STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087059	A. BUILDING: _____ B. WING _____	08/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD OF CRESTVIEW	600 N 127TH STREET EAST WICHITA, KS 67206

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S 000	INITIAL COMMENTS The following citations represent the findings of a resurvey with investigation of complaints #121569, #126491, and #131330 of the above assisted living facility on 8/13/18, 8/14/18, and 8/16/18.	S 000		
S3102 SS=F	26-41-202 (i) Negotiated Service Agreement Service Received (i) Each administrator or operator shall ensure that each resident receives services according to the provisions of that resident ' s negotiated service agreement This REQUIREMENT is not met as evidenced by: KAR 26-41-202(i) The facility reported a census of 19 residents. The sample included 3 residents and 2 focus review residents. Based on record review and interview for all residents, the operator failed to ensure that each resident received services according to the provisions of that resident's negotiated service agreement. Findings included: - Record review for resident #751 revealed an admission date of 12/30/17 with diagnoses of type 2 diabetes mellitus, hypertension, atrial fibrillation, chronic kidney disease, and chronic obstructive pulmonary disease. During an interview at 10:27 a.m. on 8/14/18, surveyor reviewed resident's negotiated service agreement/health care service plan and asked if resident received these services. Resident stated his/her bed was unmade because he/she could	S3102		

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

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S3102	Continued From page 1	S3102		

not make bed and staff did not come in to make his/her bed daily. Resident stated the bed linens had not been changed for more than 2 weeks and staff would only change sheets if he/she asked staff to change the sheets. Resident stated staff members did not clean his/her apartment every week.

Functional capacity screens dated 12/30/17 and 8/13/18 each indicated resident was unable to perform laundry and housekeeping by self. Negotiated service agreements dated 12/30/17 and 8/13/18 each documented service of housekeeper will clean apartment weekly; each day certified staff will tidy room, take out trash, and make the bed. Laundry service provided by facility and bedding will be laundered and changed weekly.

- Record review for resident #754 revealed an admission date of 5/31/18 with diagnoses of atrial fibrillation and type 2 diabetes mellitus.

During an interview at 11:00 a.m. on 8/14/18, resident #754 stated his/her apartment had been cleaned one time since he/she moved to the facility on 5/31/18. Resident stated the person who cleaned his/her apartment only cleaned the bathroom and vacuumed the carpet. Resident stated his/her family member changed the bed linens one to two times a week.

Functional capacity screen dated 5/31/18 and 8/6/18 each indicated resident was unable to do laundry and housekeeping for self.

Negotiated service agreements dated 5/31/18 and 8/6/18 each documented housekeeping services of weekly cleaning of apartment, certified staff to take out trash, tidy room, and make the

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S3102	Continued From page 2	S3102		

bed daily, and laundry services included bedding laundered, changed weekly, and as needed.

- During an interview at 11:39 a.m. on 8/14/18 certified staff F stated the certified staff completed housekeeping services for residents "if we have time." Certified staff G stated he/she had cleaned some apartments.

- During an interview at 12:52 p.m. on 8/14/18 resident #756 stated someone at facility told his/her family member that facility staff would provide housekeeping services. Resident stated he/she moved to the facility on 5/1/18 and had not seen staff clean the shower, mop the bathroom floor, or dust and had only observed staff vacuum carpet one or two times. Resident stated Monday was his/her laundry day and that he/she removed sheets from bed and placed in laundry on that day. Resident stated approximately 3 weeks ago he/she asked for sheets to be put on bed and operator helped him/her do this.

- During an interview at 1:34 p.m. on 8/14/18, licensed nurse C stated that approximately six weeks ago he/she began scheduling certified staff G to work as housekeeper 2 days a week to clean resident apartments but when a scheduled certified staff person did not come to work on those days then certified staff G provided resident care and housekeeping was not completed. Licensed nurse C stated previous staffing pattern of 4 certified staff on day shift, 3 certified staff on evening shift, and 2 certified staff on night shift and then decreased staffing to 2 certified staff on all 3 shifts with housekeeping duties to be completed by the certified staff on duty. At 2:49 p.m. on 8/14/18, licensed nurse C stated the staff reduction was effective 4/1/18. Licensed nurse C stated prior to 4/1/18 he/she scheduled certified

