to any of the following: (A) Verbal, mental, sexual, or physical abuse, including corporal punishment and involuntary seclusion; (B) neglect; or (C) exploitation. This REQUIREMENT is not met as evidenced by: KAR 26-41-101 (f) (1) (b) The facility reported a census of 41 residents. The sample included 4 residents and 3 closed records reviewed. The operator failed to provide service reasonably necessary to ensure safety and well-being and avoid physical harm or illness on when resident #5 received food items not listed on the mechanical soft diet plan and choked in the dining room. The licensed nurse further failed to conduct follow up assessment and seek medical care related to choking episodes. These failures placed the resident in immediate jeopardy for harm, injury, or death. Findings included:	S3026		

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

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S3026	Continued From page 1 During review of resident roster at 2:40 p.m. on 2/25/16, licensed nurse #A stated (resident #5) was currently in the hospital due to aspiration pneumonia. Record review for resident #5 revealed an admission date of 12/31/15 with diagnoses that included of dysphagia. The record contained an inter-agency transfer form dated and signed by a medical care provider 12/30/15 from a skilled nursing facility with an order and instructions for a regular soft diet with nectar thick liquids. The resident was to double swallow for each drink, clear throat, to be upright for 30 minutes after eating/drinking, and no straws. The record contained a medical care provider's order dated 1/7/16 to change to a regular mechanical soft diet. The functional capacity screen dated 12/31/15 indicated the resident was independent with eating and experienced impaired short-term memory. The negotiated service agreement/health care service plan (NSA/HCSP) dated 12/31/15 recorded dietary services of a regular mechanical soft diet and liquids to be nectar thickened. The NSA/HCSP documented "Staff to remind (resident) to eat slow and to take a drink after each bite to aid in less coughing/choking. (Resident) should not use straws at this time, usage causes swallowing difficulties." Clinical notes contained the following entries by licensed nurse #A:	S3026		

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S3026	Continued From page 2 1/2/16 at 3:59 p.m. resident arrived to the facility at 10:45 a.m. on 12/31/15. Will contact (home health agency) about doing a speech evaluation to clarify diet order. Resident has been having some difficulty with swallowing. Thickener has been provided to make liquids nectar consistency per order from rehab (rehabilitation) hospital. 1/15/16 at 4:59 p.m. speech therapist in today to evaluate resident. The therapist stated he/she would work with resident ' s swallowing and some cognition exercises. 2/24/16 at 10:56 a.m. licensed nurse #A documented "On 2/23/16 resident had a choking spell at lunch on a tortilla shell. Staff helped (resident) clear throat and get food out. Later CMA (certified medication aide) reported that resident yelled help later in the afternoon and when (CMA) went to (resident) room (CMA) found (resident) holding Fixodent and it was all over (resident's) mouth in a large amount. (CMA) did not know if (resident) swallowed any. Later in the evening around 1900 (7:00 p.m.) resident's (family member) came to visit and told staff (he/she) thought resident sounded congested and was coughing up a lot of phlegm. Resident told (family member) (resident) wanted to go the hospital so (family member) took (resident). Hospital called back later and told a staff member that (resident's) lungs were full and (resident) was admitted." Note: the resident ' s record lacked documentation of an assessment by a licensed nurse that included resident ' s lung sounds, oxygen saturation, and vital signs. The record lacked documentation the licensed nurse notified the resident ' s medical care provider and the	S3026		

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S3026	Continued From page 3	S3026		

resident ' s family member.

Review of the hospital emergency room (ER) record documented resident with a pulse oximetry (measure the oxygen level (oxygen saturation) of the blood) reading of 77% when resident #5 arrived in ER. A reading of 95 % or above is considered normal and a level less than 92% is consider low blood oxygen.

Review of hospital admission history and physical dated 2/23/16 documented he/she " was found to initially be hypoxic (body had an inadequate supply of oxygen) having oxygen requirement at 15 (L) liters " Assessment and plan: 1. Acute hypoxemic respiratory failure, currently on 9 L nasal cannula. This is most likely secondary to aspiration. . . 2. Aspiration pneumonia. ..3. Congestive heart failure. . .

