STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087147	A. BUILDING: _____ B. WING _____	10/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWLARK LEECREST	1425 LEECREST STREET WICHITA, KS 67209

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S 000	INITIAL COMMENTS The following citations represent the findings of a Re-Licensure Survey for the above named Home Plus Facility conducted on 10/03/23 and 10/04/23.	S 000		
S5095 SS=E	26-42-201 (d) Functional Capacity Screen Accurate (d) Designated staff shall ensure that each resident ' s functional capacity at the time of screening is accurately reflected on that resident ' s screening form. This REQUIREMENT is not met as evidenced by: KAR 26-42-201(d) The facility reported a census of eight residents (R). The sample included three residents. Based on observation, interview, and record review the operator failed to ensure designated staff completed two (R3 and R4) of three sampled resident's "Functional Capacity Screen" accurately to reflect the resident's functional ability related to risk for falls. Findings Included: - Review of R3's electronic medical record revealed he moved into the facility on 05/09/23 with diagnoses of bipolar disorder and post traumatic stress disorder. R3's "Functional Capacity Screen" dated	S5095		

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

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S5095	Continued From page 1 09/12/23 identified the resident used a walker for a mobility assistive device but did not identify the resident at risk for falls. R3's "Negotiated Service Agreement" dated 09/12/23 identified the resident used a four wheeled walker for mobility but did not identify the resident at risk for falls or services related to falls. R3's "Health Care Plan" included a " Risk for Falls" section which included the following fall interventions: Resident to wear non-skid socks and shoes when out of bed - encourage to get up slowly - bed in lowest position - safety rounds q 1 hour. Resident refuses alarm. On 10/04/23 at 02:43 PM R3 walked past surveyor and Administrative Licensed Nurse A without using a walker or other type of assistive device, went to the freezer in extra kitchen area and then walked back to his room with a cup of ice. On 10/04/23 at 02:03 PM Administrative Licensed Nurse A reported the resident came in with a history of falls, so he is considered high risk and initiate basic interventions on admission. The operator failed to ensure designated staff completed R3's "Functional Capacity Screen" accurately regarding his risk for falls. - Review of R4's electronic medical record revealed she moved into the facility on 05/06/23 with diagnoses of schizophrenia and type two diabetes mellitus.	S5095		

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S5095	Continued From page 2 R4's "Functional Capacity Screen" dated 09/12/23 identified the resident used an assistive device for mobility but did not identify the resident at risk for falls. R4's "Negotiated Service Agreement" dated 09/12/23 identified the resident used a four-wheeled walker for mobility but did not identify the resident at risk or any services related to the resident being at risk for falls. R4's "Health Care Plan" dated 05/06/23 and updated on 09/12/23 identified the resident was at risk for falls and used a walker which was new to the resident. It also included for the resident to wear non-skid socks or shoes when out of bed, staff to do safety rounds every one hour, provide assistance when requested, call lanyard in place, and bed in the lowest position. On 10/02/23 at 03:45 PM resident walked into the facility from being on a day trip and walked independently using her four-wheeled walker. On 10/04/23 at 02:54 PM Administrative Licensed Nurse A reported the resident was at risk for falls because there are times when R4 will not have on non-skid socks or come out barefooted and she will forget to use her walker and needs reminding to use it. The operator fail4ed to ensure designated staff completed R4's "Functional Capacity Screen" accurately regarding R4's risk for falls.	S5095		
S5105 SS=F	26-42-202 (a) Negotiated Service Agreement a) The administrator or operator of each home	S5105		

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S5105	Continued From page 3 plus shall ensure the development of a written negotiated service agreement for each resident, based on the resident ' s functional capacity screening, service needs, and preferences, in collaboration with the resident or the resident ' s legal representative, the case manager, and, if agreed to by the resident or the resident ' s legal representative, the resident ' s family. The negotiated service agreement shall provide the following information: (1) A description of the services the resident will receive; (2) identification of the provider of each service; and (3) identification of each party responsible for payment if outside resources provide a service. This REQUIREMENT is not met as evidenced by: KAR 26-42-202(a)(1)(2) The facility reported a census of eight residents(R). The sample included three residents. Based on interview, and record review for three (R3, R4,R5) of three sampled residents the operator failed to ensure designated staff developed a "Negotiated Service Agreement" based on the resident's "Functional Capacity Screen" and the resident's service needs that included a description of the services the resident would receive and the identification of the provider of each service. Findings included: - Review of R3's electronic medical record revealed he moved into the facility on 05/09/23	S5105		

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S5105	Continued From page 4	S5105		

with diagnoses of bipolar disorder and post traumatic stress disorder.

