STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087137	A. BUILDING: _____ B. WING _____	C 06/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLSPRINGS OF WICHITA LLC	6311 E MARJORIE ST WICHITA, KS 67208

(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 abbreviated (complaint) survey #97830 and #97861 conducted at the above named facility on 5-31-16, 6-1-16, and 6-2-16 revealed the following citation.	S 000		
S5300 SS=E	26-42-205 (d) (1-2) Facility Administration of Medications (d) Home administration of resident ' s medications. If a home is responsible for the administration of a resident ' s medications, the administrator or operator shall ensure that all medications and biologicals are administered to that resident in accordance with a medical care provider ' s written order, professional standards of practice, and each manufacturer ' s recommendations. The administrator or operator shall ensure that all of the following are met: (1) Only licensed nurses and medication aides shall administer and manage medications for which the home has responsibility. (2) Medication aides shall not administer medication through the parenteral route. This REQUIREMENT is not met as evidenced by: KAR 26-42-205(d) The facility identified 5 residents. The sample included 5 residents. Based on observations, record reviews, and interviews for 3 (#1, 4, #3) of 5 residents sampled, the operator failed to ensure all medications administered to each resident in accordance of professional standards of practice and each manufacturer's recommendations.	S5300		

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
	B087137	A. BUILDING: _____ B. WING _____	C 06/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLSPRINGS OF WICHITA LLC	6311 E MARJORIE ST WICHITA, KS 67208

(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
S5300	Continued From page 1 Findings included: - Record review on 5-31-16 at 2:00 p.m. for resident #1 revealed an admit date of 1-23-15 with diagnoses of dementia, bipolar, anxiety, non-insulin dependent diabetic and right sided paralysis. The functional capacity screen dated 8-14-15 recorded resident required physical assistance for medication administration. The negotiated service agreement and health care service plan dated 8-1-15 recorded facility staff to administer and manage medications. Review of record medication administration record (MAR) and medical care provider orders revealed: baclofen 5 Milligrams (MG), (antispasmodic/muscle relaxer) two times a day, documented as administered at 8:00 a.m. and 5:00 p.m. depakote 125 MG (for seizures) two times a day, documented as administered at 8:00 a.m. and 5:00 p.m. glucotrol 10 MG (for diabetes) two times a day, documented as administered at 8:00 a.m. and 5:00 p.m. metformin 1000 MG (for diabetes) two times a day, documented as administer at 8:00 a.m. and 5:00 p.m. neurotin 600 MG (for seizures) three times a day, documented as administered at 8:00 a.m., 12:00 p.m., and 5:00 p.m. seroquel 150 MG (for bipolar/anxiety) two times a day, documented as administered at 8:00 a.m. and 5:00 p.m. Telephone interview on 6-1-16 at 12:00 p.m. with	S5300		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087137	A. BUILDING: _____ B. WING _____	C 06/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLSPRINGS OF WICHITA LLC	6311 E MARJORIE ST WICHITA, KS 67208

(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
S5300	Continued From page 2	S5300		

licensed nurse A stated he/she determined the time the medications was to be administered and did not have a policy or time for therapeutic/time released medications to be administered.

Review of prescribing information identify these medications ordered two times a day should be administered twelve hours apart and medications ordered three times a day should be administered every 8 hours.

- Record review on 5-31-16 at 3:40 p.m. for resident #4 revealed an admit date of 8-11-14 with diagnoses parkinson's, depression, gout, and lupus.

The functional capacity screen dated 8-14-15 recorded resident required physical assistance for medication administration.

The negotiated service agreement/health care service plan dated 8-14-15 recorded facility staff to administer and manage medications.

Review of record medication administration record (MAR) and medical care provider orders revealed :
carbidopa-levodopa 25/100 Milligrams (MG) (for parkinson's) take 2 and 1/2 tablets four times a day, documented as administered at 6:00 a.m., 10:00 a.m., 2:00 p.m., and 6:00 p.m.
plazuenil 200 MG (for arthritis) take two times a day, documented as administered at 8:00 a.m. and 5:00 p.m.
keppra 500 MG (for seizures) take two times a day, documented as administered at 8:00 a.m. and 5:00 p.m.
baclofen 10 MG (for spasticity) take 0.5 MG three times a day, documented as administered at 8:00 a.m., 12:00 p.m. 5:00 p.m.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087137	A. BUILDING: _____ B. WING _____	C 06/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLSPRINGS OF WICHITA LLC	6311 E MARJORIE ST WICHITA, KS 67208

(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
S5300	Continued From page 3 Telephone interview on 6-1-16 at 12:00 p.m. with licensed nurse A stated he/she determined the time the medications was to be administered and did not have a policy or time for therapeutic/time released medications to be administered. Review of prescribing information identify these medications ordered two times a day should be administered twelve hours apart and medications ordered three times a day should be administered every 8 hours. - Record review on 5-31-16 at 2:20 p.m. for resident #3 revealed an admit date of 3-15-16 with diagnoses cancer of esophagus, dementia, hypothyroidism, has stoma due to cancer of esophagus. The functional capacity screen dated 3-15-16 recorded resident required physical assistance for medication administration. The negotiated service agreement/health care service plan dated 3-15-16 recorded facility staff to administer and manage medications. Review of record medication administration record (MAR) and medical care provider orders revealed: seroquel 25 Milligrams (MG) (for anxiety/dementia) three times a day, documented as administered at 8:00, 12:00 p.m., and 5:00 p.m. Telephone interview on 6-1-16 at 12:00 p.m. with licensed nurse A stated he/she determined the time the medications was to be administered and did not have a policy or time for therapeutic/time	S5300		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087137	A. BUILDING: _____ B. WING _____	C 06/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLSPRINGS OF WICHITA LLC	6311 E MARJORIE ST WICHITA, KS 67208

(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
S5300	Continued From page 4 released medications to be administered. Review of prescribing information identify this medication ordered three times a day should be administered eight hours apart. For residents #1, #4, and #3, the operator failed to ensure all medications administered to each resident in accordance of professional standards of practice and each manufacturer's recommendations.	S5300		