STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087054	A. BUILDING: _____ B. WING _____	08/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE EAST WICHITA	9191 E 21ST STREET NORTH 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 Re-Licensure survey for the above named Assisted Living facility conducted on 08/03/23 and 08/07/23.	S 000		
S 150 SS=D	26-39-103 (k) Resident Right Work (k) Work. (1) The administrator or operator shall ensure that each resident is afforded the right to refuse to perform services for the adult care home. (2) A resident may perform services for the adult care home, if the resident wishes and if all of the following conditions are met: (A) The administrator or operator, or the designee, has documented the resident ' s need or desire for work in the plan of care or negotiated service agreement. (B) The plan of care or negotiated service agreement specifies the nature of the services performed and whether the services are voluntary or paid. (C) The resident or resident ' s legal representative has signed a written agreement consenting to the work arrangement described in the plan of care or negotiated service agreement. This STANDARD is not met as evidenced by: KAR 26-39-103 (k)(2)(A)(B)(C) The facility reported a census of 34 residents. The sample included three residents. Based on observation, interview, and record review the operator failed to ensure the resident the right to perform services for the care home if the resident	S 150		

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
	N087054	A. BUILDING: _____ B. WING _____	08/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE EAST WICHITA	9191 E 21ST STREET NORTH 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 150	Continued From page 1 wished to do so and failed to document the residents desire to work in the Negotiated Service Agreement (NSA) or Health Care Service Plan (HCSP), specified the nature of the services performed, if services were voluntary or paid and failed to have a signed written agreement with the resident's legal representative consenting to the work arrangement described in the NSA or HCSP. Findings included" - Review of R3's medical record revealed she moved into the facility on 04/24/23 with diagnosis of dementia. R3's "Functional Capacity Screen" dated 04/24/23 identified the resident required supervision with bathing, dressing and toileting and was unable to manage her medications. R3's "Negotiated Service Agreement" (NSA) "Health Care Service Plan" dated 05/21/23 lacked documentation of services the resident would provide for the facility, such as cleaning off tables after a meal and sweeping the floor. Observation on 08/03/23 at 12:45 PM R3 finished her meal. She got up out of her chair and if there were dirty dishes on the table, she removed the plates from the table and took them to the cart with a dish tub on it. She continued to do this with staff directing her if that person was done eating or not. At 01:10 PM she went to the drink station area and came back with a broom and started to move chairs away from the tables and sweep the floors.	S 150		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087054	A. BUILDING: _____ B. WING _____	08/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE EAST WICHITA	9191 E 21ST STREET NORTH 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 150	Continued From page 2 08/03/23 at 02:20 PM Certified Nurse Aide H reported the resident liked to help in the dining room and with cleaning tasks. She loves to clean the tables and help with other things as well. 08/07/23 at 11:52 AM Licensed Nurse G reported she had been told the resident started this "service" right after she moved in and will not give it up. She acknowledged her cleaning off the tables and sweeping the dining room floor were not in her care plan and did not have a specific agreement with her legal representative for her to be able to do the dining room cleaning. The operator failed to ensure the services R4 provided the facility were care planned and specified in an agreement with R4's legal representative.	S 150		
