STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087084	A. BUILDING: _____ B. WING _____	06/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HEALTHCARE RESORT OF WICHITA	7057 WEST VILLAGE CIRCLE WICHITA, KS 67205

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S 000	INITIAL COMMENTS The following citations represent the findings of an initial survey at the above named attached assisted living facility conducted on 06/02/2021; 06/03/2021; 06/07/2021; and 06/08/2021.	S 000		
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: KAR 26-41-205(g)(3) The census equaled 8 residents, the sample included 3 residents. Based on observations and interview, the administrator failed to ensure licensed nurses or pharmacists placed the full name of resident on each package of the resident's over the counter medication. Findings included: - Observation on 6/2/21 at 11:26 AM revealed a	S3211		

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

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S3211	Continued From page 1 closed medication room with one locked medication cart. The following over the counter medications were without first and last names: One bottle of Aspirin (pain, fever) 81 mg (milligrams) of 120 tablets, one bottle of Nasal Spray 3 oz (ounces) two bottles of Refresh Lubricant Eye Drops 0.33 oz Interview on 6/2/21 at 11:27 AM with certified staff #D confirmed the above listed medications were without full first and last names. Interview with operator on 09/21/2020 at 3:37 PM stated she was told they could use initials and room number. Facility's "Labeling of Medication Containers" policy obtained on 6/7/21 recorded, " 6. Labels for over-the-counter drugs shall include all necessary information such as: b. The resident's name" The administrator failed to ensure licensed nurses or pharmacists placed the full name of Resident on each package of the resident's over the counter medication.	S3211		
S3280 SS=E	26-41-104 (d) Disaster and Emergency Preparedness (d) Each administrator or operator shall ensure disaster and emergency preparedness by ensuring the performance of the following: (1) Orientation of new employees at the time of employment to the facility ' s emergency management plan; (2) education of each resident upon	S3280		

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S3280	Continued From page 2 admission to the facility regarding emergency procedures; (3) quarterly review of the facility ' s emergency management plan with employees and residents; and (4) an emergency drill, which shall be conducted at least annually with staff and residents. This drill shall include evacuation of the residents to a secure location. This REQUIREMENT is not met as evidenced by: KAR 26-41-104 (d) (3) The facility reported a census of 8 residents. Based on record review and interview, the administrator failed to ensure disaster and emergency preparedness by ensuring the performance of quarterly review of the facility's entire emergency plan with residents and staff. Findings included: - Review of the facility emergency management plan revealed the plan contained procedures to manage potential emergencies and disasters including Fire, Flood, Severe Weather, Tornado, Explosion, Natural Gas Leak, Lack of electrical or water service and Missing Residents. - Review on 6/2/21 of the facility's quarterly reviews of the emergency management plan with residents revealed the following reviews with residents: On 6/28/2020, reviewed fire, severe weather and	S3280		

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S3280	Continued From page 3 loss of electrical. On 4/29/21, reviewed fire, flood and loss of electrical. Facility missing first, third and fourth quarter of 2020 and first quarter of 2021. Interview on 6/2/21 at 2:15 PM with non-certified staff #C, whom holds resident council, confirmed he only has one review for 2020 and one review for 2021 with residents. - Review on 6/2/21 of the facility's quarterly reviews of the emergency management plan with staff revealed no quarterly reviews. Interview on 6/2/21 at 3:40 PM with administrator confirmed they do not complete quarterly reviews of the entire emergency management plan with staff. Administrator stated staff complete an online course upon hire and annually titled, "Workplace emergencies and natural disasters", but it is not completed quarterly. For all residents and staff, the administrator failed to ensure disaster and emergency preparedness by ensuring the performance of quarterly review of the facility's entire emergency plan with residents and staff.	S3280		
S3298 SS=E	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	S3298		

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S3298	Continued From page 4 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: KAR 26-41-206 (d) The facility reported a census of 8 residents. Based on record review and interview for all residents living in the facility and receiving meal services, the administrator failed to ensure the facility staff served food at the proper temperature. Findings included: On 6/2/21 at 11:37 AM, requested facility food temperature monitoring logs. Food temperature monitoring logs for May 2021 and June 2021 obtained. Record lacked lunch food temperatures for the following dates: 5/24/21, 5/26/21, 5/27/21, 5/30/21, 6/2/21 Record lacked supper food temperatures for the	S3298		

