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CARRINGTON AT CHERRY CREEK	8200 E PAWNEE ST WICHITA, KS 67207

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S 000	INITIAL COMMENTS The following citations represents the findings of a resurvey with complaint investigations #168475, #168836, #169021, #169193, #169191, #169359, #169354, #169350, #169442, #169716, #169956, #170064, #170702, #170739, #171461, #171583, #171754, #171872, #171860, #171934, #172614, #172606, #172580, #172846, #172869, #173034, #173266, #173380, and #173525 for the above named facility conducted on the following dated: 08/03/22, 08/04/22, 08/08/22, 08/09/22, 08/10/22, and 08/11/22	S 000		
S3082 SS=E	26-41-201 (d) Functional Capacity Screen Accurate d) Designated facility 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: K.A.R 26-41-201 (d) The facility reported a census of 105 residents (R). The sample included six residents, one focused record review and six closed record reviews. Based on record review and interview the Operator failed to ensure designated facility staff completed R807's and R810's "Functional Capacity Screening" accurately to reflect the resident received Home Health services for wound care. Findings included:	S3082		

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

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S3082	Continued From page 1 - Review of R807's medical record revealed she moved into the facility on 04/29/20 with diagnoses of diabetes mellitus type II and heart failure. The resident's "Functional Capacity Screen" dated 11/11/21 identified the residents received Home Health Services for compression wraps but did not identify services related to wound care. The resident's "Negotiated Service Agreement" dated 11/11/21 also identified the resident received Home Health services for compression wraps but nothing related to wound care. Review of the physician's order dated 11/05/21 revealed the resident admitted to Home Health for services to assess and perform wound care/compression wraps three times per week. On 08/10/22 at 03:12 PM "Licensed Nurse" (LN) G acknowledged the resident's "Functional Capacity Screen" should have included the resident had physician ordered therapies for Home Health to provide wound care services. The Operator failed to ensure designated staff completed R807's Functional Capacity Screen to accurate reflect the resident's status related to wound care needs. - Review of R810's medical record revealed the resident moved into the facility on 01/01/18 with diagnoses of mood affective disorder, diabetes mellitus II, and epilepsy.	S3082		

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S3082	Continued From page 2 R810's current "Functional Capacity Screen" FCS dated 02/28/22 revealed the resident required physical assistance with activities of daily living except for being independent with eating. It identified the resident had ordered therapies and treatments to include Home Health services for supra-pubic catheter changes and Physical therapy and Occupational therapy. The FCS did not identify any services related to wound care. Review of a Home Health note dated 11/05/21 revealed the skilled nurse would provide wound care for a wound on the resident's left foot that had an onset date of 11/01/21. It was a skin tear that measure 2.7centimeters (cm) by 2.5 cm with a moderate amount of drainage. On 08/10/22 at 03:03 PM "Licensed Nurse" G reported she did not realize he had a wound on the top of his foot but acknowledged she should have included wound care services if he had one. The Operator failed to ensure designated staff completed R807's Functional Capacity Screen to accurately reflect R807 and R810's status related to wound care needs.	S3082		
S3085 SS=E	26-41-202 (a) Negotiated Service Agreement (a) The administrator or operator of each assisted living facility or residential health care facility shall ensure the development of a written negotiated service agreement for each resident, based on the resident ' s functional capacity screening, service needs, and preferences, in collaboration with the resident or the resident ' s	S3085		

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S3085	Continued From page 3 legal representative, the case manager, and, if agreed to by the resident or the resident ' s legal representative, the resident ' s family. The negotiated service agreement shall provide the following information: (1) A description of the services the resident will receive; (2) identification of the provider of each service; and (3) identification of each party responsible for payment if outside resources provide a service. This REQUIREMENT is not met as evidenced by: KAR 26-41-202(a)(1)(2) The facility reported a census of 105 residents. The sample included six residents, one focused record review and six closed record reviews. Based on record review and interview the Operator failed to ensure designated facility staff developed R807's and R810's "Negotiated Service Agreement" based on their service needs to include the description of the services the residents would receive and who would provide those services related to wound care. Findings included: - Review of R807's medical record revealed she moved into the facility on 04/29/20 with diagnoses of diabetes mellitus type 2 and heart failure. The resident's "Functional Capacity Screen" dated 11/11/21 identified the residents needed	S3085		

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S3085	Continued From page 4	S3085		

physical assistance with bathing dressing and transfers. She also needed physical assistance with management of treatments. It identified she had ordered treatments through Home Health Services for compression wraps but did not identify services related to wound care.