R3's "Functional Capacity Screen" dated 09/12/23 revealed he was independent with all activities of daily living including management of medications and medical treatments and had impaired vision.

R3's "Negotiated Service Agreement" (NSA) dated 09/12/23 failed to address that qualified staff administered the resident's medications even though he could do it himself and failed to address his impaired vision.

On 10/04/23 at 02:08 PM Administrative Licensed Nurse looked at R3's NSA and stated it included that she was the Licensed Nurse who supervised the administration of medications but acknowledged it did not specify "who" actually administered medications. She also acknowledged the resident had impaired vision which was addressed in the care plan but not on the NSA.

The operator failed to ensure designated staff developed a NSA for R3 based upon her FCS needs related to medication administration and impaired vision.

- Review of R4's electronic medical record revealed she moved into the facility on 05/06/23 with diagnoses of schizophrenia and type two diabetes mellitus.

R4's "Functional Capacity Screen" (FCS) dated 09/12/23 identified the resident required supervision with management of medications and

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S5105	Continued From page 5	S5105		

treatments, had impaired vision, and was not at risk for falls.

R4's "Negotiated Service Agreement" dated 09/12/23 included "The resident would like to self administer insulin or injections related to diabetes." It did not address services that qualified staff administered resident's medications including the preparing and dialing of R4's Ozempic (for diabetes) so the resident could self-inject. It also failed to include services related to the resident having impaired vision.

On 10/04/23 at 02:45 PM Administrative Licensed Nurse A confirmed the resident had impaired vision, was considered at risk for falls, and that facility medication aides administered the resident her medications and dialed her Ozempic pen because R4 had a hard time turning the dial sometimes. Administrative Licensed Nurse A acknowledged R4's NSA did not included services specific to who administer medications and that the medication aides dialed the insulin for R4 to inject and did not address her poor vision.

The operator failed to ensure designated staff developed a NSA for R4 based upon her FCS needs and according to service needs related to medication administration, fall risk, and impaired vision.

- Review of R5's electronic medical record revealed she moved into the facility on 04/01/23 with diagnoses of heart failure and atrial fibrillation.

R5's "Functional Capacity Screen" (FCS) dated

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S5105	Continued From page 6	S5105		

09/12/23 revealed the resident required physical assistance with bathing and mobility, was independent in management of medications but unable to manage medical treatments. It also identified she was at risk for falls and had impaired vision.

R5's "Negotiated Service Agreement" (NSA) dated 09/12/23 identified a list of personal care services that were provided by the facility and that R5 required stand by/minimal assistance with bathing. The NSA did not identify "who" would provide her assistance. The NSA also included a list of professional services provided by the facility which included medication management but failed to identify the facility medication aides administered the resident her medications. The NSA also failed to address her risk for falls, her medical treatment to her venous ulcer on her right leg, and her impaired vision.

On 10/04/23 at 03:02 PM Administrative Licensed Nurse A acknowledged R5's NSA does not identify "who" provided services for bathing and medication administration. She also acknowledged it did not address R5's fall risk, her treatment to ulcer on her leg, or her impaired vision.

On 10/04/23 at 03:04 PM Administrative Licensed Nurse A acknowledged the "Negotiated Service Agreement" for all residents had the same basic form which did not specify who provided services related to activity of daily living or administration of medications, and did not address falls, vision, or medical treatments.

For all residents in the facility, the operator failed

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S5105	Continued From page 7 to ensure designated staff developed a NSA based off the needs identified on the FCS and any other identified service needs related to activities of daily living, medication and medical treatment administration, and risk for falls.	S5105		
S5265 SS=D	26-42-205 (a) (1) Medication Self Administration Assessment (a) Self-administration of medication. Any resident may self-administer and manage medications independently or by using a medication container or syringe prefilled by a licensed nurse or pharmacist or by a family member or friend providing this service gratuitously, if a licensed nurse has performed an assessment and determined that the resident can perform this function safely and accurately without staff assistance. (1) An assessment shall be completed before the resident initially begins self-administration of medication, if the resident experiences a significant change of condition, and annually. This REQUIREMENT is not met as evidenced by: KAR 26-42-205 (a)(1) The facility reported a census of eight Residents (R). The sample included three residents. Based on observation, interview, and record review for one (R4) of one resident who self-administer	S5265		

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S5265	Continued From page 8	S5265		

injectable medication, the operator failed to ensure a Licensed Nurse (LN) assessed the resident prior to self-administration to ensure the resident could perform the function safely and accurately without staff assistance.

