STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087071	A. BUILDING: _____ B. WING _____	C 02/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHISHOLM PLACE	1859 N WEBB ROAD 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 represent the findings of resurvey with complaint investigation #138052, #143005, #150337, #151971, and #152156 for the above named assisted living facility conducted on 1/25,26,27,28/2021 and 2/1/2021 which resulted in the following deficiencies.	S 000		
S3081 SS=E	26-41-201 (c) Functional Capacity Screen Reassessment (c) Designated facility staff shall conduct a screening to determine each resident ' s functional capacity according to the following requirements: (1) At least once every 365 days; (2) following any significant change in condition as defined in K.A.R. 26-39-100; and (3) at least quarterly if the resident receives assistance with eating from a paid nutrition assistant. This REQUIREMENT is not met as evidenced by: K.A.R.26-41-201(c)(1) The facility census totaled 34 residents. The sample included 4 residents and 7 focused record reviews. Based on record review and interview for 2 (#125 and #425) of 3 sampled residents the administrator failed to ensure designated staff conducted a screening to determie each resident's functional capacity at least every 365 days. Findings included: - Review of resident #125's medical record revealed she admitted to the facility on 7/19/14	S3081		

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
	N087071	A. BUILDING: _____ B. WING _____	C 02/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHISHOLM PLACE	1859 N WEBB ROAD 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
S3081	Continued From page 1	S3081		

with diagnoses of hypothyroidism, constipation and congestive heart failure.

Review of the resident's functional capacity screen dated 10/15/20 revealed the resident could not manage bathing, dressing, toileting, eating, or medications and needed physical assistance with transfers and mobility. The resident also had impaired cognition and communication abilities.

Review of the resident's record revealed staff completed the prior FCS on 9-3-19, more than 365 days prior to current FCS.

-- Review of resident #425's medical record revealed the resident admitted into the facility on 1-10-19 with diagnoses of diabetes, depression, and edema.

Review of the resident's current functional capacity screen dated 1-19-21 revealed the resident needed physical assistance with bathing and could not manage her own medications. The resident also had current problems with fall risk, impaired vision and hearing and impaired decision making abilities.

Review of the resident's record revealed staff completed the prior FCS on 1-14-20, more that 356 days prior to the current FCS.

An interview on 1-28-21 at 9:47 AM licensed nursing staff B reported each resident's functional capacity screen was to be completed at least every 365 days.

The administrator failed to ensure designated staff completed the residents functional capacity

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087071	A. BUILDING: _____ B. WING _____	C 02/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHISHOLM PLACE	1859 N WEBB ROAD 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
S3081	Continued From page 2 screens at least every 365 days.	S3081		
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 payment if outside resources provide a service. This REQUIREMENT is not met as evidenced by: KAR 26-41-202 (d)(1)(2) The facility reported a census of 34 residents. The sample included 4 residents and 7 focused record reviews. Based on record review and interview for 3 (#125, #425, #525) of 4 sampled residents, the administrator failed to ensure designated staff developed a written negotiated service agreement, that included the following (1) a description of the services the resident received; (2) identification of the provider of each service; and (3) party responsible for payment if	S3085		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087071	A. BUILDING: _____ B. WING _____	C 02/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHISHOLM PLACE	1859 N WEBB ROAD 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
S3085	Continued From page 3 an outside resource provides a service. Findings included: - Review of resident #125's medical record revealed she admitted to the facility on 7/19/14 with diagnoses of hypothyroidism, constipation and congestive heart failure. Review of the resident's functional capacity screen dated 10-15-20 revealed the resident could not manage bathing, dressing, toileting, eating, or medications and needed physical assistance with transfers and mobility. The resident also had impaired cognition and communication abilities. Review of the resident's medical record revealed staff completed a negotiated service agreement on 10-20-20. The negotiated service agreement lacked identification that the resident received podiatry services, who provided the service and responsible party for payment of the service. - Review of resident #425's medical record revealed the resident admitted into the facility on 1-10-19 with diagnoses of diabetes, depression and edema. Review of the resident's current functional capacity screen dated 1-19-21 revealed the resident needed physical assistance with bathing and could not manage her own medications. The resident also had current problems with fall risk, impaired vision and hearing and impaired decision making abilities. Review of the resident's current negotiated service agreement dated 1-21-21 lacked	S3085		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087071	A. BUILDING: _____ B. WING _____	C 02/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHISHOLM PLACE	1859 N WEBB ROAD 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
S3085	Continued From page 4	S3085		