The resident's "Negotiated Service Agreement" dated 11/11/21 identified staff would help with showers and dressing, transfers from low surfaces, and perform simple medical treatments. It also identified the resident received Home Health services for compression wraps but nothing related to wound care.

Review of the physician's order dated 11/05/21 revealed the resident admitted to Home Health for services to assess and perform wound care/compression wraps three times per week.

On 08/10/22 at 03:12 PM "Licensed Nurse" (LN) G acknowledged the resident's "Negotiated Service Agreement" should have included that Home Health would also provide wound care services.

The Operator failed to ensure designated staff completed the "Negotiated Service Agreement" to include that Home Health provided wound care services.

- Review of R810's medical record revealed the resident moved into the facility on 01/01/18 with diagnoses of mood affective disorder, diabetes mellitus II, and epilepsy.

R810's current "Functional Capacity Screen" FCS dated 02/28/22 revealed the resident

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S3085	Continued From page 5	S3085		

required physical assistance with activities of daily living except for being independent with eating. It identified the resident had ordered therapies and treatments to include Home Health services for Supra-pubic catheter changes and Physical therapy and Occupational therapy. The FCS did not identify any services related to wound care.

R810's "Negotiated Service Agreement" dated 11/11/21 revealed that staff would provide physical assistance with activities of daily living and perform simple medical treatments. It also identified Home Health provided skilled nursing for catheter changes and Physical and Occupational Therapy. It failed to identify the resident received services for wound care.

Review of a Home Health note dated 11/05/21 revealed the skilled nurse would provide wound care for a wound on the resident's left foot that had an onset date of 11/01/21. It was a skin tear that measure 2.7centimeters (cm) by 2.5 cm with a moderate amount of drainage.

On 08/10/22 at 03:03 PM "Licensed Nurse" G reported she did not realize he had a wound on the top of his foot but acknowledged she should have included wound care services on the "Negotiated Service Agreement"

Review of the facilities undated policy and procedure for "Negotiated Service Agreement" (NSA) revealed the NSA shall describe the services to be provide and identify the provider of the service.

The Operator failed to ensure designated staff

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S3085	Continued From page 6 completed R807's Negotiated Service Agreement to accurately reflect R807 and R810's status related to wound care needs.	S3085		
S3171 SS=E	26-41-204 (i) Health Care Services Standards of Practice (i) All health care services shall be provided to residents by qualified staff in accordance with acceptable standards of practice. This REQUIREMENT is not met as evidenced by: KAR 26-41-204 (i) The facility reported a census of 105 residents (R). The sample included six residents, one focused record review and six closed record reviews. Based on observation, interviews and record review the operator failed to ensure the Licensed Nurse provided health care services for two (R804, R807) of six sampled residents and 1 (R810) discharge resident according to acceptable standards of practice related to wound care. Findings included: - Review of R804's record revealed he moved into the facility on 07/20/20 with diagnoses of diabetes mellitus II, chronic kidney disease, and bilateral below the knee amputee. Review of the residents "Functional Capacity screen" dated 03/03/22 identified the resident was alert and oriented, needed physical	S3171		

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assistance with bathing, dressing, and management of medications and medical treatments. It also identified the resident had ordered treatments for Home Health for wound care services.

Review of the residents "Negotiated Service Agreement" dated 03/03/22 revealed the staff helped with bathing and dressing, assisted with administration of medications and simple medical treatments. Staff also dialed the resident's insulin pen to the correct dosage and he self-injected it. It identified the resident had a history of walking on his stumps.

The "Health Service Plan" (HSP) identified the resident had Home Health for wound care. The HSP failed to include any services for facility staff to provide, such as notifying Home Health when the wound dressing came off and monitoring for signs of infection or patient education and encouragement.

Review of the resident's Progress Notes lacked evidence the facility Licensed Nurse monitored and measured the wound to identify if it was healing or worsening as well as times when resident was non-compliant and walking on his "stumps" which increased the risk of his wounds deteriorating.

On 08/09/22 at 01:08 PM R804 sat at the entrance door waiting to get on the bus to go on the Walmart trip. He was dressed appropriate for the weather and clean and well groomed. The resident wore shorts and the resident had bilateral below the knee amputee. On his right stump he had two open sores with one being a

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little bigger than a quarter and the other about the size of a half dollar. There was no current bleeding but could tell they had been at some point earlier. The resident stated he often walks on his "knees" and that is why he has the sores. He said he had knee pads, but they do not stay on, so he doesn't wear them. There were no open areas on his left stump.

