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 _____	R 08/09/2018

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 citations represent the findings of a revisit for correction order 18-109 of the above residential health care facility on 8/7/18, 8/8/18, and 8/9/18.	{S 000}		
{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(a)(1)(2)(3) The facility reported a census of 40 residents, the sample included 3 residents. Based on record review and interview for 1 (#1051) of 1 residents sampled receiving services provided by an outside resource, administrator B failed to ensure the development of a written negotiated service agreement (NSA) for the resident, based on the	{S3085}		

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 _____	R 08/09/2018

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 1 resident's functional capacity screening, service needs, and preferences, in collaboration with the resident's legal representative, that included a description of services the resident would receive from the outside resource, identification of the outside resource, and each party responsible for payment of the services. Based on record review and interview for 2 (#1050 and #1052) of 3 residents sampled, administrator B failed to ensure the development of a written negotiated service agreement (NSA) for each resident, based on the resident's functional capacity screening, service needs, and preferences, in collaboration with the resident's legal representative, that included a description of the service and provider of management of medications and medical treatments. Findings included: - Record review for resident #1051 revealed an admission date of 6/5/17 with diagnosis of dementia. Functional capacity screen dated 4/21/18 indicated resident was unable to perform transfer, mobility, and eating. Licensed nurse D who completed the screening documented what looked like a score of 3 (unable to perform) written over a score of 2 (physical assistance needed) for bathing, dressing, and toileting. Functional capacity screen indicated resident was unable to perform management of medications, was incontinent of urine, experienced impaired short-term memory, long-term memory, memory recall, and impaired decision making; was at risk for falls; and required a wheelchair for mobility. Health care service plan dated 6/16/18	{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 _____	R 08/09/2018

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 2	{S3085}		

documented a hospice aide visited resident two times a week to bathe resident, a licensed nurse visited resident at least weekly, chaplain and social work visited monthly and as needed. The NSA dated 6/16/18 did not include the name of the hospice, services provided, and party responsible for payment of the services.

During an interview at 3:03 p.m. on 8/7/18, licensed nurse C stated resident's NSA needed to be reviewed and revised to include hospice as an outside provider.

Administrator B failed to ensure the development of a written NSA for resident #1051, based on the resident's functional capacity screening, service needs, and preferences, in collaboration with the resident's legal representative, that included a description of services the resident would receive from the outside resource, identification of the outside resource, and each party responsible for payment of the services.

- Record review for resident #1050 revealed an admission date of 8/17/17 with diagnoses of dementia, hypertension, and hypothyroidism.

Functional capacity screen dated 7/14/18 indicated resident was unable to perform management of medications and treatments.

Negotiated service agreement and health care service plan each dated 7/16/18 did not specify the provider of management and administration of medications and treatments.

Review of the July 2018 medication administration record (MAR) and the August 2018 MAR revealed facility certified medication aides

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 _____	R 08/09/2018

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	{S3085}		

and licensed nurses administered medications to resident.

During an interview at 3:17 p.m. on 8/7/18, licensed nurse C reviewed resident's NSA and health care service plan and confirmed each lacked the provider of management of medications and treatments.

Administrator B failed to ensure the development of a written NSA for resident #1050, based on the resident's functional capacity screening, service needs, and preferences, in collaboration with the resident's legal representative, that included a description of the service and provider of management of medications and medical treatments.

- Record review for resident #1052 revealed an admission date of 3/6/18 with diagnoses of vascular dementia, anxiety, atrial fibrillation, and hypertension.

Functional capacity screen dated 3/5/18 indicated resident was unable to perform management of medications and treatments.

NSA and health care service plan each dated 7/8/18 did not document the provider of medication and treatment management.

Review of the July 2018 medication administration record (MAR) and the August 2018 MAR revealed facility certified medication aides and licensed nurses administered medications to resident.

During an interview at 1:08 p.m. on 8/7/18, licensed nurse C confirmed NSA lacked 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 _____	R 08/09/2018

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 provider of management of medications and treatments. Administrator B failed to ensure the development of a written NSA for resident #1052, based on the resident's functional capacity screening, service needs, and preferences, in collaboration with the resident's legal representative, that included a description of the service and provider of management of medications and medical treatments.	{S3085}		
{S3101} SS=E	26-41-202 (h) NSA Signatures (h) Each individual involved in the development of the negotiated service agreement shall sign the agreement. The administrator or operator shall ensure that a copy of the initial agreement and any subsequent revisions are provided to the resident or the resident's legal representative. This REQUIREMENT is not met as evidenced by: KAR 26-41-202(h) The facility reported a census of 40 residents. The sample included 3 residents. Based on record review and interview for 3 (#1051, #1050, and #1052) of 3 residents sampled, administrator B failed to ensure each individual involved in the development of the negotiated service agreement (NSA) signed the agreement. Findings included: - Record review for resident #1051 revealed an admission date of 6/5/17 with a diagnosis of	{S3101}		