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 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	S3085		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087054	A. BUILDING: _____ B. WING _____	08/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE EAST WICHITA	9191 E 21ST STREET NORTH 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
S3085	Continued From page 3 payment if outside resources provide a service. This REQUIREMENT is not met as evidenced by: KAR 26-41-202 (a)(1)(2)(3) The facility reported a census of 34 residents (R). The sample included three residents. Based on record review and interview, the operator failed to ensure designated staff completed the Negotiated Service Agreement/Health Care Service Plan for three (R3, R4, R5) of three sampled residents based on the resident's "Functional Capacity Screen" and service needs which included the identification of "who" provided the service. Findings included: - Review of R3's medical record revealed she moved into the facility on 04/24/23 with diagnosis of dementia. R3's "Functional Capacity Screen" dated 04/24/23 identified the resident required supervision with bathing, dressing and toileting and was unable to manage her medications. R3's "Negotiated Service Agreement" (NSA) dated 05/21/23 failed to include who provided physical assistance with showering, dressing and toilet needs as well as who administered the resident her medications as not all "staff" in the facility are certified to provide direct care or administer medications.	S3085		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087054	A. BUILDING: _____ B. WING _____	08/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE EAST WICHITA	9191 E 21ST STREET NORTH 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
S3085	Continued From page 4 On 08/07/23 at 11:46 AM Licensed Nurse G acknowledged R3's NSA did not identify who provided the bathing, dressing, toileting, and medication administration assistance for R3. Licensed Nurse G reported she had usually just documented that "staff" would do the care but had not specified a certified nurse aide or certified medication aide would provide the services as required to be provided by qualified staff. The operator failed to ensure designated staff developed an NSA for R3 that identified that qualified staff provided assistance with activities of daily living and with medication administration. - Review of R4's medical record revealed she moved into the facility on 03/22/18 with diagnosis of dementia. R4's "Functional Capacity Screen" dated 02/06/23 revealed she needed physical assistance with all activities of daily living and was unable to manage her medications and medical treatments. R4's "Negotiated Service Agreement" (NSA) 02/06/23 failed to include who provided physical assistance with dressing, toileting, transfers, mobility and eating and with administration of her medications as not all staff are qualified to assist with direct care or administer medications. On 08/07/23 at 11:46 AM Licensed Nurse G acknowledged R4's NSA did not identify who provided the bathing, dressing, toileting, and medication administration assistance for R3. Licensed Nurse G reported she had usually just	S3085		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087054	A. BUILDING: _____ B. WING _____	08/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE EAST WICHITA	9191 E 21ST STREET NORTH 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
S3085	Continued From page 5	S3085		