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S3102	Continued From page 3 staff member two days a week dedicated to housekeeping. Licensed nurse C stated it was expected that this person could clean the apartments in 2 halls per day. Licensed nurse C stated there was not a person assigned to housekeeping from 4/1/18 until 6/18/18. At 1:59 p.m. on 8/14/18, when surveyor asked for number of days per week certified staff G cleaned apartments, certified staff G stated he/she provided resident care and was not always able to clean each assigned apartment. The operator failed to ensure that each resident received services according to the provisions of that resident's negotiated service agreement.	S3102		
S3170 SS=D	26-41-204 (g) (h) Health Care Services (g) Skilled nursing care shall be provided in accordance with K.S.A. 39-923 and amendments thereto. (1) The health care service plan shall include the skilled nursing care to be provided and the name of the licensed nurse or agency responsible for providing each service. (2) The licensed nurse providing the skilled nursing care shall document the service and the outcome of the service in the resident ' s record. (3) A medical care provider ' s order for skilled nursing care shall be documented in the resident ' s record in the facility. A copy of the medical care provider ' s order from a home health agency or hospice may be used. Medical care provider orders in the clinical records of a home health agency located in the same building as the facility may also be used if the clinical records are available to licensed nurses and direct care staff of the facility.	S3170		

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S3170	Continued From page 4 (4) The administrator or operator shall ensure that a licensed nurse is available to meet each resident ' s unscheduled needs related to skilled nursing services. (h) A licensed nurse may provide wellness and health monitoring as specified in the resident ' s negotiated service agreement. (i) All health care services shall be provided to residents by qualified staff in accordance with acceptable standards of practice This REQUIREMENT is not met as evidenced by: KAR 26-41-204(g)(2) The facility reported a census of 19 residents. The sample included 3 residents and 2 focus review residents. Based on record review and interview for 1 (#750) of 1 sampled resident receiving home health services for skilled nursing insulin injection, the operator failed to ensure the licensed nurse providing insulin injections documented the service and the outcome of the service in the resident's record. Findings included: - Record review for resident #750 revealed an admission date of 9/29/17 with diagnoses of type 2 diabetes mellitus and dementia. Admission functional capacity screen dated 9/29/17 and functional capacity screen dated 3/23/28 indicated resident was unable to perform management of medications.	S3170		

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S3170	Continued From page 5 Negotiated service agreements/health care service plans dated 9/29/17 and 3/23/18 each documented the name of a home health provider for skilled nursing visits daily, 7 days a week for insulin administration. Resident's record lacked documentation by the home health nurse that insulin was administered and the outcome of the service. During an interview at 3:17 p.m. on 8/14/18, licensed nurse C stated the home health nurse did not document insulin injections in the resident's record. The operator failed to ensure the licensed nurse providing insulin injections to resident #750, documented the service and the outcome of the service in the resident's record.	S3170		
S3214 SS=D	26-41-205 (g) (4) Sample & Indigent Medication Program Meds (g) (4) Licensed nurses and medication aides may administer sample medications and medications from indigent medication programs if the administrator or operator ensures the development of policies and implementation of procedures for receiving and identifying sample medications and medications from indigent medication programs that include all of the following conditions: (A) The medication is not a controlled medication. (B) A medical care provider ' s written order accompanies the medication, stating the resident ' s name; the medication name, strength, dosage, route, and frequency of administration; and any cautionary instructions regarding administration.	S3214		

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S3214	Continued From page 6 (C) A licensed nurse or medication aide receives the medication in its original, unbroken manufacturer ' s package. (D) A licensed nurse documents receipt of the medication by entering the resident ' s name and the medication name, strength, and quantity into a log. (E) A licensed nurse places identification information on the medication or package containing the medication that includes the medical care provider ' s name; the resident ' s name; the medication name, strength, dosage, route, and frequency of administration; and any cautionary instructions as documented on the medical care provider ' s order. Facility staff consisting of either two licensed nurses or a licensed nurse and a medication aide shall verify that the information on the medication matches the information on the medical care provider ' s order. (F) A licensed nurse informs the resident or the resident ' s legal representative that the medication did not go through the usual process of labeling and initial review by a licensed pharmacist pursuant to K.S.A. 65-1642 and amendments thereto, which requires the identification of both adverse drug interactions or reactions and potential allergies. The resident ' s clinical record shall contain documentation that the resident or the resident ' s legal representative has received the information and accepted the risk of potential adverse consequences. This REQUIREMENT is not met as evidenced by: KAR 26-41-205(g)(4)(D)(E)(F) The facility reported a census of 19 residents.	S3214		