identification the resident received podiatry services, who provided the service and responsible party for payment of the service. It also lacked identification of what company provided Hospice services and payment source for the service.

- Review of resident #525's record revealed she admitted to the facility on 5-20-19 with diagnoses of Dementia and Bipolar disease.

Review of the residents functional capacity screen dated 11-10-20 revealed the resident required physical assistance with all activities of daily living except supervision with eating, had problems with falls and could not manage her medications. The resident also had cognitive impairment and bladder incontinence.

Review of the resident's current negotiated service agreement dated 11-15-20 revealed the negotiated service agreement lacked identification that the resident received podiatry services, who provided the service and responsible party for payment of the service.

During an interview on 1-18-21 at 9:52 AM licensed nurse B confirmed all outside providers needed to be included in the negotiated services agreement along with the name of the company and payment source. Licensed nurse B provided an addendum notebook for when a resident starts and stops therapy and confirmed podiatry services were not in the addendums either.

The administrator failed to ensure designated staff developed a written negotiated service agreement, that included the following (1) a description of the services the resident received;

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087071	A. BUILDING: _____ B. WING _____	C 02/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHISHOLM PLACE	1859 N WEBB ROAD 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
S3085	Continued From page 5 (2) identification of the provider of each service; and (3) party responsible for payment if an outside resource provides a service.	S3085		
S3092 SS=E	26-41-202 (d) Negotiated Service Agreement Revisions (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; (2) following any significant change in condition, as defined in K.A.R. 26-39-100; (3) at least quarterly, if the resident receives assistance with eating from a paid nutrition assistant; and (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. This REQUIREMENT is not met as evidenced by: KAR 26-41-202 (d)(1)(2) The facility reported a census of 34 residents. The sample included 4 residents and 7 focused record reviews. Based on record review and interview for 3 (#125, #425, #525) of 4 sampled residents, the administrator failed to ensure the review and, if necessary, the revision of each negotiated service agreement according to the following requirements: (1) At least once every 365 days; (2) Following any significant change in condition, as defined in KAR 26-39-100.	S3092		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087071	A. BUILDING: _____ B. WING _____	C 02/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHISHOLM PLACE	1859 N WEBB ROAD 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
S3092	Continued From page 6 Findings included: - Review of resident #125's medical record revealed she admitted to the facility on 7/19/14 with diagnoses of hypothyroidism, constipation and congestive heart failure. Review of the resident's functional capacity screen dated 10-15-20 revealed the resident could not manage bathing, dressing, toileting, eating, or medications and needed physical assistance with transfers and mobility. The resident also had impaired cognition and communication abilities. Review of the resident's medical record revealed staff completed a negotiated service agreement on 10-20-20. The negotiated service agreement identified facility staff would assist the resident with her activities of daily living including administering her medications. The residents record included the prior negotiated service agreement which staff completed on 9-13-19, more then 365 days prior to current negotiated service agreement. - Review of resident #425's medical record revealed the resident admitted into the facility on 1-10-19 with diagnoses of diabetes, depression and edema. Review of the resident's current functional capacity screen dated 1-19-21 revealed the resident needed physical assistance with bathing and could not manage her own medications. The resident also had current problems with fall risk, impaired vision and hearing and impaired decision making abilities.	S3092		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087071	A. BUILDING: _____ B. WING _____	C 02/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHISHOLM PLACE	1859 N WEBB ROAD 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
