STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087242	A. BUILDING: _____ B. WING _____	09/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN BOOMERS 2	6900 STONEGATE ST 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 the licensure resurvey for the above named facility conducted on 09/07/22 - 09/08/22.	S 000		
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: KAR 26-42-201(d) The facility reported a census of six residents with three included in the sample. Based on observation, interview, and record review the operator failed to ensure Resident (R) 907's "Functional Capacity Screen" (FCS) accurately reflected the resident's status. Findings included: - Record review for R907 revealed an admission date of 07/25/19 with the following diagnoses: neurocognitive disorder, history of cerebrovascular accident with left hemiplegia, and hypertension. The 11/08/21 admission "FCS" identified R907 required supervision with bathing, dressing, toileting, and eating. He was unable to perform management of medications and treatments, was always incontinent of bladder, and had short-term	S5095		

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

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S5095	Continued From page 1 and long-term memory, memory/recall, and decision-making cognitive impairment. . The 11/08/21 combined "Negotiated Service Agreement/Healthcare Service Plan" (NSA/HSP) directed facility staff to provide R907 set-up and supervision with bathing and dressing, supervision with toileting and eating, management medications, and facility staff and his guardian assist with cognitive impairments. Management of treatments and bladder incontinence was not addressed on R907's "NSA/HP." The 11/08/21 "FCS" for R907 was not marked for inappropriate behavior. The 07/26/22 "Physician's Orders" documented sertraline medication 100 milligrams (mg) by mouth daily for "inappropriate sexual behaviors." On 09/08/22 at 10:52 AM Administrative Nurse B stated R909 did exhibit sexually inappropriate behavior and confirmed it was not marked on his current "FCS." The operator failed to ensure R907's "FCS" accurately reflected his status by the failure to mark inappropriate behavior.	S5095		
S5105 SS=F	26-42-202 (a) Negotiated Service Agreement a) The administrator or operator of each home plus 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 legal representative, the case manager, and, if	S5105		

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S5105	Continued From page 2 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 26-42-202(a)(1) The facility reported a census of six residents with three included in the sample. Based on observation, interview, and record review the operator failed to ensure Residents (R) 907, R908, and R909's, "Negotiated Service Agreements" (NSA) described the services each resident would receive based on their "Functional Capacity Screens" (FCS). Finding included: - Record review for R907 revealed an admission date of 07/25/19 with the following diagnoses: neurocognitive disorder, history of cerebrovascular accident with left hemiplegia, and hypertension. The 11/08/21 admission "FCS" identified R907 was unable to perform management of treatments and was always incontinent of bladder. The 11/08/21 "NSA" failed to identify who would provide management and payment of treatments	S5105		

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S5105	Continued From page 3	S5105		

and bladder incontinence.

Observation on 09/07/22 at 11:51 AM revealed R909 sat in a recliner in the common area watching TV. Certified Medication Aide (CMA) E asked R909 if he would like to go use the bathroom. He denied needing to go.

- Record review for R908 revealed an admission date of 07/19/22 with the following diagnoses: paroxysmal atrial fibrillation and hypertension.

The 07/19/22 admission "FCS" identified R908 was frequently incontinent of bladder and short-term memory, memory/recall, and decision-making impairment.

The 07/19/22 "NSA" failed to identify who would provide management and payment of R908's bladder incontinence and cognition impairments.

- Record review for R909 revealed an admission date of 09/09/21 with the following diagnoses: dementia, diabetes mellitus, and right heel ulcer.

The 01/19/22 significant change "FCS" identified R909 was sometimes understandable and sometimes understood others when communicating.

The 01/19/22 "NSA" failed to identify who would provide management and payment of R909's communication impairment.

On 09/07/22 at 11:45 AM R909 sat at the dining table playing a game with the aid and another resident. His speech was unclear.

