STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087215	A. BUILDING: _____ B. WING _____	03/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRIST CARE HOME PLUS, LLC	7901 W JENNIE STREET WICHITA, KS 67212

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S 000	INITIAL COMMENTS The following citations represent the findings of a Re-Licensure survey for the above named facility conducted on 03/04/24 and 03/05/24.	S 000		
S5105 SS=E	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 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)(2)(3) The facility reported a census of eight residents(R). The sample included three residents. Based on interview, and record review for three (R3, R4 and R5) of three sampled residents, the operator failed to ensure designated staff developed a "Negotiated Service Agreement" based on the resident's "Functional Capacity Screen" and service needs	S5105		

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S5105	Continued From page 1 that included identification of services provided related to falls, cognition, impaired vision, and impaired decision-making ability. Findings included: - R3's medical record revealed she moved into the facility on 02/26/24 with diagnosis of diabetes mellitus type II. R3's "Functional Capacity Screen" (FCS) completed on 02/26/24 revealed she was at risk for falls. R3's "Negotiated Service Agreement" (NSA) dated 02/26/24 failed to include services the staff provided related to R3 being at risk for falls. On 03/05/24 at 07:30 AM Licensed Nurse E reviewed R3's NSA and acknowledged it did not address services related to R3's risk for falls. The operator failed to ensure designated staff completed R3's NSA to include a description for services related to her risk for falls. - R4's medical record revealed she moved into the facility on 09/10/22 with a diagnosis of Crohn's disease. R4's "Functional Capacity Screen" dated 09/19/23 revealed she had impaired cognition and impaired decision-making ability. R4's "Negotiated Service Agreement" (NSA) dated 09/19/23, failed to include a description of services related to R4's impaired cognition and impaired decision-making ability.	S5105		

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S5105	Continued From page 2 On 03/05/24 at 07:37 AM Licensed Nurse E reviewed R4's NSA and confirmed it did not include a description of services related to cognition and impaired decision-making ability. - R5's medical record revealed she moved into the facility on 09/24/21 with diagnosis of bipolar disorder. R5's "Functional Capacity Screen" dated 09/30/23 revealed she had current risk/problems with falls, had impaired vision and impaired decision-making ability. R5's "Negotiated Service Agreement" signed 09/30/23 failed to include a description of services related to R5's risk for falls, impaired vision and impaired decision-making ability. On 03/05/24 at 07:39 AM Licensed Nurse E reviewed R5's NSA and confirmed it did not include services related to falls, impaired vision and impaired decision-making ability. The operator failed to ensure designated staff completed R5's NSA to include a description of services related to falls, impaired vision, and impaired decision-making ability.	S5105		
S5251 SS=E	26-42-105 (f) (11) Resident Records 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.	S5251		

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S5251	Continued From page 3 This REQUIREMENT is not met as evidenced by: KAR 26-42-105(f)(11) The facility reported a census of four residents(R). The sample included three residents. Based on interview and record review the operator failed to ensure the medical record contained documentation of all incidents, symptoms, and other indications of illness or injury including the date and time, action taken, and results of the action for two (R4 and R5) of three sampled residents. Findings included: - R4's medical record revealed she moved into the facility on 09/10/22 with a diagnosis of Crohn's disease. R4's "Functional Capacity Screen" dated 09/19/23 revealed she required physical assistance with bathing, was unable to participate in the management of her medications and medical treatments. She also had impaired cognition, bladder incontinence, and impaired decision-making ability. R4's "Negotiated Service Agreement" (NSA) dated 09/19/23, revealed facility staff provided R4 assistance with bathing, qualified staff administered medications and managed medical treatments. R4's medical record included the following medication orders:	S5251		

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S5251	Continued From page 4 12/04/23 - increase Seroquel (an antipsychotic) to twice a day instead of bedtime only. The record lacked documentation of behaviors or symptoms to account for the need to increase the medication or follow up if the increase was effective. 01/15/24 - increase Lorazepam (antianxiety) to 1 milligram at bedtime and every four hours as needed. The record lacked follow-up on the effectiveness of the changes in her antianxiety medication. On 03/05/24 at 07:38 AM Licensed Nurse E acknowledged she had not documented follow up when R4 had changes to her antipsychotic and antianxiety medications. The operator failed to ensure R4's record included documentation of the results of actions taken related to changes in R4's antipsychotic and antianxiety medication. - R5's medical record revealed she moved into the facility on 09/24/21 with diagnosis of bipolar disorder. R5's "Functional Capacity Screen" dated 09/30/23 revealed she needed physical assistance with all activities of daily living except for eating, was unable to manage her medications or medical treatments, and was at risk for falls. R5's "Negotiated Service Agreement" signed 09/30/23 revealed qualified staff provided R5 assistance with activities of daily living and administered her medications.	S5251		

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S5251	Continued From page 5 R5's nursing notes revealed the following: 09/14/23 - has days of being lethargic and other days she is talkative and more alert - decrease hydroxyzine to daily and hold Melatonin but can give if not sleeping at night. The record lacked follow up on holding the melatonin or the results of the decreasing of the Hydroxyzine (antihistamine). 10/20/23 - has been lethargic last four mornings, new orders to decreasing Norco (narcotic pain medication) to every 8 hours. The record lacked follow up related to the resident having lethargy or how decreasing the Norco effected the resident's pain. 11/30/23 - resident started on Remeron (antidepressant). The record lacked documentation related to the effects of the resident starting on and antidepressant. On 03/05/24 at 07:42 PM Licensed Nurse E reviewed R5's nursing notes and acknowledged they lacked documentation of the effectiveness and any adverse effects related to medications changes. The operator failed to ensure R5's record included documentation of the results of actions taken related to changes in R5's medications.	S5251		
S5266 SS=D	26-42-205 (a) (2) Self Administration Assessment content (a) (2) Each assessment shall include an evaluation of the resident ' s physical, cognitive, and functional ability to safely and accurately self-administer and manage medications independently or by using a prefilled medication container or prefilled syringe.	S5266		