documented that "staff" would do the care but had not specified a certified nurse aide or certified medication aide would provide the services as required to be provided by qualified staff.

The operator failed to ensure designated staff developed an NSA for R4 that identified that qualified staff provided assistance with activities of daily living and with medication administration.

- Review of R5's medical record revealed he moved into the facility on 05/01/23 with diagnosis of dementia.

R5's "Functional Capacity Screen" dated 07/13/23 revealed the resident needed physical assistance with all activities of daily living and with management of his medications.

R5's "Negotiated Service Agreement" (NSA) dated 07/13/23 failed to identify "who" provided assistance with activities of daily living and medication administration as not all facility "staff" are certified to provide medication administration.

On 08/07/23 at 11:46 AM Licensed Nurse G acknowledged R5's NSA did not identify certified staff provided assistance with activities of daily living and medication administration. Licensed Nurse G reported she had usually just documented that "staff" would do the care but had not specified a certified nurse aide or certified medication aide would provide the services as required to be provided by qualified staff.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087054	A. BUILDING: _____ B. WING _____	08/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE EAST WICHITA	9191 E 21ST STREET NORTH 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
S3085	Continued From page 6 The operator failed to ensure designated staff developed an NSA for R5 that identified that qualified staff provided assistance with activities of daily living and with medication administration.	S3085		
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)(2) The facility reported a census of 34 residents (R). The sample included three residents. Based on interview and record review the administrator failed to ensure designated staff reviewed and revised the combined "Negotiated Service Agreement/Health Care Service Plan" if necessary, for two (R4 and R5) of three sampled residents who had significant changes in status related to the initiation and discontinuation of	S3092		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087054	A. BUILDING: _____ B. WING _____	08/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE EAST WICHITA	9191 E 21ST STREET NORTH 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
S3092	Continued From page 7 services provided by an outside resource. Findings included: - Review of R4's medical record revealed she moved into the facility on 03/22/18 with diagnosis of dementia. R4's "Functional Capacity Screen" dated 02/06/23 revealed she needed physical assistance with all activities of daily living and was unable to manage her medications and medical treatments. R4's "Negotiated Service Agreement" (NSA) 02/06/23 revealed 1 person assist for dressing, 2-person assistance with toileting and transfers and assistance of 1 person for mobility with a wheelchair. The record lacked addendums or revisions to the NSA for changes in Home Health (HH) and Hospice Services. Review of the resident's record included the following changes in her Hospice and Home Health services which are provided by an outside source: 12/06/22 - Hospice was discontinued and a local Home Health (HH) agency to provide skilled nursing for wound care. 12/28/22 -Local Mobile Wound care company came in to provide wound care along with HH 01/19/23 - Local Hospice evaluation and will initiate care - HH notified to discontinue services. 07/13/23 - Hospice planned to discharge the resident - 07/20/23 - Local HH skilled nursing service initiated.	S3092		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087054	A. BUILDING: _____ B. WING _____	08/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE EAST WICHITA	9191 E 21ST STREET NORTH 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
S3092	Continued From page 8 On 08/07/23 at 12:41 PM Licensed Nurse G stated she would have completed a new NSA each time the resident started and stopped the service as it is considered a significant change. Licensed Nurse G acknowledge the NSA had not been revised to reflect the changes in services the resident received. The operator failed to ensure designated staff revised R4's NSA when she had significant changes in services provided by outside resources. - Review of R5's medical record revealed he moved into the facility on 05/01/23 with diagnosis of dementia. R5's "Functional Capacity Screen" dated 07/13/23 revealed the resident needed physical assistance with all activities of daily living and with management of his medications. R5's "Negotiated Service Agreement" (NSA) dated 07/13/23 identified the resident needed physical assistance of 1 with activities of daily living. It also included "will attempt to get PT [physical therapy] eval.". The NSA lacked addendum or revision for when the resident started physical therapy and what company provided the service. The resident record revealed he currently received services from physical therapy that were initiated on 07/25/23. On 08/07/23 at 12:41 PM Licensed Nurse G stated she would have completed a new NSA each time the resident started and stopped the	S3092		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087054	A. BUILDING: _____ B. WING _____	08/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE EAST WICHITA	9191 E 21ST STREET NORTH 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
S3092	Continued From page 9 service as it is considered a significant change. Licensed Nurse G acknowledge the NSA had not been revised to reflect the changes in services the resident received. The operator failed to ensure designated staff revised R5's NSA when she had significant changes in services provided by outside resources.	S3092		