By interview at 12:25 p.m. on 2/29/16, dietary staff #B confirmed resident #5 received a mechanical soft diet. Dietary staff #B stated a speech therapist was working with resident #5 and determined resident required a mechanical soft diet due to resident choking on "everything." Follow up interview on 3/1/16 at 10:20 a.m. with dietary staff #B referred to copy of production sheet showing the menu for the day. The supper menu for ' taco Tuesday ' was served at lunch included hamburger and a soft tortilla with substitution of taco burger on a bun for mechanical soft. Certified staff #B stated resident #5 was not given bun " because he/she chokes on bread "

During an interview at 11:20 a.m. on 3/1/16, licensed nurse #A stated he/she interviewed 2

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S3026	Continued From page 4	S3026		

staff members regarding the resident choking on food served at lunch on 2/23/16 with one staff member stating the resident choked on lettuce and another stating resident choked on the tortilla shell. Licensed nurse #A stated he/she did not conduct an investigation in order to determine if staff member served the resident foods allowed and prepared according to a mechanical soft diet.

At 12:20 p.m. on 3/1/16, certified staff #D stated he/she served a plate to resident at lunch on 2/23/16 of taco meat and sauce rolled in a soft tortilla and possibly some refried beans. Certified staff #D stated the taco was not cut up and that resident held the taco to eat.

At 12:30 p.m. on 3/1/16, certified staff #E provided a written statement that at noon on 2/23/16 he/she was passing medications in the dining room when he/she heard resident (#5) choking. As he/she walked toward the resident he/she observed a large piece of tortilla come out of resident's mouth. Resident stated he/she was okay but did not want any more to eat. Certified staff #E wrote that he/she went to report the incident to the nurse but the nurse was at lunch. Then at approximately 12:40 p.m. on 2/23/16, he/she heard resident yell for help from the resident's room. Certified staff #E went to the resident's room and found resident with dentures out of his/her mouth and resident stated "I choked on a mouth full of Fixodent." and certified staff #E observed a large amount of Fixodent in the trash can. Certified staff #E wrote that he/she reported this to the nurse who went to assess the resident.

Licensed nurse #A provided a written statement

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S3026	Continued From page 5 at 12:30 p.m. on 3/1/16 that documented he/she was made aware by certified staff members between 1:00 p.m. and 2:00 p.m. on 2/23/16 of resident's choking episode at lunch and choking on Fixodent. Licensed nurse #A assessed the resident's lungs and documented "clear bilaterally but (resident) was congested up higher in chest area and still coughing. Resident finally stopped coughing continually about 15 minutes later." Licensed nurse #A documented that he/she instructed the aides to keep an eye on (resident) and if anything changed to let this nurse know. Around 7:00 p.m. on 2/23/16 certified staff member notified nurse that a family member took resident to the hospital. At 4:45 p.m. on 2/29/16, licensed nurse #F provided written instructions for mechanical soft diet that included the use of this diet for people with dysphagia individualized and modified according to recommendations by a speech language pathologist for the specific food tolerances of the resident. A mechanical soft diet excludes foods that are very hard, sticky, crunchy, or hard to chew. Food should be moist and fork tender. Meat is ground our shopped into bite-size pieces (1/2 inch or smaller). . .Vegetables are cooked soft, moist and fork tender . . No raw vegetables are planned except finely shredded lettuce and diced tomatoes. Dry, hard crusty breads are excluded. Speech language pathologist evaluation dated 2/10/16 recommended: " Resident should continue on a mechanical soft diet with nectar thickened liquids. Resident did well with taking small bites and swallowing before taking another bite but (resident ' s) chewing and movement of food slowed as meal progressed. "	S3026		

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S3026	Continued From page 6 Review of facility policy for ' mechanically altered food preparation ' stated diet spread sheets (menu production sheet) will be used for all mechanical soft and puree diets. Production sheet provided 3/1/16 Mechanical soft diet substitute taco burger on bun for soft taco for noon meal 2/23/16. Resident #5 choked after being served a meal that contained food not listed on the diet plan. A short time later, the resident was again found choking in his room after attempting to replace his dentures. The licensed nurse failed to notify the physician and family and failed to monitor the resident ' s respiratory status. The resident was taken to the emergency room by his/her family with an initial pulse oximetry reading of 77 and admitted with a diagnosis of acute respiratory failure due to aspiration. The facility failed to provide service reasonably necessary to ensure safety and well-being and avoid physical harm or illness on 2/23/16 when resident #5 received food not listed on the mechanical soft diet plan and when the licensed nurse failed conduct follow up assessment and seek medical care following two choking episodes. These failures placed the resident in immediate jeopardy for harm, injury, or death. The jeopardy was corrected on 3/2/16 when the facility implemented changed in dietary services to include education of all staff preparing and serving food regarding individuals receiving	S3026		

