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 _____	R 06/02/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEACE OF MIND LLC II	223 N BURR OAK RD 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 represent the findings of a revisit for Correction Order 14-38, Notice of Assessment 14-39, and Ban on Admission 14-4 for the above named home plus facility conducted on 5-28-14, 5-29-14 and 6-2-14.	{S 000}		
{S5080} SS=F	26-42-201 (a) (b) Functional Capacity Screen on Admission (a) On or before each individual ' s admission to a home plus, a licensed nurse, a licensed social worker, or the administrator or operator shall conduct a screening to determine the individual ' s functional capacity and shall record all findings on a screening form specified by the department. The administrator or operator may integrate the department ' s screening form into a form developed by the home, which shall include each element and definition specified by the department. (b) A licensed nurse shall assess any resident whose functional capacity screening indicates the need for health care services. This REQUIREMENT is not met as evidenced by: KAR 26-42-201(a) The facility reported a census of 6 residents. The sample included 3 residents. Based on record review and interview for 3 (#1500, #1502, #1504) of 3 sampled residents, the operator failed to ensure the functional capacity screening forms were completed using the definitions specified by	{S5080}		

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 _____	R 06/02/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEACE OF MIND LLC II	223 N BURR OAK RD 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
{S5080}	Continued From page 1 the department. Findings included: - Record review for resident #1500 revealed admission on 4-3-14 with diagnoses Diabetes Mellitus, Neurogenic Bladder, Dementia with Behaviors, Hypertension, Depression, and Cecal Volvulous. The functional capacity screen (FCS) dated 4-3-14 recorded resident required supervision with dressing, physical assistance with bathing, toileting, transfers, walking/mobility; unable to perform management of medications/treatments and independent with eating. Continent of bladder. Communication: usually understandable, usually understands. Under "Cognition", the FCS documented an "A" for short term memory and lacked documentation for long term memory, memory/recall and decision making. Current problems/risks identified included decision-making. Review of resident roster revealed resident #1500 with an impaired cognitive status. Nurse's Notes dated 5-17-14 at 10:30 am: "Resident assessed at this time, alert and confused with repetitive statements..." Signed by licensed nurse B. Interview on 5-28-14 at 5:26 pm with the operator confirmed the FCS lacked documentation for Cognition using the definitions specified by the department. Interview on 5-29-14 at 11:50 am with licensed nurse B confirmed he/she completed the FCS and wasn't aware there was a manual that	{S5080}		

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 _____	R 06/02/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEACE OF MIND LLC II	223 N BURR OAK RD 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
{S5080}	Continued From page 2 provided instructions for how to complete the FCS form. For resident #1500, designated staff failed to ensure the resident's functional capacity screening form was completed using the definitions specified by the department. - Record review for resident #1502 revealed admission on 4-12-14 with diagnoses Dementia with Behaviors, Type II Diabetes Mellitus, Hypertension, Atheroscerosis, Anemia, Osteoporosis and Depression. The Functional Capacity Screen (FCS) dated 5-28-14 recorded resident unable to perform bathing, dressing, toileting and management of medications/treatments; physical assistance with walking/mobility and eating. Occasionally incontinent of bladder. Under "Cognition", the FCS documented checkmarks for short term memory, long term memory, memory/recall and decision-making. According the the FCS manual only a "0" for no problem or a "1" for a problem with short and long term memory, memory/recall and decision-making ability is to be entered. Review of resident roster revealed resident #1502 with an impaired cognitive status. Nurses Notes revealed: 5-9-14 at 11:00 am: "Resident assessed at this time. Alert and confused." Signed by licensed nurse B. 5-26-14 at 6:30 pm: "Resident assessed at this time, alert and oriented to self with confusion. Language barrier noted." Signed by licensed nurse B.	{S5080}		