S3166 SS=E	26-41-204 (e) Delegation of Duties (e) A licensed nurse may delegate nursing procedures not included in the nurse aide or medication aide curriculums to nurse aides or medication aides, respectively, under the Kansas nurse practice act, K.S.A. 65-1124 and amendments thereto. This REQUIREMENT is not met as evidenced by: KAR 26-41-204(e) The facility reported a census of 34 residents. Based on interview and record review the administrator failed to ensure two of two sampled Certified Medication Aides (CMA) were trained by a licensed nurse and delegated the nursing procedure for obtaining blood glucose checks according to the nurse practice act and amendments thereto. Findings included: - On 08/03/23 at 09:38 AM during completion of	S3166		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087054	A. BUILDING: _____ B. WING _____	08/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE EAST WICHITA	9191 E 21ST STREET NORTH 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
S3166	Continued From page 10 entrance checklist, Administrative Staff A reported the Certified Medication Aide is the one who checks resident's blood sugars. Review of Certified Medication Aide (CMA) D's employee file revealed a hire date of 01/19/23. It included a delegation for completion of "Blood Glucose Testing" completed on 06/30/23, More than five months after working as a CMA. Review of CMA E's employee file revealed a hire date of 06/28/22. It included a delegation for completion of "Blood Glucose Testing" completed on 06/23/23, almost one year after her hire date. The operator failed to ensure a licensed nurse delegated the nursing procedure of checking a resident's blood glucose via glucometer according to the nurse practice act, KSA 65-1124 and amendments thereto prior to completion of the task.	S3166		
S3248 SS=F	26-41-102 (d) Staff Qualifications Employee Records (d) The employee records and agency staff records shall contain the following documentation: (1) Evidence of licensure, registration, certification, or a certificate of successful completion of a training course for each employee performing a function that requires specialized education or training; (2) supporting documentation for criminal background checks of facility staff and contract staff, excluding any staff licensed or registered by a state agency, pursuant to K.S.A. 39-970 and amendments thereto;	S3248		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087054	A. BUILDING: _____ B. WING _____	08/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE EAST WICHITA	9191 E 21ST STREET NORTH 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
S3248	Continued From page 11 (3) supporting documentation from the Kansas nurse aide registry that the individual does not have a finding of having abused, neglected, or exploited a resident in an adult care home; and (4) supporting documentation that the individual does not have a finding of having abused, neglected, or exploited any resident in an adult care home, from the nurse aide registry in each state in which the individual has been known to have worked as a certified nurse aide. This REQUIREMENT is not met as evidenced by: KAR 26-41-102(d)(1)(2) The facility reported a census of 34 residents. Based on record review of five newly hired employees, the operator failed to have evidence of registration, and certification of training for one of four newly hired staff who required specialized education and training verified upon hire. The operator also failed to ensure four of five newly hired employees file contained evidence the facility completed a criminal background check upon hire by the required state agency, pursuant to K.S.A.39-970 and amendments thereto. The findings included: - On 08/07/23 review of three newly hired certified staff records who required specialized education and training verification revealed the following:	S3248		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087054	A. BUILDING: _____ B. WING _____	08/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE EAST WICHITA	9191 E 21ST STREET NORTH 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
S3248	Continued From page 12 Certified Medication Aide (CMA) E, hired on 06/28/23 did not have her registry check completed until 07/26/23. On 08/07/23 at 09:08 AM Administrative staff A stated the resident checks are to be completed on or before hire date and acknowledged CMA E did not have one completed until after she was hired and started work. The Operator failed to ensure designated staff conducted a registry check for verification of certification for CMA E prior to working at the facility. - On 08/07/23, review of the five newly hired employee records provided by Administrative Staff A, revealed the following concerns: Dietary Staff B, hired on 03/13/23 did not have the required criminal background check completed until 08/03/23, more than five months after start of employment. Certified Nurse Aide C, hired on 01/23/23 did not have the required criminal background check completed until 08/03/23, more than six months after start of employment. Certified Medication Aide D, hired on 01/19/23 did not have the required criminal background check completed until 08/03/23, more than five months after start of employment. Certified Medication Aide E, hired on 06/28/22 did not have the required criminal background check completed until 08/03/23, more than a year after start of employment.	S3248		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087054	A. BUILDING: _____ B. WING _____	08/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE EAST WICHITA	9191 E 21ST STREET NORTH 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
S3248	Continued From page 13 On 08/07/23 at 09:08 AM Administrative Staff A stated criminal background checks are to be completed through the required agency upon hire. She acknowledged for four of the five newly hired employees the criminal background checks were not completed upon hire. The operator failed to ensure designated staff completed criminal background checks through KDADS upon hire as required.	S3248		
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 34 residents (R). The sample included three residents. Based on interview and record review the operator failed to ensure each resident record contained documentation of all incidents, symptoms, and other indications of illness or injury, what was done, and the results of action taken for two (R3 and R5) of three sampled residents. Findings included:	S3261		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087054	A. BUILDING: _____ B. WING _____	08/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE EAST WICHITA	9191 E 21ST STREET NORTH 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
S3261	Continued From page 14	S3261		

