STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N048003	A. BUILDING: _____ B. WING _____	03/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WHEATLANDS HEALTH CARE CENTER	750 W WASHINGTON ST KINGMAN, KS 67068

(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 03/25/24.	S 000		
S3261 SS=D	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 14 residents (R). The sample included three residents. Based on interview and record review the operator failed to ensure one (R5) of three sampled residents records contained documentation of all incidents, symptoms, and other indications of illness or injury, what was done, and the results of action taken related to increased edema. Findings included: - R5 moved into the facility on 10/31/22 with diagnosis of Parkinson's disease. R5's "Functional Capacity Screen dated 10/31/23 indicated he was independent with activities of daily living, and administration of his medications but was unable to manage medical treatments.	S3261		

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
	N048003	A. BUILDING: _____ B. WING _____	03/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WHEATLANDS HEALTH CARE CENTER	750 W WASHINGTON ST KINGMAN, KS 67068

(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 1 On 03/25/24 at 10:44 AM Administrative Nurse B reported the "Negotiated Service Agreement" and the "Health Care Service Plan" (NSA/HCSP) were one document. R5's NSA/HCSP dated 10/31/23 identified medical treatments would be completed by facility qualified staff. Review of nursing progress notes from 03/01/23 to current revealed the following: 10/10/23 - Resident returned from medical providers office with new orders to wrap bilateral legs with ACE wraps every morning from the toes up to the knee. Remove wraps at bedtime and massage with lotion on both legs. 10/20/23 - voice mail left with medical provider regarding worsening edema in both lower extremities with blistering to the top of R5's feet and refusal to wear wraps due to discomfort. 10/20/23 - new orders for furosemide (diuretic) 40 milligrams daily and lymphedema (swelling in legs due to blockage in lymphatic system) treatments. 10/26/23 - Home Health contacted about providing lymphedema treatments and orders with medical provider. 11/10/23 - continue daily wraps. The record lacked documentation regarding if home health services were being provided for lymphedema treatments and lacked documentation on the effectiveness of the wraps as related to edema in resident's lower legs. On 03/25/24 at 03:37 PM Administrative Nurse B	S3261		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N048003	A. BUILDING: _____ B. WING _____	03/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WHEATLANDS HEALTH CARE CENTER	750 W WASHINGTON ST KINGMAN, KS 67068

(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 2 reported R5 did not receive treatments from Home Health as they were unable to provide services like the medical provider had initially wanted. She acknowledged the record should have included information related to R5's edema, if it was improving or not and treatment plans. The executive director failed to ensure designated staff documented all symptoms of illness, incidents, what action was taken, and effectiveness of that action related to R5's edema.	S3261		
S3320 SS=F	28-39-254 CONSTRUCTION (a) The assisted living facility or residential health care facility shall be designed, constructed, equipped and maintained to protect the health and safety of residents, personnel and the public. (b) All new construction, renovation, remodeling and changes in building use in existing buildings shall comply with building and fire codes, ordinances and regulations enforced by city, county, and state jurisdictions, including the state fire marshal. (c) New construction, modifications and equipment shall conform to the following codes and standards: (1) Title III of the Americans with disabilities act, 42 U.S.C. 12181, effective as of January 26, 1992; and (2) "Food Service Sanitation Manual," health, education, and welfare (HEW) publication	S3320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N048003	A. BUILDING: _____ B. WING _____	03/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WHEATLANDS HEALTH CARE CENTER	750 W WASHINGTON ST KINGMAN, KS 67068

(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
S3320	Continued From page 3 no. FDA 78-2081, as in effect on July 1, 1981. This REQUIREMENT is not met as evidenced by: KAR 28-39-254 (a) The facility reported a census of 14 residents(R). Based on observation and interview the administrator failed to ensure staff secured all chemicals to maintain the safety of all residents, personnel, and the public. Findings included: - On 03/25/24 at 09:57 AM during initial tour the following chemicals were observed in areas of the facility that were accessible to residents and visitors: In the kitchen serving area in the cabinet under the kitchen sink was a plastic container of dish washer pods, a bottle of automatic dishwasher liquid, a spray bottle of cleaner for mold and mildew, a spray bottle of window cleaner, canister of comet, and a bottle of jet dry, all with warning "to keep out of the reach of children". Another cabinet in the same area had a bottle of Reliance bleach that also had a warning label on it to "keep out of reach of children". On 03/25/24 at 10:02 AM Dietary Staff C reported the cabinet under the sink was not kept locked and neither was the cabinet that contained the bleach. On 03/25/24 at 10:43 AM Administrative Staff A reported she did not think they were to keep the chemicals in that cabinet, and it should be	S3320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N048003	A. BUILDING: _____ B. WING _____	03/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WHEATLANDS HEALTH CARE CENTER	750 W WASHINGTON ST KINGMAN, KS 67068

(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
S3320	Continued From page 4 locked. At 10:53 AM Administrative staff A reported dietary manager reported the cabinet lock was broke but was on the list to get it fixed. The administrator failed to ensure chemicals were secured for the safety of all residents, personnel, and visitors.	S3320		