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-C 10/01/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CYPRESS SPRINGS - WICHITA	1859 N WEBB RD 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 are the result of a Revisit and Correction Order visit #15-78 at the above named Residential Health Care Facility in Wichita, Kansas on 9/29/15, 9/30/15, and 10/01/15.	{S 000}		
S3015 SS=F	26-41-101 (c) Administration Position Description (c) Administrator and operator position description. Each licensee shall adopt a written position description for the administrator or operator that includes responsibilities for the following: (1) Planning, organizing, and directing the facility; (2) implementing operational policies and procedures for the facility; and(3) authorizing, in writing, a responsible employee who is 18 years old or older to act on the administrator ' s or operator's behalf in the absence of the administrator or operator. This REQUIREMENT is not met as evidenced by: KAR 26-41-101(c) The census equalled 46 the sample included three Residents. Based on interviews, for all Residents, Residents' family members, Residents' legal representatives, and employees of facility, the licensee failed to adopt operational policies and procedures for the facility that authorized in writing a responsible employee to act on the Administrator's behalf in the absence of the Administrator. Findings included: - On 9/29/15 at 11:15am, at time of entrance to	S3015		

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

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S3015	Continued From page 1 facility, Business Office Manager #B stated Administrator #Q (the Administrator of record according to department assignment documentation) was "let go" on Thursday, 9/24/15. Business Office Manager #B stated I am not sure who is in charge at this point... confirmed nothing available in writing and no verbal declaration of who to be in charge of facility in Administrator's absence... #B stated I will contact the Regional Director of Operations #D and ask who is to be in charge. On 9/29/15 at 11:45am, Business Office Manager #B reported: I have an Operator certificate... according to Regional Director of Operations #D, I am to be in charge of facility for now... corporate plans to install another company individual #W on Monday, October 05, 2015... The licensee failed to adopt operational policies and procedures for the facility that authorized in writing a responsible employee to act on the Administrator's behalf in the absence of the Administrator.	S3015		
{S3028} SS=E	26-41-101 (f) (3) Staff Treatment of Residents Reporting (f) (3) Each allegation of abuse, neglect, or exploitation shall be reported to the administrator or operator of the facility as soon as staff is aware of the allegation and to the department within 24 hours. The administrator or operator shall ensure that all of the following requirements are met: (A) An investigation shall be started when the administrator or operator, or the designee, receives notification of an alleged violation.	{S3028}		

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{S3028}	Continued From page 2 (B) Immediate measures shall be taken to prevent further potential abuse, neglect, or exploitation while the investigation is in progress. (C) Each alleged violation shall be thoroughly investigated within five working days of the initial report. Results of the investigation shall be reported to the administrator or operator. (D) Appropriate corrective action shall be taken if the alleged violation is verified. (E) The department ' s complaint investigation report shall be completed and submitted to the department within five working days of the initial report. (F) A written record shall be maintained of each investigation of reported abuse, neglect, or exploitation. This REQUIREMENT is not met as evidenced by: KAR 26-41-101(f)(3)(A)(B)(C)(D)(E)(F) The census equalled 46 the sample included three Residents. Based on reviews of record and interviews; For two of three sampled (#1072 and #1074), the Administrator failed to thoroughly investigate and report incidents with injury or complaints of pain when Resident unable to explain, in order to rule out potential abuse or neglect; and For two of three sampled (#1072 and #1074), the Administrator failed to ensure potential allegations of abuse or neglect reported to Department within 24 hours; failed to ensure an investigation completed and submitted to the Department within five working days of a reported incident; and failed to ensure a written record maintained of	{S3028}		

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{S3028}	Continued From page 3 each investigation, in order to rule out abuse or neglect. Findings included: - Review of record revealed #1072 admitted to facility 10/30/14 with diagnoses of Dementia, Hypertension, Urinary tract infection, Coronary artery disease, and Pelvic fracture. Current functional capacity screen (FCS) of 10/31/4 assessed #1072 unable to perform (3) bathing, dressing, toileting, medication and treatment management; in need of physical assistance (2) with transfers, mobility, eating; with bladder incontinence, cognitive impairment, communication, vision, hearing, and decision making deficits; with history of falls, and required wheelchair. Negotiated service agreement (NSA) of 6/01/15 documented facility staff to provide services to meet these needs: Has diagnosis of dementia that limits ability to communicate needs... aides help with telephone, letter writing, mail... encourages Resident to speak his/her needs Resident uses a wheelchair for all transportation... aide is to assist Resident at all times with ambulating and escorting to and from meals, activities... assist with ADL's (activities of daily living)... needs two person assist at all times... Resident will try and get up out of chair... unsteady on feet... has dementia... does not realize can not ambulate alone... aide assists to and from meals... make sure fall mats and a personal alarm are in place to minimize falls... hospital bed to be in lowest position at all times... Resident can not dress self... aide is to set up	{S3028}		

