| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175564 | A. Building<br>B. Wing | 03/18/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Center at Waterfront LLC | 1541 North Lindberg Circle<br>Wichita, KS 67206 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES<br>(Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0558<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Reasonably accommodate the needs and preferences of each resident.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31078<br><br>The facility reported a census of 60 residents with 17 selected for review, which included two residents reviewed for Activities of Daily Living (ADL). Based on observation, interview, and record review, the facility failed to provide one Resident (R)29, reasonable accommodations to his physical environmment, when he could not access the mirror.<br><br>Findings included:<br><br>- Review of Resident (R)29's medical record revealed diagnosis that included Parkinson's disease (slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, mask-like faces, shuffling gait, muscle rigidity and weakness).<br><br>The Admission Minimum Data Set (MDS), dated [DATE], assessed the resident with a Brief Interview for Mental Status (BIMS) score of 14, which indicated normal cognitive function. The resident required supervision or touching (helper to provide verbal cues of touching/steadying assistance as resident completes the activity) for personal hygiene.<br><br>The Activity of Daily Living (ADL)/ Functional Rehabilitation Care Area Assessment (CAA), dated 02/21/24, was not developed.<br><br>The Care Plan, reviewed 03/04/24, instructed staff to provide assistance as needed with grooming, bathing, and personal hygiene.<br><br>Observation, on 03/14/24 at 09:57 AM, revealed R29 seated in his wheelchair in his room. The resident responded appropriately to questions. The resident had areas of unshaven facial hair. The resident stated he had difficulty seeing the mirror to shave due to the location in the bathroom as he did not stand to shave.<br><br>Interview, on 03/14/24 at 11:07 AM, with Licensed Nurse (LN) J, revealed staff assisted R29 with set up for grooming.<br><br>Interview, on 03/14/24 at 12:43 PM, with Certified Nurse Aide (CNA) Q, revealed R29 required staff assistance with shaving.<br><br>Observation, on 03/18/24 at 07:31 AM, revealed R29 had several days growth of facial hair. The resident stated he preferred to be clean shaven but could not see the mirror to complete the task.<br><br>(continued on next page) |

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.

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 175564 | A. Building<br>B. Wing | 03/18/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| F 0558<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Interview, on 03/18/24 at 07:45 AM, with CNA N, revealed R29 did ask her for assistance shaving this morning.<br><br>Interview, on 03/18/24 at 10:30 AM, with Administrative Nurse D, revealed she would expect staff to provide grooming assistance per resident preferences.<br><br>The facility policy ADL Services reviewed 03/14/24, instructed staff to provide assistance with ADL every shift as appropriate, to include shaving.<br><br>The facility failed to provide reasonable accommodations to his physical environmment, when R29 could not access the mirror. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175564 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 03/18/2024 |
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| NAME OF PROVIDER OR SUPPLIER Center at Waterfront LLC | | STREET ADDRESS, CITY, STATE, ZIP CODE 1541 North Lindberg Circle Wichita, KS 67206 | |

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| F 0582<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.<br><br>31078<br><br>The facility reported a census of 60 residents. Based on interview and record review, the facility failed to notify one Resident (R) 167, a Notice of Medicare Non-Coverage (NOMNC) at least two days before the end of a Medicare covered Part A stay.<br><br>Findings included:<br><br>- On 03/14/24, Administrative staff A provided a list of discharged Medicare A residents with three residents chosen for review. One Resident (R)167 had no NOMNC completed when Medicare Part A services were terminate to let the resident know how many days of the 100 days available remained.<br><br>On 03/18/24 at 10:20 AM, Administrative Nurse D reported the Social Service Designee (SSD) was responsible to complete the beneficiary notices (NOMNCs), however had quit about six weeks ago.<br><br>Review of the facility policy for Notice of Medicare Non-Coverage, dated 06/20/23, revealed the facility must deliver a completed copy of the Notice of Medicare Non-Coverage to beneficiaries/enrollees receiving covered skilled nursing. The NOMNC must be delivered at least two calendar days before Medicare covered services end or the second to last day of service if care is not being provided daily. A NOMNC must be delivered even if beneficiaries agree with the termination of services. The provider must ensure the beneficiary or representative signs and dates the NOMNC to demonstrate the beneficiary or representative received the notice and understands the termination decision can be disputed.<br><br>The facility failed to give one resident, R167, a Notice of Medicare Non-Coverage (NOMNC) at least two days before the end of a Medicare covered Part A stay, as required. |

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| F 0623<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28560<br><br>The facility reported a census of 60 residents with 17 residents selected for review. Based on observation, interview, and record review, the facility failed to ensure staff notified the State Ombudsman of four of the four discharged /transferred residents reviewed. Resident (R)62 who left the facility against medical advice, and R 60, R18 and R 44 who transferred to acute care.<br><br>Findings included:<br><br>- Review of Resident (R)60's medical record revealed diagnoses included acute kidney failure with renal dialysis (procedure where impurities or wastes were removed from the blood) diabetes (procedure where impurities or wastes were removed from the blood) and heart disease.<br><br>The resident admitted to the facility on [DATE] and discharged to acute care on 01/08/24.<br><br>On 03/14/24 at 2:45 PM Administrative Staff A, confirmed lack of notification of the state ombudsman when residents were transferred/discharged from the facility.<br><br>The facility lacked a policy for notification of ombudsman.<br><br>The facility failed to notify the state Ombudsman when residents discharged /transferred from the facility as required.<br><br>- Review of Resident (R)62's medical record revealed diagnoses that included pancytopenia (a low number of red and white blood cells, usually due to a problem with bone marrow) fibromyalgia (condition of musculoskeletal pain, spasms, stiffness, fatigue, and severe sleep disturbance) and malignant (cancerous) neoplasm (tumor) of the breast.<br><br>The resident admitted to the facility on [DATE] and left the facility against medical advice on 02/29/24.<br><br>On 03/14/24 at 2:45 PM Administrative Staff A, confirmed lack of notification of the state ombudsman when residents were transferred/discharged from the facility.<br><br>The facility lacked a policy for notification of ombudsman.<br><br>The facility failed to notify the state Ombudsman when residents discharged /transferred from the facility as required.<br><br>31078<br><br>(continued on next page) |

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| F 0623<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | - R18's signed physician orders dated 02/20/24 revealed the following diagnoses: Peripheral Vascular disease(PVD slow and progressive circulation disorder causing narrowing, blockage, or spasms in a blood vessel), osteomyelitis (local or generalized infection of the bone and bone marrow) in the left ankle and foot, diabetes mellitus type 2 (when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin) with foot ulcer.<br><br>Review of R18's Minimum Data Set (MDS) tracking form documented the resident discharged to the hospital on 02/09/24 and returned on 02/13/24.<br><br>Review of R18's Electronic Medical Record lacked evidence of written notification of the facility-initiated hospitalization transfer/discharge notice to the representative of the Office of the State Long Term Care Ombudsman.<br><br>Observation on 03/13/24 at 10:05 AM revealed the resident was in his electric chair rolling in the halls. The resident had an amputation on his left leg below the knee.<br><br>On 03/14/24 at 02:45 PM, Administrative staff A reported he was unaware of the need to inform the Ombudsman of hospital admissions.<br><br>On 03/18/24 a facility policy regarding the Ombudsman notification was requested. No policy was provided.<br><br>The facility failed to notify the Long-Term Care Ombudsman, as required, of R18's discharge from the facility to the hospital. This placed the resident at risk for impaired rights and/or advocate involvement.<br><br>34056<br><br>- Review of Resident (R)44's electronic medical record (EMR) included a diagnosis of metabolic encephalopathy (condition in which brain function is disturbed either temporarily or permanently due to different diseases or toxins in the body).<br><br>The Admission Minimum Data Set (MDS), dated [DATE], documented the resident had a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition.<br><br>The Activities of Daily Living (ADL) Function/Rehabilitation Potential Care Area Assessment (CAA), dated 01/24/24, documented the resident was dependent on staff for assistance with ADLs.<br><br>The Discharge MDS, dated [DATE], documented the resident discharged from the facility to an acute hospital with return anticipated.<br><br>The Entry MDS, dated [DATE], documented the resident readmitted to the facility from an acute hospital.<br><br>The care plan for ADLs, dated 01/17/24, instructed staff the resident had a decline in his ability to perform ADLs.<br><br>(continued on next page) |