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 _____	R 08/09/2018

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
{S3101}	Continued From page 5 dementia. Functional capacity screen (FCS) dated 4/21/18 indicated resident was unable to perform transfer, mobility, and eating. Licensed nurse D who completed the screening documented what looked like a score of 3 (unable to perform) written over a score of 2 (physical assistance needed) for bathing, dressing, and toileting. FCS indicated resident was unable to perform management of medications, was incontinent of urine, experienced impaired short-term memory, long-term memory, memory recall, and impaired decision making; was at risk for falls; and required a wheelchair for mobility. FCS indicated resident was unable to perform meal preparation, shopping, money management, transportation, use of telephone, laundry, and housekeeping. NSA dated 6/16/18 documented resident received health care services of assistance with bathing, dressing, toileting, transferring, mobility with wheelchair, eating, and incontinence care. NSA documented facility provided meal service, activities, transportation, assistance with phone use, housekeeping, and laundry services. NSA documented family would perform money management and complete resident's shopping. The NSA was signed by licensed nurse D and not signed by resident's family member or legal representative. During an interview at 3:03 p.m. on 8/7/18, licensed nurse C stated he/she planned to develop a new NSA with resident's representative and would obtain all signatures on the NSA. Administrator B failed to ensure each individual involved in the development of the NSA for resident #1051 signed the NSA.	{S3101}		

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 _____	R 08/09/2018

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
{S3101}	Continued From page 6 - Record review for resident #1050 revealed an admission date of 8/17/17 with diagnoses of dementia, hypertension, and hypothyroidism. Functional capacity screen (FCS) dated 7/14/18 indicated resident required supervision with dressing, mobility in wheelchair, and eating; physical assistance with bathing, toileting, and transferring; was unable to perform management of medications and treatments; was incontinent of urine; experienced impaired short-term memory, long-term memory, memory recall, and impaired decision making; was at risk for falls; and exhibited socially inappropriate disruptive behavior. FCS also indicated resident was unable to perform meal preparation, shopping, money management, transportation, use of telephone, laundry, and housekeeping. NSA dated 7/16/18 documented facility staff provided health care services of physical assistance with bathing, toileting, and transferring; supervision of mobility in wheelchair, eating, and dressing. NSA documented facility provided services of housekeeping and laundry. The NSA contained the signature of licensed nurse C and the signature of administrator B. The NSA did not contain the signature of the resident's family member or legal representative. During an interview at 5:10 p.m. on 8/7/18, administrator B stated he/she e-mailed the NSA to resident's family member with no response. Administrator B failed to ensure each individual involved in the development of the NSA for resident #1051 signed the NSA. - Record review for resident #1052 revealed an	{S3101}		

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 _____	R 08/09/2018

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
{S3101}	Continued From page 7	{S3101}		

admission date of 3/6/18 with diagnoses of vascular dementia, anxiety, atrial fibrillation, and hypertension.

Functional capacity screen (FCS) dated 3/5/18 indicated resident was independent with transferring, walking, and eating; required supervision with toileting and dressing; required physical assistance with bathing; experienced impaired short-term memory, long-term memory, memory recall, and decision making; and exhibited wandering behavior and socially inappropriate behavior. FCS also indicated resident was unable to perform meal preparation, shopping, money management, transportation, use of telephone, and laundry and housekeeping.

NSA dated 7/8/18 documented facility provided health care services of supervision with bathing, ensure resident dressed appropriately, hourly safety check at night, and safety check every 2 hours during day and evening. On 7/22/18, licensed nurse added intervention of resident out in courtyard only with staff due to resident's elopement from the courtyard. NSA also documented facility provided services of activities. The NSA did not contain the signature of resident's family member or legal representative.

During an interview at 1:08 p.m. on 8/7/18, licensed nurse C confirmed the resident's family member did not sign the NSA.

Administrator B failed to ensure each individual involved in the development of the NSA for resident #1052 signed the NSA.