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{S3028}	Continued From page 4 and dress Resident AM and PM and as needed... needs total assistance with grooming... aide gives total care with grooming... Hospice bathes Resident two times weekly... Aide toilets Resident every two hours and checks and changes every two hours over night... provides all incontinent care... Aide will set up food for Resident... at times assist with eating Aide will transport to and from activities... provide IPOD for music... Cue Resident as needed about memories and interactions with other Residents... Nurse or medications aide to administer all medications... According to Nurses' Notes: 9/05/15 - 0644 - at about 0505am one of the caregivers notified me that #1072 was on the floor... I found Resident bleeding profusely from the left side of face... pressure applied... 911 called... Resident sent via EMS (emergency medical service)... family, administrator, and medical care provider notified... The medical record lacked evidence of an investigation into the cause of this head injury, in order to rule out abuse or neglect. The medical record lacked evidence this incident reported to the Department. The documentation failed to demonstrate consideration given to causal factors, condition or status of Resident prior to incident, and failed to demonstrate a revision of plan or interventions to avoid further incidents. The documentation provided failed to demonstrate a thorough investigation completed to rule out potential neglect or abuse, when #1072 unable to explain what or why incident occurred.	{S3028}		

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{S3028}	Continued From page 5 By interview on 9/29/15 at 4:28pm, Health Service Director (HSD) #A and Business Office Manager #B provided two documents, a "First Responder" form and an "Incident/Investigation" form. These failed to demonstrate a thorough investigation completed by Administrator #Q, and failed to indicate a report made to the Department as required. On 9/30/15 at 2:45pm, the Registered Nurse Consultant #M confirmed no investigation completed for this incident on 9/05/15... stated we were between nurses and Administrator #Q did not do an investigation or report to the Department. The Administrator failed to ensure the incident was reported to the Department within 24 hours; failed to ensure an investigation completed and submitted to the Department within five working days of a reported incident; and failed to ensure a written record maintained of each investigation, in order to rule out abuse or neglect for #1072's unwitnessed fall with head injury. - Review of record revealed #1074 admitted to facility 11/08/14 with diagnoses of Alzheimer's, Irritable bowel syndrome, Hyperlipidemia, and History of breast cancer. The current 11/08/14 functional capacity screen (FCS) assessed #1074 in need of supervision (1) with bathing and dressing, independent (0) with toileting, transfers, mobility and eating; unable to perform (3) medications and treatment management; continent of bladder; with impaired cognition, impaired communication, and impaired	{S3028}		

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{S3028}	Continued From page 6	{S3028}		

decision making.

By interview on 9/30/15 at 1:32pm, Certified direct care staff #G stated I have been here six months... we have always helped with some ADL's... more help now with sling on arm, but we have always helped with some ADL's...

The medical record contained an initial NSA "printed" 9/09/15. This NSA not yet signed by anyone.
The medical record contained an NSA of 5/26/15. The NSA of 9/09/15 changed #1074 from a "High Fall Risk" (5/26/15) to a "Limited Fall Risk", in spite of falls documented in Nurses' Notes between 5/26/15 and 9/09/15... directed staff to "provide supervision if needed walking around"...
Grooming... needs help with set up and completion... hands on help sometimes needed
Is incontinent... aides to toilet Resident every two hours or as needed...
Has end stage Dementia... cue with any needs... escort to meals and activities...
Listen to Resident concerns when anxious in the evening... redirect... encourage participation in activities...

The Nurses' Notes documented:
9/16/15 - 1900 - Resident was found on the floor in the hall yelling help... had small laceration on back of head and small hematoma... called 911 and send to hospital... was complaining of pain from fall... family, administrator, and physician notified...

The medical record lacked evidence of an investigation into the cause of fall, head laceration, and hematoma, unwitnessed in hall way, in order to rule out abuse or neglect.
The medical record lacked evidence this incident

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{S3028}	Continued From page 7	{S3028}		

reported to the Department.
The documentation failed to demonstrate consideration given to causal factors, condition or status of Resident prior to incident, and revision of plan or interventions to avoid further incidents. The documentation provided failed to demonstrate a thorough investigation completed to rule out potential neglect or abuse, when #1074 unable to explain what or why fall and injuries occurred.