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S3026	Continued From page 7 special diets and procedures for monitoring and reviewing production sheets outlining requirements for each meal.	S3026		
S3028 SS=E	26-41-101 (f) (3) Staff Treatment of Residents Reporting (f) (3) Each allegation of abuse, neglect, or exploitation shall be reported to the administrator or operator of the facility as soon as staff is aware of the allegation and to the department within 24 hours. The administrator or operator shall ensure that all of the following requirements are met: (A) An investigation shall be started when the administrator or operator, or the designee, receives notification of an alleged violation. (B) Immediate measures shall be taken to prevent further potential abuse, neglect, or exploitation while the investigation is in progress. (C) Each alleged violation shall be thoroughly investigated within five working days of the initial report. Results of the investigation shall be reported to the administrator or operator. (D) Appropriate corrective action shall be taken if the alleged violation is verified. (E) The department ' s complaint investigation report shall be completed and submitted to the department within five working days of the initial report. (F) A written record shall be maintained of each investigation of reported abuse, neglect, or exploitation. This REQUIREMENT is not met as evidenced by: KAR 26-41-101(f)(3)(A)(C)(E)	S3028		

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S3028	Continued From page 8 The facility reported a census of 41 residents. The sample included 4 residents and 3 closed records reviewed. Based on record review and interview for 1 (#5) of 4 residents sampled, the operator failed to ensure an allegation of resident neglect was reported to the department within 24 hours and failed to conduct a thorough investigation of the incident. Based on record review and interview for 1 (#8) of 3 closed records reviewed, the operator failed to conduct a thorough investigation of an incident reported by a facility staff member to the department and failed to submit an investigation report to the department within 5 working days of the initial report. Findings included: - At 2:40 p.m. on 2/25/16, licensed nurse #A stated (resident #5) was currently in the hospital due to aspiration pneumonia. Record review for resident #5 revealed an admission date of 12/31/15 and diagnoses of dysphagia, hypertension, muscle weakness, and hypothyroidism. The functional capacity screen dated 12/31/15 indicated the resident was independent with eating and experienced impaired short-term memory. The negotiated service agreement/health care service plan (NSA/HCSP) dated 12/31/15 recorded dietary services of a regular mechanical soft diet and liquids to be nectar thickened. The NSA/HCSP documented "Staff to remind (resident) to eat slow and to take a drink after each bite to aid in less coughing/choking.	S3028		

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(Resident) should not use straws at this time, usage causes swallowing difficulties."

The clinical notes contained an entry by licensed nurse #A at 10:56 a.m. on 2/24/16 as follows: "On 2/23/16 resident had a choking spell at lunch on a tortilla shell. Staff helped (resident) clear throat and get food out. Later CMA (certified medication aide) reported that resident yelled help later in the afternoon and when (CMA) went to (resident) room (CMA) found (resident) holding Fixodent and it was all over (resident's) mouth in a large amount. (CMA) did not know if (resident) swallowed any. Later in the evening around 1900 (7:00 p.m.) resident's (family member) came to visit and told staff (he/she) thought resident sounded congested and was coughing up a lot of phlegm. Resident told (family member) (resident) wanted to go the hospital so (family member) took (resident). Hospital called back later and told a staff member that (resident's) lungs were full and (resident) was admitted."
At 10:59 a.m. on 2/26/16, licensed nurse #A documented he/she spoke with a nurse at the hospital and was informed resident would have a PEG tube (percutaneous endoscopic gastrostomy feeding tube) placed today and would require feedings and medications administered through the PEG tube.

The record contained an inter-agency transfer form dated and signed by a medical care provider 12/30/15 from a skilled nursing facility with an order and instructions for a regular soft diet with nectar thick liquids, (resident) to double swallow for each drink, clear throat, to be upright for 30 minutes after eating/drinking, and no straws.

The record contained a medical care provider's order dated 1/7/16 to change to a regular

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mechanical soft diet.

At 12:25 p.m. on 2/29/16, dietary staff #B confirmed resident #5 received a mechanical soft diet. Dietary staff #B stated a speech therapist was working with resident #5 and determined resident required a mechanical soft diet due to resident choking on "everything."

During an interview at 11:20 a.m. on 3/1/16, licensed nurse #A stated he/she interviewed 2 staff members regarding the resident choking on food served at lunch on 2/23/16 with one staff member stating resident choked on lettuce and another stating resident choked on the tortilla shell. Licensed nurse #A stated he/she did not conduct an investigation in order to determine if staff member served the resident foods allowed and prepared according to a mechanical soft diet and did not report the incident to the department.