On 09/07/22 at 04:02 PM R909 sat in a recliner in the common area visiting with his son. He would

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S5105	Continued From page 4 not answer direct questions by state surveyor. R909's son stated his father's primary language was not English. On 09/08/22 at approximately 10:52 AM Administrative Nurse B confirmed R907's current NSA did not address treatment or bladder incontinence, R708's current NSA did not address bladder incontinence or cognition and R909's current NSA did not address communication. The operator failed to ensure R907, R908, and R909's, "NSAs" described the services each resident would receive based on their "FCS'.	S5105		
S5127 SS=D	26-42-202 (i) NSA Services Received (i) Each administrator or operator shall ensure that each resident receives services according to the provisions of that resident ' s negotiated service agreement. This REQUIREMENT is not met as evidenced by: KAR 26-42-202(i) The facility reported a census of six residents with three included in the sample. Based on interview and record review the operator failed to ensure Resident (R) 909 received assistance by two staff for all transfers according to his "Negotiated Service Agreement" (NSA). Findings included: - Record review for R909 revealed an admission date of 09/09/21 with the following diagnoses:	S5127		

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S5127	Continued From page 5	S5127		

dementia, diabetes mellitus, and right heel ulcer.

The 01/19/22 significant change "Functional Capacity Screen" (FCS) identified R909 required physical assistance with transfers.

The 01/19/22 combined "NSA/Healthcare Service Plan (HSP)" directed facility staff to provide physical assistance with two staff for transfers.

The 01/19/22 combined "NSA/HSP" was signed by all persons involved in the development of the NSA including R909's family and the operator.

The 09/03/22 "Nurse's Note" by Administrative Nurse B documented R909 continued to need two staff assistance and was sometimes able to stand better and require only one staff assistance with walker for sit to stand transfers and ambulation.

The 09/07/22 "Nurse's Note" by Administrative Nurse B documented R909 was in bed that morning when she arrived. He required two staff to check and change his brief and assist him out of bed that morning.

On 09/07/22 at 01:03 PM R909 ambulated with a walker and gait belt assisted by Certified Medication Aide (CMA) E from the hallway to the common area and transferred from standing to sitting in a recliner without difficulty.

On 09/07/22 at 02:05 PM CMA E stated R909 had good days when he required assistance with one staff while using a walker and gait belt for transfers and walking/mobility and bad days when he required assistance with two staff. He required staff to propel him in a wheelchair for long distances.

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S5127	Continued From page 6 On 09/07/22 at 04:02 PM R909's unidentified family member stated R909 usually required assistance of two staff with getting up and walking depending on if the staff was male or female due to R909's tall stature. On 09/07/22 at 04:11 PM during a phone call R909's unidentified family member stated the owner of the facility had called and told her it was determined that R909 required two-person care and the facility needed to be paid more money. The unidentified family member stated even though insurance pays for two-person care, sometimes there was only one person in the facility to care for R909 during the day. On 09/07/22 at 04:44 PM Administrative Nurse B stated R909 required one-to-two staff assistance depending on the day. On 09/07/22 at 04:47 PM Administrative Staff A stated R909 used to require only one staff assistance, but now required one-to-two staff assistance depending on the day. On 09/08/22 at 10:58 AM Administrative Staff A stated R909 was usually a one-person assist, but if there were two staff present, they would both help. He would require one person to assist him out of the facility during an emergency. On 09/08/22 at 11:04 AM Administrative Nurse B state R909 required two-staff to assist him the morning of 09/07/22 because he was just getting out of bed, but he required only one staff assistance thereafter the rest of the day. The operator failed to ensure R909 received assistance by two staff for all transfers according	S5127		

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S5127	Continued From page 7 to his "NSA."	S5127		
S5161 SS=D	26-42-204 (d) Health Care Services (d) The negotiated service agreement shall contain a description of the health care services to be provided and the name of the licensed nurse responsible for the implementation and supervision of the plan. This REQUIREMENT is not met as evidenced by: KAR 26-42-204(d) The facility reported a census of six residents with three included in the sample. Based on interview and record review the operator failed to ensure two resident's "Negotiated Service Agreement" (NSA) named the licensed nurse responsible for implementing and supervising the "Healthcare Service Plan" (HSP). Findings included: - Record review for R907 revealed an admission date of 07/25/19 with the following diagnoses: neurocognitive disorder, history of cerebrovascular accident with left hemiplegia, and hypertension. The 11/08/21 admission "Functional Capacity Screen" (FCS) identified R907 required supervision with bathing, dressing, toileting, and eating. He was unable to perform management of medications and treatments, was always incontinent of bladder, and had short-term and long-term memory, memory/recall, and decision-making cognitive impairment.	S5161		