On 08/09/22 at 03:15 PM "Licensed Nurse" (LN) G confirmed the resident received services from Home Health for skilled nursing for his wounds. LN G stated she did not do anything with resident wounds. If a resident had a wound, the Home Health Nurse did all the care and services for it.

On 08/10/22 at 04:35 PM Administrative staff H acknowledged the LN needed to document her observation of the wounds in the progress notes including a description of the wound, wound measurements, and any changes or signs of infection.

The Operator failed to ensure licensed nursing staff provide nursing health care services according to standards of practice for the resident's wounds by the failure to measure and monitor the resident's wounds for healing/infection and document her observations in the resident record.

- Review of R807's medical record revealed she moved into the facility on 04/29/20 with diagnoses of diabetes mellitus type 2 and heart failure.

The resident's "Functional Capacity Screen"

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dated 11/11/21 identified the resident required physical assistance with bathing dressing and transfers. She also required physical assistance with management of treatments. It identified she had ordered treatments through Home Health Services for compression wraps but did not identify services related to wound care.

The resident's "Negotiated Service Agreement" dated 11/11/21 identified staff would help with showers and dressing, transfers from low surfaces, and perform simple medical treatments. It also identified the resident received Home Health services for compression wraps but nothing related to wound care.

The resident's Health Service Plan lacked any health care services staff needed to provide related to wounds.

Review of the physician's order dated 11/05/21 revealed the resident admitted to Home Health for services to assess and perform wound care/compression wraps three times per week. The Home Health records included documentation of treating a wound on the resident's right planter foot and which worsened and required the resident to go to local wound clinic for more extensive care.

On 08/09/22 at 03:15 PM "Licensed Nurse" (LN) G confirmed the resident received services from Home Health for skilled nursing for his wounds. LN G stated she did not do anything with resident wounds. If a resident had a wound, the Home Health Nurse did all the care and services for it.

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S3171	Continued From page 10 On 08/10/22 at 04:35 PM Administrative staff H acknowledged the LN needed to document her observation of the wounds in the progress notes including a description of the wound, wound measurements, and any changes or signs of infection. The Operator failed to ensure licensed nursing staff provide nursing health care services according to standards of practice for the resident's wounds by the failure to measure and monitor the resident's wounds for healing/infection and document her observations in the resident record. - Review of R810's closed medical record revealed the resident moved into the facility on 01/01/18 with diagnoses of mood affective disorder, diabetes mellitus II, and epilepsy. R810's "Functional Capacity Screen" (FCS) dated 02/28/22 revealed the resident required physical assistance with activities of daily living except for being independent with eating. It identified the resident had ordered therapies and treatments to include Home Health services for Supra-pubic catheter changes and Physical therapy and Occupational therapy. The FCS did not identify any services related to wound care. R810's "Negotiated Service Agreement" dated 11/11/21 revealed that staff would provide physical assistance with activities of daily living and perform simple medical treatments. It also identified Home Health provided skilled nursing for catheter changes and Physical and Occupational Therapy. It failed to identify the resident received services for wound care.	S3171		

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S3171	Continued From page 11 The "Health Service Plan" dated 11/11/21 did not include any care services related to wounds. Review of a Home Health notes revealed the following: 11/05/21 revealed the skilled nurse would provide wound care for a wound on the resident's left foot that had an onset date of 11/01/21. It was a skin tear that measure 2.7centimeters (cm) by 2.5 cm with a moderate amount of drainage. On 06/20/22 the notes identified a different wound on his left foot with an onset date of 06/15/22. On 06/27/22 the resident had another new wound on his left fourth toe that was a traumatic injury and open to full thickness. On 07/04/22 the notes included an order to obtain would cultures for both his toes and top of his foot. 07/07/22 Home Health documented an order for Bactrim DS (antibiotic) for wound infections and another Home Health note with the same date identified the resident was discharged from Home Health services due to hospitalization. On 08/10/22 at 03:03 PM "Licensed Nurse" G reported she did not realize he had a wound on the top of his foot knew about the wound on his 4th toe. Review of the facilities undated policy and procedure for "Negotiated Service Agreement" (NSA) revealed the NSA shall describe the services to be provide and identify the provider of the service. The operator failed to ensure the Licensed	S3171		

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S3171	Continued From page 12 Nurse provided health care services according with acceptable standards of practice for residents with wounds.	S3171		
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 105 residents (R). The sample included six residents, one focused record review and six closed record reviews. Based on interview and record review the Operator failed to ensure the record contained documentation of all incidents, symptoms, and other indications of illness or injury for two (R806 and R813) of six closed records. Findings included: -- Review of R806's medical record revealed he moved into the facility on 07/29/21 with diagnoses of paranoid schizophrenia, gout and vascular dementia. R806's "Functional Capacity Screen" dated 01/28/22 identified the resident had no cognitive	S3261		

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impairment, needed physical assistance with bathing, dressing, medication management, and used an electric scooter for mobility.