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| F 0623<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of the resident's EMR revealed the resident admitted to an acute hospital on 02/09/24 with a diagnosis of sepsis (systemic infection of the blood).<br><br>The resident's EMR lacked a signed bed hold for his hospital admission on 02/09/24.<br><br>On 03/14/24 at 02:40 PM, Administrative Nurse D stated she was unaware of the need to inform the Ombudsman of hospital admissions.<br><br>On 03/14/24 at 02:45 PM, Administrative Staff A stated he was unaware of the need to inform the Ombudsman of hospital admissions.<br><br>The facility lacked a policy for Ombudsman notification for resident discharges.<br><br>The facility failed to notify the Long-Term Care Ombudsman, as required, of R44's discharge from the facility to the hospital. |

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| F 0625<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34056<br><br>The facility reported a census of 60 residents with 17 residents sampled, including three residents reviewed for hospitalization . Based on interview and record review, the facility failed to provide the two Residents (R)18 and R 44 and/or their representative with a written notice specifying the duration and cost of the bed hold policy, at the time of the resident's transfer to the hospital.<br><br>Findings included:<br><br>- Review of Resident (R)44's electronic medical record (EMR) included a diagnosis of metabolic encephalopathy (condition in which brain function is disturbed either temporarily or permanently due to different diseases or toxins in the body).<br><br>The Admission Minimum Data Set (MDS), dated [DATE], documented the resident had a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition.<br><br>The Activities of Daily Living (ADL) Functional/Rehabilitation Potential Care Area Assessment (CAA), dated 01/24/24, documented the resident was dependent on staff for assistance with ADLs.<br><br>The Discharge MDS, Return Anticipated MDS, dated [DATE], documented the resident discharged from the facility to an acute hospital. This discharge was return anticipated.<br><br>The Entry MDS, dated [DATE], documented the resident readmitted to the facility from an acute hospital.<br><br>The care plan for ADLs, dated 01/17/24, instructed staff the resident had a decline in his ability to perform ADLs.<br><br>Review of the resident's EMR revealed the resident admitted to an acute hospital on 02/09/24 with a diagnosis of sepsis (systemic infection of the blood).<br><br>The resident's EMR lacked a signed bed hold for his hospital admission on 02/09/24.<br><br>On 03/18/24 at 08:24 AM, Licensed Nurse (LN) I stated a bed hold would need to be signed when a resident transferred to the hospital.<br><br>On 03/14/24 at 02:40 PM, Administrative Nurse D stated the nurses did not complete bed holds for residents when they transferred to the hospital.<br><br>On 03/24/24 at 02:45 PM, Administrative Staff A stated he was unaware of the need for residents and/or their representatives to sign a bed hold when transferred to the hospital.<br><br>(continued on next page) |

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F 0625

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

The facility policy for Bed Holds, revised 03/15/24, included: The facility will provide all residents with notice of bed-holds upon admission and at the time of transfer to the hospital and if applicable the resident's representative at time of transfer to the hospital. In cases of emergency transfer, notice will be offered within 24 hours.

The facility failed to provide the resident and/or his representative with a written notice specifying the duration and cost of the bed hold policy, at the time of the resident's transfer to the hospital.

31078

- Review of R18's Minimum Data Set (MDS) tracking form documented the resident discharged to the hospital on 02/09/24 and returned on 02/13/24.

Review of R18's Electronic Medical Record lacked evidence of written notification of the facility-initiated hospitalization transfer and bed hold to R18 or his representative.

Observation on 03/13/24 at 10:05 AM revealed the resident was in his electric chair. The resident had an amputation on his left leg below the knee.

On 03/14/24 at 2:30 PM, Administrative Staff B reported when she is aware of a resident being transferred to the hospital, she should fill out a short online report about the bed hold. She might talk to the family if available, but reported she would get signatures for any bed holds. The nurses could also complete a bed hold form when a resident transferred to a hospital.

On 03/14/24 at 02:40 PM, Administrative Nurse D reported the nurses do not complete bed holds on residents.

On 03/14/24 at 2:45 PM. Administrative Staff A reported he was unaware of the bed holds not being completed on the residents who were discharged to a hospital with return anticipated. He reported he never really worried about it because with the census, the facility would always have a bed for whatever resident needs to return after hospitalization .

The facility policy for Bed Holds, revised 03/15/24, included: The facility will provide all residents with notice of bed-holds upon admission and at the time of transfer to the hospital and if applicable the resident's representative at time of transfer to the hospital. In cases of emergency transfer, notice will be offered within 24 hours.

The facility failed to provide the resident and/or his representative with a written notice specifying the duration and cost of the bed hold policy, at the time of the resident's transfer to the hospital.

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| F 0636<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31078<br><br>The facility census totaled 60 residents with 17 included in the sample. Based on observation, interview, and record review, the facility failed to develop comprehensive assessments by the failure to complete the Care Area Assessments (CAAs) for further investigation and development of the comprehensive care plan for seven of the residents included in the sample. Resident (R)40 for respiratory status, R18 for medications, activities of daily living, and pain, R22 for skin issues, R29 for Activities of daily living, pressure ulcers and medications, R43 for pain, R3 for pain, urinary catheter, and skin conditions, and R35 for medications.<br><br>Findings included:<br><br>- Resident (R)18's signed physician orders dated 02/20/24 revealed the following diagnoses: Peripheral Vascular disease(PVD- abnormal condition affecting the blood vessels, osteomyelitis (local or generalized infection of the bone and bone marrow) in the left ankle and foot, and diabetes mellitus (when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin) with foot ulcer.<br><br>The Admission Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The resident used a motorized wheelchair for mobility. R18 required substantial/maximum assist with toileting, transfers, and dressing. R18 received as needed pain (prn) medication for frequent pain at 4/10 scale. He had infection in one foot and no open sores, Medications included anticoagulant (medication to prevent blood clots), diuretic (medication to promote the formation and excretion of urine), opioid (narcotic pain medication), insulin (a hormone produced in the pancreas which regulates the amount of glucose in the blood). and intravenous (IV) antibiotics (medication to treat infections).<br><br>The Care Area Assessment (CAA) dated 02/20/24, revealed no CAAs triggered for further investigation to develop the comprehensive care plan.<br><br>Observation on 03/13/24 at 10:05 AM, the resident was in his electric chair. The resident had an amputation on his left leg below the knee.<br><br>Observation on 03/14/24 at 11:10 AM revealed the resident sat in his electric chair in his room.<br><br>On 03/14/24 at 11:50 AM, Certified Nursing Assistant (CNA) M reported the resident was a two-person transfer with a slide board. He used a urinal for toileting.<br><br>On 03/14/24 at 11:57 AM, administrative nurse DD reported the corporate nurse worked on assessments prior to her arrival and marked the CAAs as they would be care planned but did not complete the summary areas of the CAAs.<br><br>On 03/14/24 at 11:30 AM, administrative nurse D reported the facility utilized the Resident Assessment Instrument (RAI) manual when completing the CAAs.<br><br>(continued on next page) |