S3092	Continued From page 7 Review of the resident's current negotiated service agreement was dated 1-21-21 revealed staff assisted the resident to bathe, administered the residents medication and had interventions to reduce fall risk. The resident's record included the prior negotiated service agreement completed on 1-15-20, more than 365 days prior. - Review of resident #525's record revealed she admitted to the facility on 5-20-19 with diagnoses of Dementia and Bipolar disease. Review of the residents functional capacity screen dated 11-10-20 revealed the resident required physical assistance with all activities of daily living except supervision with eating, had problems with falls and could not manage her medications. The resident also had cognitive impairment and bladder incontinence. Review of the resident's current negotiated service agreement dated 11-15-20 revealed staff would provide assistance with activities of daily living, administer the medications, and included a lit of interventions to reduce fall risk. The resident's record also included a prior negotiated service agreement staff completed on 10-14-2019, more than 365 days prior. During an interview on 1-28-21 at 9:47 AM licensed nursing staff B reported a residents negotiated service agreement/health care service plan needed to be completed at the time of admission and then yearly unless the resident had a change in condition and needed revised	S3092		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087071	A. BUILDING: _____ B. WING _____	C 02/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHISHOLM PLACE	1859 N WEBB ROAD 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
S3092	Continued From page 8 sooner. The administrator failed to ensure designated staff reviewed and revise 3 resident's functional capacity screen at least every 365 days.	S3092		
S3166 SS=E	26-41-204 (e) Delegation of Duties (e) A licensed nurse may delegate nursing procedures not included in the nurse aide or medication aide curriculums to nurse aides or medication aides, respectively, under the Kansas nurse practice act, K.S.A. 65-1124 and amendments thereto. This REQUIREMENT is not met as evidenced by: KAR-26-41-204 (e) The facility reported a census of 34 residents. Based on interview and record review of 4 newly hired certified medication aides the operator failed to ensure the delegation of the nursing procedure of blood sugar monitoring to each certified medication aide under the Kansas nurse practice act, K.S.A.65-1124 and amendments thereto. This had the potential to effect all residents who had their blood sugar checked by certified medication aides. Findings included: - Review of employee records revealed certified medication aide staff E,F,G,and H did not have evidence of licensed nurse delegation for blood glucose testing which is not part of the certified	S3166		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087071	A. BUILDING: _____ B. WING _____	C 02/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHISHOLM PLACE	1859 N WEBB ROAD 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
S3166	Continued From page 9 medication aide curriculum. During an interview on 1-25-21 at 1:00 PM licensed nurse C reported the licensed nurse and the certified medication aides completed monitoring of resident's blood sugars (accu-checks). During an interview on 1-27-28 at 2:21 PM licensed nursing staff C confirmed the facility did not have evidence of delegation of monitoring accuchecks/blood sugar checks for their certified medication aides. The administrator failed to ensure the delegation of the nursing procedure of blood sugar monitoring to each certified medication aide under the Kansas nurse practice act, K.S.A.65-1124 and amendments thereto. The failure had the potential to effect all residents who had blood sugar checks monitored by certified medication aides.	S3166		
S3200 SS=D	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 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.	S3200		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087071	A. BUILDING: _____ B. WING _____	C 02/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHISHOLM PLACE	1859 N WEBB ROAD 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
S3200	Continued From page 10 (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 34 residents. The sample included 4 residents and 7 focused record reviews. Based on record review and interview the administrator failed to ensure that all medications and biologicals were administered for 1 (#425) of 4 sampled residents were administered in accordance with a medical care provider's written order and according to professional standards of practice. Findings included: - Review of resident #425's medical record revealed the resident admitted into the facility on 1-10-19 with diagnoses of diabetes, depression and edema. Review of the resident's current functional capacity screen dated 1-19-21 revealed the resident needed physical assistance with bathing and could not manage her own medications. The resident also had current problems with fall risk, impaired vision and hearing and impaired decision making abilities. Review of the resident's current negotiated service agreement/health care service plan dated 1-21-21 revealed a caregiver/staff needed to	S3200		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087071	A. BUILDING: _____ B. WING _____	C 02/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHISHOLM PLACE	1859 N WEBB ROAD 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
S3200	Continued From page 11	S3200		

administer medications and perform all tasks related to ordered treatments according to medical care providers orders.

