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	175539	A. BUILDING _____ B. WING _____	C 07/30/2019

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VIA CHRISTI VILLAGE RIDGE	3636 NORTH RIDGE RD BLDG 400 WICHITA, KS 67205

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F 000	INITIAL COMMENTS The following citations represent the findings of complaint investigation #KS00143686. The 2567 was electronically sent on 08/06/19	F 000		
F 562 SS=E	Immediate Access to Resident CFR(s): 483.10(f)(4)(i)(A)-(G) §483.10(f)(4)(i) The facility must provide immediate access to any resident by: (A) Any representative of the Secretary, (B) Any representative of the State, (C) Any representative of the Office of the State long term care ombudsman, (established under section 712 of the Older Americans Act of 1965, as amended 2016 (42 U.S.C. 3001 et seq.), (D) The resident's individual physician, (E) Any representative of the protection and advocacy systems, as designated by the state, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15001 et seq), (F) Any representative of the agency responsible for the protection and advocacy system for individuals with mental disorder (established under the Protection and Advocacy for Mentally Ill Individuals Act of 2000 (42 U.S.C. 10801 et seq.), and (G) The resident representative. This REQUIREMENT is not met as evidenced by: The facility census totaled 72 residents. Based on observation and interview the facility failed to provide a representative of the State Agency (State Surveyor) immediate access to the facility and residents on 07/29/19. The failure delayed the State Surveyor direct access to assess the safety of the residents and the staffing level in the	F 562		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 08/06/2019

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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facility for 22 minutes until the State Surveyor followed a staff member through the front doors of the facility when she reported for her scheduled shift on 07/29/19 at 5:35 AM.

Findings included:

- Observation on 07/29/19 at 05:18 AM revealed the State Surveyor attempted to enter the facility to conduct a complaint investigation for quality care and staffing and the front door was locked. The surveyor observed a video door bell, which was positioned on the north side of the entry way on the wall of the facility. A sign above the video doorbell instructed visitors to push the doorbell for service. The surveyor pressed the doorbell three times between 05:18 AM and 05:23 AM without a response from the facility staff on duty. The surveyor contacted the facility via phone at 05:23 AM and Certified Nurse Aide (CNA) C answered the phone. The State surveyor identified herself, explained the purpose for the visit, and requested entry to the facility. CNA C stated, "I will be right down to let you in". The surveyor continued to wait in the entry way of the facility until 05:33 AM. The surveyor notified her Regional Manager she was unable to gain access to the facility since her arrival on-site at 5:18 AM. The regional manger advised the surveyor to call the facility back and request entry again. The surveyor called the facility again at 05:35 AM and staff C answered the phone and stated "oh, I forgot," and at that time another staff member entered the facility and the surveyor followed the staff member into the facility at 5:36 AM

Interview on 07/29/19 at 05:42 AM with CNA D revealed each unit could hear the doorbell when it was pushed however, the units had no access to

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F 562	Continued From page 2 the video surveillance feed. CNA D revealed she heard the doorbell ring a little while ago, but was in a room with a resident and assumed another staff member had addressed the doorbell. Interview on 07/29/19 at 05:49 AM with Licensed Nurse (LN) E revealed the units in the facility had no access to the video feed from the video doorbell. LN E revealed staff were required to go to the front door of the facility and open it to allow the individual access to the facility. Interview at 07/30/2019 at 07:33 AM with Administrative Staff A revealed the facility staff should have responded to the doorbell in a timely manner as long as the resident in the staff's care were deemed safe for them to leave the unit to open the door. Administrative Staff A revealed staff should have given the State surveyor the door code once she identified herself and requested entry. Administrative Staff A revealed he would re-educate the staff on responding to the doorbell after hours. The facility failed to provide a policy regarding the doorbells function and expected responses as requested on 07/29/19. The facility failed to respond to the after-hours alert doorbell in the facility lobby to allow a State surveyor immediate access to the facility and the resident's during a complaint survey to ensure the resident safety and the staffing levels in the facility at the time of entry.	F 562		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care	F 684		

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Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.
This REQUIREMENT is not met as evidenced by:
The facility census totaled 72 residents. Based on interview and record review the facility failed to ensure Resident (R)1 received medications as ordered by her physician when licensed nursing (LN) staff contacted a certified nurse aide (CNA) for assistance when she could not access the facility automated medication dispensary system and was advised to let the resident sleep for an hour then check on her. The LN and CNA further failed to notify the licensed nurse on-call that nursing staff were not able to access the automated medication dispensary system in a timely manner.

