STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087041	A. BUILDING: _____ B. WING _____	05/10/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORNERSTONE ASSISTED LIVING INC	1240 N BROADMOOR AVENUE 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 resurvey of the above assisted living facility on 5/8/18, 5/9/18, and 5/10/18.	S 000		
S3082 SS=D	26-41-201 (d) Functional Capacity Screen Accurate d) Designated facility staff shall ensure that each resident ' s functional capacity at the time of screening is accurately reflected on that resident ' s screening form. This REQUIREMENT is not met as evidenced by: KAR 26-41-201(d) The facility reported a census of 37 residents. The sample included 3 residents. Based on record review and interview for 1 (#150) of 3 residents sampled, licensed nurse C failed to ensure the functional capacity screen accurately reflected the resident's cognitive status at the time of screening. Findings included: - Record review for resident #150 revealed an admission date of 6/30/17 with diagnoses of hypothyroidism and hypertension. Functional capacity screens dated 7/25/17 and 4/12/18 each indicated resident did not experience impaired short-term memory, long-term memory, memory recall, or decision-making ability. At approximately 11:00 a.m. on 5/9/18, surveyor observed certified staff D assist resident to locate	S3082		

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

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S3082	Continued From page 1 his/her room. During an interview with resident #150 in his/her room at 1:25 p.m. on 5/9/18, resident was unable to state the city where he/she currently lived, the current month, the current year, or the name of the president of the United States. During an interview at 1:47 p.m. on 5/9/18, licensed nurse C stated each functional capacity screen should contain '4' (to indicate resident experienced impaired short-term memory, long-term memory, memory recall, and decision making) and not '0' as the score for resident's cognitive ability. Licensed nurse C failed to ensure the functional capacity screen accurately reflected resident #150's cognitive status at the time of screening.	S3082		
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		

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S3085	Continued From page 2 payment if outside resources provide a service. This REQUIREMENT is not met as evidenced by: KAR 26-41-202(a)(1)(2) The facility reported a census of 37 residents. The sample included 3 residents. Based on record review and interview for 2 (#160 and #150) of 3 residents sampled, the operator failed to ensure the development of a written negotiated service agreement based on the resident's functional capacity screen, service needs, and preferences of the resident that included a description of services the resident would receive and the identification of the provider of each service. Findings included: - Record review for resident #160 revealed an admission date of 12/30/16 with diagnoses of type 2 diabetes mellitus and chronic kidney disease. Functional capacity screen dated 4/23/18 indicated resident required physical assistance with management of medications and treatment and meal preparation. Negotiated service agreement/health care service plan (NSA/HCSP) dated 4/23/18 documented staff administered medications, supervised resident injecting insulin, occasionally assisted resident with treatments, and facility provided 3 meals a day. Clinical notes contained an entry by a licensed	S3085		

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S3085	Continued From page 3	S3085		

nurse dated 12/29/17 that resident's nephrologist wrote an order for resident to receive "Low potassium renal diet if possible." The 4/11/18 signed medical care provider's orders included a diet order of "renal diet, 1 high K, 2 dairies." Resident's NSA/HCSP lacked documentation of facility to provide a therapeutic diet.

Resident's April 2018 medication administration record documented resident received blood sugar testing before lunch and at bedtime. The NSA/HCSP lacked a description of blood sugar monitoring and the identification of the provider of the testing.

During an interview at 3:39 p.m. on 5/8/18, certified staff D stated certified medication aides performed blood sugar testing for the resident using a glucometer.

During an interview at 11:38 a.m. on 5/9/18, licensed nurse C stated the resident's NSA/HCSP lacked a description of the diet resident received and that CMAs tested resident's blood sugar using a glucometer. Licensed nurse C provided dietary instructions from facility kitchen that specified the renal diet as a no added salt diet, limit 1 high potassium food and 2 dairy products per day.

The operator failed to ensure the development of a written negotiated service agreement for resident #160 based on the resident's functional capacity screen, service needs, and preferences of the resident that included a description of services the resident would receive and the identification of the provider of each service.

- Record review for resident #150 revealed an admission date of 6/30/17 with diagnoses of

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S3085	Continued From page 4	S3085		

hypothyroidism and hypertension.

Functional capacity screen dated 4/28/18 indicated resident required supervision toileting, transferring, and walking with walker, physical assistance with bathing and dressing; experienced impaired decision-making; exhibited wandering behavior; and was at risk for falls.