R806's "Negotiated Service Agreement" dated 01/28/22 identified the staff assisted the resident with showers, dressing, and medications and treatments.

Review of the resident's progress notes included the following documentation:

01/20/2022 - Resident was seen by medical provider on 01/19/22 for his mood and wrote orders to decrease Divalproex (an anticonvulsant).
The record lacked follow-up of the effectiveness of decreasing the Divalproex.

03/04/2022 - Medical provider saw the resident on 03/02/22 for increased pain and stiffness to bilateral feet and ordered Gabapentin (nerve pain medication) three times a day for four weeks.
The record lacked follow-up of the Gabapentin effectiveness.

03/08/2022 - Resident seen by medical provider for mental health and wrote an order to decrease Trifulophenazine (an antipsychotic) as the resident has requested a decrease in his antipsychotic medications.
The record lacked documentation of the effectiveness of the decrease in Trifulophenazine and of the pain in the resident's feet.

03/14/2022 - Doppler (test to monitor blood flow) completed on 01/11/22 with results faxed to

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medical provider. The record continued to lack documentation of effectiveness of the Gabapentin for resident foot pain.

04/20/2022 -Resident seen medical provider related to Gabapentin not helping with foot pain.

04/22/2022 - Received order this day to increase Gabapentin for foot pain.

The resident record continued to lack follow-up by a licensed nurse regarding the decrease in the resident's Trifulophenazine, decrease in Divalproex, or the increase in his Gabapentin.

05/03/2022 -Resident seen this day medical provider and he requested a dosage reduction of this medications. New orders received to decrease Trifulophenazine.

05/24/2022 -Resident seen this day by medical provider for mental health due to recently refusing all medications except for blood pressure medications. Discussed concerns of uncontrolled movements and new orders received.
Changes included: discontinue Trifulophenazine and start Cogentin (antiparkinson) and Trifulophenazine ordered monthly instead of every two weeks.

The resident record lacked follow up documentation from a "Licensed Nurse" regarding the resident's foot pain and multiple changes in his psychiatric medications.

An interview on 08/09/22 at 05:23 PM R806 stated that he recently would not take his

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	N087043	A. BUILDING: _____ B. WING _____	08/11/2022

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medications because they caused him to have uncontrolled movements. He stated the physician made changes and the movements are gone.

On 08/10/22 at 4:35 PM "Administrative Staff" H confirmed a licensed nurse should have followed up in the progress notes on how medication changes effected the resident and stated they have been working on that situation.

The operator failed to ensure designated staff included documentation of all action taken, and results of the action for R806 related to changes in his psychiatric medications.

- Review of R813's medical record revealed he moved into the facility on 11/18/21 with diagnoses of schizoaffective disorder and seizures.

R813's "Functional Capacity Screen" dated 11/18/21 revealed the resident required physical assistance with dressing, bathing, and had impaired decision-making abilities.

R813's "Negotiated Service Agreement dated 11/18/22 revealed staff would assist the resident with bathing, dressing, and management of medications. Staff would also monitor decision making while drinking alcohol.

The resident's billing record revealed staff stopped billing the resident on 02/28/22.

The last progress note in the resident's record dated 01/20/22 mentioned the resident was seen by the medical provider.

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S3261	Continued From page 16 The record lacked documentation as to the resident leaving the facility for a family visit and resident did not return. On 08/10/22 at 03:22 PM "Licensed Nurse" G reported the resident and his "wife" left to go visit friends and never came back. Licensed Nurse G confirmed she should have documented in the resident's record the day he left on leave and that he did not come back. The operator failed to ensure designated staff documented all incidents in the resident's record.	S3261		
S3305 SS=F	26-41-207 (a) (b) Infection Control (a) The administrator or operator of each assisted living facility or residential health care facility shall ensure the provision of a safe, sanitary, and comfortable environment for residents. (b) Each administrator or operator shall ensure the development of policies and implementation of procedures to prevent the spread of infections. These policies and procedures shall include the following requirements: (1) Using universal precautions to prevent the spread of blood-borne pathogens; (2) techniques to ensure that hand hygiene meets professional health care standards; (3) techniques to ensure that the laundering and handling of soiled and clean linens meet professional health care standards; (4) providing sanitary conditions for food service; (5) prohibiting any employee with a communicable disease or any infected skin	S3305		