- Review of R3's medical record revealed she moved into the facility on 04/24/23 with diagnosis of dementia.

R3's "Functional Capacity Screen" dated 04/24/23 identified the resident required supervision with bathing, dressing and toileting and was unable to manage her medications.

R3's "Negotiated Service Agreement" (NSA) dated 05/21/23 revealed the resident needed one-person physical assistance with showers and dressing. She needed reminders to toilet and someone to administer her medications.

Review of R3's progress notes revealed the following:
06/28/23 the medical provider was in the facility for anxiety and agitation and started the resident on Sertraline (antidepressant) 50 milligrams daily.
07/19/23 the medical provider was in the facility and increased the Sertraline to 75 milligrams daily.
The record failed to include documentation of symptoms or behaviors the resident had to indicate a need to initiate the Sertraline, failed to include documentation of the symptoms not being controlled and needing an increase in the medication.

On 08/07/23 at 11:51 AM Licensed Nurse G acknowledged the record lacked documentation of symptoms related to the initiation and increase in R3's antidepressant medication.

The operator failed to ensure designated staff documented all incidents, symptoms, and other

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087054	A. BUILDING: _____ B. WING _____	08/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE EAST WICHITA	9191 E 21ST STREET NORTH 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
S3261	Continued From page 15 indications of illness or injury, what was done, and the results of action taken for R3 related to her Sertraline. - Review of R5's medical record revealed he moved into the facility on -5/01/23 with diagnosis of dementia. R5's "Functional Capacity Screen" dated 07/13/23 revealed the resident needed physical assistance with all activities of daily living and with management of his medications. R5's "Negotiated Service Agreement" (NSA) dated 07/13/23 identified the resident needed physical assistance of 1 with activities of daily living. Review of R5's progress notes revealed the following: 07/07/23 started on Lorazepam (antianxiety) 0.5 milligrams. The record lacked documentation of symptoms to indicate need for an antianxiety medication or follow up as to the new medications effectiveness. 07/26/23 started on Tramadol (opioid pain medication) 50 milligrams twice a day. The record lacked documentation of the resident complaining of pain prior to initiate of the medications or follow up on the effectiveness of the medications. On 08/03/23 at 03:39 PM Licensed Nurse acknowledged R5's record should have included symptoms related to the need for medication change and follow up on the effectiveness of the new medication.	S3261		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087054	A. BUILDING: _____ B. WING _____	08/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE EAST WICHITA	9191 E 21ST STREET NORTH 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
S3261	Continued From page 16 The operator failed to ensure designated staff documented all incidents, symptoms, and other indications of illness or injury, what was done, and the results of action taken for R5 related to the initiation of an antianxiety medication and an opioid pain medication.	S3261		
S3280 SS=E	26-41-104 (d) Disaster and Emergency Preparedness (d) Each administrator or operator shall ensure disaster and emergency preparedness by ensuring the performance of the following: (1) Orientation of new employees at the time of employment to the facility ' s emergency management plan; (2) education of each resident upon admission to the facility regarding emergency procedures; (3) quarterly review of the facility ' s emergency management plan with employees and residents; and (4) an emergency drill, which shall be conducted at least annually with staff and residents. This drill shall include evacuation of the residents to a secure location. This REQUIREMENT is not met as evidenced by: KAR 26-41-104(d)(3) The facility reported a census of 34 residents. Based on record review and interview for all facility employees, the administrator failed to ensure disaster and emergency preparedness by	S3280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087054	A. BUILDING: _____ B. WING _____	08/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE EAST WICHITA	9191 E 21ST STREET NORTH 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