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| F 0636<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 03/14/24 at 11:57 AM, administrative staff A reported there were two MDS nurses. One of the MDS staff left soon after the administrator started in mid-February 2024. Shortly after, the other nurse went on maternity leave. A corporate nurse was to complete the MDS's. He was not aware they were not complete.<br><br>On 03/18/24 at 09:10 AM, administrative nurse D acknowledged the CAAs, and the Care Plans were not updated. She reported one of the MDS coordinators quit and the other went on leave. They have a new MDS Coordinator but was unable to catch them up.<br><br>The facility had no written policy for completion of the MDS or CAAs and utilized the Resident Assessment Instrument (RAI) manual when completing the CAAs.<br><br>The facility failed to develop comprehensive assessments by the failure to complete the Care Area Assessments (CAAs) for further investigation and development of the comprehensive care plan for R18.<br><br>- Resident (R)22's signed physician orders revealed the following diagnoses: cellulitis (skin infection caused by bacteria characterized by heat, redness and swelling), and skin tear.<br><br>The Admission Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition. The resident was dependent on a wheelchair for mobility with an above the knee amputation on one leg. The resident required partial/moderate assistance for daily care. R22 received pain medication on schedule and as needed for frequent pain at 04/10 pain scale. The resident was dependent on oxygen and received continuous positive airway pressure (CPAP, a device that delivers pressurized air into your nose and mouth to keep your airways open and prevent breathing interruptions.) at night. The resident had a skin tear with dressing treatment. Medications included insulin injections (a hormone produced in the pancreas by the islets of Langerhans, which regulates the amount of glucose in the blood), antidepressant (class of medications used to treat mood disorders and relieve symptoms of depression), antibiotics (medication to treat infections), diuretic (medication to promote the formation and excretion of urine), opioid pain meds (narcotic pain medication), and antiplatelets (medication to prevent blood clots). The resident received intravenous (IV) antibiotics per midline access.<br><br>The Care Area Assessment (CAA) dated 02/29/24 revealed no CAAs completed for further investigation to develop the comprehensive care plan.<br><br>On 03/12/2024 at 08:03 AM, review of the Skin/Wound Note revealed the resident was seen for wound evaluation this shift, a scab within the original wound came off and become an open area. The resident reported she rubbed the tubigrip (elastic tube dressing), dressing and ripped the scab off.<br><br>The right thigh area one had a skin tear and the wound tissue type was epithelial (new skin growing in a superficial wound), and yellow slough (dead tissue), with the wound edge attached, scant serosanguinous drainage (clear flood that comes out of wound), ( peri-wound pink and blanchable, fragile. no erythema (abnormal redness of skin) observed, no signs of infection., The resident reported pain to the area at the time of the dressing change which resolved when the dressing change completed.<br><br>The right thigh, area two, revealed a skin tear wound with the tissue type of epithelial and yellow adherent slough, wound edge attached, with an exudate of scant serosanguinous drainage, peri-wound (around the wound) was pink and blanchable, and determined as fragile.<br><br>(continued on next page) |

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| F 0636<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | The right thigh area third skin tear wound had a tissue type of epithelial tissue, and the wound edge attached, with no exudate. The resident reported the area becomes swollen when resting her leg down and when lymphedema wraps (elastic wraps to put pressure on areas of swelling) intact.<br><br>Review of the wound care orders, dated 03/13/24, documented for the right calf open area, clean the wound with normal saline, apply a skin barrier film to the peri-wound, then apply hydrofera blue (antibacterial wound dressing) moistened with normal saline to the wound bed, cover with a dry dressing and change on Monday, Wednesday, and Friday.<br><br>The orders for the right anterior thigh wound, cover the wound bed with hydrofera blue classic (antibacterial wound dressing) (moistened with Normal saline), cover with ABD (thick, padded dressing), wrap with Kerlix and ace wrap and change every three days.<br><br>On 03/14/23 at 9:00 AM, observation revealed Licensed Nurse (LN) K entered the resident room to provide wound care. She set her dressing supplies directly in a chair beside the resident. The resident sat in a wheelchair. LN K provided wound care.<br><br>On 03/14/24 at 11:40 AM, Certified Nursing Assistant (CNA) M reported the resident was a two-person transfer. She had an amputation of her left leg above the knee but was able to bear weight and pivot transfer.<br><br>On 03/14/24 at 11:57 AM, Administrative nurse DD reported the corporate nurse worked on assessments prior to her arrival. The corporate nurse marked the CAAs as they would be care planned but did not complete the summary areas of the CAAs.<br><br>On 03/14/24 at 11:57 AM, Administrative staff A reported there were two MDS nurses. One of the MDS staff left soon after the administrator started in mid-February 2024. Shortly after, the other nurse went on maternity leave. A corporate nurse was to complete the MDS's. He was not aware they were not complete.<br><br>On 03/14/24 at 11:30 AM, Administrative nurse D reported the facility utilized the Resident Assessment Instrument (RAI) manual when completing the CAAs.<br><br>On 03/18/24 at 09:10 AM, Administrative nurse D acknowledged the CAAs, and the Care Plans were not updated. She reported one of the MDS coordinators quit and the other went on leave. They have a new MDS Coordinator but was unable to catch them up.<br><br>The facility had no written policy for completion of the MDS or CAAs and utilized the Resident Assessment Instrument (RAI) manual when completing the CAAs.<br><br>The facility failed to develop comprehensive assessments by the failure to complete the Care Area Assessments (CAAs) for further investigation and development of the comprehensive care plan for R22.<br><br>- Resident (R)40's signed physician orders revealed the following diagnoses: acute and chronic respiratory failure with hypoxia (inadequate supply of oxygen), and chronic obstructive pulmonary disease (COPD - progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing).<br><br>(continued on next page) |

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| NAME OF PROVIDER OR SUPPLIER Center at Waterfront LLC | | STREET ADDRESS, CITY, STATE, ZIP CODE 1541 North Lindberg Circle Wichita, KS 67206 | |

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| F 0636<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | The Admission Minimum Data Set (MDS), dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 12, indicating moderate cognitive impairment. The resident used a walker for mobility. The resident required partial/moderate staff assistance to toilet, shower, dress, and personal hygiene. The resident had no pain, no falls and received insulin, antianxiety (class of medications that calm and relax people with excessive anxiety, nervousness, or tension), antibiotic (medication to treat infection), and antiplatelet (medications that prevent blood clots from forming), medications daily. The resident received continuous oxygen therapy.<br><br>The Care Area Assessment (CAA) dated 02/28/24 revealed no CAAs for further investigation in developing a comprehensive care plan.<br><br>The physician order dated 01/11/24 revealed oxygen to be on at (1-5) liters per minute (continuously), delivered through (NC) may titrate to greater than or equal to 88% every shift and prn. Okay for therapy to titrate every shift for shortness of breath (SOB) and as needed for SOB/decreased blood oxygen saturation.<br><br>On 03/13/24 at 12:24 PM, R40 was eating lunch in his room, and had oxygen (O2) on per nasal cannula. The resident exhibited shortness of breath while he ate.<br><br>On 03/14/24 at 09:00 AM revealed the resident was in bed with his O2 on per nasal cannula.<br><br>On 03/13/24 at 12:25 PM, the resident reported he had pneumonia (inflammation of the lungs), and was currently on antibiotics to treat the pneumonia.<br><br>On 03/14/24 at 10:30 AM, Certified Nursing Assessment (CNA)M reported the resident was moderate assistance of one staff. He always wore oxygen.<br><br>On 03/14/24 at 11:57 AM, Administrative nurse DD reported the corporate nurse worked on assessments prior to her arrival. The corporate nurse marked the CAAs as they would be care planned but did not complete the summary areas of the CAAs.<br><br>On 03/14/24 at 11:30 AM, Administrative nurse D reported the facility utilized the Resident Assessment Instrument (RAI) manual when completing the CAAs.<br><br>On 03/14/24 at 11:57 AM, Administrative staff A reported there were two MDS nurses. One of the MDS staff left soon after the administrator started in mid-February 2024. Shortly after, the other nurse went on maternity leave. A corporate nurse was to complete the MDS's. He was not aware they were not complete.<br><br>On 03/18/24 at 09:10 AM, Administrative nurse D acknowledged the lack of completion of the CAAs, and the care plans were not completed.<br><br>The facility had no written policy for completion of the MDS or CAAs and utilized the Resident Assessment Instrument (RAI) manual when completing the CAAs.<br><br>The facility failed to develop comprehensive assessments by the failure to complete the Care Area Assessments (CAAs) for further investigation and development of the comprehensive care plan for R40.<br><br>(continued on next page) |