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 _____	R 06/02/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEACE OF MIND LLC II	223 N BURR OAK RD 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
{S5080}	Continued From page 3 Interview on 5-28-14 at 5:26 pm with the operator confirmed the FCS lacked documentation for Cognition using the definitions specified by the department. For resident #1502, designated staff failed to ensure the resident's functional capacity screening form was completed using the definitions specified by the department. - Record review for resident #1504 revealed admission on 2-11-13 with diagnoses Dementia, Obstructive Sleep Apnea, Hypothyroidism, Diabetes Mellitus, Atrial Fibrillation, Left Knee Sepsis, Arthritis and Hypertension. The functional capacity screen (FCS) dated 5-28-14 recorded resident unable to perform bathing, dressing, toileting, transfers and management of medications/treatments; supervision with eating. Usually continent of bladder. Under "Cognition", the FCS documented checkmarks for short term memory, memory/recall and decision-making. Long term memory left blank. According the the FCS manual only a "0" for no problem or a "1" for a problem with short and long term memory, memory/recall and decision-making ability is to be entered. Review of resident roster revealed resident #1504 with an impaired cognitive status. Nurses Notes revealed: 5-11-14 at 5:00 pm: "Resident assessed at this time. Alert and oriented with confusion. able to make needs and wants known." Signed by licensed nurse B. 5-26-14 at 8:00 pm: Resident assessed at this time alert and oriented with confusion." Signed by licensed nurse B.	{S5080}		

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 _____	R 06/02/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEACE OF MIND LLC II	223 N BURR OAK RD 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
{S5080}	Continued From page 4 Interview on 5-28-14 at 5:26 pm with the operator confirmed the FCS lacked documentation for Cognition using the definitions specified by the department. For resident #1504, designated staff failed to ensure the resident's functional capacity screening form was completed using the definitions specified by the department.	{S5080}		
{S5095} SS=D	26-42-201 (d) Functional Capacity Screen Accurate (d) Designated staff shall ensure that each resident ' s functional capacity at the time of screening is accurately reflected on that resident ' s screening form. This REQUIREMENT is not met as evidenced by:	{S5095}		
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.	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 _____	R 06/02/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEACE OF MIND LLC II	223 N BURR OAK RD 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 5 This REQUIREMENT is not met as evidenced by: KAR 26-42-204(a) The facility reported a census of 6 residents. The sample included 3 residents. Based on observation, record review and interview for 1(#1502) of 3 sampled residents, the operator failed to ensure that a licensed nurse provided or coordinated the provision of necessary health care services that met the needs of the resident who had a history of pocketing food. Findings included: - Record review for resident #1502 revealed admission on 4-12-14 with diagnoses Dementia with Behaviors, Type II Diabetes Mellitus, Hypertension, Atheroscerosis, Anemia, Osteoporosis and Depression. The Functional Capacity Screen (FCS) dated 5-28-14 recorded resident unable to perform bathing, dressing, toileting and management of medications/treatments; physical assistance with walking/mobility and eating. Occasionally incontinent of bladder. Cognition: problems with short term and long term memory, memory/recall and decision-making. Communication: sometimes understandable and sometimes understands. Current problems/risks included: falls/unsteadiness, impaired vision, impaired hearing and impaired decision-making. Resident uses wheelchair. The Negotiated Service Agreement (NSA) dated 5-28-14 recorded the following dietary services: Food Service: three meals per day provided by and served by home staff; Snacks provided,	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 _____	R 06/02/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEACE OF MIND LLC II	223 N BURR OAK RD 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 6	S5155		

Glucerna 3 times per day, by staff; Special Diet request: Mechanical Soft (5-5-14); resident only has 4 teeth. Diet was changed to Mechanical Soft.

Observations and interview on 5-28-14 at 2:20 pm immediately after arrival to the facility fire department first responders arrived then Emergency Medical Services (EMS) arrived. Licensed nurse A stated resident tends to pocket food. The resident had eaten lunch and when staff went to lay him/her down, he/she started coughing and choking, possibly sucked a peach into throat and 911 was called.

Observation of dinner on 5-28-14 between 5:10 and 5:45 pm revealed 2 residents sitting at dining room table with resident #1502. Staff member served resident #1502 a meal of tacos, refried beans and spanish rice. Certified staff F stated the taco shell was not given to resident 1502 because it might be too hard for him/her. Observed certified staff E in the kitchen with medication cart and certified staff F bringing residents to the dining room then taking a resident who had been in the kitchen with certified staff E to the bathroom. No certified staff at the table with resident #1502 while he/she was eating. Licensed staff A left the facility around 4:35 pm without giving written or verbal instructions to the certified staff regarding eating assistance and observation of eating.