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 _____	R 08/09/2018

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
{S3155}	Continued From page 8	{S3155}		
{S3155} SS=D	26-41-204 (a) Health Care Services . (a) The administrator or operator in each assisted living facility or residential health care facility shall ensure that a licensed nurse provides or coordinates the provision of necessary health care services that meet the needs of each resident and are in accordance with the functional capacity screening and the negotiated service agreement. This REQUIREMENT is not met as evidenced by: KAR 26-41-204(a) The facility reported a census of 40 residents. The sample included 3 residents. Based on record review and interview for 1 (#1052) of 3 residents sampled, administrator B failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services that met the needs of the resident and were in accordance with the functional capacity screening and the negotiated service agreement. Findings included: - Record review for resident #1052 revealed an admission date of 3/6/18 with diagnoses of vascular dementia, anxiety, atrial fibrillation, and hypertension. Functional capacity screen dated 3/5/18 indicated resident was independent with transferring and walking; experienced impaired short-term memory, long-term memory, memory recall, and	{S3155}		

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 _____	R 08/09/2018

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
{S3155}	Continued From page 9	{S3155}		

decision making; and exhibited wandering behavior and socially inappropriate behavior.

Negotiated service agreement dated 7/8/18 documented facility staff to perform safety checks of resident every hour during the night and every 2 hours during day and evening. On 7/22/18, licensed nurse C added intervention of resident out in courtyard only with staff due to resident's elopement from the courtyard.

Health care service plan dated 7/8/18 also contained the same intervention of safety checks and on 7/22/18 licensed nurse C added intervention of resident out in courtyard only with staff due to resident's elopement from the courtyard.

The progress notes contained documentation of the resident's elopement on 7/22/18 with follow-up documentation on resident's injury. On 7/28/18 a licensed nurse documented at 12:00 a.m. that resident was exit seeking this evening, arguing with staff, and hard to redirect. Resident went to bed at 12:00 a.m. arguing that it was not his/her rom and that he/she was leaving tomorrow.

Resident's negotiated service agreement and health care service plan lacked interventions put in place prior to or after resident's elopement to address management of exit seeking behaviors and anxiety.

At 11:00 a.m. on 8/7/18, administrator B provided the facility self-report and investigation of resident's elopement from the courtyard at approximately 8:30 p.m. on 7/22/18. Resident #1052 was sitting outside on the patio just off the dining room with other residents. No staff

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 _____	R 08/09/2018

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
{S3155}	Continued From page 10	{S3155}		

members were outside with the resident. Resident pushed on the gate with alarm sounding and when gate released resident apparently went out into parking lot, fell, got self up, and came back into facility with blood on hand and abrasion to nose. Resident was transported to hospital emergency room for evaluation due to hitting head and required sutures to laceration on left index finger.

At 11:05 a.m. on 8/7/18, surveyor went to the patio with administrator B who stated employee had left the door to the dining room propped open, but staff did not supervise residents on the patio. Administrator B demonstrated the gate alarmed when pressure applied, and that gate would eventually release and open after pressure applied. Administrator B explained that the alarm should have alerted the I-pods staff carry but the sensor to send the signal had been deactivated when fence boards were replaced. Administrator showed surveyor where resident likely fell in parking lot since that was where staff found blood on curb.

During an interview at 1:08 p.m. on 8/7/18, when asked for interventions in place to address resident's exit seeking behavior and anxiety, licensed nurse C stated resident wore a wander guard bracelet that alerted staff when resident was near an exit. Licensed nurse C stated this was not effective because an employee had propped the dining room door open evening of 7/22/18 to prevent wander guard from alerting the staff I-pod. Licensed nurse C did not state any other interventions to address resident's exit seeking behavior and anxiety.

Administrator B failed to ensure a licensed nurse provided or coordinated the provision of

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 _____	R 08/09/2018

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
{S3155}	Continued From page 11 necessary health care services that met the needs of resident #1052 and were in accordance with the functional capacity screening and the negotiated service agreement.	{S3155}		
{S3165} SS=E	26-41-204 (d) Health Care Services (d) The negotiated service agreement shall contain a description of the health care services to be provided and the name of the licensed nurse responsible for the implementation and supervision of the plan. This REQUIREMENT is not met as evidenced by: KAR 26-41-204(d) The facility reported a census of 40 residents. The sample included 3 residents. Based on record review and interview for 3 (#1051, #1050, and #1052) of 3 residents sampled, administrator B failed to ensure the negotiated service agreement (NSA) documented the name of the licensed nurse responsible for the implementation and supervision of the health care service plan. Findings included: - Record review for resident #1051 revealed an admission date of 6/5/17 with a diagnosis of dementia. Functional capacity screen (FCS) dated 4/21/18 indicated resident was unable to perform transfer, mobility, and eating. Licensed nurse D who completed the screening documented what looked like a score of 3 (unable to perform)	{S3165}		