At 12:20 p.m. on 3/1/16, certified staff #D stated he/she served a plate to resident at lunch on 2/23/16 of taco meat and sauce rolled in a soft tortilla and possibly some refried beans. Certified staff #D stated the taco was not cut up and that resident held the taco to eat.

At 12:30 p.m. on 3/1/16, certified staff #E provided a written statement that at noon on 2/23/16 he/she was passing medications in the dining room when he/she heard resident (#5) choking. As he/she walked toward the resident he/she observed a large piece of tortilla come out of resident's mouth. Resident stated he/she was okay but did not want any more to eat. Certified staff #E wrote that he/she went to report to the nurse but nurse was at lunch. Then at approximately 12:40 p.m. on 2/23/16, he/she heard resident yell for help from the resident's

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room. Certified staff #E went to the resident's room and found resident with dentures out of mouth and resident stated "I choked on a mouth full of Fixodent." and certified staff #E observed a large amount of Fixodent in the trash can. Certified staff #E wrote that he/she reported this to the nurse who went to assess the resident.

Licensed nurse #A provided a written statement at 12:30 p.m. on 3/1/16 that documented he/she was made aware by certified staff members between 1:00 p.m. and 2:00 p.m. on 2/23/16 of resident's choking episode at lunch and choking on Fixodent. Licensed nurse #A assessed the resident's lungs and documented "clear bilaterally but (resident) was congested up higher in chest area and still coughing. Resident finally stopped coughing continually about 15 minutes later." Licensed nurse #A documented that he/she instructed the aides to keep an eye on (resident) and if anything changed to let this nurse know. Around 7:00 p.m. on 2/23/16 certified staff member notified nurse that a family member took resident to the hospital.

For resident #5, the operator failed to ensure an allegation of resident neglect was reported to the department within 24 hours and failed to conduct a thorough investigation.

- On 11/30/15, a facility staff member reported to the department that resident (#8) called for assistance to get out of bed to bathroom at 1:15 a.m. on 11/28/15 and fell while ambulating to the bathroom with a staff member present in the resident's room. Resident experienced a compound fracture of the tibia and required hospitalization for surgery on 11/28/15 to repair the fracture. The reporter stated resident would then require a second surgery to place a rod in

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the fractured leg. The facility did not submit results of the investigation to the department.

Closed record review for resident #8 revealed an admission date of 11/17/14 and diagnoses of diabetes and hypertension.

The functional capacity screen dated 9/10/15 indicated the resident was independent with toileting, transferring, and mobility and was at risk for falls.

The record contained a negotiated service agreement that lacked a date and interventions to address the resident's risk for falls.

The clinical notes lacked documentation of a fall on 11/28/15. The last entry in the clinical notes was dated 10/23/15 and documented a visit by the medical care provider with new medication orders received.

At 12:50 p.m. on 3/1/16, licensed nurse #F stated he/she could not locate an investigation of the resident's fall. Licensed nurse #F provided a written statement by certified staff #G pertaining to a fall experienced by resident #8 at 1:10 a.m. on 11/11/15. Certified staff #G wrote that resident called for assistance to change clothes. Certified staff member #G assisted resident to stand up to walker with resident then walking to bathroom. Resident stated (he/she) was not steady and when certified staff moved away to get wheelchair resident fell in bathroom doorway. Resident fell on to left side with left foot twisted and blood coming from leg. Nurse and paramedics notified. Resident transported by ambulance to hospital at 1:56 a.m.

For resident #8, the operator failed to conduct a

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(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
S3028	Continued From page 13 thorough investigation of an incident reported by a facility staff member to the department and failed to submit an investigation report to the department within 5 working days of the initial report.	S3028		
S3261 SS=E	26-41-105 (f) (11) Resident Record Documentation of Incidents (f) (11) documentation of all incidents, symptoms, and other indications of illness or injury including the date, time of occurrence, action taken, and results of the action This REQUIREMENT is not met as evidenced by: KAR 26-41-105(f)(11) The facility reported a census of 41 residents. The sample included 4 residents and 3 closed records reviewed. Based on record review and interview for 1 (#5) and 1 (#8) of 3 closed records reviewed, licensed nurses failed to ensure each resident ' s record contained documentation of incidents, symptoms, and other indications of illness or injury including the date, time of occurrence, action taken, and results of the action. Findings included: - At 2:40 p.m. on 2/25/16, licensed nurse #A stated (resident #5) was currently in the hospital due to aspiration pneumonia. Record review for resident #5 revealed an	S3261		

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	N087042	A. BUILDING: _____ B. WING _____	03/07/2016

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S3261	Continued From page 14	S3261		

admission date of 12/31/15 and diagnoses of dysphagia, hypertension, muscle weakness, and hypothyroidism.

