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 _____	02/04/2025

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 Re-Licensure Survey with complaint investigations 186831, 186825, 191176, and 192639 for the above named Assisted Living Facility conducted on 02/03/25 and 02/04/25.	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 29 residents(R). The sample included three residents and two closed record reviews. Based on interview and record review the executive director failed to ensure one (R3) of three sampled residents records contained documentation of all incidents, symptoms, and other indications of illness or injury, what action taken, and the results of the action taken. Findings included: - R3's "Electronic medical Record" revealed she moved into the facility on 06/13/2019 with diagnosis of bipolar disorder.	S3261		

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

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S3261	Continued From page 1 R3's "Functional Capacity Screen" (FCS) dated 12/11/24 identified she needed physical assistance of staff with bathing, dressing, toileting, and with her medications. She also had impaired cognition and impaired decision-making ability. R3's "Service Plan/Negotiated Service Agreement" dated 12/11/24 revealed qualified staff assisted R3 with activities of daily living, administered her medications and medical treatments and provided cues, coaching and redirection as needed. Review of R3's electronic "ID Notes" revealed the following documentation: 05/07/24 -New order for increasing Remeron (antidepressant) and change Melatonin to as needed. The record lacked symptoms indicating a need for increased Remeron and follow-up related to changes in symptoms for which Remeron was increased or how not getting scheduled Melatonin affected resident's ability to sleep. 05/30/24 - Durable Power of Attorney (DPOA) notified of weight loss and nurse requested health shakes to be started. The record lacked follow-up related to resident's weight and if health shakes were effective to help maintain weight and nutritional status. 06/28/24 - DPOA requested Xanax (antianxiety) be scheduled at 01:00 PM and 08:00 PM with the medical provider notified of DPOA request. 07/01/24 Medical provider agreed with medication changes. The record lacked documentation of symptoms identifying a need for the changes in Xanax and follow up if the changes were effective.	S3261		

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S3261	Continued From page 2 Interview on 02/04/25 at 09:54 AM Administrative Licensed Nurse C reported documentation should include when something happens such as a fall, get new orders, document follow up on falls and will document lab results. Administrative Licensed Nurse C acknowledged the staff had not always followed through on new medications as they should have. The executive director failed to ensure R3's medical record included documentation of all symptoms related to medication changes needed, or other changes in care and results of those changes.	S3261		
S3280 SS=F	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.	S3280		

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S3280	Continued From page 3 This REQUIREMENT is not met as evidenced by: KAR 26-41-104(d)(3) The facility reported a census of 29 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 residents. Findings included: - Review of the disaster plan "Quarterly Disaster Training Sign in Sheet" provided by Administrative Staff A on 02/03/25 revealed the facility conducted staff in-services on 05/01/24 and 10/09/24. The records failed to include the first and third quarter reviews of the emergency management plan. - Review of the resident response in emergency situations review revealed on 05/07/24 and 10/29/24 staff reviewed the emergency plan with residents. The records failed to include the first and third quarter reviews of the emergency management plan. Interview on 02/03/25 at 10:25 AM Activities Staff B reported she reviewed the emergency plan with residents quarterly and if a resident is not in attendance, she reviewed it with them individually. Interview on 02/23/25 at 10:31 AM with	S3280		

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S3280	Continued From page 4 Administrative Staff A and Activities staff B both acknowledged they could not find additional reviews of the emergency management plan. The executive director failed to ensure the facility's emergency management plan was reviewed with all employees and residents quarterly.	S3280		