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 _____	R 08/09/2018

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
{S3165}	Continued From page 12 written over a score of 2 (physical assistance needed) for bathing, dressing, and toileting. FCS indicated resident was unable to perform management of medications, was incontinent of urine, experienced impaired short-term memory, long-term memory, memory recall, and impaired decision making; was at risk for falls; and required a wheelchair for mobility. FCS indicated resident was unable to perform meal preparation, shopping, money management, transportation, use of telephone, laundry, and housekeeping. NSA dated 6/16/18 documented facility provided meal service, activities, transportation, assistance with phone use, housekeeping, and laundry services and family provided money management and shopping. The NSA documented resident received health care services of assistance with bathing, dressing, toileting, transferring, mobility with wheelchair, eating, incontinence care, and management of medications and treatments. The NSA lacked the name of the licensed nurse responsible for the implementation and supervision of the health care service plan. During an interview at 3:03 p.m. on 8/7/18, licensed nurse C confirmed the resident's NSA lacked the name of the nurse responsible for the implementation and supervision of the health care service plan. Licensed nurse C stated NSA to be reviewed and revised. Administrator B failed to ensure resident #1051's NSA documented the name of the licensed nurse responsible for the implementation and supervision of the health care service plan. - Record review for resident #1050 revealed an admission date of 8/17/17 with diagnoses of dementia, hypertension, and hypothyroidism.	{S3165}		

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 _____	R 08/09/2018

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
{S3165}	Continued From page 13 Functional capacity screen (FCS) dated 7/14/18 indicated resident required supervision with dressing, mobility in wheelchair, and eating; physical assistance with bathing, toileting, and transferring; was unable to perform management of medications and treatments; was incontinent of urine; experienced impaired short-term memory, long-term memory, memory recall, and impaired decision making; was at risk for falls; and exhibited socially inappropriate disruptive behavior. FCS also indicated resident was unable to perform meal preparation, shopping, money management, transportation, use of telephone, laundry, and housekeeping. NSA dated 7/16/18 documented facility provided services of housekeeping and laundry. NSA documented health care services provided by facility staff of physical assistance with bathing, toileting, and transferring; supervision of mobility in wheelchair, eating, and dressing. Licensed nurse C signed the NSA on 7/14/18 as "Nurse responsible for implementation/supervision of the NSA." The NSA did not specify the licensed nurse responsible for the implementation and supervision of the health care service plan. At 3:17 p.m. on 8/7/18, licensed nurse C stated he/she was responsible for the implementation and supervision of the health care service plan. Administrator B stated the NSA would be revised. Administrator B failed to ensure resident #1051's NSA documented the name of the licensed nurse responsible for the implementation and supervision of the health care service plan. - Record review for resident #1052 revealed an admission date of 3/6/18 with diagnoses of	{S3165}		

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 _____	R 08/09/2018

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
{S3165}	Continued From page 14 vascular dementia, anxiety, atrial fibrillation, and hypertension. Functional capacity screen (FCS) dated 3/5/18 indicated resident was unable to perform meal preparation, shopping, money management, transportation, use of telephone, and laundry and housekeeping. FCS indicated resident was independent with transferring, walking, and eating; required supervision with toileting and dressing; required physical assistance with bathing; experienced impaired short-term memory, long-term memory, memory recall, and decision making; and exhibited wandering behavior and socially inappropriate behavior. NSA dated 7/8/18 documented facility provided health care services of supervision with bathing, ensure resident dressed appropriately, hourly safety check at night, and safety check every 2 hours during day and evening. On 7/22/18, licensed nurse added intervention of resident out in courtyard only with staff due to resident's elopement from the courtyard. NSA also documented facility provided services of activities. The NSA did not specify the licensed nurse responsible for the implementation and supervision of the health care service plan. During an interview at 1:08 p.m. on 8/7/18, licensed nurse C stated he/she was responsible for the implementation and supervision of the health care service plan. Administrator B failed to ensure resident #1052's NSA documented the name of the licensed nurse responsible for the implementation and supervision of the health care service plan.	{S3165}		

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 _____	R 08/09/2018

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 15	{S3200}		
{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 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 40 residents. The sample included 3 residents. Based on record review and interview for 3 (#1050, #1051, and #1052) of 3 residents sampled, administrator B failed to ensure medications were administered to each resident in accordance with a medical care provider's written order and professional standards of practice. Findings included: - Record review for resident #1050 revealed an admission date of 8/17/17 with diagnoses of	{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 _____	R 08/09/2018