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S5266	Continued From page 6 This REQUIREMENT is not met as evidenced by: KAR 26-42-205(a)(2) The facility reported a census of four resident's (R). The sample included three residents. Based on interview, and record review, the operator failed to ensure license nurse assessed R3 for her ability to self-inject her insulin after qualified staff prepared and dialed the insulin pen to the correct ordered dosage. Findings included: - R3's medical record revealed she moved into the facility on 02/26/24 with diagnosis of diabetes mellitus type II. R3's Functional Capacity screen dated 02/26/24 revealed the resident was unable to manage her own medications or medical treatments. R3's Negotiated Service Agreement dated 02/26/24 revealed facility Certified Medication Aides and Licensed Nurses will administer the resident's medications and medical treatments. R3's Health Care Service Plan dated 02/26/24 identified she administered her insulin injections, and the rest of her medications were administered by facility staff. R3's medical record lacked evidence of a licensed nurse assessing the resident to ensure she could accurately and safely self inject her insulin.	S5266		

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S5266	Continued From page 7 On 03/05/24 at 07:27 AM Licensed Nurse E confirmed she had not completed a self-medication assessment that included R3's physical, cognitive, and functional ability to safely and accurately self manage injecting her insulin after prepared by qualified facility staff. The operator failed to ensure a license nurse assessed R3 for her ability to self-inject her insulin after her insulin pen was prepared and dialed to the correct ordered dosage.	S5266		
S5302 SS=D	26-42-205 (d) (4) Delegation of Medication Administration (4) Any licensed nurse may delegate nursing procedures not included in the medication aide curriculum to medication aides under the Kansas nurse practice act, K.S.A. 65-1124 and amendments thereto. This REQUIREMENT is not met as evidenced by: KAR 26-42-205(d)(4) The facility reported a census of four residents(R). Based on interview and record review for four of four current "Certified Medications Aide's", revealed the operator failed to ensure a Licensed Nurse delegated the nursing procedure for dialing of insulin pens for each certified medication under the Kansas nurse practice act, K.S.A. 65-1124 and amendments thereto.	S5302		

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S5302	Continued From page 8 Findings included: - Review of the resident roster provided by Operator/Certified Medication Aide (CMA) revealed one resident received insulin injections. On 03/04/24 at 02:07 PM surveyor requested to review delegation for Certified Medication Aide (CMA) A, CMA B, CMA C, and CMA D regarding the preparing of insulin pens and dialing them to the ordered administration dosage. On 03/04/25 at 02:26 Operator/ CMA C stated the nurse left instructions in the Medication Administration Record for how to prepare the insulin pen but was unable to find delegation that the licensed nurse oriented and instructed the CMAs how to prepare and dial an insulin pen correctly. The operator failed to ensure the procedure for dialing of insulin pens was delegated to CMA's according to the Kansas nurse practice act, K.S.A. 65-1124 and amendments thereto.	S5302		
S5315 SS=F	26-42-205 (h) Medication Storage (h) Storage. Licensed nurses and medication aides shall ensure that all medications and biologicals are securely and properly stored in accordance with each manufacturer ' s recommendations or those of the pharmacy provider and with federal and state laws and regulations. (1) Licensed nurses or medication aides shall store non-controlled medications and biologicals managed by the home in a locked medication room, cabinet, or medication cart. Licensed	S5315		

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S5315	Continued From page 9 nurses and medication aides shall store controlled medications managed by the home in separately locked compartments within a locked medication room, cabinet, or medication cart. Only licensed nurses and medication aides shall have access to the stored medications and biologicals. (2) Each resident managing and self-administering medication shall store medications in a place that is accessible only to the resident, licensed nurses, and medication aides. (3) Any resident who self-administers medication and is unable to provide proper storage as recommended by the manufacturer or pharmacy provider may request that the medication be stored by the home. (4) A licensed nurse or medication aide shall not administer medication beyond the manufacturer ' s or pharmacy provider ' s recommended date of expiration. This REQUIREMENT is not met as evidenced by: KAR 26-42-205(h)(1) The facility reported a census of four residents (R). Based on observation, interview, and record review the operator failed to ensure staff stored controlled non-controlled medications managed by the home securely in a locked cabinet and controlled medications in separately locked compartment within a locked medication cabinet or cart to ensure only licensed nurses and medication aides have access to the stored medications.	S5315		

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S5315	Continued From page 10 Findings included: - Observation on 03/04/24 at 10:10 AM the small refrigerator in the laundry room was unlocked. The refrigerator contained the following medications, three Lantus insulin pens, three Trulicity pens, and five insulin Aspart pens for R3. A box of Latanoprost eye drops and a box of Arformoterol Tartrate inhalation solution for R6. The refrigerator also contained a lock box that Operator/Certified Medication Aide A thought was empty. Staff A unlocked the lockbox which contained a syringe with a "cream" in it and it's label partially torn off. Staff A stated it had to have been for a Hospice resident and did not know who it belonged to. The operator failed to ensure medications were stored securely in locked cabinet to ensure only "Licensed Nurses" and "Certified Medication Aides" had access to controlled and non-controlled medications.	S5315		