On 9/29/15 at 5:00pm, Health Service Director (HSD) #A stated that literally occurred the day before I started... so I have no idea who did the investigation or what was done...

On 9/29/15 at 5:14pm, HSD #A and Business Office Manager #B provided an "Incident/Investigation" report located in the previous Administrator #Q's office. This document failed to demonstrate a thorough investigation into the causal factors of fall and injuries, in order to rule out abuse or neglect. This document failed to demonstrate the incident reported to the Department as required.

On 9/30/15 at 2:45pm, the Registered Nurse Consultant #M confirmed no investigation completed for this incident on 9/16/15... stated we were between nurses and Administrator #Q did not do an investigation or report to the Department.

The Administrator failed to ensure the incident reported to the Department within 24 hours; failed to ensure an investigation completed and submitted to the Department within five working days of a reported incident; and failed to ensure a written record maintained of each investigation, in order to rule out abuse or neglect for #1074's

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{S3028}	Continued From page 8 unwitnessed fall with injuries.	{S3028}		
{S3080} SS=D	26-41-201 (a) (b) Functional Capacity Screen on Admission a) On or before each individual ' s admission to an assisted living facility or residential health care facility, a licensed nurse, a licensed social worker, or the administrator or operator shall conduct a screening to determine the individual ' s functional capacity and shall record all findings on a screening form specified by the department. The administrator or operator may integrate the department ' s screening form into a form developed by the facility, which shall include each element and definition specified by the department. (b) A licensed nurse shall assess any resident whose functional capacity screening indicates the need for health care services. This REQUIREMENT is not met as evidenced by: KAR 26-41-201(a) The facility census equalled 46 the sample included three Residents. The facility identified one new admission since the last Resurvey. Based on review of record and interview, for one of one new admission to facility (#1070), the Administrator failed to ensure on or before admission, a licensed nurse conducted a screening to determine Resident's functional capacity. Findings included: - Review of record revealed #1070 admitted to	{S3080}		

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{S3080}	Continued From page 9 facility 9/12/15 with diagnoses of Dementia, Hypertension, Urinary tract infection, Renal failure, Depression, Acidosis, and Heart disease. The current functional capacity screen (FCS) of 9/11/15 assessed #1070 unable to perform (3) bathing, dressing, toileting, transfers, mobility, medication and treatment management; with incontinence, cognitive impairment, communication impairment, history of falls, with hearing and vision deficits, and used a wheelchair. This FCS assessed the need for multiple health care services. This FCS lacked the signature of the person who completed the assessment. The FCS and medical record failed to demonstrate a licensed nurse participated in this assessment of #1070, on or before admission to facility. The Administrator failed to ensure a licensed nurse conducted an assessment of functional status on or before #1070's admission to the facility.	{S3080}		
{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 census equalled 46 the sample	{S3165}		

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{S3165}	Continued From page 10	{S3165}		

included three Residents. Based on interviews, observations, and reviews of records, for three of three sampled (#1074, #1072, and #1070), the Administrator failed to ensure the negotiated service agreement (NSA) contained 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.

Findings included:

- Review of record revealed #1070 admitted to facility 9/12/15 with diagnoses of Dementia, Hypertension, Urinary tract infection, Renal failure, Depression, Acidosis, and Heart disease.

The current functional capacity screen (FCS) of 9/11/15 assessed #1070 unable to perform (3) bathing, dressing, toileting, transfers, mobility, medication and treatment management; with incontinence, cognitive impairment, communication impairment, history of falls, with hearing and vision deficits, and used a wheelchair.

This FCS assessed the need for multiple health care services.

The medical record contained an NSA "printed" on 9/24/15.
This NSA contained the printed statement "last update by Administrator #Q on 9/14/15."
This NSA lacked the name of the licensed nurse responsible for care and services supervision.
This NSA lacked the signature of a license nurse.