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S5161	Continued From page 8 . The 11/08/21 combined "NSA/HSP" directed facility staff to provide R907 set-up and supervision with bathing and dressing, supervision with toileting and eating, management medications, and facility staff and his guardian assist with cognitive impairments. Management of treatments and bladder incontinence was not addressed on R907's "NSA/HP". The nurse responsible on R907's "NSA" was Licensed Nurse D. On 09/07/22 at 04:30 PM Administrative Nurse B stated Licensed Nurse D no longer worked at the facility. R907's record lacked documentation of the licensed nurse responsible for implementing and supervising his HSP. - Record review for R909 revealed an admission date of 09/09/21 with the following diagnoses: dementia, diabetes mellitus, and right heel ulcer. The 01/19/22 significant change "FCS" identified R909 required physical assistance with bathing, dressing, toileting, transfers, walking/mobility, and eating; he was unable to manage medications and treatments; was always incontinent of bladder; had short-term memory, memory/recall, and decision-making cognitive impairments, was sometimes understandable and sometimes understood others when communicating; and was marked for falls, impaired vision, and impaired decision-making. The 01/19/22 combined "NSA/HSP" directed facility staff to provide physical assistance twice weekly for bathing and twice daily for dressing;	S5161		

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S5161	Continued From page 9 physical assistance every two hours as needed for toileting; assistance with two staff for transfers; physical assistance with a gait belt for walking/mobility; set up assistance, cutting up of food, supervision, and occasional cueing for eating; management medications and treatments; R909 wore briefs for incontinence; staff would provide redirection, cueing, and one on one assistance as needed for cognition; facility staff would provide assistance with all transfers and walking for falls ;he wore glasses which staff would clean and assist with putting on for impaired vision; and his durable power of attorney (DPOA) and staff would assist with impaired decision-making. Communication was not addressed on the NSA/HSP. The nurse responsible on R909's NSA was "Golden Boomers Home Plus Nurse." R909's record lacked documentation of the licensed nurse responsible for implementing and supervising his HSP. On 09/07/22 at 04:30 PM Administrative Nurse B confirmed R907 and R909's current NSA's lacked documentation of the nurse responsible for implementing and supervising their HSP's. The operator failed to ensure R907 and R909's NSA named the licensed nurse responsible for implementing and supervising the HSP.	S5161		
S5205 SS=D	26-42-104 (a) Disaster and Emergency Preparedness a) The administrator or operator of each home plus shall ensure the provision of a sufficient number of staff members to take residents who would require assistance in an emergency or	S5205		

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S5205	Continued From page 10 disaster to a secure location. This REQUIREMENT is not met as evidenced by: KAR 26-42-104(a) The facility reported a census of six residents with three included in the sample. Based on observation, interview and record review the operator failed to ensure enough staff were present to take Resident (R) 909 to a secure location in case of an emergency. Findings included: - Record review for R909 revealed an admission date of 09/09/21 with the following diagnoses: dementia, diabetes mellitus, and right heel ulcer. The 01/19/22 significant change "Functional Capacity Screen" (FCS) identified R909 required physical assistance with transfers and walking/mobility. The 01/19/22 combined "Negotiated Service Agreement/Healthcare Service Plan" (NSA/HSP) directed facility staff to provide physical assistance with two staff for transfers and physical assistance with a gait belt for walking/mobility. The 09/03/22 "Nurse's Note" by Administrative Nurse B documented R909 continued to need two staff assistance and was sometimes able to stand better and require only one staff assistance with walker for sit to stand transfers and ambulation. The 09/07/22 "Nurse's Note" by Administrative	S5205		