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S3214	Continued From page 7 The sample included 3 residents and 2 focus review residents. Based on record review, interview, and observation for 1 (#751) of 1 focus review resident receiving a sample medication, licensed nurse C failed to document the receipt of the medication by entering the resident's name and the medication name, strength, and quantity into a log; place identification information on the package containing the medication that included the medical care provider's name, the resident's name, the medication name, strength, dosage, route, and frequency of administration; and any cautionary instructions as documented on the medical care provider's order; ensure two licensed nurses or a licensed nurse and a medication aide verified the information on the medication matched the information on the medical care provider's order; document in the resident's record that he/she informed the resident or the resident's legal representative that the medication did not go through the usual process of labeling and initial review by a licensed pharmacist pursuant to K.S.A. 65-1642 and amendments thereto, which required the identification of both adverse drug interactions or reactions and potential allergies. Findings included: - Record review for resident #751 revealed an admission date of 12/30/17 with diagnoses of type 2 diabetes mellitus, hypertension, atrial fibrillation, chronic kidney disease, and chronic obstructive pulmonary disease. Admission functional capacity screen dated 12/30/17 and significant change functional capacity screen dated 8/13/18 each indicated resident was unable to perform management of medications.	S3214		

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S3214	Continued From page 8 Negotiated service agreements/health care service plans dated 12/30/17 and 8/13/18 each documented medication administration by certified medication aides and licensed nurses. The clinical notes contained an entry by licensed nurse C dated 7/31/18 that resident returned from an appointment with a dermatologist with an order for Otezla (medication to treat moderate to severe plaque psoriasis) and to follow package titration directions then take one tablet two times a day. At 10:15 a.m. on 8/13/18, licensed nurse C stated facility allowed residents to receive sample medications and that (resident #751) received Otezla provided by resident's medical care provider. Review of the facility's policy and procedure manual revealed the lack of a policy and procedure for sample medications. At 3:15 p.m. on 8/13/18, surveyor asked licensed nurse E for the facility's sample and indigent medication policy and procedure. Licensed nurse E stated he/she was trying to find the policy and procedure. At 3:30 p.m. on 8/13/18 in the medication room, certified medication aide D removed the package of Otezla from the medication cart. The medication did not have a pharmacy prescription label but did have a label that medication was checked by licensed nurse C. Licensed nurse C came into the medication room and stated this was a sample medication provided by resident's dermatologist. Surveyor asked licensed nurse C for the facility's policy and procedure for receipt of	S3214		

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S3214	Continued From page 9	S3214		

sample medications. Licensed nurse C stated (licensed nurse E) "is getting a policy and procedure for me." Licensed nurse C stated he/she did not enter the medication and information in a log and did not document informing resident the medication did not go through the usual process of labeling and initial review by a licensed pharmacist. Licensed nurse C confirmed the medication package lacked the dermatologist's order for when and how to administer the medication.

At 10:08 a.m. on 8/14/18, licensed nurse C provided a "Sample and Indigent Medication" policy and procedure dated March 6, 2015.

During an interview at 1:42 p.m. on 8/14/18, licensed nurse C stated and confirmed did not follow the policy and procedure for receipt of the sample medication.

For resident #751 receiving a sample medication, licensed nurse C failed to document the receipt of the medication by entering the resident's name and the medication name, strength, and quantity into a log; place identification information on the package containing the medication that included the medical care provider's name, the resident's name, the medication name, strength, dosage, route, and frequency of administration; and any cautionary instructions as documented on the medical care provider's order; ensure two licensed nurses or a licensed nurse and a medication aide verified the information on the medication matched the information on the medical care provider's order; document in the resident's record that he/she informed the resident or the resident's legal representative that the medication did not go through the usual process of labeling and initial review by a licensed

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S3214	Continued From page 10 pharmacist did not go through the usual process of labeling and initial review by a licensed pharmacist pursuant to K.S.A. 65-1642 and amendments thereto, which required the identification of both adverse drug interactions or reactions and potential allergies.	S3214		