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| F 0636<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 28560<br><br>- Review of Resident (R)29's medical record revealed a diagnosis that included Parkinson's disease (slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity and weakness).<br><br>The Admission Minimum Data Set (MDS), dated [DATE], assessed the resident with a Brief Interview for Mental Status (BIMS) score of 14, which indicated normal cognitive function. The resident received antibiotic (medication used to treat infections) antidepressant (medications use to treat depression), and anticoagulant medication (medication used to treat the blood from forming clots). The resident was at risk for pressure ulcer (localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction) development. The resident admitted with two stage two (partial-thickness skin loss into but no deeper than the dermis including intact or ruptured blisters) pressure ulcers. The resident was dependent on staff for activities of daily living.<br><br>The Psychoactive (medications that affect mood) Medication Care Area Assessment (CAA), dated 02/21/24, was undeveloped.<br><br>The Pressure Ulcer CAA dated 02/21/24, was not developed.<br><br>The Activity of Daily Living (ADL)/Functional Rehabilitation CAA dated 02/21/24 was not developed .<br><br>Interview, on 03/14/24 11:25 AM, with Administrative Staff A, revealed the since mid-February 2024, corporate nurses completed the MDS for the facility.<br><br>Interview, on 03/14/24 at 11:57 AM, with Administrative Nurse DD, confirmed with the CAA was not developed, the MDS would not be complete.<br><br>The facility followed the Resident Assessment Instrument (RAI) manual when completing the CAAs.<br><br>The facility failed to ensure staff completed the CAAs to develop a comprehensive care plan as required.<br><br>- Review of Resident (R)3's medical record, revealed diagnoses that included atrial fibrillation (rapid irregular heartbeat), lymphedema (swelling caused by an accumulation of lymph that leaked from blood vessels), and muscle weakness.<br><br>The Admission Minimum Data Set (MDS), dated [DATE], assessed the resident with a Brief Interview for Mental Status (BIMS) score of 15, which indicated normal cognitive function. The resident was dependent on staff for bed mobility and at risk for pressure ulcers (localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction) and had a skin tear and moisture associated skin damage (MASD- inflammation or skin erosion caused by prolonged exposure to a source of moisture such as urine, stool, sweat, wound drainage, saliva or mucous). The resident received scheduled pain medications and described her pain as occasional and mild. The resident had a urinary catheter (device used to drain urine from the bladder).<br><br>(continued on next page) |

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| F 0636<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | The Pressure Ulcer Care Area Assessment (CAA) for the MDS dated [DATE], was not developed.<br><br>The Pain CAA, for the MDS dated [DATE], was not developed.<br><br>The Urinary Incontinence and Indwelling Catheter CAA for the MDS dated [DATE] was not developed.<br><br>Interview, on 03/14/24 11:25 AM, with Administrative Staff A, revealed the since mid-February 2024, corporate nurses completed the MDS for the facility.<br><br>Interview, on 03/14/24 at 11:57 AM, with Administrative Nurse DD, confirmed with the CAA was not developed, the MDS would not be complete.<br><br>The facility followed the Resident Assessment Instrument (RAI) manual when completing the CAAs.<br><br>The facility failed to ensure staff completed the CAA to develop a comprehensive care plan as required.<br><br>34056<br><br>- Review of Resident (R)43's electronic medical record (EMR) included a diagnosis of osteoarthritis (degenerative changes to one or many joints characterized by swelling and pain).<br><br>The Admission Minimum Data Set (MDS), dated [DATE], documented the resident had a Brief Interview for Mental Status (BIMS) score of 13, indicating intact cognition. She received scheduled and non-medication interventions for pain. The resident reported frequent pain in the past five days of the look back period which affected her sleep, day to day activities that interfered with her therapy. She reported her worst pain in the five days was a seven out of a scale of 1-10 pain scale. She received opioid medications (a class of drugs that derive from, or mimic, natural substances found in the opium poppy plant. Opioids work in the brain to produce a variety of effects, including pain relief) during the assessment period.<br><br>The Pain Care Area Assessment (CAA), dated 03/06/24, triggered back lacked an analysis of findings.<br><br>The care plan for pain, dated 02/28/24, instructed staff the resident had acute (sudden on-set) and chronic (persisting for a long time) pain. Staff were to acknowledge the resident's presence of pain and discomfort.<br><br>Review of the resident's EMR revealed the following physician's orders:<br><br>Norco (an opioid medication combined with Acetaminophen), 10-325 milligrams (mg), by mouth (po), every (Q) four hours, for pain, ordered 03/02/24.<br><br>On 03/13/24 at 08:29 AM, the resident stated she had a lot of pain which she took pain medication to relieve.<br><br>On 03/13/24 at 08:39 AM, Licensed Nurse (LN) I stated the resident took pain medication every four hours.<br><br>(continued on next page) |

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| F 0636<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 03/14/24 at 11:57 AM, Administrative Nurse D confirmed the pain CAA had not been completed for this resident who had pain and received opioid pain medication.<br><br>The facility follows the Resident Assessment Instrument (RAI) manual when completing the CAAs.<br><br>The facility failed to complete the Pain CAA for this resident who had pain and received pain medication.<br><br>- Review of Resident (R)35's electronic medical record (EMR) included a diagnosis of dementia (progressive mental disorder characterized by failing memory, confusion) with psychotic disturbance (any major mental disorder characterized by a gross impairment in reality perception), anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear) and mood disturbance (category of mental health problems, feelings of sadness, helplessness, guilt, wanting to die were more intense and persistent than what may normally be felt from time to time).<br><br>The Admission Minimum Data Set (MDS), dated [DATE], documented the resident had a Brief Interview for Mental Status (BIMS) score of eight, indicating moderate cognitive impairment. He received antipsychotic (class of medications used to treat major mental conditions which cause a break from reality) medication during the assessment period.<br><br>The Psychotropic Drug Use Care Area Assessment (CAA), dated 02/29/24, triggered but lacked an analysis of findings.<br><br>The Psychosocial Well-Being CAA, dated 02/29/24, triggered but lacked an analysis of findings.<br><br>The Cognitive Loss/Dementia CAA, dated 02/29/24, triggered but lacked an analysis of findings.<br><br>The care plan for psychotropic medications (a group of drugs that affects behavior, mood, thoughts or perception) medications, dated 02/22/24, instructed staff to monitor for adverse reactions to the medication.<br><br>Review of the resident's electronic medical record (EMR), revealed the following physician's order:<br><br>Seroquel (an antipsychotic medication), 25 milligrams (mg), by mouth (po), every day (QD), for forgetfulness and possible dementia, ordered, 02/27/24.<br><br>On 03/13/24 at 08:39 AM, Licensed Nurse (LN) I stated the resident took antipsychotic medications daily.<br><br>On 03/14/24 at 11:57 AM, Administrative Nurse D confirmed the Psychotropic Drug Use, Psychosocial Well-Being and the Cognitive Loss/Dementia CAAs had not been completed for this resident who had dementia with psychotic disturbances.<br><br>The facility follows the Resident Assessment Instrument (RAI) manual when completing the CAAs.<br><br>The facility failed to complete the Psychotropic Drug Use, Psychosocial Well-Being and the Cognitive Loss/Dementia CAAs for this resident who had dementia with psychotic disturbances. |