Negotiated service agreement/health care service plan (NSA/HCSP) dated 4/12/18 documented service of staff or hospice to provide bathing assistance; staff to assist with dressing; resident independent with toileting needs; remind resident to use walker; occasional assistance with ambulation and transferring; and staff to check on resident every 30 minutes if sitting in lift chair with feet elevated. In the NSA/HCSP under the "Category: Fall Risk" licensed nurse C documented "(Resident) is a fall risk. Staff will identify and implement measures to prevent further falls."

Clinical notes contained the following entries by licensed nurses:

7/2/17 resident found on floor at 6:10 a.m. on his/her side. Resident had slid out of recliner.

8/30/17 Resident fell going into bathroom. Certified staff found resident behind door at 6:45 a.m. Resident did not have walker and did not call for assistance. Received bruise to right arm.

9/10/17 Certified staff reported resident's fall at 6:50 a.m. on 9/9/17 after finding resident on the floor. Resident's walker was in the bathroom.

9/27/17 Certified staff witnessed resident fall and stated it looked like resident's knees gave out.

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S3085	Continued From page 5 1/29/18 Resident reported he/she fell last night and knees hurt. Certified staff not aware resident fell. 3/28/18 Resident fell at 6:35 p.m. Notified nurse and hospice nurse at time of fall. Resident's NSA/HCSP lacked a description of interventions implemented to reduce resident's risk for falls. During an interview at 10:12 a.m. on 5/9/18, certified staff stated he/she made sure resident had shoes on, no clutter on floor, and good lighting in room as interventions to reduce resident's risk for falls. During an interview at 12:00 p.m. on 5/9/18, licensed nurse C stated each fall was reviewed for the possible cause and interventions put into place. Licensed nurse C stated unable to enter interventions on NSA/HCSP electronically. Licensed nurse stated the interventions were passed on verbally to staff. The operator failed to ensure the development of a written negotiated service agreement for resident #150 based on the resident's functional capacity screen, which identified resident at risk for falls, that included a description of services to reduce resident's risk for falls.	S3085		
S3200 SS=E	26-41-205 (d) (1-2) Facility Administration of Medications (d) Facility administration of resident ' s medications. If a facility is responsible for the administration of a resident ' s medications, the	S3200		

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S3200	Continued From page 6 administrator or operator shall ensure that all medications and biologicals are administered to that resident in accordance with a medical care provider ' s written order, professional standards of practice, and each manufacturer ' s recommendations. The administrator or operator shall ensure that all of the following are met: (1) Only licensed nurses and medication aides shall administer and manage medications for which the facility has responsibility. (2) Medication aides shall not administer medication through the parenteral route. This REQUIREMENT is not met as evidenced by: KAR 26-41-205(d) The facility reported a census of 37 residents. The sample included 3 residents. Based on record review and interview for 3 (#160, #140, and #150) of 3 residents sampled, the operator failed to ensure that all medications and biologicals were administered to each resident in accordance with a medical care provider's written order. Findings included: - Record review for resident #160 revealed an admission date of 12/30/16 with diagnoses of type 2 diabetes mellitus and chronic kidney disease. Functional capacity screens dated 7/7/17 and 4/23/18 indicated resident required physical assistance with medication management.	S3200		

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S3200	Continued From page 7 Negotiated service agreement/health care service plans dated 7/21/17 and 4/23/18 each documented staff administered medications to resident with resident to self-administer insulin with staff supervision. Clinical notes contained an entry by licensed nurse C dated 1/10/18 of new order to decrease Levemir to 20 units and change administration time from bedtime to 8:00 a.m. daily. On 1/17/18, licensed nurse C documented resident received Levemir 20 units at 8:00 a.m. and at bedtime on 1/15/18 and on 1/16/18. Licensed nurse C documented received medical care provider order to check resident's blood sugar at midnight tonight and tomorrow fasting and 2 hours after meals. Medication administration record (MAR) updated and certified medication aide educated. Resident to notify staff if feels blood sugar is low. During an interview at 11:28 a.m. on 5/9/18, licensed nurse C stated administration time changed for Levemir from bedtime to 8:00 a.m. due to resident having low blood sugar. Licensed nurse C explained that a certified medication aide (CMA) had not looked at the MAR for administration time, was accustomed to resident injecting Levemir at bedtime, and took the insulin pen to the resident at bedtime on those 2 dates for resident to self-inject. Review of the April 2018 MAR revealed documentation resident to receive ferrous sulfate 325 milligrams by mouth daily for anemia. The MAR contained documentation on 4/6/18 and 4/8/18 that resident did not receive the medication due to "waiting on pharmacy" and on 4/6/18 a CMA documented resident self-administered the medication.	S3200		

