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	N087048	A. BUILDING: _____ B. WING _____	05/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD ESTATES WICHITA	10550 E 21ST STREET NORTH WICHITA, KS 67206

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S 000	INITIAL COMMENTS The following citations represent the findings of a Re-Licensure survey with complaint investigations 165406, 167035 and 171857 for the above named Assisted Living Facility conducted on 05/16/23 and 05/17/23.	S 000		
S3092 SS=E	26-41-202 (d) Negotiated Service Agreement Revisions (d) Each administrator or operator shall ensure the review and, if necessary, revision of each negotiated service agreement according to the following requirements:(1) At least once every 365 days; (2) following any significant change in condition, as defined in K.A.R. 26-39-100; (3) at least quarterly, if the resident receives assistance with eating from a paid nutrition assistant; and (4) if requested by the resident or the resident ' s legal representative, facility staff, the case manager, or, if agreed to by the resident or the resident ' s legal representative, the resident ' s family. This REQUIREMENT is not met as evidenced by: KAR 26-41-202 (d)(1)(2) The facility reported a census of 64 residents (R). The sample included three residents and four focused record reviews. Based on interview and record review the administrator failed to ensure staff reviewed and revised the "Negotiated Service Agreement" if necessary, for two (R3and R4) of three sampled residents	S3092		

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

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S3092	Continued From page 1 who experienced a significant change in status related to initiation and discontinuation of therapy services. Findings included: - Review of R3's medical record revealed she moved into the facility on 07/10/19 with diagnoses of dementia, hypertension, and major depressive disorder. On 05/16/23 at 03:35 PM Administrative Licensed Nurse A reported the FCS and NSA are all one document. R3's "Functional Capacity Screen/Negotiated Service Agreement" dated 02/04/23 revealed the resident required physical assistance with bathing, dressing, and management of medications. R3's record included two "Addendum to Negotiated Service Agreement" forms but did not include addendums for when the resident received services from an outside resource for physical and occupational therapy. Review of R3's medical record included occupational and physical therapy notes indicating the following. Physical Therapy and occupational therapy had a start of service date of 03/07/23. Occupation therapy was discharged on 04/13/23 and physical therapy was discharged on 04/19/23. On 05/17/23 at 12:00 PM Administrative Licensed Nurse B acknowledged she had not been doing addendums for the negotiated	S3092		

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S3092	Continued From page 2	S3092		

Service Agreements related to therapy services in the past.

The administrator failed to ensure designated staff reviewed and revised R3's "Negotiated Service Agreement" when she initiated and discontinued physical and occupational therapy services.

- Review of R4's medical record revealed she moved into the facility on 11/09/22 with a diagnosis of diabetes type II.

On 05/16/23 at 03:35 PM Administrative Licensed Nurse A reported the FCS and NSA are all one document.

R4's "Functional Capacity Screen/Negotiated Service Agreement" dated 03/20/23 identified the resident required physical assistance provided by staff for all activities of daily living except for eating.

Review of R4's medical record lacked Addendums to the Negotiated Service Agreement for when the resident received services provided by an outside resource for physical and occupational therapy.

R3's record included physical and occupational therapy notes indicating physical and occupational therapy started on 11/16/22 and physical therapy was discontinued on 01/12/23.

On 05/17/23 at 12:00 PM Administrative Licensed Nurse B acknowledged she had not been doing addendums for the negotiated Service Agreements related to therapy services

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S3092	Continued From page 3 in the past. The administrator failed to ensure designated staff reviewed and revised R3's "Negotiated Service Agreement" when she initiated and discontinued physical and occupational therapy services.	S3092		
S3175 SS=D	26-41-205 (a) (1) Self Administration of Medication (a) Self-administration of medication. Any resident may self-administer and manage medications independently or by using a medication container or syringe prefilled by a licensed nurse or pharmacist or by a family member or friend providing this service gratuitously, if a licensed nurse has performed an assessment and determined that the resident can perform this function safely and accurately without staff assistance. (1) An assessment shall be completed before the resident initially begins self-administration of medication, if the resident experiences a significant change of condition, and annually. This REQUIREMENT is not met as evidenced by: KAR 26-41-205 (a)(1) The facility reported a census of 64 resident (R)s. The sample included three residents and four focused record reviews. Based on	S3175		

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S3175	Continued From page 4 interview, and record review for one (R4) of three sampled residents, the administrator failed to ensure a licensed nurse assessed R4 prior to self-injection of insulin to ensure she was able to self-inject her insulin safely and correctly once it had been prepared and dialed to the ordered dosage by the Certified Medication Aide. Findings included: - Review of R4's medical record revealed she moved into the facility on 11/09/22 with diagnosis of diabetes type II. On 05/16/23 at 03:35 PM Administrative Licensed Nurse A reported the FCS and NSA are all one document and the Service plan in PCC is the health care service plan. R4's "Functional Capacity Screen/Negotiated Service Agreement" dated 03/20/23 identified the resident needed physical assistance with management of her medications and medical treatments. It also revealed the resident could self- administer insulin that staff prepared. Review of the residents "Electronic Medical Record" included a medical providers order for Humalog KwickPen solution to inject 13 units subcutaneously in the morning at breakfast, 15 units subcutaneously with lunch and 13 units subcutaneously with supper. Review of R4's electronic medical record included an assessment for self-injection of her insulin completed on 01/05/23, 51 days after moving into the facility.	S3175		

