STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087075	A. BUILDING: _____ B. WING _____	09/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE OXFORD GRAND	3051 N PARKDALE CIRCLE WICHITA, KS 67205

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S 000	INITIAL COMMENTS The following citations represent the findings of a resurvey with a complaint #166117, 170689 and 171600 at the above named Assisted Living conducted on 09/22/22, 09/26/22 - 09/27/22.	S 000		
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 81 residents. The sample included six residents and two focused reviews. Based on interview, and record review the administrator failed to ensure the "Negotiated Service Agreement" (NSA) for Resident (R)101 and R104 was signed by all individuals involved in the development of the NSA to include the resident's legal representative. Findings included: - R101's medical record revealed the resident moved into the facility on 11/06/19 with a diagnosis of dementia.	S3101		

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

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S3101	Continued From page 1 The 06/15/22 "Functional Capacity Screen" (FCS) documented R101 had difficulty with both short-term, long-term memory, memory/recall and decision-making. The 06/15/22 NSA documented was signed by the licensed nurse but was not signed by R101's legal representative. On 09/27/22 at 04:34 PM Administrative Nurse A stated the NSA should be signed by the R101's legal representative but only had a "verbal." The Administrator failed to ensure R101's NSA was signed by all individuals involved in the development of the NSA. - R104's medical record revealed the resident moved into the facility on 02/05/18 with a diagnosis of hemiplegia. The 06/15/22 FCS documented R104 had difficulty with short-term memory, memory/recall and decision-making. The 06/15/22 NSA documented was signed by the licensed nurse but was not signed by R104's legal representative. On 09/27/22 at 10:32 AM Administrative Nurse A stated the NSA should be signed by the R104's legal representative but only had a "verbal." The Administrator failed to ensure R104's NSA was signed by all individuals involved in the development of the NSA.	S3101		

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S3211	Continued From page 2	S3211		
S3211 SS=E	26-41-205 (g) (3) OVER THE COUNTER DRUGS (3) A licensed nurse or medication aide may accept over-the-counter medication only in its original, unbroken manufacturer ' s package. A licensed pharmacist or licensed nurse shall place the full name of the resident on the package. If the original manufacturer ' s package of an over-the-counter medication contains a medication in a container, bottle, or tube that can be removed from the original package, the licensed pharmacist or a licensed nurse shall place the full name of the resident on both the original manufacturer ' s medication package and the medication container. This REQUIREMENT is not met as evidenced by: 3211 KAR 26-41-205 (g)(3) The facility reported a census of 81 residents. Based on observation and interview the administrator failed to ensure a licensed pharmacist or licensed nurse placed the full name of the resident on the original package of over-the-counter medications for four residents. A total of 17 containers of medications were not labeled. Findings included: - Observation on 09/27/22 at 11:32 AM revealed the Hathaway House Memory Care Unit	S3211		

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S3211	Continued From page 3	S3211		

medication cart contained the following over-the counter medications which were not labeled with a resident's full name:

Resident (R) 407:
A bottle of Aspirin 81 milligrams (mg) listed only a first name of the resident.
A bottle of Complete Multi-vitamins marked with only the number 407.
A bottle of Nature Made Super B-Complex marked with a question mark (?)

Observation on 09/27/22 at 11:46 AM revealed the AL-2 medication cart contained the following over-the-counter medications which were not labeled with a resident's full name:

R210:
A bottle of Equate Completed Multivitamin marked only with 210.
A bottle of Melatonin 3 mg marked only with 210.
A box of Imodium A-D marked only with 210.

R218:
A bottle of Aspirin 81 mg marked only with 218.
A bottle of Vitamin B12 1000 micrograms (mcg) marked only with 218.
A bottle of Ibuprofen marked only with 218.
A box of Mucinex marked on with 218.

R221:
A bottle of One a Day Advanced Multivitamin marked only with 221.

There were six other bottles of over-the-counter medications stored in another compartment.

On 09/27/22 at 11:50 AM Administrative Nurse A

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S3211	Continued From page 4 stated she expected all over-the-counter medications belonging to residents to be labeled with the resident's full name. The 10/2017 "Medication Storage" policy documented, "Medications are to be stored according to resident's name and apartment number." The administrator failed to ensure all over-the-counter medications were labeled with the resident's full name.	S3211		
S3298 SS=F	26-41-206 (d) Food Preparation (d) Food preparation. Food shall be prepared using safe methods that conserve the nutritive value, flavor, and appearance and shall be served at the proper temperature. (1) Food used by facility staff to serve to the residents, including donated food, shall meet all applicable federal, state, and local laws and regulations. (2) Food in cans that have significant defects, including swelling, leakage, punctures, holes, fractures, pitted rust, or denting severe enough to prevent normal stacking or opening with a manual, wheel-type can opener, shall not be used. (3) Food provided by a resident ' s family or friends for individual residents shall not be required to meet federal, state, and local laws and regulations. This REQUIREMENT is not met as evidenced by:	S3298		

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S3298	Continued From page 5 3298 KAR 26-41-206 (d) The facility had a census of 81 residents. All 81 residents ate food prepared in the same kitchen. Based on observation and interview the administrator failed to ensure food items were served at the proper temperature. Findings included: On 09/27/22 at 12:54 PM during a walk through of the kitchen no documentation of food temperatures prior to distribution was located. On 09/27/22 at 12:55 PM Administrative Staff B stated the cooks monitored food temperatures but did not document these temperatures. The 10/2017 "Food Preparation" policy documented, "The temperature of foods held in steam tables will be monitored by food service staff, including prior to distribution." According to the Kansas Department of Agriculture "Focus on Food Safety" revised August 2017, hot foods must be maintained at an internal temperature of 135 Fahrenheit (F) or higher and cold foods must be maintained at an internal temperature of 41 F or below. The administrator failed to ensure food items were served at the proper temperature.	S3298		