Findings included:

- Interview on 07/29/19 at 08:12 AM with certified nurse aide (CNA) H revealed she was the on-call staff member the night of 05/10/19 and morning of 05/11/19. Staff H stated she received a call from licensed nurse (LN) F who stated she was unable to access the automated medication dispensary system. CNA H revealed LN F reported to him/her R1 received an order for an antianxiety medication and LN F could not access the facility automated medication dispensary system because she was the only staff member with access and she required a second licensed nursing staff member to sign the medication out

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of the automated system. CNA H explained to LN F she was not a licensed nurse and did not have access to the automated medication dispensary system. CNA H revealed she discussed the resident's condition and was advised the resident was sleeping comfortably. CNA H stated she advised LN F she would contact the licensed on-call nursing staff about the automated medication dispensary system, advised LN F to let the resident sleep, and check her again in an hour for any changes in the resident's condition. Further interview with CNA H revealed she contacted the on-call licensed nurse sometime the next morning about the automated medication dispensary system but was unable to recall what time she made the notification.

Interview on 7/29/19 at 10:45 AM with LN F revealed she received an order for R1, faxed the pharmacy and received a code required to open the automated system with a second licensed staff member. LN F revealed she called the after-hours on-call phone, which was answered by non-licensed CNA H. LN F revealed she reported she could not access the facility automated medication dispensary system to administer the antianxiety medication ordered by R1's physician. LN F revealed she gave CNA H an update on the resident's condition and was advised by CNA H to let the resident sleep for an hour and then recheck her. LN F revealed CNA H told her she would contact the on-call licensed nurse about the issue.

Interview on 7/29/19 at 9:06 AM with Administrative Nurse I revealed she was the licensed nurse on-call on 5/11/19. Administrative Nurse I revealed she was unaware the facility nursing staff were unable to access the

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automated medication dispensary system until she was contacted by CNA H around 10:00 AM the morning of 5/11/19.

Interview on 7/29/19 at 8:08 AM with Administrative Nurse B revealed she was aware LN F and LN G were unable to access the automated medication dispensary system on 5/11/19 to obtain a medication for R1. She confirmed licensed nurse staff failed to contact the licensed nurse on-call and CNA H should have reported the issues to on-call licensed nursing staff immediately. Administrative Nurse B confirmed CNA H was not qualified to advise LN F on the care of the resident, and it was out of CNA H's scope of practice.

Interview on 7/29/19 at 11:30 AM with Administrative Staff A revealed he was unaware of the facility's inability to access the antianxiety medication for R1 on 5/11/19. Administrative Staff A confirmed the facility did not complete a formal investigation into the incident. Administrative Staff A confirmed the facility failed to record and track the training for the licensed nursing staff to ensure the staff could access the automated medication dispensary system as needed.

Interview on 7/30/19 at 7:39 AM with Administrative Staff A revealed non-licensed CNA H should have not given his/her opinion or directed the licensed nurse staff regarding R1's care and should have notified the licensed on-call nurse immediately.

The facility failed to provide a policy on the scope of practice on a non-licensed direct care staff member and direct care staff members abilities to

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F 684	Continued From page 6 take call as requested on 7/29/19 and 7/30/19. The facility failed to ensure R1 received medications as ordered by her physician when licensed nursing (LN) staff contacted a certified nurse aide (CNA) for assistance when he/she could not access the facility automated medication dispensary system and was advised to let the resident sleep for an hour then check on her. The CNA further failed to notify the licensed nurse on-call that nursing staff were not able to access the automated dispensary system in a timely manner.	F 684		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.	F 755		

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§483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and

§483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.
This REQUIREMENT is not met as evidenced by:
The facility census totaled 72 residents. Based on interview and record review the facility failed to ensure Licensed Nursing Staff had access to the facility automated medication dispensary system. The facility further failed to ensure Licensed Nursing Staff had the knowledge to use the non-automated emergency medication kit in the facility when Resident (R)1 required medication for anxiety and Licensed Nursing Staff did not have access to it.