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S3200	Continued From page 8 During an interview at 11:40 a.m. on 5/9/18, licensed nurse C stated resident did not receive ferrous sulfate on those 3 dates due to medication not refilled on time. The operator failed to ensure that all medications and biologicals were administered to resident #160 in accordance with a medical care provider's written order. - Record review for resident #140 revealed an admission date of 4/1/11 with a diagnosis of chronic pain syndrome. Functional capacity screens dated 7/8/17 and 4/29/18 each indicated resident required physical assistance with management of medications. Negotiated service agreement/health care service plans dated 8/20/17 and 4/29/18 each documented staff administered medications to resident. Clinical notes contained an entry by licensed nurse C that resident received Methadone (used to treat pain) on 3/26/18 at 6:00 a.m., 8:00 a.m., and 2:00 p.m. instead of 6:00 a.m., 2:00 p.m., and 8:00 p.m. Medical care provider contacted and order received to hold the 8:00 p.m. dose and then resume scheduled dosing. On 4/3/18 licensed nurse C documented CMA (certified medication aide) reported at 2:30 p.m. he/she had given the morning dose of methadone outside the scheduled time. Medical care provider gave order to hold 8:00 p.m. dose and resume scheduled dosing tomorrow. Review of the April 2018 medication administration record (MAR) revealed	S3200		

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S3200	Continued From page 9	S3200		

documentation for resident to receive Methadone 1/2 of 5 milligram tablet by mouth 3 times a day for chronic pain syndrome at 6:00 a.m., 2:00 p.m., and 8:00 p.m. The MAR contained documentation on 4/13/18 that resident received the 6:00 a.m. dose but did not receive the 2:00 p.m. and 8:00 p.m. doses due to medication unavailable. The MAR contained documentation for resident to receive potassium chloride (supplement) 20 milliequivalents 1 tablet by mouth daily. A CMA documented medication not administered on 4/16/18 due to "waiting on pharmacy."

During an interview at 12:30 p.m. on 5/9/18, licensed nurse C stated that a CMA read the March and April MAR wrong on 3/26/18 and 4/3/18 as Methadone to be given at 8:00 a.m. and did not read the time of administration as 6:00 a.m. Licensed nurse C stated on those 2 dates resident received Methadone at 6:00 a.m. and 8:00 a.m. Licensed nurse C stated pharmacy was slow to refill as reason Methadone and potassium chloride not available.

Further review of the March 2018 MAR revealed resident to receive lorazepam 2 milligrams 1 tablet by mouth 3 times a day for anxiety. MAR contained documentation that resident did not receive 8:00 p.m. dose on 3/11/18 or the 8:00 a.m. dose and 2:00 p.m. dose on 3/12/18 due to medication unavailable.

The operator failed to ensure that all medications were administered to resident #140 in accordance with a medical care provider's written order.

- Record review for resident #150 revealed an admission date of 6/30/17 with diagnoses of

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S3200	Continued From page 10	S3200		

hypothyroidism and hypertension.

Functional capacity screens dated 7/25/17 and 4/28/18 each indicated resident required physical assistance with management of medications.

Negotiated service agreement/health care service plans dated 6/30/17 and 4/12/18 each documented service of staff to administer medications to resident.

Clinical notes contained an entry by licensed nurse C on 3/14/18 that medical care provider ordered Minocycline (an antibiotic) after a wound culture obtained. On 3/19/18, licensed nurse C documented at 3:29 p.m. that he/she found that Minocycline had not been administered to resident for four days. Medical care provider notified and administration of Minocycline resumed.

Review of the April 2018 medication administration record revealed resident to receive hydrocodone 5 milligrams with acetaminophen 325 milligrams 1 tablet by mouth 3 times a day for pain. Certified medication aides (CMAs) documented on 4/16/18 that the 6:00 a.m. dose was not available and on 4/17/18 that the 2:00 p.m. and 9:00 p.m. doses were not available.