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| F 0655<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28560<br><br>The facility reported a census of 60 residents with 17 residents selected for review. Based on observation, interview, and record review, the facility failed to develop baseline a care plans for three residents, that included one Resident (R)20 regarding not having a baseline care plan, R214, regarding failure to include dialysis (procedure where impurities or wastes were removed from the blood), and R 221, regarding failure to include psychotropic (alters mood or thought) medication.<br><br>Findings included:<br><br>- Review of Resident (R)20's medical record, revealed diagnoses included aftercare for extraction of knee joint prosthesis, diabetes (DM-when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), chronic kidney disease, and atrial fibrillation (rapid, irregular heartbeat).<br><br>The resident admitted to the facility on [DATE].<br><br>The medical record lacked a Baseline Care Plan.<br><br>Interview, on 03/18/24 at 10:30 AM, with Administrative Nurse D, confirmed the lack of a Baseline Care Plan.<br><br>The facility policy for Person Centered Care, dated 10/20/17, included: The facility will complete and implement a baseline care plan within 48 hours of a resident's admission to assist and promote continuity of care and communication among staff.<br><br>The facility failed to complete a Baseline Care Plan as required.<br><br>34056<br><br>- Review of Resident (R)221's Physician Order Sheet (POS), undated, included a diagnosis of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure).<br><br>The Admission Minimum Data Set (MDS), was not completed.<br><br>The care plan for behaviors, dated 03/05/24, lacked staff instruction regarding the use of antipsychotic medication.<br><br>Review of the resident's electronic medical record (EMR), revealed the following physician's orders:<br><br>Aripiprazole (an antipsychotic medication used to treat psychosis-related conditions and symptoms), 20 milligrams (mg), by mouth (po), at bedtime (HS), for dementia with psychosis, ordered 03/04/24. The order was discontinued on 03/06/24.<br><br>(continued on next page) |

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| F 0655<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Aripiprazole, 20 mg, po, every day (QD), for dementia with psychosis, ordered 03/06/24.<br><br>On 03/14/24 at 08:47 AM, Certified Nurse Aide (CNA) P stated will get restless around evening time and will have behaviors such as yelling out or being non-cooperative with staff in regards to his cares.<br><br>On 03/14/24 at 08:52 AM, CNA O stated the resident could have behaviors at times which was why he had a sitter with him throughout the day.<br><br>On 03/14/24 at 12:32 PM, Licensed Nurse (LN) H stated antipsychotic medications should be included on the care plans. All nurses were able to add to the care plans.<br><br>On 03/18/24 at 09:07 AM, Administrative Nurse D stated it was the expectation for antipsychotic medications be included on the care plans.<br><br>The facility policy for Person Centered Care, dated 10/20/17, included: The facility will complete and implement a baseline care plan within 48 hours of a resident's admission to assist and promote continuity of care and communication among staff.<br><br>The facility failed to include antipsychotic medications on the baseline care plan for this dependent resident who took antipsychotic medication.<br><br>- Review of Resident (R)214's electronic medical record (EMR) revealed a diagnosis of end stage renal disease (ESRD-a terminal disease of the kidneys).<br><br>The Admission Minimum Data Set, was in progress.<br><br>The baseline care plan, dated 03/06/24, lacked staff instruction regarding dialysis.<br><br>Review of the resident's EMR revealed a physician's order, which included:<br><br>Resident will receive dialysis at a local dialysis center on Tuesdays and Saturdays, ordered 03/06/24.<br><br>Review of one Dialysis Communication Form, dated 03/12/24 and provided by the facility, was incomplete. The form lacked information including the name of the resident's physician, the contact person for the resident at the facility, the facility phone number, face sheet, medication list, vital signs (VS), medications received before dialysis and medications sent with the resident to the dialysis center. No other Dialysis Communication Form was made available.<br><br>On 03/14/24 at 12:32 PM, Licensed Nurse (LN) H stated dialysis cares should be included on the care plans. All nurses were able to add to the care plans.<br><br>On 03/18/24 at 09:07 AM, Administrative Nurse D stated it was the expectation for dialysis cares to be included on the care plans.<br><br>(continued on next page) |

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| F 0655<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The facility policy for Person Centered Care, dated 10/20/17, included: The facility will complete and implement a baseline care plan within 48 hours of a resident's admission to assist and promote continuity of care and communication among staff.<br><br>The facility failed to include dialysis cares on the baseline care plan for this resident who received dialysis two times per week. |

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| F 0676<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28560<br><br>The facility reported a census of 60 residents with 17 selected for review, which included two residents reviewed for Activities of Daily Living (ADL). Based on observation, interview, and record review, the facility failed to provide one Resident (R)29, assistance with facial shaving.<br><br>Findings included:<br><br>- Review of Resident (R)29's medical record revealed diagnosis that included Parkinson's disease (slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, mask-like faces, shuffling gait, muscle rigidity and weakness).<br><br>The Admission Minimum Data Set (MDS), dated [DATE], assessed the resident with a Brief Interview for Mental Status (BIMS) score of 14, which indicated normal cognitive function. The resident required supervision or touching (helper to provide verbal cues of touching/steadying assistance as resident completes the activity) for personal hygiene.<br><br>The Activity of Daily Living (ADL)/ Functional Rehabilitation Care Area Assessment (CAA), dated 02/21/24, was not developed.<br><br>The Care Plan, reviewed 03/04/24, instructed staff to provide assistance as needed with grooming, bathing, and personal hygiene.<br><br>Observation, on 03/14/24 at 09:57 AM, revealed R29 seated in his wheelchair in his room. The resident responded appropriately to questions. The resident had areas of unshaven facial hair. The resident stated he had difficulty seeing the mirror to shave due to the location in the bathroom as he did not stand to shave.<br><br>Interview, on 03/14/24 at 11:07 AM, with Licensed Nurse (LN) J, revealed staff assisted R29 with set up for grooming.<br><br>Interview, on 03/14/24 at 12:43 PM, with Certified Nurse Aide (CNA) Q, revealed R29 required staff assistance with shaving.<br><br>Observation, on 03/18/24 at 07:31 AM, revealed R29 had several days growth of facial hair. The resident stated he preferred to be clean shaven but could not see the mirror to complete the task.<br><br>Interview, on 03/18/24 at 07:45 AM, with CNA N, revealed R29 did ask her for assistance shaving this morning.<br><br>Interview, on 03/18/24 at 10:30 AM, with Administrative Nurse D, revealed she would expect staff to provide grooming assistance per resident preferences.<br><br>The facility policy ADL Services reviewed 03/14/24, instructed staff to provide assistance with ADL every shift as appropriate, to include shaving.<br><br>(continued on next page) |