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S3298	Continued From page 5 following dates: 5/11/21, 5/21/21, 5/23/21, 5/24/21, 5/25/21, 6/2/21 Interview on 6/2/21 at 11:37 AM with non-certified staff #I confirmed food temperature logs were not completed at each meal. Interview on 6/2/21 at 1:10 PM with administrator confirmed food temperature logs were not completed at each meal and confirmed staff are to temp food prior to serving. On 6/7/21 at 12:35 PM during an electronic interview, licensed nurse #B confirmed all residents eat at facility. Kansas Department of Agriculture Food Safety guidelines records hot food must be maintained at a temperature of 135 degrees Fahrenheit or above, cold foods at 41 degrees Fahrenheit or below. Facility "Food Preparation and Service" policy obtained on 6/2/21 recorded, "The "danger zone" for food temperature is between 41 degrees and 135 degrees Fahrenheit. This temperature range promotes the rapid growth of pathogenic microorganisms that causes foodborne illness. Thermometers will be placed in hot and cold storage areas and checked for accuracy in accordance with accepted public health standards." For all residents of the facility, the operator failed to ensure facility staff served food at the proper temperature.	S3298		

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S3310	Continued From page 6	S3310		
S3310 SS=E	26-41-207 (b) (5-6) (c) Infection Control Policies (b) (5) prohibiting any employee with a communicable disease or any infected skin lesions from coming in direct contact with any resident, any resident ' s food, or resident care equipment until the condition is no longer infectious; (6) providing orientation to new employees and employee in-service education at least annually on the control of infections in a health care setting; and (c) Each administrator or operator shall ensure the facility ' s compliance with the department ' s tuberculosis guidelines for adult care homes adopted by reference in K.A.R. 26-39-105 This REQUIREMENT is not met as evidenced by: K.A.R 26-41-207 (c) The facility reported a census of 8 residents. The sample included 3 residents and review of 5 employee records. Based on record review and interview for 2 (#207, #419) of 3 sampled residents and 5 of 5 sampled staff, the administrator failed to ensure compliance with the department's TB (tuberculosis) guidelines. Findings included: - Review of resident #207's record revealed she admitted to the facility on 5/16/19 and the record lacked evidence of completion of a TB questionnaire upon admission and annually.	S3310		

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S3310	Continued From page 7 - Review of resident #419's record revealed he admitted to the facility on 8/21/2020 and the record lacked evidence of completion of a 2nd step TB test upon admission. Record lacked evidence of completion of a TB questionnaire upon admission. - Review of 5 newly hired employees file revealed the following: Licensed nurse #B hired onto the facility on 6/2/2020. Staff #B's record lacked evidence of a TB questionnaire upon hire. Certified staff #E hired onto the facility on 1/30/2020. Staff #E's record lacked evidence of completion of a TB questionnaire upon hire and annually. Certified staff #F hired onto the facility on 10/26/2020. Staff #F's record lacked evidence of completion of TB testing upon hire. Record lacked completion of a TB questionnaire upon hire. Certified staff #G hired onto the facility on 10/29/2020. Staff #G's record lacked completion of a TB questionnaire upon hire. Certified staff #H hired onto the facility on 3/19/2020. Staff #H's record lacked completion of a TB questionnaire upon hire and annually. Interview on 6/2/21 at 1:16 PM with licensed nurse #B confirmed no TB questionnaire completed upon admission or annually for resident #207. Interview on 6/2/21 at 1:24 PM with licensed	S3310		

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S3310	Continued From page 8	S3310		

nurse #B confirmed no 2nd step TB testing or TB questionnaire completed upon admission for resident #419.

Interview on 6/2/21 at 3:46 PM with administrator confirmed TB questionnaires are not completed upon hire or annually for staff.

Interview on 6/2/21 at 4:53 PM with administrator confirmed no evidence of TB testing completed on certified staff #F upon hire.

Facility's "Tuberculosis, (TB) Screening Residents" policy obtained on 6/2/21 recorded, "
a. The facility will screen referrals for admission and readmission for information regarding exposure to, or symptoms of, TB and will check results of recent (within 12 months) tuberculin skin tests (TST), blood assay for Mycobacterium tuberculosis (BAMT) or chest x-rays (CXR).
b. Any resident without documented negative TST, BAMT or CXR within the previous 12 months will receive a baseline (two-step) TST or (one-step) BAMT upon admission. If the first TST is negative, a follow-up TST will be administered 1 to 3 weeks after the initial test is read. The BAMT is a one-step test.
g. Screening of new admissions or readmissions for Tuberculosis infection and disease will be in compliance with State regulations."

Facility's "Tuberculosis, (TB) Employee Screening" policy obtained on 6/2/21 recorded, "
1. Each newly hired employee will be screened for TB infection and disease after an employment offer has been made but prior to employee's duty assignment.
1. The facility's employment health coordination will administer a TST to all newly hire employees except those who have documented BCG

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S3310	Continued From page 9 vaccination, positive TST or BAMT results, and those who provide documented verification of having had a negative TST or BAMT within the preceding 12 months. 2. The initial TB testing will be a two-step TST performed by infecting 0.1 milliliters of purified protein derivative (PPD) intradermally. a. if the reaction to the first skin test is negative, the facility will administer a second skin test 1 to 2 weeks after the first test." The administrator failed to ensure the facility remained in compliance with the department's tuberculosis guidelines for adult care homes adopted by reference in K.A.R. 26-39-105.	S3310		