Review of the residents signed physician order sheet dated 12-8-20 included the following as needed (PRN) sliding scale insulin orders:
If blood sugar greater than 250 give 3 units of Novolog insulin, if greater than 325 give 6 units, if greater than 400 give 10 units. and if greater than 500 give 14 units.

Review of the January 2021 medication administration record revealed the following elevated blood sugars:
8 am -on 1-6-21 blood sugar was 254
Noon - on 1-6-21 blood sugar was 425, 1-15-21 blood sugar was 295, and on 1-21-21 it was 296
5 PM - on 1-20-21 blood sugar 274, on 1-21-21 blood sugar was 262
9 PM - on 1-14-21 blood sugar of 309, 1-18-21 blood sugar of 267, on 1-24-21 a blood sugar of 285
The record lacked evidence to show that the PRN additional sliding scale doses were administered as ordered.

On 1-28-21 at 9:58 AM licensed nursing staff B stated the nurse may have given the PRN insulin but just didn't write that she administered it in the PRN dosages.

On 1-28-21 at 10:55 AM licensed nursing staff D reviewed the administration records and stated the nurse would already give the scheduled 3 units with each meal and if the resident's blood sugar was greater than 250 the nurse needed to document the extra insulin in the PRN sliding scale section of the administration record. Nurse D looked in the resident's nurses notes and the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087071	A. BUILDING: _____ B. WING _____	C 02/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHISHOLM PLACE	1859 N WEBB ROAD 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
S3200	Continued From page 12 administration record and then confirmed that according to the record the resident did not receive her insulin for elevated blood sugars according to the physicians sliding scale orders. The administrator failed to ensure resident #425 received insulin as ordered and according to standards of practice.	S3200		
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. This REQUIREMENT is not met as evidenced by: KAR 26-41-104(d)(3)(4) The facility reported a census of 34 residents. Based on record review and interview for all residents and all facility employees, the	S3280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087071	A. BUILDING: _____ B. WING _____	C 02/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHISHOLM PLACE	1859 N WEBB ROAD 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 13 administrator failed to ensure disaster and emergency preparedness by ensuring performance of quarterly review of the facility's emergency management plan with employees and residents. Findings included: - On 1-26-21 at 1:35 PM administrative staff A provided information to review which she stated was for the quarterly emergency management plan reviews. Administrator A provided resident council minutes from 6-11-19 to 10-27-20 which revealed the following: 6-11-19 reviewed the fire drill 1-14-20 reviewed the tornado drill For the other months provided, July, August, September, and October of 2020 lacked any mention of reviewing the emergency management plan. Administrator A provided 4 staff inservices to review for disaster preparedness which revealed the following: 2-27-20- Reviewed tornado, disaster spring weather, and emergency plan 5-20-20 - Lacked evidence of review for disaster preparedness 7-22-20 - Reviewed evacuation drill, elopement, and disasters 10-14-20 - Reviewed missing residents Review of the information provided for the emergency management plan plans were not completed with residents and staff quarterly (every 90 days) and did not include each of the required potential disasters (fire,flood, severe weather, tornado, explosion, natural gas leak,	S3280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087071	A. BUILDING: _____ B. WING _____	C 02/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHISHOLM PLACE	1859 N WEBB ROAD 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 lack of electrical or water service and missing resident). On 1-26-21 at 1:35 PM administrator A reported the emergency management plan is reviewed with resident during resident council and reviewed with staff during inservices. Review of the emergency and disaster plan policy revealed the community will maintain ongoing awareness training for all employees. For all residents and staff the operator failed to ensure the completion of quarterly reviews of the emergency management plan.	S3280		