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| F 0676<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The facility failed to ensure R29 received assistance with shaving as needed when he could not effectively see the mirror to ensure clean shaven appearance to enhance personal wellbeing. |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28560<br><br>The facility reported a census of 60 residents with 17 residents selected for review, which included three residents reviewed for skin issues. Based on observation, interview, and record review, the facility failed to ensure one Resident (R)3, of the three residents received appropriate treatment for an unidentified skin injury and sanitary dressing change.<br><br>Findings included:<br><br>- Review of Resident (R)3's medical record, revealed diagnoses that included atrial fibrillation (rapid irregular heartbeat), lymphedema (swelling caused by an accumulation of lymph), and muscle weakness.<br><br>The Admission Minimum Data Set (MDS), dated [DATE], assessed the resident with a Brief Interview for Mental Status (BIMS) score of 15, which indicated normal cognitive function. The resident was dependent on staff for bed mobility and at risk for pressure ulcers (localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction) and had a skin tear and moisture associated skin damage (MASD- inflammation or skin erosion caused by prolonged exposure to a source of moisture such as urine, stool, sweat, wound drainage, saliva or mucous).<br><br>The Pressure Ulcer Care Area Assessment (CAA) for the MDS dated [DATE], was not developed.<br><br>The Care Plan, reviewed 03/12/24, instructed staff the resident had a potential for skin breakdown related to impaired mobility. Staff instructed to monitor, remind, and assist the resident to turn and reposition frequently and as needed or requested.<br><br>A Skin Evaluation, dated 02/29/24, revealed a right thigh wound with drainage, and open area to buttock, bilateral (both) upper extremity bruising and bilateral lower extremity edema (swelling resulting from an excessive accumulation of fluid in the body tissues) and bruising/discoloration.<br><br>A Skin Evaluation, dated 03/04/14, assessed R3 with a right thigh open wound with drainage, an open area to her buttock, and bilateral lower extremity bruising, edema, and discoloration.<br><br>On 03/01/24, the physician instructed staff to apply xeroform(Vaseline infused) gauze and a dry dressing daily and as needed to the right anterior (front) thigh abrasion(scraping or rubbing away of skin).<br><br>On 03/15/24, the physician instructed staff to cleanse R3's coccyx (area at the base of the spine) open area with normal saline, and apply calcium alginate (a substance that turns into a gel and absorbs drainage) to the wound bed and cover with a dry dressing daily and as needed.<br><br>Interview, on 03/13/24 at 8:25 AM, with the R3 revealed she had lymphedema in her lower extremities and received therapy. The resident sat positioned in bed eating breakfast.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175564 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 03/18/2024 |
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Center at Waterfront LLC | 1541 North Lindberg Circle Wichita, KS 67206 |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Observation, on 03/18/24 at 07:54 AM, revealed R3 positioned in bed. Administrative Nurse F and D assisted the resident to turn on her side. Upon turning, the sheet beneath the bed saver pad, contained a large area of yellow tan drainage. The resident did not have a dressing on her coccyx and was incontinent of bowels. Administrative Nurse F provided incontinent care, then removed her gloves and donned another pair of gloves without sanitizing/ cleansing her hands. Administrative Nurse F cleansed R3's coccyx wound with normal saline and applied xeroform gauze. Administrative Nurse F stated the resident had MASD, and the open area was shallow. The resident repositioned on her back and Consulting Provider HH, examined the resident's right anterior upper thigh area, and noted an area of fluid seepage. Administrative Nurse F stated the drainage on the sheet probably came from this area and provided wound care. Administrative Nurse F and D assisted the resident to turn for a bed change and noted a dressing on her right posterior (back) thigh. The dressing was undated and contained serosanguineous drainage (bloody drainage) across the entire surface. Administrative Nurse F removed the dressing and assessed the area as a previous blister that opened, with an exposed shallow surface and measured the area as 3.2 by 2.3 centimeters (cm). Administrative Nurse F cleansed the area and applied a dry dressing, and stated she would notify the provider, and obtain orders for daily wound care.<br><br>Interview, on 03/18/24 at 10:30 AM, with Administrative Nurse D, confirmed the area on the resident's posterior thigh had not been assessed until today and the dressing should have had a date on it, and she would expect staff to document the wound and provide treatment.<br><br>The facility policy for Pressure Ulcers, revised 08/04/22, included: The facility will provide the necessary requirements to ensure that a resident receives the treatment and care in accordance with professional standards of practice.<br><br>The facility failed to ensure sanitary dressing change for R3 and failed to identify and treat the posterior thigh wound and failed to provide sanitary bed linen to prevent the spread of infection . |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate pressure ulcer care and prevent new ulcers from developing.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34056<br><br>The facility reported a census of 60 residents with 17 residents sampled, including two residents reviewed for pressure ulcers (PU). Based on observation, interview and record review, the facility failed to appropriately clean the PU of one Resident (R)5, by failing to cleanse the wound before applying a new dressing to the area.<br><br>Findings included:<br><br>- Review of Resident (R)5's electronic medical record (EMR) included diagnoses of obesity (excessive body fat) and stage III pressure ulcer (PU-involves the full thickness of the skin and may extend into the subcutaneous tissue layer).<br><br>The Admission Minimum Data Set (MDS), dated [DATE], documented the resident had a Brief Interview for Mental Status (BIMS) score of nine, indicating moderately impaired cognition. He was dependent on staff for rolling left and right, transitioning from sitting to lying, lying to sitting and moving from a chair to a bed and from a bed to a chair. He was frequently incontinent of bowel and was at risk for PUs with an unhealed stage II (partial-thickness skin loss with exposed dermis) PU upon admission. He had a pressure reducing device in his wheelchair and his bed and was on a turning and repositioning program.<br><br>The Pressure Ulcer/Injury Care Area Assessment (CAA), dated 01/17/24, documented the resident was at risk for the development of PUs due to weakness, decreased mobility and bowel and bladder incontinence. He was totally dependent on staff for his activities of daily living (ADL), transfers and mobility. He had a pressure relieving mattress to his bed and a cushion in his wheelchair. Staff reposition the resident every one to two hours.<br><br>The potential for skin breakdown care plan, dated 01/10/24, instructed staff the resident admitted to the facility with an open area to his coccyx (area at the base of the spine). Staff were to change the dressing to his wound, as ordered.<br><br>Review of documentation in the resident's EMR, dated 03/12/24, revealed the resident had a stage III PU to his coccyx which measured 5.5 centimeters (cm) in length (L) by 4.5 cm width (W) by 0.2 cm depth (D). The wound had yellow adherent slough (firmly attached, dead tissue, usually cream or yellow in color) over approximately 90 percent (%) of the wound bed and a small amount of serosanguineous (semi-thick blood-tinged drainage) exudate with the surrounding skin fragile and pink.<br><br>Review of the resident's EMR included the following physician's orders:<br><br>Calcium alginate (an absorbent dressing made from seaweed), cut to fit the wound bed and cover with a dry dressing, change every day (QD), ordered 01/12/24. The order was discontinued on 02/06/24.<br><br>Calcium alginate cut to fit the wound bed and cover with a dry dressing, every shift (QS), ordered 02/06/24.<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 03/14/24 at 09:54 AM, Administrative Nurse F, and Certified Nurse Aide (CNA) O, entered the resident's room to change the dressing to the PU on his coccyx. Administrative Nurse F removed the old dressing and re-dressed the wound., Administrative Nurse F failed to clean the wound before placing the calcium alginate and the dry dressing onto the wound.<br><br>On 03/14/24 at 07:56 AM, CNA O stated the staff turn and reposition the resident at least every two hours.<br><br>On 03/14/24 at 09:57 AM, Administrative Nurse F stated the resident admitted to the facility with the wound on his coccyx. The wound had deteriorated since admission due to the resident's declining condition. LN I stated she had not cleansed the wound because the order, dated 02/06/24, did not include the cleansing of the wound. LN, I verified she had not asked for clarification of the order.<br><br>On 03/14/24 at 12:30 PM, Licensed Nurse (LN) H stated when she changed the resident's dressing, she would cleanse the wound with normal saline (NS).<br><br>On 03/18/24 at 11:17 AM, Consultant GG stated she would expect the staff to cleanse a wound with wound cleanser or NS every time the dressing was changed. Consultant GG stated the wound did not deteriorate due to not being cleansed. It was the belief of Consultant GG the wound deteriorated due to the resident's overall decline in health.<br><br>On 03/18/24 at 07:23 AM, Administrative Nurse D stated it was the expectation for staff to cleanse a wound before putting a clean dressing on.<br><br>The facility policy for Pressure Ulcers, revised 08/04/22, included: The facility will provide the necessary requirements to ensure that a resident receives the treatment and care in accordance with professional standards of practice.<br><br>The facility failed to appropriately clean the PU of this dependent resident. |

