| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | N087049 | A. BUILDING: _____ B. WING _____ | 02/06/2025 |

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|---|---|
| LAKEPOINT WICHITA, LLC | 1315 N WEST STREET WICHITA, KS 67203 |

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| S 000 | INITIAL COMMENTS<br><br>The following citations represent the findings of a Re-Licensure Survey with complaint investigations 183375, 188093, 188529, 190272, 190241, 190753, and 192504 for the above named Assisted Living Facility conducted on 02/05/25 and 02/06/25. | S 000 | | |
| S3092 SS=E | 26-41-202 (d) Negotiated Service Agreement Revisions<br><br>(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;<br>(2) following any significant change in condition, as defined in K.A.R. 26-39-100;<br>(3) at least quarterly, if the resident receives assistance with eating from a paid nutrition assistant; and<br>(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.<br><br>This REQUIREMENT is not met as evidenced by:<br>KAR 26-41-202 (d)(2)<br><br>The facility reported a census of 45 residents(R). The sample included three residents, one closed record review. Based on observation, interview, and record review the executive director failed to ensure designated staff reviewed and revised the "Negotiated Service Agreement" for two (R3, R7) | S3092 | | |

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

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| S3092 | Continued From page 1 | S3092 | | |

of three sampled residents when the resident had a significant change in service needs related to skilled therapy.

Findings included:

- R3's "Electronic Medical Record" (EMR) revealed he moved into the facility on 10/08/24 with diagnoses of type II diabetes Mellitus and coronary artery disease.

R3's "Functional Capacity Screen" (FCS) dated 10/08/24 identified he needed supervision with bathing and physical assistance with management of medications and medical treatments. Staff identified he also had a current risk/problem for falls.

R3's "Negotiated Service Agreement" (NSA) Dated 10/08/24 did not identify R3 received any outside services related to physical or occupational therapy.

R3's EMR included the following orders:
01/21/25 - Physical therapy/ Occupational Therapy/ Speech therapy evaluate and treat.
01/21/25 - Occupational therapy clarification - treat three times per week x four weeks.
01/22/25 - Physical therapy clarification - treat three times per week x four weeks.
01/23/25 - speech therapy clarification - treat three times per week x eight weeks.

Observation on 02/06/25 at 07:57 R3 got up from the breakfast table, looked around and then walked toward the front door to visit with his spouse. His did not use an assistive device, his gait was slow and steady with occasional need to

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| S3092 | Continued From page 2 | S3092 | | |

touch furniture for balance.

Interview on 02/06/25 at 12:21 PM Administrative Licensed Nurse B acknowledged R3 had started therapy services through a local therapy company. She also acknowledged that she had not completed an addendum to the NSA identifying that he had a change in services needs related the initiation of skilled therapy.

The executive director failed to ensure designated staff reviewed and revised R3's NSA/HCSP when he had a significant change in service needs related to Physical, occupational and speech therapy.

- R7's Paper and Electronic medical record revealed she moved into the facility on 04/03/24 with diagnosis of chronic kidney disease.

R7's "Functional Capacity Screen" dated 04/03/24 revealed she needed supervision with bathing and administration of her medications but was unable to manager her medical treatments. She also had a current or problem with risk for falls.

R7's "Negotiated Service Agreement" (NSA) dated 04/03/24 did not include outside services related to therapy services. R7's record lacked evidence of reviewing or revising the NSA when she started and stopped physical therapy.

R7's Electronic Medical record included information that she received Physical therapy from 09/13/24 to 01/10/25 from an outside resource.

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| S3092 | Continued From page 3<br><br>Interview ON 02/06/25 at 01:52 PM Administrative Licensed Nurse B acknowledged she had not completed an addendum to R7's NSA when she started or stopped therapy services.<br><br>The executive director failed to ensure designated staff reviewed and revised R7's NSA when she had significant a change in service needs related to physical therapy. | S3092 | | |
| S3256 SS=E | 26-41-105 (c) Resident Records Safeguards<br><br>(c) Each administrator or operator shall ensure the safeguarding of resident records against the following:(1) Loss;<br>(2) destruction;<br>(3) fire;<br>(4) theft; and<br>(5) unauthorized use.<br><br>This REQUIREMENT is not met as evidenced by:<br>KAR 26-41-105(c)(4),(5)<br><br>The facility reported a census of 45 residents. Based on observation and interview. Based on observation, interview the executive director failed to ensure closed resident medical records were kept safe and free from the possibility of theft or unauthorized use.<br><br>Findings included: | S3256 | | |