The functional capacity screen dated 12/31/15 indicated the resident was independent with eating and experienced impaired short-term memory.

The negotiated service agreement/health care service plan (NSA/HCSP) dated 12/31/15 recorded dietary services of a regular mechanical soft diet and liquids to be nectar thickened. The NSA/HCSP documented "Staff to remind (resident) to eat slow and to take a drink after each bite to aid in less coughing/choking. (Resident) should not use straws at this time, usage causes swallowing difficulties."

The clinical notes contained an entry by licensed nurse #A at 10:56 a.m. on 2/24/16 as follows: "On 2/23/16 resident had a choking spell at lunch on a tortilla shell. Staff helped (resident) clear throat and get food out. Later CMA (certified medication aide) reported that resident yelled help later in the afternoon and when (CMA) went to (resident) room (CMA) found (resident) holding Fixodent and it was all over (resident's) mouth in a large amount. (CMA) did not know if (resident) swallowed any. Later in the evening around 1900 (7:00 p.m.) resident's (family member) came to visit and told staff (he/she) thought resident sounded congested and was coughing up a lot of phlegm. Resident told (family member) (resident) wanted to go the hospital so (family member) took (resident). Hospital called back later and told a staff member that (resident's) lungs were full and (resident) was admitted."

The clinical notes lacked documentation of an

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S3261	Continued From page 15	S3261		

assessment of the resident by a licensed nurse after each choking incident and action taken.

During an interview at 11:20 a.m. on 3/1/16, licensed nurse #A stated he/she learned about the resident choking on food at lunch when staff informed her/him of resident choking on Fixodent. Licensed nurse #A stated he/she could not remember the time of the assessment but it was after resident choked on Fixodent. Licensed nurse #A confirmed he/she did not document the assessment and action taken.

At 12:30 p.m. on 3/1/16, licensed nurse #A provided a written statement that documented he/she was made aware by certified staff members between 1:00 p.m. and 2:00 p.m. on 2/23/16 of resident's choking episode at lunch and choking on Fixodent. Licensed nurse #A assessed the resident's lungs and documented "clear bilaterally but (resident) was congested up higher in chest area and still coughing. Resident finally stopped coughing continually about 15 minutes later." Licensed nurse #A documented that he/she instructed the aides to keep an eye on (resident) and if anything changed to let this nurse know. Around 7:00 p.m. on 2/23/16 certified staff member notified nurse that a family member took resident to the hospital.

For resident #5, a licensed nurse failed to ensure the resident ' s record contained documentation of all incidents and other indications of illness or injury including the date, time of occurrence, action taken, and results of the action.

- On 11/30/15, a facility staff member reported to the department that resident (#8) called for assistance to get out of bed to bathroom at 1:15 a.m. on 11/28/15 and fell while ambulating to the

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bathroom with a staff member present in the resident's room. Resident experienced a compound fracture of the tibia and required hospitalization for surgery on 11/28/15 to repair the fracture. The reporter stated resident would then require a second surgery to place a rod in the fractured leg.

Closed record review for resident #8 revealed an admission date of 11/17/14 and diagnoses of diabetes and hypertension.

The functional capacity screen dated 9/10/15 indicated the resident was independent with toileting, transferring, and mobility and was at risk for falls.

The record contained a negotiated service agreement that lacked a date and interventions to address the resident's risk for falls.

At 12:50 p.m. on 3/1/16, licensed nurse #F provided a written statement by certified staff #G pertaining to a fall experienced by resident #8 at 1:10 a.m. on 11/11/15. Certified staff #G wrote that resident called for assistance to change clothes. Certified staff member #G assisted resident to stand up to walker with resident then walking to bathroom. Resident stated (he/she) was not steady and when certified staff moved away to get wheelchair resident fell in bathroom doorway. Resident fell on to left side with left foot twisted and blood coming from leg. Nurse and paramedics notified. Resident transported by ambulance to hospital at 1:56 a.m.

The last entry in the clinical notes was dated 10/23/15 and documented a visit by the medical care provider with new medication orders received. The clinical notes lacked

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S3261	Continued From page 17 documentation of a fall on 11/11/15 and/or on 11/28/15 including injuries and resident's admission to the hospital, Licensed nurse #F confirmed a licensed nurse did not document the resident's fall with fracture, action taken and results of the action. For resident #8, a licensed nurse failed to ensure the resident ' s record contained documentation of incidents and other indications of injury including the date, time of occurrence, action taken, and results of the action.	S3261		