Findings included:

- Review of R1's physician order sheet dated 05/10/19 revealed the resident had the following diagnoses: fractured left hip with surgical repair and chronic pain.

Review of the progress note dated 05/11/19 at 06:31 AM revealed Licensed Nursing (LN) F observed R1 to be restless and moaning. LN F assessed the resident and the resident reported she experienced pain. LN F called the resident's primary care physician and received a one-time order for lorazepam (an antianxiety medication) 0.5 milligrams (mg) to be given by mouth. LN F called and faxed the new order to the pharmacy for a medication code which allowed facility staff

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to open the automated medication storage/dispensary system.

Interview on 07/29/19 at 08:12 AM with Certified Nurse Aide (CNA) H revealed she was the on-call staff member the night of 05/10/19 and morning of 05/11/19. CNA H revealed she received a call from LN F who stated she could not access the automated medication system. CNA H revealed LN F reported to her LN F received an order for the antianxiety medication for R1. LN F stated she could not access the automated system because she was the only staff member with access and the medication system required a second Licensed Nursing Staff member to sign out the medication. CNA H explained to LN F she was not a Licensed Nurse and did not have access to the medication dispensary system. CNA H confirmed she did not have the ability to put a Licensed Staff member into the system, but three administrative nurses employed by the facility had the ability to grant staff access to the medication dispensary system off of campus.

Interview on 07/29/19 at 10:45 AM with LN F revealed she received the order for R1, faxed the pharmacy, and received a code from the pharmacy required to open the automated medication dispensary system with a second LN with access to the system. LN F stated the facility had a total of three other nurses on shift at the time the order was received. LN F stated two of the other licensed nurses did not have login access to the medication dispensary system and Licensed Nurse G had received her login to access the system however the login access was not activated in the system and LN G was denied entry to the drug delivery system. LN F stated CNA H told her they would contact the on-call

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Licensed Nurse about the issue. LN F failed to use the facility non-automated emergency medication kit to obtain the antianxiety medication for R1.

Interview on 07/29/19 at 02:55 PM with LN G revealed he attended the training class on the automated dispensary system provided by the pharmacy, received a login, and believed he was granted access to use the medication dispensary system. LN G revealed he did not know his login information was not active until 5/11/19 when he attempted to help LN F obtain a medication for R1 and his access was denied.

Interview on 07/29/19 at 10:45 AM with Consultant Pharmacist (CP) J revealed the pharmacy provided the original training class on the automated medication dispensary system on 04/22/19 and 04/23/19. CP J stated the facility provided further training sessions after the original mandatory training sessions as well. CP J stated the pharmacy granted three nurse managers from the facility access to input/grant access to Licensed facility staff as needed. CP J revealed the facility had the ability to add Licensed Nursing staff to the automated dispensary system offsite as well. CP J believed the pharmacy left emergency medication kits in the facility until the automated dispensary system was fully functional.

Interview on 07/29/19 at 09:06 AM with Administrative Nurse I revealed she was the licensed nurse on-call on 05/11/19. Administrative Nurse I revealed she did not know the facility nursing staff could not access the automatic dispensary system until CNA H contacted her around 10:00 AM. Administrative

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Nurse I revealed CNA H informed her three of the four nurses on the night shift did not have access to the automatic dispensary system to obtain medication for R1. Administrative Nurse I did not know if facility staff were trained to use the non-automated emergency medication kit until the automated dispensary system was fully functional.

Interview on 7/30/19 at 7:39 AM with Administrative Staff A revealed the facility identified five or six licensed nursing staff the facility failed to train on the automatic medication dispensary system.

Review of the undated Automated Drug Delivery System policy revealed the facility and the pharmacy would develop and implement written policies and procedures to ensure safety, accuracy, accountability, security, patient confidentiality, and maintenance of the quality, potency and purity of the stored drugs in the facility remote automated medication systems.

The facility failed to ensure licensed nursing staff had access to the facility automated medication dispensary system. The facility further failed to ensure licensed nursing staff had the knowledge to use the non-automated emergency medication kit in the facility when R1 required medication for anxiety and licensed nursing staff did not have access to it.