STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087189	A. BUILDING: _____ B. WING _____	02/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REFLECTION LIVING MAIZE COURT 1	623 S MAIZE COURT WICHITA, KS 67209

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS The licensure resurvey conducted on 02/10/22 at the above named facility resulted in the following deficiency citations.	S 000		
S5313 SS=E	26-42-205 (g) (3) Over the counter medication (g) (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 26-42-205 (g) (3) The facility reported a census of 11 residents and identified facility medication management for all 11 residents. Based on observation, staff interview, and record review the operator failed to ensure a licensed pharmacist or licensed nurse placed the full name of the residents on over the counter (OTC) medications for 4 of 11 residents for whom the facility managed their medications (#123, #710, #715 and #954). Findings included: - On 02/10/22 licensed nurse (LN) A provided a	S5313		

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

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S5313	Continued From page 1 resident roster which identified the facility managed medications for all 11 residents. On 02/10/22 at 08:44 AM certified medication aide (CMA) B opened the only medication cart for inspection. Observation revealed the cart contained the following OTC medications without the resident's name: Resident #123 had two opened OTC medications which CMA B identified as belonging to resident #123. Resident #710 had one opened OTC medication which CMA B said it belonged to resident #710. Resident #715 had several open medications both prescribed and OTC which were in a zip-lock type plastic bag. The bag lacked a resident specific name for the contents. Within the bag were three bottles of OTC medications and CMA B reported they belonged to resident #715. Resident #954 had two opened OTC medications which CMA B said they belonged to resident #954. Interview on 02/10/22 at 03:10 PM with LN A confirmed the OTC medications lacked the required identification/labeling for the residents. Interview on 02/10/22 at 03:50 PM with administrative staff C confirmed the facility lacked a policy regarding the management of OTC medications. The operator failed to ensure a licensed pharmacist or licensed nurse placed the full name of the resident on OTC medications for 4 of 11 residents.	S5313		
S5315 SS=E	26-42-205 (h) Medication Storage	S5315		

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S5315	Continued From page 2 (h) Storage. Licensed nurses and medication aides shall ensure that all medications and biologicals are securely and properly stored in accordance with each manufacturer ' s recommendations or those of the pharmacy provider and with federal and state laws and regulations. (1) Licensed nurses or medication aides shall store non-controlled medications and biologicals managed by the home in a locked medication room, cabinet, or medication cart. Licensed nurses and medication aides shall store controlled medications managed by the home in separately locked compartments within a locked medication room, cabinet, or medication cart. Only licensed nurses and medication aides shall have access to the stored medications and biologicals. (2) Each resident managing and self-administering medication shall store medications in a place that is accessible only to the resident, licensed nurses, and medication aides. (3) Any resident who self-administers medication and is unable to provide proper storage as recommended by the manufacturer or pharmacy provider may request that the medication be stored by the home. (4) A licensed nurse or medication aide shall not administer medication beyond the manufacturer ' s or pharmacy provider ' s recommended date of expiration. This REQUIREMENT is not met as evidenced by: KAR 26-42-205 (h)(1) The facility reported a census of 11 residents and	S5315		

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S5315	Continued From page 3 identified facility management of medications for all 11 residents. Based on observation, staff interview, and record review the operator failed to ensure licensed nurses (LN) and medication aides (CMA) securely and properly stored medications in a locked medication room, cabinet or medication cart. Findings included: - On 02/10/22 during the entrance tour of the facility at 08:43 AM observation revealed an upper cabinet in the area adjacent to the kitchen and next to the medication cart. The cabinet doors were labeled PRN (as needed) medications and two cabinet doors had locks, but the cabinets freely opened. Observation revealed a total of 11 baskets on the shelves which were labeled with resident names and room numbers. Within the baskets were various non-controlled substance PRN tablets, creams, ointments and liquids. At 08:44 AM CMA B approached the area from another area and confirmed the cabinets were not locked. She said the cabinets should be locked. She said she had not accessed the cabinets since starting her shift around 07:00 AM that day. Observation revealed on 02/10/22 at 12:25 PM CMA B after preparing medications for a resident walked away from the medication cart to the resident's room and failed to lock the medication cart. At 12:35 AM the cart remained unlocked with no staff in the area and 2 residents sat at the adjacent dining room table with their walkers next to them. Interview on 02/10/22 at 12:43 PM with CMA B confirmed the cart remained unlocked and she failed to lock the cart when she left it at 12:25 PM.	S5315		

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S5315	Continued From page 4 Interview on 02/10/22 at 03:10 PM with LN A confirmed an expectation for the medication cart and cabinets to be locked when staff were not preparing medications The undated facility policy titled, Receipt and Disposition of Medications directed the LN or CMA will ensure that all medications are securely and properly stored in accordance with each manufacturer's recommendations. The LN or CMA will store non-controlled medications in a locked space/cabinet. The operator failed to ensure licensed nurses and medication aides securely and properly stored medications in a locked medication room, cabinet or medication cart.	S5315		