STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087162	A. BUILDING: _____ B. WING _____	09/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARJORIE'S HOME LLC	14601 TIMBER LAKE RD WICHITA, KS 67230

(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 a resurvey of the above home plus facility on 9/21/15 and 9/22/15. revised 2567 mailed to facility 10/9/15	S 000		
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) The facility reported a census of 7 residents. The sample included 3 residents. Based on record review, observation, and interview for 1 (#200) of 1 resident requiring a pureed diet and thickened liquids, the operator/licensed nurse failed to ensure the diet and liquids were prepared according to instructions from a medical care provider or licensed dietitian. Findings included:	S5185		

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
	B087162	A. BUILDING: _____ B. WING _____	09/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARJORIE'S HOME LLC	14601 TIMBER LAKE RD WICHITA, KS 67230

(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 1 - Record review for resident #200 revealed an admission date of 10/1/11 and a diagnosis of dementia. The functional capacity screen dated 9/3/15 indicated the resident was unable to feed self. The negotiated service agreement and health care service plan dated 9/3/15 contained documentation dated 9/15/15 that resident required a pureed diet and thickened liquids. The record contained a diet order written 9/15/15 by a hospice licensed nurse and signed by a medical care provider on 9/16/15 of "Patient to have puree diet due to pocketing of food." At 12:30 p.m. on 9/21/15, observed certified staff #C feeding resident #200 pureed food. During an interview at 2:45 p.m. on 9/21/15, licensed nurse #A stated staff did not have instructions from a medical care provider or a licensed dietitian on how to prepare a pureed diet and thickened liquids. The operator/licensed nurse failed to ensure certified staff prepared a pureed diet and thickened liquids for resident #200 according to instructions from a medical care provider or licensed dietitian.	S5185		
S5335 SS=F	28-39-437 Construction (a) Each home-plus facility shall be designed, constructed, equipped, and maintained to protect the health and safety of residents, personnel, and the public. (b) All new construction, renovation, remodeling, and changes in building use in existing buildings	S5335		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087162	A. BUILDING: _____ B. WING _____	09/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARJORIE'S HOME LLC	14601 TIMBER LAKE RD WICHITA, KS 67230

(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 2 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(a) The facility reported a census of 7 residents. The sample included 3 residents. Based on observation, record review, and interview for all residents, the operator/licensed nurse failed to ensure staff maintained a safe environment. Findings included: - Upon entrance to the facility at 9:45 a.m. on 9/21/15, observed resident #300 quickly wheeling self in a wheelchair throughout the dining room, kitchen, and west hallway. Resident #300 opened the bathroom door located at the end of the kitchen and tried to open the sliding glass door in the kitchen. Certified staff #C stated resident was admitted last Friday (9/17/15) and wanted to go home. At 9:45 a.m. on 9/21/15 walked through facility and observed an open door to the laundry room with a small unlocked refrigerator. Observed 2 Levemir (insulin) Flextouch pens and 1 Humalog (insulin) Kwikpen. Across the hall from the laundry room, observed an unlocked closet with the following items: Glass cleaner spray Stain remover spray Tilex shower cleaner Endust Pledge multi-surface cleaner Comet powder	S5335		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087162	A. BUILDING: _____ B. WING _____	09/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARJORIE'S HOME LLC	14601 TIMBER LAKE RD WICHITA, KS 67230

(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 3	S5335		

Lysol toilet bowl cleaner
Raid spray can
Lysol bathroom cleaner\
The closet contained other chemicals but had to close the door when resident #300 propelled self in wheel chair to this door.

At 10:05 a.m. on 9/21/15, observed a container of disinfectant wipes and a can of spray disinfectant on the back of the toilet in the bathroom located at the end of the kitchen.

At 10:10 a.m. on 9/21/15, in a lower cabinet in the kitchen, observed numerous "Boricult" urine culture plastic containers each with a 400 milligram tablet of boric acid.

At 10:20 a.m. on 9/21/15 under the kitchen sink, observed powdered dishwasher soap, Ajax powder, dishwasher liquid soap, Cascade rinse aid liquid, container of disinfecting wipes, and liquid dish soap. Observed that these cabinet doors did not have a locking mechanism.

Review of the resident roster revealed 5 of the 7 residents experienced impaired cognition.

Record review for resident #300 revealed an admission date of 9/17/15 and a diagnosis of subdural hematoma. The functional capacity screen dated 9/17/15 indicated the resident experienced impaired short-term memory, decision making, and memory recall.

At 11:05 a.m. on 9/21/15, informed operator that chemical closet and refrigerator with 3 insulin pens were unlocked when arrived at facility. Also informed operator/licensed nurse of urine culture containers with boric acid tablets were accessible to residents. Operator/licensed nurse placed the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087162	A. BUILDING: _____ B. WING _____	09/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARJORIE'S HOME LLC	14601 TIMBER LAKE RD WICHITA, KS 67230

(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 4 containers in a closet. During an interview at 2:50 p.m. on 9/21/15, operator/licensed nurse confirmed staff members were to keep the chemical closet locked and no chemicals were to be out of the cabinet in the bathroom. Operator/licensed nurse stated he/she would put a lock on cabinets under the kitchen sink. The operator/licensed nurse failed to ensure staff maintained a safe environment for residents.	S5335		