During an interview at 12:14 p.m. on 5/9/18, licensed nurse C stated he/she investigated Minocycline not given to resident as ordered and found that CMAs had not given 2 doses because pharmacy sent an 8:00 a.m. bubble pack and an 8:00 p.m. bubble pack. CMAs administered the a.m. and p.m. dose from one card until medication from that card was given and did not know there was another card available. Licensed nurse C confirmed resident did not receive

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S3200	Continued From page 11 hydrocodone as ordered by medical care provider. The operator failed to ensure that all medications were administered to resident #150 in accordance with a medical care provider's written order.	S3200		
S3215 SS=E	26-41-205 (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 facility in a locked medication room, cabinet, or medication cart. Licensed nurses and medication aides shall store controlled medications managed by the facility 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 facility. (4) A licensed nurse or medication aide shall not	S3215		

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S3215	Continued From page 12 administer medication beyond the manufacturer ' s or pharmacy provider ' s recommended date of expiration. This REQUIREMENT is not met as evidenced by: KAR 26-41-205(h)(4) The facility reported a census of 37 residents. The sample included 3 residents. Based on record review, interview, and observation for 1 (#160) of 3 residents sampled and 1 (#170) non-sampled resident, licensed nurses and medication aides failed to ensure medications were not administered beyond the manufacturer's recommended date of expiration. Findings included: - Record review for resident #160 revealed an admission date of 12/30/16 with a diagnosis of type 2 diabetes mellitus. Functional capacity screen dated 4/23/18 indicated resident required physical assistance with management of medications. Negotiated service agreement/health care service plan dated 4/23/18 documented staff administered medications to resident with resident to self-administer insulin with staff supervision. Review of the April 2018 medication administration record revealed resident self-injected Humalog insulin before lunch and before evening meal daily and Levemir insulin every morning. During an interview at 3:39 p.m. on 5/8/18, certified staff D stated medication aides applied needle to resident's insulin pens and resident then self-injected the insulin. Certified staff D	S3215		

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S3215	Continued From page 13 opened the medication cart and provided a box for resident #160 that contained an opened and in-use Humalog insulin pen and a Levemir pen. Each pen lacked a date to indicate the date the pen was opened to ensure the insulins were not administered past the expiration date. Note: the manufacturer of Humalog insulin recommends discarding the pen 28 days after opening the pen and the manufacturer of Levemir insulin recommends discarding the pen 42 days after opening. Also during this interview, certified staff D provided an open Humalog insulin pen and an open Levemir insulin pen for resident #170. Each of these pens lacked a date to indicate when each pen was opened. Licensed nurses and medication aides failed to ensure medications were not administered to residents #160 and #170 beyond the manufacturer's recommended date of expiration.	S3215		
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	S3280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087041	A. BUILDING: _____ B. WING _____	05/10/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORNERSTONE ASSISTED LIVING INC	1240 N BROADMOOR AVENUE 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 14 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)(4) The facility reported a census of 37 residents. The sample included 3 residents. Based on record review and interview for all residents and all employees, the operator failed to ensure disaster and emergency preparedness by ensuring the performance of a quarterly review of the facility's emergency management plan with employees and residents and an emergency drill conducted at least annually with staff and residents that included evacuation of the residents to a secure location. Findings included: - At 11:50 a.m. on 5/8/18, when asked for documentation of emergency drills with evacuation of residents since 5/26/16, administrative staff B provided documentation of an emergency drill dated 3/15/18. Administrative staff B stated he/she could not locate documentation of an emergency drill with evacuation of residents prior to 3/15/18. Administrative staff B also provided documentation of quarterly review of the emergency management plan with residents and employees since 5/26/16. The documentation included a review with residents at resident council meeting dated 7/8/16 with 18 residents	S3280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S3280	Continued From page 15 attending, 8/4/17, 9/1/17 with 20 residents attending, and 3/15/18 with 20 residents attending. Employees reviewed the emergency management plan in July of 2017, 12/15/17, and 3/15/18. During an interview at 2:17 p.m. on 5/9/18, administrative staff B stated he/she could not find additional dates of review of the plan with residents and employees. The operator failed to ensure disaster and emergency preparedness by ensuring the performance of a quarterly review of the facility's emergency management plan with employees and residents and an emergency drill conducted at least annually with staff and residents that included evacuation of the residents to a secure location.	S3280		