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S3175	Continued From page 5 On 05/17/23 at 11:02 AM Administrative Licensed Nurse B reported the resident self injected her insulin since admission and if she refuses to do it herself then the staff come and get the nurse to do it. Nurse B stated the self -assessment for self-injection should have been completed on admission and acknowledged it was done after she moved into the facility. Review of the "Self-Administration of Medication" policy provided by Administrative staff A dated 11/28/17 revealed a self-administration of insulin assessment will be completed before the resident will be allowed to self-administer the medication. The administrator failed to ensure a licensed nurse assessed R4 to ensure she was able to self-inject her insulin safely and correctly after the insulin pen had been prepared and dialed to the correct dosage by a Certified Medication Aide.	S3175		
S3214 SS=D	26-41-205 (g) (4) Sample & Indigent Medication Program Meds (g) (4) Licensed nurses and medication aides may administer sample medications and medications from indigent medication programs if the administrator or operator ensures the development of policies and implementation of procedures for receiving and identifying sample medications and medications from indigent medication programs that include all of the following conditions: (A) The medication is not a controlled medication. (B) A medical care provider ' s written order	S3214		

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S3214	Continued From page 6 accompanies the medication, stating the resident ' s name; the medication name, strength, dosage, route, and frequency of administration; and any cautionary instructions regarding administration. (C) A licensed nurse or medication aide receives the medication in its original, unbroken manufacturer ' s package. (D) A licensed nurse documents receipt of the medication by entering the resident ' s name and the medication name, strength, and quantity into a log. (E) A licensed nurse places identification information on the medication or package containing the medication that includes the medical care provider ' s name; the resident ' s name; the medication name, strength, dosage, route, and frequency of administration; and any cautionary instructions as documented on the medical care provider ' s order. Facility staff consisting of either two licensed nurses or a licensed nurse and a medication aide shall verify that the information on the medication matches the information on the medical care provider ' s order. (F) A licensed nurse informs the resident or the resident ' s legal representative that the medication did not go through the usual process of labeling and initial review by a licensed pharmacist pursuant to K.S.A. 65-1642 and amendments thereto, which requires the identification of both adverse drug interactions or reactions and potential allergies. The resident ' s clinical record shall contain documentation that the resident or the resident ' s legal representative has received the information and accepted the risk of potential adverse consequences.	S3214		

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S3214	Continued From page 7 This REQUIREMENT is not met as evidenced by: KAR 26-41-205(g)(4)(D)(E)(F) The facility reported a census of 64 residents (R). The sample included three residents and 4 focused record reviews. Based on observation, interview and record review the administrator failed to ensure one (R9) of one resident that received sample medications included the following: 1. License Nurse document receipt of medication with appropriate information into a log; 2. Licensed Nurse failed to included required information on each box/container and indicate verification of such information.; 3. A licensed nurse failed to inform the resident or resident's legal representative the medications were not received through a pharmacy and were not reviewed by a pharmacist. Findings included: - Review of R9's medical record revealed he moved into the facility on 08/14/21 with diagnoses of urinary retention. On 05/16/23 at 03:35 PM Administrative Licensed Nurse A reported the FCS and NSA are all one document and the Service plan in PCC is the health care service plan. R9's "Functional Capacity Screen/Negotiated Service Agreement" dated 05/01/13 identified the resident needed physical assistance with management of his medications and that Facility staff would administer his medications.	S3214		

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S3214	Continued From page 8 On 05/16/23 at 12:30 PM "Certified Medication Aide" (CMA) D opened the medication cart for inspection. Observation revealed a sample bottle of Gemtesa (for overactive bladder) with R9's name written on it. On 05/16/23 at 01:20 PM Administrative Licensed Nurse A reported she did not know any additional information needed to be gathered or documented regarding the resident using sample medications. Review of the "Sample Drugs" policy dated 03/2011 revealed sample medication can be used with the appropriate labeling information to include the patient's full name, date dispensed, physicians name, address and phone number, name and strength and quantity of medications, directions for use, expiration date of medications and lot number. The administrator failed to ensure the appropriate information regarding the administration of sample medications for R9 was written and explained to the resident or his/her legal representative, failed to include appropriate information on the medication container, and failed to have the appropriate information regarding the acceptance of the medication in the facility.	S3214		
S3299 SS=F	26-41-206 (e) (1) Facility Food Storage (e) Food storage. Facility staff shall store all food under safe and sanitary conditions. (1) Containers of poisonous compounds and cleaning supplies shall not be stored in the areas used for food storage, preparation, or serving.	S3299		

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S3299	Continued From page 9 This REQUIREMENT is not met as evidenced by: KAR 26-41-206(e) The facility reported a census of 64 residents. Based on observation and interview the facility failed to store all food under safe conditions. Findings included: - Observations on 05/16/23 at 02:20 PM during the kitchen tour with Dietary Staff D revealed a small freezer with the following bags that were open and not dated, bag of chicken nuggets, chicken patties, french fries, and chicken tenders. Dietary Staff D acknowledged the bags should have been sealed after used for lunch and should have had a date opened on them. Observation in the walk-in refrigerator include three trays of hamburger patties, covered with parchment paper which did not include a date on them, six styrofoam containers with a slice of cake in them that were not dated. Dietary staff D reported she had prepared the hamburgers earlier in the day for tomorrows lunch and the styrofoam containers were from yesterdays meal. Staff D acknowledged both the patties and containers should have been dated when they were put in the refrigerator. Review of the "Food Strage" policy dated 04/06/20 revealed all food items must be labeled and dated and all left over foods should be	S3299		

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S3299	Continued From page 10 labeled with the name of the food item and the expiration date. The administrator failed to ensure designated labeled and stored foods under safe conditions.	S3299		