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S5205	Continued From page 11 Nurse B documented R909 was in bed that morning when she arrived. He required two staff to check and change his brief and assist him out of bed that morning. Review of staff clock-in times from 08/01/22 to 09/07/22 for Golden Boomers House 2 revealed staff worked three shifts each day. Out of 114 available shifts there were zero staff clocked in during seven shifts and only one staff clocked in during 62 shifts which revealed there were insufficient staff to transfer R909 during 60% of all available shifts. Review of staff clock-in times from 08/01/22 to 09/07/22 for Golden Boomers House 1 revealed staff worked three shifts each day. Out of 114 available shifts there was only one staff clocked in during 13 shifts. If Golden Boomers House 2 required a second staff member to transfer R909 there would not be one available from Golden Boomers House 1 during 13 shifts which was 11% of all shifts. (Assuming there were no residents who required two-staff assistance in House 1). On 09/07/22 at 01:03 PM R909 ambulated with a walker and gait belt assisted by Certified Medication Aide (CMA) E from the hallway to the common area and transferred from standing to sitting in a recliner without difficulty. On 09/07/22 at 02:05 PM CMA E stated R909 had good days when he required assistance with one staff while using a walker and gait belt for transfers and walking/mobility and bad days when he required assistance with two staff. He required staff to propel him in a wheelchair for long distances.	S5205		

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S5205	Continued From page 12 On 09/07/22 at 04:02 PM R909's unidentified family member stated R909 usually required assistance of two staff with getting up and walking depending on if the staff was male or female due to R909's tall stature. On 09/07/22 at 04:11 PM during a phone call R909's unidentified family member stated the owner of the facility had called and told her it was determined that R909 required two-person care and the facility needed to be paid more money. The unidentified family member stated even though insurance pays for two-person care, sometimes there was only one person in the facility to care for R909 during the day. On 09/07/22 at 04:44 PM Administrative Nurse B stated R909 required one-to-two staff assistance depending on the day. On 09/07/22 at 04:47 PM Administrative Staff A stated R909 used to require only one staff assistance but now required one-to-two staff assistance depending on the day. She confirmed there was only staff scheduled for the night shift on 09/07/22. She stated another staff would float between two houses as needed. Administrative Staff A brought up the distance and travel time on the Google Maps app on her smartphone which revealed 1.9 miles driving distance and six minutes travel time. Administrative Staff A stated the facility was not equipped with a sprinkler system in case of a fire. On 09/08/22 at 10:58 AM Administrative Staff A stated R909 was usually a one-person assist but if there were two staff present, they would both help. He would require one person to assist him out of the facility during an emergency.	S5205		

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S5205	Continued From page 13 On 09/08/22 at 11:04 AM Administrative Nurse B state R909 required two staff to assist him the morning of 09/07/22 because he was just getting out of bed but he required only one staff assistance thereafter the rest of the day. The operator failed to ensure enough staff were present to take R909 to a secure location in case of an emergency.	S5205		
S5210 SS=F	26-42-104 (b) Written Emergency Plan b) Each administrator or operator shall ensure the development of a detailed written emergency management plan to manage potential emergencies and disasters, including the following: (1) Fire; (2) flood; (3) severe weather; (4) tornado; (5) explosion; (6) natural gas leak; (7) lack of electrical or water service; (8) missing residents; and (9) any other potential emergency situations. This REQUIREMENT is not met as evidenced by: KAR 26-42-104(b)(2)(8) The facility reported a census of six residents with three included in the sample. Based on interview and record review the operator failed to ensure flood and missing resident were included in the written emergency plan. Findings included:	S5210		

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GOLDEN BOOMERS 2	6900 STONEGATE ST 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
S5210	Continued From page 14 - Review of the facility's emergency management preparedness book provided upon request lacked evidence of detailed written plans to manage flood and missing resident emergencies. On 09/07/22 at 11:05 AM Administrative Staff C confirmed flood and missing resident were not included in the emergency management plan. On 09/07/22 at 11:44 AM Administrative Staff A stated the emergency management plan was updated "about a month ago" to include flood and missing resident. She confirmed the updated plan had not been added to the emergency plan book that was available to all staff, residents, and visitors. The operator failed to ensure flood and missing resident was included in the written emergency plan.	S5210		