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S3305	Continued From page 17 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; and (7) transferring a resident with an infectious disease to an appropriate health care facility if the administrator or operator is unable to provide the isolation precautions necessary to protect the health of other residents. This REQUIREMENT is not met as evidenced by: KAR 26-41-207 (a)(b)(4) The facility reported a census of 105 residents. Based on observations, interview and record review the Operator failed to ensure staff implemented procedures to prevent the spread of infections by the failure to ensure housekeeping staff cleaned residents' rooms, including the bathroom, sufficiently to provide a sanitary environment and failed to ensure dietary staff did not touch ready to eat food with potentially contaminated gloves. This had the potential to affect all residents who ate meals at the facility. Findings included: - Observation on 08/09/22 at 06:00 AM in the upstairs public rest room, there was dried brown residue on the handrail. Surveyor asked,	S3305		

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"Certified Medication Aide" what it was, and she stated it looked like "poop".

- On 08/08/22 at 10:32 AM R816 stated staff did come in and cleaned her room but some of them do not do a very good job. Confirmed they were supposed to clean her bathroom, kitchen area and dust her nick-nacks and vacuum. Observation of her room revealed that her toilet would not flush properly, resident said she had told them about it, and it was in the maintenance book. The wall and floor beside the resident's toilet were covered with dried feces. She stated she had a colostomy bag and when she empties it sometimes it splashes on the wall. R816 said the housekeepers are supposed to clean the wall but they don't do a good job.

On 08/09/22 at 09:52 AM observation of R816's bathroom with "housekeeping staff" I, revealed the feces remained all over the wall and floor beside the resident's toilet. Housekeeping staff I, stated the last time the resident would have had her room cleaned would have been last Wednesday. When she saw the feces on the wall and floor, she stated nursing staff are supposed to do the initial clean up and then housekeepers do the chemical clean up. Staff I acknowledge that either a housekeeper or nursing staff should have cleaned the feces off the resident's wall and floor.

The operator failed to ensure designated staff thoroughly cleaned R 816's room in order to provide her a sanitary and comfortable environment.

- On 08/08/22 from 07:30 AM to 08:00 AM

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observed "Dietary Cook" A, plated breakfast food. He failed to change gloves after touching potentially dirty surfaces, such as his clothing and boxes from the back storage area. While plating food he picked up toast and sausage with his potentially contaminated hands.

At 07:37 AM observed "Certified Nurse Aide" B passing plates to residents, she touched chairs and residents. She then went around to the back side of the steam table and got two slices of bacon out of the table using her fingers and served them to a resident.

- On 08/08/22, during the noon meal service, "Dietary Cook" A prepared to serve the meal, he had gloves on both hands. He went into the kitchen and got two pans of rolls off the kitchen cabinet. While he plated the foods, he did not change his gloves during the whole service. He would pick the dinner rolls out of the tray using his gloved hands and while waiting for residents to be ready would frequently adjust his shorts and then proceed to plate food touching dinner rolls with the same gloved hands. "Dietary Cook:" C also wore gloves as he prepared "ready to eat" foods for sandwiches, without changing his gloves after moving the oven mitts and touching the handles of the fryer basket. "Dietary Cook" D opened a bread bag and got out a bun, twisted it shut and then went over to the stove and got a piece of chicken out of the steam pan using his gloved hand and put it on the bread.

- On 08/09/22 at 07:19 AM observation of breakfast service revealed "Dietary Cook" A had prepared the steam table and brought out different pans with eggs and bacon in them

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wearing gloves. With the same gloved hands, he brought out a cookie sheet with sausage patties on it and then used a spatula to put the sausage in the steam pan. He then put on an oven mitt and put the cookie sheet in the kitchen and came right back out and began to serve breakfast without changing his gloves. Dietary staff A proceeded to plate residents' food using his gloved hands to put bacon, sausage, and toast on the plates.

08/09/22 at 02:30 PM "Dietary Supervisor" acknowledged staff should have changed their gloves and/or used tongs to serve ready to eat foods.

08/11/22 at 08:30 AM "Resident Director" reported she would email the food handling policy. Polixy was not received as of 11:15 AM.

The operator failed to ensure dietary staff served foods using techniques to ensure the prevention of the spread of infections, by the failure of staff to use proper glove usage when handling ready to eat foods.