S3280	Continued From page 17 ensuring performance of quarterly reviews of the facility's emergency management plan with all employees. Findings included: - On 08/03/23 at 02:24 PM Administrative Staff A provided employee training for reviewing of the emergency management plan. She provided the one she completed on 07/13/23 and reported the only other one she could find was dated 02/16/23. On 08/03/23 at 02:24 PM Administrative staff A acknowledged the employee reviews of the emergency management plan had not been completed quarterly according to required regulations. The operator failed to ensure the facility's emergency management plan was reviewed with all employees quarterly.	S3280		
S3310 SS=F	26-41-207 (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; and (c) Each administrator or operator shall ensure the facility ' s compliance with the department ' s tuberculosis guidelines for adult care homes	S3310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087054	A. BUILDING: _____ B. WING _____	08/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE EAST WICHITA	9191 E 21ST STREET NORTH 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
S3310	Continued From page 18 adopted by reference in K.A.R. 26-39-105 This REQUIREMENT is not met as evidenced by: KAR 26-41-207(c) The facility reported a census of 34 residents (R). The sample included three residents. Based on interview and record review the administrator failed to ensure the facility remained in compliance with the department's tuberculosis (TB) guidelines for adult care homes adopted by reference in KAR 26-39-105 for five of five newly hired staff and two (R3, R5) of three sampled residents. Findings included: - Review of five newly hired employee records revealed the following: Dietary Staff B hired on 03/13/23 had a one step TB skin test completed on 03/15/23 but did not receive a second TB skin test until 07/21/23. She also did not receive a TB symptoms screen questionnaire until 07/13/23, more than seven days after her hire date. Certified Nurse Aide C hired on 01/23/23 had a one step TB skin test completed on 01/26/23 but did not receive a second TB skin test until 07/21/23. She also did not receive a TB symptoms screen questionnaire until 07/15/23, more than seven days after her hire date.	S3310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087054	A. BUILDING: _____ B. WING _____	08/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE EAST WICHITA	9191 E 21ST STREET NORTH 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
S3310	Continued From page 19 Certified Medication Aide (CMA) D hired on 01/19/23 revealed she did not have a TB symptom screen until 07/15/23 and did not have a TB skin test until 07/21/23, more than seven days after her hire date. CMA E's had a hire date of 06/28/22 and she did not have a TB symptom screen completed until 12/20/22, more than seven days after hire date. Licensed Nurse F had a hire dated of 03/27/23 and did not have a TB symptoms screen or a two-step TB skin test completed. The department's June 2013 "Tuberculosis (TB) Guidelines for Adult Care Homes" documented "Each new employee shall have an initial TB symptom screen. . . within seven days of employment. . . Each new employee shall receive a two-step TST. . . within seven days of residency or employment." On 08/07/23 at 09:08 AM Administrative staff A reported new employees were to receive a two step on hire and a TB symptom screen upon hire. The administrator failed to ensure the facility remained in compliance with the department's tuberculosis guidelines for adult care homes adopted by reference in KAR 26-39-105. - Review of R3's medical record revealed she moved into the facility on 04/23/23. Her record included TB skin test planted on 07/12/23 and 07/21/23 but did not include the date they were read and were done more than seven days after admission to the facility.	S3310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087054	A. BUILDING: _____ B. WING _____	08/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE EAST WICHITA	9191 E 21ST STREET NORTH 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
S3310	Continued From page 20 - Review of R5's medical record revealed he moved into the facility on 05/01/23. His record included TB skin tests planted on 07/12/23 and 07/21/23 but did not include a date they were read and they were done more than seven days after admission to the facility. On 08/07/23 at 11:45 AM Licensed Nurse G reported they try to get the TB skin tests started on the day they move in but it doesn't always happen. She acknowledged they are supposed to be initiated within seven days of moving into the facility. The department's June 2013 "Tuberculosis (TB) Guidelines for Adult Care Homes" documented "Each new resident shall have an initial TB symptom screen. . . within seven days of employment. . . Each new resident shall receive a two-step TST. . . within seven days of residency". The operator failed to ensure designated staff completed TB skin tests for new residents according to the department's tuberculosis guidelines for adult care homes adopted by reference in KAR 26-39-105.	S3310		