Nurses Notes:
4-22-14: "Seen by nurse practitioner with new order ok to crush pills, Speech Therapy to evaluate and treat. Sugar Free Supplement three times per day, diagnosis Weight loss." Signed by licensed nurse B.
4-29-14 at 8:30 pm: "(Family) called back with

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 _____	R 06/02/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEACE OF MIND LLC II	223 N BURR OAK RD 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	S5155		

choice of home health , all demographics will be sent to home health." Signed by licensed nurse B.
5-5-14 at 7:00 pm: "Seen by primary care provider with new order for mechanical soft diet with thin liquids per consult per nurse practitioner." Signed by licensed nurse B.
5-28-14 at 8:00 pm: "Late Entry - at approximately 3:00 today resident was being put to bed by certified nurse aide (CNA) and CNA called for help. When entered room, CNA yelled, 'she is choking!' I looked at the resident and he/she was turning blue. CNA was attempting to do the Heimlich maneuver then the resident went limp. We laid him/her down in the bed and attempted to open the resident's mouth to do a finger sweep and to start CPR. Resident would not open mouth. He/She started coughing and breathing with gurgling sounds. resident turned to recovery position on right side and he/she continued breathing. Second CNA had called 911 when resident had went limp. First responders arrive first to assess the resident. Oxygen saturation was 89%, but resident's breathing was better. EMS arrived and after they assessed the resident, then noted that oxygen saturation over 90 % and resident's lung sound were clear. They determined that resident had recovered well and that it wasn't necessary for resident to go to the hospital. CNA got the resident up and brought him/her in the living room where he/she could be monitored better and placed him/her in a recliner. CNA were instructed to continue to monitor resident and to monitor vital signs and if temperature becomes elevated to call the nurse on call to report it." Signed by licensed nurse A. The record lacked documentation of instructions to certified staff.

Physician's Orders:

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 _____	R 06/02/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEACE OF MIND LLC II	223 N BURR OAK RD 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 4-22-14: Speech Therapy Evaluation and treat for pocketing/dysphagia. 5-5-14 at 12:45 pm: "Diet: Mechanical Soft diet with thin liquids" Nurse Practitioner's Progress Note dated 4-22-14: History of Present Illness: "Patient seen today for pocketing pills and food. Staff report patient will spit pills out. If they are crushed, patient will pocket them and spit them out later. Plan: Dysphagia - crush pills. Speech Therapy to evaluate and treat." Review of record revealed the record lacked documentation of the speech therapy evaluation and treatment recommendations. Interview on 5-28-14 at 4:20 pm with licensed nurse A confirmed the record lacked documentation of the Speech Therapy evaluation and did not know which home health performed the evaluation. Licensed Nurse A checked with home health agencies and requested the speech therapy evaluation be faxed to the facility. Speech Therapy Evaluation (received by the facility on 5-29-14) dated 5-5-14: "Missing back teeth creating difficulty chewing and manipulating hard solid foods. Swallow actually strong and timely. No signs/symptoms of aspiration seen. Safe with puree and semi solid foods." Speech Therapy Discharge Note (received by the facility on 5-29-14) dated 5-7-14: "Lunch of spaghetti tolerated very well. No pocketing. Upon discharge, patient was safely swallowing a mechanical soft diet with thin liquids. staff reported this diet much better for patient. Able to eat on his/her own. No signs/symptoms of aspiration. Safe to discharge on this diet."	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 _____	R 06/02/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEACE OF MIND LLC II	223 N BURR OAK RD 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 Interview on 5-29-14 at 10:17 am with certified staff D stated resident #1502 was having trouble eating due to problems with teeth. Confirmed the staff had to feed him/her at times and "there's someone in here at all times with them when they're eating." Further confirmed had not received instructions on how to prepare a mechanical soft diet. Confidential interview stated there is not always a certified staff member at the table when residents are eating. One staff is usually with another resident who eats in his/her room and the other staff member is "often running back and forth" between kitchen and attending to other residents. Interview on 5-29-14 at 11:09 am with licensed nurse A confirmed the NSA lacked documentation of health care services to address resident #1502's choking risk. Confirmed the NSA lacked information regarding resident pocketing food or necessity to clean his/her mouth out after meals, and that staff needed to feed resident at times. Licensed staff A made the following changes to NSA on 5-29-14 at 11:35 am: "Resident needs cueing with feeding at times and needs feeding at times. Resident pockets food. He/She should sit up after meal for 30 minutes to 1 hour. Staff should provide oral care after each meal to assure resident is not pocketing food. Staff will observe resident at all times when eating." For resident #1502, the operator failed to put services in place to address the resident's risk for choking after the resident with a history of pocketing food experienced a chocking incident.	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 _____	R 06/02/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEACE OF MIND LLC II	223 N BURR OAK RD 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 10	S5185		
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(a)(b)(c) The facility reported a census of 6 residents. The sample included 3 residents. Based on record review and interview for 2 (#1500, #1502) of 3 sampled residents, the operator failed to ensure if the resident's negotiated service agreement included the provision of a therapeutic diet, or mechanically altered diet the diet shall be prepared according to instructions from a medical care provider or licensed dietitian. Findings included: - Record review for resident #1500 revealed admission on 4-3-14 with diagnoses Diabetes Mellitus, Neurogenic Bladder, Dementia with Behaviors, Hypertension, Depression, and Cecal	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 _____	R 06/02/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEACE OF MIND LLC II	223 N BURR OAK RD 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 Volvulous. The Negotiated Service Agreement dated 4-3-14 recorded Food Service: Low Concentrated Sweets Diet per physician's order. Interview on 5-28-14 at 2:49 pm with operator confirmed no instructions for a low concentrated sweets diet from a medical care provider or licensed dietitian. - Record review for resident #1502 revealed admission on 4-12-14 with diagnoses Dementia with Behaviors, Type II Diabetes Mellitus, Hypertension, Atheroscerosis, Anemia, Osteoporosis and Depression. The Negotiated Service Agreement (NSA) dated 5-28-14 recorded the following dietary services: Food Service: three meals per day provided by and served by home staff; Snacks provided, Glucerna 3 times per day, by staff; Special Diet request: Mechanical Soft (5-5-14); resident only has 4 teeth. Diet was changed to Mechanical Soft. Physician's Orders: 4-22-14: Speech Therapy Evaluation and treat for pocketing/dysphagia. 5-5-14 at 12:45 pm: "Diet: Mechanical Soft diet with thin liquids" Nurse Practitioner's Progress Note dated 4-22-14: History of Present Illness: "Patient seen today for pocketing pills and food. Staff report patient will spit pills out. If they are crushed, patient will pocket them and spit them out later. Plan: Dysphagia - crush pills. Speech Therapy to evaluate and treat."	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 _____	R 06/02/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEACE OF MIND LLC II	223 N BURR OAK RD 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 Speech Therapy Evaluation dated 5-5-14: "Missing back teeth creating difficulty chewing and manipulating hard solid foods. Swallow actually strong and timely. No signs/symptoms of aspiration seen. Safe with puree and semi solid foods." Speech Therapy Discharge Note dated 5-7-14: "Lunch of spaghetti tolerated very well. No pocketing. Upon discharge, patient was safely swallowing a mechanical soft diet with thin liquids. Staff reported this diet much better for patient. Able to eat on his/her own. No signs/symptoms of aspiration. Safe to discharge on this diet." Interview on 5-28-14 at 2:49 pm with operator confirmed no instructions for a low concentrated sweets diet from a medical care provider or licensed dietitian. For residents #1500 and #1502, the operator failed to ensure if the resident's negotiated service agreement included the provision of a therapeutic diet, or mechanically altered diet the diet shall be prepared according to instructions from a medical care provider or licensed dietitian.	S5185		
{S5230} SS=F	26-42-207 (b)(5)(6) (c) Infection Control Policies (b)(5) prohibiting any employee with a communicable disease or any infected skin lesions from coming in direct contact with any resident, any resident ' s food, or resident care equipment until the condition is no longer infectious; (6) providing orientation to new employees and employee in-service education at least annually on the control of infections in a health care setting;	{S5230}		

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 _____	R 06/02/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEACE OF MIND LLC II	223 N BURR OAK RD 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
{S5230}	Continued From page 13 (c) Each administrator or operator shall ensure the home ' s compliance with the department ' s tuberculosis guidelines for adult care homes adopted by reference in K.A.R. 26-39-105. This REQUIREMENT is not met as evidenced by: KAR 26-42-207(c) The facility reported a census of 6 residents. The sample included 3 residents. Based on record review and interview for 1 of 1 newly hired certified staff, the operator failed to ensure the home's compliance with the department's tuberculosis guidelines for adult care homes adopted by reference in K.A.R. 26-39-105. Findings included: - Personnel record review conducted on 5-28-14 at 5:15 pm with operator revealed Certified Staff C with date of hire 5-10-14: no tuberculosis (TB) screening questionnaire and the first step of the TB skin test lacked documentation of result. Interview on 5-28-14 at 5:15 pm with operator confirmed the record lacked documentation of TB screening questionnaire or 2-step TB skin testing. For certified staff C, the operator failed to ensure the home's compliance with the department's tuberculosis guidelines for adult care homes adopted by reference in K.A.R. 26-39-105.	{S5230}		