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 16 dementia, hypertension, and hypothyroidism. Functional capacity screen dated 7/14/18 indicated resident was unable to perform management of medications and treatments. Negotiated service agreement and health care service plan each dated 7/16/18 did not specify the provider of management and administration of medications and treatments. Review of the July 2018 medication administration record (MAR) and the August 2018 MAR revealed facility certified medication aides and licensed nurses administered medications to resident. Record contained a pharmacist's recommendation to resident's medical care provider to order a trial discontinuance of triazolam (to treat insomnia). Medical care provider indicated medication to be discontinued and signed the order 7/12/18. The July 2018 MAR contained an entry for Triazolam 0.25 milligrams (mg) 1 tablet by mouth every HS (bedtime) for insomnia with an administration time of 8:00 p.m. from 7/1/18 through 7/11/18 and an administration time of 10:00 p.m. from 7/12/18 through 7/31/18 with initials to indicate resident received the medication every night in July. The July 2018 MAR also had an entry for Triazolam 0.25 mg 1 tablet by mouth every evening at bedtime for insomnia that was assigned a time of prn (as needed). The July 2018 MAR did not indicate resident received an as needed dose of the medication from 7/1/18 through 7/11/18 and appeared to be discontinued on 7/12/18. The August 2018 MAR contained documentation to indicate resident received a routine dose of Triazolam at bedtime every night 8/1/18 through 8/6/18.	{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 _____	R 08/09/2018

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 17 During an interview at 3:17 p.m. on 8/7/18, licensed nurse C reviewed the signed order to discontinue Triazolam and confirmed documentation on MAR indicated resident was still receiving the medication. Licensed nurse C stated he/she would look for an order to restart the medication. At 4:50 p.m. on 8/7/18, licensed nurse C and licensed nurse E each stated they could not find an order to restart Triazolam. Further review of the August 2018 MAR revealed resident did not receive memantine (to improve memory) 10 mg tablet by mouth, venlafaxine (to treat anxiety) 75 mg tablet by mouth, and application of topical triple antibiotic ointment to fifth toe right foot at 5:00 p.m. on 8/6/18. Certified medication aide (CMA) F documented "other" as reason resident did not receive medications. During an interview at 4:07 p.m. on 8/7/18, CMA F stated he/she did not give medications to resident or apply the ointment since resident was asleep at the time. CMA F stated he/she did not attempt to give the medications to resident again and did not report to licensed nurse C that resident did not receive the medications and treatment. Administrator B failed to ensure medications were administered to resident #1050 in accordance with a medical care provider's written order and professional standards of practice. - Record review for resident #1051 revealed an admission date of 6/5/17 with diagnosis of dementia. Functional capacity screen dated 4/21/18 indicated resident was unable to perform management of medications.	{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 _____	R 08/09/2018

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 18 Negotiated service agreement dated 6/16/18 documented facility provided medication management. Record contained a medical care provider's order dated 7/18/18 to discontinue Temazepam. The July 2018 medication administration record (MAR) and the August 2018 MAR each contained an entry for Temazepam 15 milligrams take one capsule by mouth at bedtime as needed for sleeplessness. The medication was not discontinued on 7/18/18. During an interview at 3:03 p.m. on 8/7/18, licensed nurse C reviewed the order and confirmed the Temazepam was to be discontinued. Administrator B failed to ensure medications were administered to resident #1051 in accordance with a medical care provider's written order and professional standards of practice. - Record review for resident #1052 revealed an admission date of 3/6/18 with diagnoses of vascular dementia, anxiety, atrial fibrillation, and hypertension. Functional capacity screen dated 3/5/18 indicated resident was unable to perform medication management and exhibited wandering behavior and socially inappropriate disruptive behaviors. Negotiated service agreement and health care service plan each dated 7/8/18 did not document the provider of medication management. Review of the August 2018 medication administration record (MAR) revealed resident did	{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 _____	R 08/09/2018

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 19 not receive his/her ordered dose of Risperidone 0.25 milligram tablet at 5:00 p.m. on 8/6/18. Certified medication aide (CMA) F documented "pharmacy has not delivered it yet." The MAR entry for the Risperidone documented resident received the medication for behaviors. During an interview at 4:17 p.m. on 8/7/18, CMA F stated there was not a 5:00 p.m. dose available and he/she did not call the pharmacy to have a dose delivered to the facility. At 4:38 p.m. on 8/6/18 CMA F stated he/she did not report the missed dose to licensed nurse C. Administrator B failed to ensure medications were administered to resident #1052 in accordance with a medical care provider's written order and professional standards of practice.	{S3200}		