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 _____	10/12/2023

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 an abbreviated survey for complaints #182962, 182779, 182668, 182400, 182398, 181820, 181174, and 174676 of the above named facility conducted on 10/10/23, 10/11/23, and 10/12/23	S 000		
S3171 SS=G	26-41-204 (i) Health Care Services Standards of Practice (i) All health care services shall be provided to residents by qualified staff in accordance with acceptable standards of practice. This REQUIREMENT is not met as evidenced by: K.A.R. 26-41-204 (i) The facility reported a census of 60 residents. The sample included 8 "Residents'". The administrator failed to ensure the qualified staff provided healthcare services in accordance with acceptable standards of practice when staff failed to respond to call lights in a timely manner, which resulted in R3 sustaining a fracture and resulted in delay in assistance for falls and potential illness or injury. Findings included: - Review of the facility provided resident roster revealed fifty-one residents required physical assistance with their activities of daily living.	S3171		

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

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S3171	Continued From page 1 - Record review for R3 revealed an admission date of 05/14/22 with diagnoses of mild cognitive impairment, long term use of anti-coagulants, nocturia, transient cerebral ischemic attack, heart failure and gout. Review of R3 FCS dated 10/09/23 revealed R3 required physical assistance with bathing, toileting, transferring, and mobility. Review of R3 combined NSA/HSP dated 10/09/23 instructed facility staff to provide the following health services: one person assistance with bathing, dressing, ambulating with her walker, and transferring. Review of R3 electronic medical records under the "Progress Note" tab revealed the following entry: 08/08/23 at 06:46 PM "The nurse was called into the R3 room by the CNA. R3 was lying on her side surrounded by a pool of blood with her feet out in front of her. The nurse applied pressure with a towel, (the note does not indicate where the pressure was being held to), Emergency medical services and family called". Resident sent to local hospital for evaluation. Record review of the facility provided self-report from to the department revealed R3 had been found lying by her bathroom door and, the hospital confirmed R3 had sustained an unspecified fracture of the sacrum from the fall and was discharged on 08/08/23 to a skilled rehabilitation facility. Record review of the facility titled document "Incidents" revealed R3 had an unwitnessed fall	S3171		

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S3171	Continued From page 2 and was found at 06:15 PM. Record review of the facility call light report revealed on 08/08/23 at 02:52:05 PM R3 pulled her bathroom call light and was found by staff at 06:15 PM on the floor by her bathroom. R3 was found 3 hours and 23 minutes after she pulled her bathroom call light. - Record review for R1 revealed an admission date of 03/10/23, with diagnoses of dementia, type two diabetes, and localized swelling, mass and lump, lower limb bilateral. Review of R1 "Functional Capacity Screen" (FCS) dated 03/10/23 revealed R1 required physical assistance with bathing, dressing toileting, transferring, and walking. Review of R1 combined "Negotiated Service Agreement" (NSA) / "Health Service Plan" (HSP) Dated 03/15/23 instructed facility staff to provide the following health services, 1-person physical assist with bathing, dressing, and walking. Review of R's1 electronic medical records under the "Progress Notes" tab revealed the following entry: 08/25/23 at 09:20 AM "At approx. 01:30 the nurse was notified of R1 being found down on the ground during facility rounding", the "Certified Nurse Aide" (CNA) heard yelling and found R1 on the ground in her bathroom. "R1 stated that the bathroom and bedroom call lights were on", "the nurse noted that neither light were on".	S3171		

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S3171	Continued From page 3 Record review of the facility document titled "Incidents" revealed R1 had an unwitnessed fall on 08/25/23 and was found at 01:30 on the ground. Record review of the facility provided untitled documents, which were identified by Administrator A as the facility call light report revealed R1 put her bathroom call light on at 01:21:56 AM and the response time was 20 minutes and 42 seconds. R1 put her bedroom call light on at 01:37 AM with a response time of 5 minutes and 3 seconds. - Record review for R2 revealed an admission date of 12/20/22 with diagnoses of dementia, repeated falls, right hip replacement, and osteoarthritis. Review of R2 FCS dated 06/02/23 revealed R2 was unable to perform any part of the task of bathing, dressing, toileting, and mobility. She required physical assistance with transferring. Review of R2 NSA/HSP dated 06/02/23 instructed facility staff to provide the following health services: one to two people for bathing and one person assist for transferring. She required physical assistance for dressing, and she required staff to propel her wheelchair. Review of R2 electronic medical record under the "Progress Notes" tab revealed the following entry: 08/18/23 at 11:59 AM "1142 AM resident heard	S3171		

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yelling out by housekeeping, who notified staff that R2 was on the floor in her bathroom".

Record review of the facility provided document titled "Incidents" revealed on 08/18/23 at R2 had an unwitnessed fall and was found at 11:42 AM.

Record review of the facility provided untitled documents, which were identified by Administrator A as the facility call light report revealed that on 08/18/23 at 11:25:18 AM R2 pulled her bedroom call light at 11:25 AM.

R2 was found on her bathroom floor 17 minutes after she activated her call light.

- R4, R5, R6, R7 and R8 were all identified on the facility provided resident roster as requiring physical assistance with his activities of daily living.

Review of the facility provided document titled "Incidents" revealed the following:

From 01/03/23 to 10/10/23 and revealed 244 entries that included the name of the resident, the reason, "unwitnessed falls" was the reason on every entry, the date of the fall and the time the resident was found. "Licensed Nurse B" confirmed the times recorded; were the times the residents were found by staff.

facility call light reports for dates 08/01/23 to 10/09/23 revealed there were 8 residents who activated their call lights and were documented as being found on the floor:

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S3171	Continued From page 5 R1 activated her light on 08/25/23 at 01:21 AM and again at 01:37 AM and was found per the nursing note at the reported time of 01:30 AM. R2 activated her light on 08/18/23 at 11:25 AM and was found at 11:42 AM. R3 activated her light on 08/08/23 at 02:53 PM and was found at 06:15 PM. R4 activated his light on 08/08/23 at 04:34 AM and was found at 05:38 AM. R5 activated her light on 10/07/23 at 09:58 PM and was found at 10:35 PM. R6 activated his light on 09/26/23 at 07:33 AM and was found at 09:30 AM. R7 activated her light on 09/11/23 at 09:41 PM and was found at 10:16 PM. R8 activated her light on 09/09/23 at 03:56 AM and was found at 04:25 AM. Review of the call light report for 10/03/23 thru 10/07/23 revealed the following call light response times: 17 calls taking greater than 15 minutes to answer. 28 calls taking greater than 30 minutes to answer. 92 calls taking greater than 60 minutes to answer. Observation on 10/12/23 at 04:19 PM in R9's	S3171		

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room. R9's daughter pulled the call cord at 04:19 PM.
CNA D came in the room and did not acknowledge the call light, she asked R9 if she would like to go to dinner. When asked about the call light being activated CNA D stated she "Didn't know the call light had been pulled". She then looked on her hand-held device and it showed R9 pulled her call light at 04:19 PM, CNA D then pressed on the side of the device and turned the volume up, she stated she "did not realize the volume had been lowered".

Interview on 10/11/23 at 09:30 AM with Administrator A and Licensed Nurse B, they confirmed the expectation of staff answering the resident call lights is 15 minutes or less.

The operator failed to ensure facility staff responded to call lights in a timely manner. R3's call light was activated for over 3 hours before staff answered and found R3 on the floor, sent out by EMS due to a fracture. This failure put all residents who required assistance for any reason at risk for delay in assistance for falls and potential illness or injury.