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| F 0698<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe, appropriate dialysis care/services for a resident who requires such services.<br><br>34056<br><br>The facility reported a census of 60 residents with 17 residents sampled, including one resident sampled for dialysis (procedure where impurities or wastes were removed from the blood). Based on observation, interview, and record review, the facility failed to ensure an appropriate system for ongoing communication with the dialysis facility regarding dialysis care and services for Resident (R)214.<br><br>Findings included:<br><br>- Review of Resident (R)214's electronic medical record (EMR) revealed a diagnosis of end stage renal disease (ESRD-a terminal disease of the kidneys).<br><br>The Admission Minimum Data Set, was in progress.<br><br>The baseline care plan, dated 03/06/24, lacked staff instruction regarding dialysis.<br><br>Review of the resident's EMR revealed a physician's order, which included:<br><br>Resident will receive dialysis at a local dialysis center on Tuesdays and Saturdays, ordered 03/06/24.<br><br>Review of one Dialysis Communication Form, dated 03/12/24 and provided by the facility, was incomplete. The form lacked information including the name of the resident's physician, the contact person for the resident at the facility, the facility phone number, face sheet, medication list, vital signs (VS), medications received before dialysis and medications sent with the resident to the dialysis center. No other Dialysis Communication Form was made available.<br><br>On 03/18/24 at 08:24 AM, Licensed Nurse (LN) I stated a dialysis communication form needed to be sent with the resident each time he went to dialysis with the appropriate sections filled out on the form.<br><br>On 03/14/24 at 11:57 AM, Administrative Nurse D stated it was the expectation for the staff to complete the pre-dialysis information on the dialysis communication form and send with the resident to the dialysis center. The facility staff should ensure the communication form was returned with the resident following dialysis.<br><br>The facility policy for Dialysis Protocol, dated 04/28/20, included: The dialysis communication sheet shall be given to the dialysis center with the facility and resident information.<br><br>The facility failed to ensure an appropriate system for ongoing communication with the dialysis facility regarding dialysis care and services for this resident. |

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| F 0757<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident’s drug regimen must be free from unnecessary drugs.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28560<br><br>The facility reported a census of 60 residents with 17 selected for review which included five residents reviewed for unnecessary medications. Based on observation, interview, and record review, the facility failed to ensure staff followed physician ordered parameters for administration of medications for two (Residents) R 29 and R 18.<br><br>Findings included:<br><br>- Review of Resident (R)29's medical record revealed diagnosis that included Parkinson's disease (slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, mask-like faces, shuffling gait, muscle rigidity and weakness).<br><br>The Admission Minimum Data Set (MDS), dated [DATE], assessed the resident with a Brief Interview for Mental Status (BIMS) score of 14, which indicated normal cognitive function. The resident received antibiotic (medication used to treat an infection), antidepressant (medication used to treat depressed mood), and anticoagulant (medication used to prevent blood clots) medication .<br><br>The Psychoactive Medication Care Area Assessment (CAA), dated 02/21/24, was undeveloped.<br><br>The Care Plan, reviewed 03/04/24, revealed the resident was at risk for fluid imbalance. Staff instructed to monitor vital signs per physician orders.<br><br>On 03/10/24, the physician instructed staff to administer Midodrine Hydrochloride, (a medication used to treat low blood pressure) 5 milligrams (mg), three times a day, for hypotension . The physician instructed staff to hold the medication for standing systolic (top number which represents the pressure of a heartbeat) blood pressure greater than 120 millimeters of mercury (mmHg).<br><br>Review of the Medication Administration Record (MAR) for March 2024, revealed staff administered the following doses of Midodrine outside of the physician ordered parameters:<br><br>On 03/12/24, at 11:00 AM, the resident's blood pressure was 134/66.<br><br>On 03/13/24 at 06:00 AM,the resident's blood pressure was 129/65.<br><br>On 03/14/24 at 07:00 PM, the resident's blood pressure was 122/87.<br><br>On 03/15/24 at 07:00 PM, the resident's blood pressure was 136/69.<br><br>On 03/17/24 at 11:00 AM, the resident's blood pressure was 166/88 and at 07:00 PM, the resident's blood pressure was 143/75.<br><br>On 03/18/24 at 06:00 AM, the resident's blood pressure was 150/68.<br><br>Interview, on 03/18/24 at 10:30 AM, with Administrative Nurse D, confirmed staff failed to hold the Midodrine per physician ordered parameters seven times.<br><br>(continued on next page) |

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| F 0757<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The facility policy Physician Orders revised 08/20/22, instructed staff to administer medications with the written order of a person duly licensed and authorized to prescribe medications.<br><br>The facility failed to ensure staff followed the physician prescribed parameters for administration of Midodrine to ensure the resident experienced no adverse effects.<br><br>31078<br><br>- R18's signed physician orders dated 02/20/24 revealed the following diagnoses: peripheral vascular disease (PVD slow and progressive circulation disorder causing narrowing, blockage, or spasms in a blood vessel), osteomyelitis (local or generalized infection of the bone and bone marrow) in the left ankle and foot, and diabetes mellitus type 2 (when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin) with foot ulcer.<br><br>The Admission Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The resident used a motorized wheelchair for mobility. R18 required substantial/maximum assist with toileting, transfers, and dressing. R18 received as needed pain medication for frequent pain at 04/10 scale. He admitted with an infection in one foot, though no open sores, Medications included anticoagulant (medication to control blood clotting), antibiotic (a medication to treat infections), diuretic (medication to help with the formation and passing of urine), opioid (narcotic pain medication), and Insulin (a hormone produced in the pancreas, which regulates the amount of glucose in the blood).<br><br>The Care Area Assessment (CAA) dated 02/13/24 revealed the following areas triggered for further investigation: Functional abilities, Urinary incontinence, nutritional status, dehydration/fluid balance, pressure ulcer/injury and pain. No CAAs completed for further investigation.<br><br>Review of the care plan, dated 02/13/24, included the resident had a potential for fluctuating blood glucose levels, diabetic complications, and poor wound healing, related to R18's insulin dependent diabetes mellitus. Staff were to educate the resident and responsible party the importance of managing R18's diabetes, compliance with medications, monitoring his blood sugars, compliance<br><br>with his diet, weight, daily skin monitoring and reporting to their physician any concerns as needed.<br><br>Monitor parameters set by the physician for low or high blood sugars and follow-up with physician as needed, and provide medications per current medication orders.<br><br>The physician orders, dated 03/06/24 included:<br><br>Admelog Solostar Subcutaneous Solution Pen-injector 100 UNIT/ML (Insulin Lispro), Inject as per sliding scale (SS):<br><br>If the resident's blood sugar was 251 to 300, administer 4 units in addition to the mealtime dose of Lispro 20 units, three times a day with meals, or as single dose for two hours after supper meal (PC), for blood sugar.<br><br>(continued on next page) |