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| S3256 | Continued From page 4<br><br>- Observation during initial tour on 02/05/25 at 08:20 AM revealed a room at the end of the 1000 hall that was unsecured and included multiple boxes of resident/staff records and manilla envelopes.<br><br>Interview on 02/05/25 at 08:25 AM Administrative Nurse C checked the "storage" room and stated resident records should be kept in a locked room and secure.<br><br>Observation on 02/06/25 at 10:53 AM with Administrative Staff A and Licensed Nurse D revealed the "storage room" remained unlocked and contained the following records, 10 boxes identified as discharged resident records dating from 2021 to 2023. The manila envelopes included staffing schedules and R5, R8 and R9's paper medical records. While checking the "storage room" Administrative Staff A reported he thought staff had locked the door yesterday and acknowledged it should be locked and records secured.<br><br>The operator failed to ensure designated staff secured resident's records in a way to maintain and safeguarded against theft and possible unauthorized use. | S3256 | | |
| S3261 SS=D | 26-41-105 (f) (11) Resident Record Documentation of Incidents<br><br>(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 | S3261 | | |

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| S3261 | Continued From page 5 | S3261 | | |

This REQUIREMENT is not met as evidenced by:
KAR 26-41-105(f)(11)

The facility reported a census of thirty-four residents(R). The sample included three residents, one closed record review. Based on interview and record review the executive director failed to ensure one (R7 ) of three sampled residents record contained documentation of all incidents, symptoms, and other indications of illness or injury, what action was taken, and the results of action taken.

Findings included:

- R7's Paper and Electronic medical record revealed she moved into the facility on 04/03/24 with diagnosis of chronic kidney disease.

R7's "Functional Capacity Screen" dated 04/03/24 revealed she needed supervision with bathing and administration of her medications but was unable to manager her medical treatments. She also had a current or problem with risk for falls.

R7's "Negotiated Service Agreement" (NSA) dated 04/03/24 did not include outside services related to therapy services. R7's record lacked evidence of reviewing or revising the NSA when she started and stopped physical therapy.

R7's Electronic Nurse Progress notes included the following documentation:

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| S3261 | Continued From page 6<br><br>05/14/2024 Resident has right knee pain, new order for Voltaren Arthritis pain Gel to right knee three times a day for 10 days.<br>The record lacked follow up if the Voltaren Gel was effective.<br>06/19/2024 new orders to titrate and discontinue Duloxetine (antidepressant) and start Sertraline antidepressant with a titration to increase dosage. The new order also included to discontinue Mybetriq (for overactive bladder).<br>The record lacked follow up as to the results of the medication changes.<br>09/23/24 - New order to restart Oxycodone (narcotic pain medication) twice a day for pain.<br>The record lacked follow up on the results of restarting the oxycodone.<br>12/31/2024 . new order for Keflex (antibiotic) three times a day for three days for Urinary Tact Infection. (UTI).<br>The record lacked documentation of resident symptoms of UTI and if they had resolved post treatment.<br><br>Interview on 02/06/25 at 01:53 PM Administrative Licensed Nurse B reported she expected nursing staff to document in the progress notes with any change in condition, new orders, change of services, when the notify families and would expect staff to document on any negative issue to make sure the physician and legal representative had been notified. Administrative Licensed Nurse B reviewed progress notes and acknowledged documentation did not include follow up when new medications were initiated, or medications discontinued.<br><br>The executive director failed to ensure R7's medical record included documentation including | S3261 | | |

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| S3261 | Continued From page 7<br>all incidents, symptoms, and other indications of illness or injury, what action was taken, and the results of action taken. | S3261 | | |
| S3280 SS=F | 26-41-104 (d) Disaster and Emergency Preparedness<br><br>(d) Each administrator or operator shall ensure disaster and emergency preparedness by ensuring the performance of the following:<br>(1) Orientation of new employees at the time of employment to the facility ' s emergency management plan;<br>(2) education of each resident upon admission to the facility regarding emergency procedures;<br>(3) quarterly review of the facility ' s emergency management plan with employees and residents; and<br>(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.<br><br>This REQUIREMENT is not met as evidenced by:<br>KAR 26-41-104(d)(3)<br><br>The facility reported a census of 45 residents. Based on record review and interview for all employees and all residents, the executive director failed to ensure disaster and emergency preparedness by ensuring performance of quarterly reviews of the facility's emergency management plan with all facility staff and | S3280 | | |