On 9/29/15 at 4:00pm, Business Office Manager #B and Health Service Director #A confirmed this NSA lacked nurse participation... confirmed no other NSA available... #A stated my first day on

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{S3165}	Continued From page 11 duty in facility was 9/17/15... #B stated the previous Health Service Director #P's last day in facility was 9/01/15. The Administrator failed to ensure the NSA for #1070 contained the name of the licensed nurse responsible for the implementation and supervision of the plan. - Review of record revealed #1072 admitted to facility 10/30/14 with diagnoses of Dementia, Hypertension, Urinary tract infection, Coronary artery disease, and Pelvic fracture. Current functional capacity screen (FCS) of 10/31/4 assessed #1072 unable to perform (3) bathing, dressing, toileting, medication and treatment management; in need of physical assistance (2) with transfers, mobility, eating; with bladder incontinence, cognitive impairment, communication, vision, hearing, and decision making deficits; with history of falls, and required wheelchair. Negotiated service agreement (NSA) of 6/01/15 documented facility staff to provide services to meet these needs: Has diagnosis of dementia that limits ability to communicate needs... aides help with telephone, letter writing, mail... encourages Resident to speak his/her needs Resident uses a wheelchair for all transportation... aide is to assist Resident at all times with ambulating and escorting to and from meals, activities... assist with ADL's (activities of daily living)... needs two person assist at all times... Resident will try and get up out of chair... unsteady on feet... has dementia... does not	{S3165}		

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{S3165}	Continued From page 12 realize can not ambulate alone... aide assists to and from meals... make sure fall mats and a personal alarm are in place to minimize falls... hospital bed to be in lowest position at all times... Resident can not dress self... aide is to set up and dress Resident AM and PM and as needed... needs total assistance with grooming... aide gives total care with grooming... Hospice bathes Resident two times weekly... Aide toilets Resident every two hours and checks and changes every two hours over night... provides all incontinent care... Aide will set up food for Resident... at times assist with eating Aide will transport to and from activities... provide IPOD for music... Cue Resident as needed about memories and interactions with other Residents... Nurse or medications aide to administer all medications... According to Nurses' Notes: 9/05/15 - 0644 - at about 0505am one of the caregivers notified me that #1072 was on the floor... I found Resident bleeding profusely from the left side of face... pressure applied... 911 called... Resident sent via EMS (emergency medical service)... family, administrator, and medical care provider notified... The NSA of 6/01/15 failed to demonstrate review or revision by a licensed nurse, in response to the incident and to plan prevention of further incidents. The NSA of 6/01/15 lacked the name of the nurse responsible for supervision and implementation of health care services. An additional NSA of 9/15/15 lacked the participation of a licensed nurse, and failed to include services to address falls for a Resident with a history of falls.	{S3165}		

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{S3165}	Continued From page 13 By interview on 9/30/15 at 2:10pm, Registered Nurse Consultant #M confirmed the NSA's lacked a description of the services to be provided to prevent falls for #1072. The Administrator failed to ensure the NSA for #1072 contained 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. - Review of record revealed #1074 admitted to facility 11/08/14 with diagnoses of Alzheimer's, Irritable bowel syndrome, Hyperlipidemia, and History of breast cancer. The current 11/08/14 functional capacity screen (FCS) assessed #1074 in need of supervision (1) with bathing and dressing, independent (0) with toileting, transfers, mobility and eating; unable to perform (3) medications and treatment management; continent of bladder; with impaired cognition, impaired communication, and impaired decision making. By interview on 9/30/15 at 1:32pm, Certified direct care staff #G stated I have been here six months... we have always helped with some ADL's... more help now with sling on arm, but we have always helped with some ADL's... The Nurses' Notes documented: 9/16/15 - 1900 - Resident was found on the floor in the hall yelling help... had small laceration on back of head and small hematoma... called 911 and send to hospital... was complaining of pain from fall... family, administrator, and physician notified...	{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-C 10/01/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CYPRESS SPRINGS - WICHITA	1859 N WEBB RD 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 The medical record contained an NSA of 5/26/15. This NSA lacked the name of the licensed nurse responsible for the supervision and implementation of health care services. The medical record contained an initial NSA "printed" 9/09/15. This NSA not yet signed by anyone. The NSA of 9/09/15 changed #1074 from a "High Fall Risk" (5/26/15) to a "Limited Fall Risk", in spite of falls documented in Nurses' Notes between 5/26/15 and 9/09/15... directed staff to "provide supervision if needed walking around"... Observation on 9/30/15 at 1:32pm in Resident's room, revealed a fall mat beside the lowered bed of #1074, and a personal alarm to be attached to Resident when in bed. The NSA failed to include a description of these services aimed at preventing falls. By interview on 9/30/15 at 2:10pm, Registered Nurse Consultant #M confirmed the NSA's lacked a description of the services to be provided to prevent falls for #1074. The Administrator failed to ensure the NSA for #1074 contained 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.	{S3165}		