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| F 0757<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | If the resident's blood sugar was 301 to 350, administer 5 units in addition to the mealtime dose of Lispro 20 units, three times a day with meals, or as single dose for two hours after supper meal, for blood sugar.<br><br>If the resident's blood sugar was 351 to 400, administer 6 units in addition to mealtime dose of Lispro 20 units, three times a day with meals, or as single dose for two hours after supper meal, for blood sugar.<br><br>Notify the provider of blood sugar higher than 400.<br><br>Review of the resident's blood glucose readings revealed the following concerns:<br><br>On 03/06/24 at 10:00 AM, R18's blood glucose was 307, and staff failed to give the ordered SS insulin.<br><br>On 03/08/24 at 02:00 PM, R18's blood glucose was 337, and staff failed to give the ordered SS insulin.<br><br>On 03/09/24 at 10:00 AM, R18's blood glucose was 272, and staff failed to give the ordered SS insulin.<br><br>On 03/09/24 at 08:00 PM, R18's blood glucose was 262, and staff failed to give the ordered SS insulin.<br><br>On 03/10/24 at 08:00 PM, R18's blood glucose was 282, and staff failed to give the ordered SS insulin.<br><br>On 03/11/24 at 06:00 AM, R18's blood glucose was 263, at 08:00 PM, R18's blood glucose was 257, and staff failed to give the ordered SS insulin.<br><br>On 03/12/24 at 08:00 PM, R18's blood glucose was 270, and staff failed to give the ordered SS insulin.<br><br>On 03/16/24 at 02:00 PM, R18's blood glucose was 317, and staff failed to give the ordered SS insulin.<br><br>On 03/17/24 at 10:00 AM, R18's blood glucose was 340, and at 02:00 PM, R18's blood glucose was 264, and staff failed to give the ordered SS insulin.<br><br>On 03/18/24 at 06:00 AM, R18's blood glucose was 259, and staff failed to give the ordered SS insulin.<br><br>On 03/14/24 at 12:30 PM, Licensed Nurse (LN) K verified the facility failed to administer sliding scale insulin as ordered. LN K verified there was no entries on the TAR or in the nurse progress notes.<br><br>(continued on next page) |

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| F 0757<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 03/18/24 at 09:10 AM, Administrative Nurse D reported she was not aware of the nursing staff not giving the resident his sliding scale insulin. She acknowledged the Certified Medication Aide (CMA) performed the blood sugars (BS) and would document the results on the Medication Administration Record (MAR). Nurses were to administer the insulin and document it on the TAR. The last BS recorded would show up on the top of the resident record, however CMA's may not document on the MAR as soon as it had been completed.<br><br>A policy for unnecessary medications was requested on 03/18/24 though no policy received.<br><br>The facility failed to administer sliding scale insulin to this resident that required the sliding scale insuln, as ordered by the physician. |

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| F 0758<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34056<br><br>The facility reported a census of 60 residents with 17 residents sampled including five residents reviewed for unnecessary medications. Based on observation, record review, and interview, the facility failed to monitor one Resident (R)35 for use of antipsychotic medications (drugs used to treat psychosis-related conditions and symptoms).<br><br>Findings included:<br><br>- Review of Resident (R)35's Physician Order Sheet, undated, revealed a diagnosis of dementia (progressive mental disorder characterized by failing memory, confusion) with psychotic disturbance (any major mental disorder characterized by a gross impairment perception).<br><br>The Admission Minimum Data Set (MDS), dated [DATE], documented the resident had a Brief Interview for Mental Status (BIMS) score of eight, indicating moderately impaired cognition. He received antipsychotic (class of medications used to treat major mental conditions which cause a break from reality) medication during the assessment period.<br><br>The Psychotropic Drug Use Care Area Assessment (CAA), dated 02/29/24, triggered but lacked an analysis of findings.<br><br>The care plan, dated 02/22/24, instructed staff the resident received psychotropic (a group of drugs that affects behavior, mood, thoughts or perception) medications.<br><br>Review of the resident's electronic medical record (EMR), revealed the following physician's order:<br><br>Seroquel (an antipsychotic medication), 25 milligrams (mg), by mouth (po), every day (QD), for forgetfulness and possible dementia, ordered, 02/27/24.<br><br>Review of the resident's EMR lacked an Abnormal Involuntary Movement Scale (AIMS-an assessment used to assess abnormal movements in people who take certain medications to assess for tardive dyskinesia [abnormal condition characterized by involuntary repetitive movements of the muscles of the face, limbs and trunk]).<br><br>On 03/18/24 at 08:55 AM, Licensed Nurse (LN) I stated an AIMS assessment would need to be completed for any resident who admitted with an antipsychotic medication or who received an order for an antipsychotic medication.<br><br>On 03/18/24 at 09:07 AM, Administrative Nurse D stated the staff had not completed an AIMS assessment when the resident received the order for the Seroquel on 02/27/24. It was the expectation for staff to complete an AIMS assessment at the time the resident received the order.<br><br>(continued on next page) |

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| F 0758<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The facility policy for Antipsychotic Medication Use, revised 02/13/24, included: Residents who use antipsychotic medications should be evaluated for tardive dyskinesia (abnormal condition characterized by involuntary repetitive movements of the muscles of the face, limbs and trunk) at least every three months. The evaluation should be completed when started in-house.<br><br>The facility failed to monitor this dependent resident for the use of his antipsychotic medication. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175564 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 03/18/2024 |
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| NAME OF PROVIDER OR SUPPLIER: Center at Waterfront LLC | | STREET ADDRESS, CITY, STATE, ZIP CODE: 1541 North Lindberg Circle Wichita, KS 67206 | |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>34056<br><br>The facility reported a census of 60 residents. Based on observation, record review, and interview, the facility failed to prepare and serve food under sanitary conditions, to the residents of the facility appropriately to prevent the potential for food borne bacteria.<br><br>Findings included:<br><br>- During an initial tour of the kitchen, on 03/13/24 at 01:51 PM, the following areas of concern were noted:<br><br>1. The bottom of the reach-in refrigerator next to the coffee machine had food debris on the bottom shelf.<br><br>2. The shelf underneath the coffee and tea machine had a plastic, slightly raised shelf cover which had a dark brown stain. Staff used the shelf to hold plastic pitchers and other clean containers.<br><br>3. The shelves underneath the tray line which held clean plates and clean plate covers, had a build-up of food debris.<br><br>4. The shelf underneath a worktable which stored boxes of oatmeal, cream of wheat and other types of cereal, had a build-up of food debris.<br><br>5. The shelf underneath the toaster had a large build-up of crumbs.<br><br>6. Four cutting boards were deeply grooved.<br><br>On 03/18/24 at 12:23 PM, Dietary Staff BB confirmed the areas of concern were things which needed to be taken care of.<br><br>The Dietary Aide Daily Cleaning Schedule, undated, included: The dietary aides are responsible for cleaning the entire surface of prep areas and for cleaning and sanitizing shelving and wiping down the insides of the reach-in coolers every shift.<br><br>The facility failed to prepare and serve food under sanitary conditions for the residents of the facility appropriately to prevent the potential for food borne bacteria. |

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|---|---|---|---|
| | 175564 | A. Building<br>B. Wing | 03/18/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Center at Waterfront LLC | 1541 North Lindberg Circle<br>Wichita, KS 67206 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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|---|---|
| F 0921<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.<br><br>34056<br><br>The resident reported a census of 60 residents. Based on observation, interview, and record review, the facility failed to provide a safe, functional, sanitary, and comfortable environment for residents and staff.<br><br>Findings included:<br><br>- During the initial tour of the kitchen on 03/13/24 at 01:51 PM, as well as a follow-up visit on 03/18/24 at 12:23 PM, the following areas of concern were noted:<br><br>The parameter of the kitchen floor contained a large amount of food debris. Several areas around the parameter of the kitchen floor had ground-in dirt.<br><br>The kitchen floor beneath the steam table, cooks' line and tray lines all had a large amount of food debris.<br><br>The kitchen floor had three drains which contained food debris and trash.<br><br>On 03/18/24 at 12:23 PM, Dietary Staff BB confirmed the areas of concern were things which needed to be taken care of.<br><br>The Dietary Aides Weekly Cleaning schedule, undated, included: The floor drains were to be cleaned on Sunday, Wednesday and Friday.<br><br>The Cooks Daily Cleaning Schedule, undated, included: The cooks are responsible for sweeping and mopping the floors on the cook line and tray line every shift.<br><br>The facility lacked a policy related to cleaning of the kitchen floors.<br><br>The facility failed to provide a safe, functional, sanitary and comfortable environment for residents and staff. |