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| S3280 | Continued From page 8<br>residents.<br><br>Findings included:<br><br>- Review of the emergency plan reviews for residents, provided by Administrative Licensed Nurse B on 02/05/25 at 11:43 AM included review of "Partial Evacuation" and "Shelter in Place or Severe Weather Tornado" conducted in December of 2024. She had no additional reviews of the eight required possible emergencies.<br><br>Interview on 02/05/25 at 11:44 AM Administrative Licensed Nurse B reported when she came to the facility, they had not been completing reviews of the emergency management plan. She also acknowledged that she had not conducted reviews for all eight required areas of possible emergencies.<br><br>- Interview on 02/06/25 at 10:20 AM Administrative Staff A reported the facility had not conducted quarterly reviews of the emergency management plan with employees.<br><br>For Employees and Residents, the executive director failed to ensure the facility's emergency plan was reviewed quarterly. | S3280 | | |
| S3310 SS=F | 26-41-207 (b) (5-6) (c) Infection Control Policies<br><br>(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; | S3310 | | |

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| S3310 | Continued From page 9<br>(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<br>(c) Each administrator or operator shall ensure the facility ' s compliance with the department ' s tuberculosis guidelines for adult care homes adopted by reference in K.A.R. 26-39-105<br><br>This REQUIREMENT is not met as evidenced by:<br>K.A.R 26-41-207(c)<br><br>The facility reported a census of 45 residents (R). The sample included three residents one closed record review. Based on interview and record review for two (R3, R7) of three sampled residents the executive director failed to ensure the facility remained in compliance with the department's TB guidelines for adult care homes adopted by reference in K.A.R. 26-39-105.<br><br>Findings included:<br><br>- R3's "Electronic Medical Record" (EMR) revealed he moved into the facility on 10/08/24 with diagnoses of type II diabetes mellitus and coronary artery disease.<br><br>R3's EMR revealed he had a TB symptom screen completed on 10/08/24, had an initial TB skin test implanted on 10/09/24 but it had not been read and identified as "status is pending" in the EMR. He also had a second TB skin test implanted on 10/16/24 which had results of | S3310 | | |

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| S3310 | Continued From page 10 | S3310 | | |

0-millimeter induration but did not include a date when staff read it.

Interview on 02/06/25 at 12:21 PM Administrative Licensed Nurse B on admission residents receive a two step TB skin test and also have a TB questionnaire completed on admission and annually. Administrative Licensed Nurse B looked through R3's electronic record and confirmed staff failed to read R3's initial TB skin test and could not find a date staff read his second TB skin test.

Review of the departments "Tuberculosis (TB) Guidelines for Adult Care Homes" June 2013 revealed each new resident shall have an initial TB symptom screen that included the components of the "Tuberculosis Symptom Screen Questionnaire" within seven days of residency and shall receive a two-step TB skin test within seven days of residency.

The executive director failed to ensure the facility remained in compliance with the department's tuberculosis guidelines for adult care homes adopted by reference in K.A.R. 26-39-105 by failing ensure designated staff completed R3's TB skin test according to TB guidelines.

- R7's paper medical record revealed she moved in on 04/03/24 with diagnosis of chronic kidney disease.

R7's record revealed she had a second TB skin test planted on 04/10/24 but designated staff failed to read the results.

Interview on 02/06/25 at 01:49 PM Administrative

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| S3310 | Continued From page 11<br><br>Licensed Nurse B acknowledged the "Tuberculosis (TB) Tracking Form" revealed her second TB skin test was not read.<br><br>Review of the departments "Tuberculosis (TB) Guidelines for Adult Care Homes" June 2013 revealed each new resident shall have an initial TB symptom screen that included the components of the "Tuberculosis Symptom Screen Questionnaire" within seven days of residency and shall receive a two-step TB skin test within seven days of residency.<br><br>The executive director failed to ensure the facility remained in compliance with the department's tuberculosis guidelines for adult care homes adopted by reference in K.A.R. 26-39-105 by failing ensure designated staff completed R7's TB skin test according to TB guidelines. | S3310 | | |