Findings included:

- Review of R4's electronic medical record revealed she moved into the facility on 05/06/23 with diagnoses of schizophrenia and type two diabetes mellitus.

R4's "Functional Capacity Screen" dated 09/12/23 identified the resident required supervision with management of medications.

R4's "Negotiated Service Agreement" dated 09/12/23 identified medication management was supervised by the Administrative Licensed Nurse A.

Review of R4's medical record lacked an assessment completed by a Licensed Nurse to ensure the resident could safely dial her Ozempic (for diabetes) to the ordered dosage and then safely self-inject the medication.

On 10/04/23 at 02:49 PM Administrative Licensed Nurse A reported that sometimes the resident can dial the pen to the correct dosage and staff just look at it to make sure she did it correctly and other times the staff fully prepare the pen, including dialing it to the correct dosage and then hand to the resident to self-inject. Administrative Licensed Nurse A confirmed she had not completed a specific assessment for the resident's ability to dial and self-inject her

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S5265	Continued From page 9 Ozempic. The operator failed to ensure a licensed nurse assessed R4 ability to self-administer her Ozempic prior to initiation of the resident self-administering her Ozempic.	S5265		
S5286 SS=D	26-42-205 (b) Administration of Selected Medications (b) Administration of select medications. Any resident who self-administers medication may select some medications to be administered by a licensed nurse or medication aide. The negotiated service agreement shall reflect this service and identify who is responsible for the administration and management of selected medications. This REQUIREMENT is not met as evidenced by: KAR 26-42-205 (b) The facility reported a census of eight residents. The sample included three residents. Based on interview, and record review the operator failed to ensure one (R3) of three sampled residents "Negotiated Service Agreement" identified the resident self-injected her Ozempic (for diabetes) after qualified staff prepared the pen, and that qualified facility staff administered all other medications. Findings included: - Review of R4's electronic medical record	S5286		

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S5286	Continued From page 10 revealed she moved into the facility on 05/06/23 with diagnoses of schizophrenia and type two diabetes mellitus. R4's "Functional Capacity Screen" (FCS) dated 09/12/23 identified the resident required supervision with management of medications. R4's "Negotiated Service Agreement" (NSA) dated 09/12/23 included "The resident would like to self administer insulin or injections related to diabetes." However, it did not identify the Certified Medication Aides dialed the residents Ozempic pen and then gave it to the resident to self inject and that the Medication Aides administered the rest of the resident's medications. On 10/02/23 at 10:50 AM R4 reported the staff give her all of her medications except they prepare her pen for her and she self-injected it. On 10/04/23 at 02:45 PM Administrative Licensed Nurse A reported she did not realize the NSA needed to specify that the resident self-injected her Ozempic and staff administered all the other medications. The operator failed to ensure designated staff completed R4's NSA to include that she chose to self inject her insulin and facility staff administered all other medications.	S5286		
S5325 SS=E	26-42-205 (l) Medication Regimen Review Frequency (l) Medication regimen review. A licensed pharmacist or licensed nurse shall conduct a	S5325		

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S5325	Continued From page 11 medication regimen review at least quarterly for each resident whose medication is managed by the home and each time the resident experiences any significant change in condition. This REQUIREMENT is not met as evidenced by: KAR 26-42-205 (l) The facility reported a census of eight residents(R). The sample included three residents. Based on interview and record review for two(R3and R4) of 3 sampled residents, the operator failed to ensure a licensed pharmacist or licensed nurse conducted a medication regiment review at least quarterly for each resident whose medication the facility managed. Findings included: - Review of R3's electronic medical record revealed he moved into the facility on 05/09/23 with diagnoses of bipolar disorder and post traumatic stress disorder. Review of R3's electronic record lacked evidence of a review of the resident's medication regimen completed by a licensed pharmacist or a licensed nurse. - Review of R4's electronic medical record revealed she moved into the facility on 05/06/23 with diagnoses of schizophrenia and type two diabetes mellitus.	S5325		

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S5325	Continued From page 12 Review of R4's electronic medical record lacked evidence of a review of the resident's medication regimen completed by a licensed pharmacist of a licensed nurse. On 10/4/23 at 02:16 PM Administrative Licensed nurse looked through the records for R3 and R4 and could not find the pharmacy review notes. She then contacted the resident's health provider and they reported they just compared the medication administration record with current orders to ensure accuracy. Administrative Licensed Nurse then called the pharmacy and they reported they did not have then and would need to contact the health provider. Administrative Licensed Nurse confirmed they did not have record of a pharmacist or licensed nurse completing a medication regimen review for R3 and R4. The operator failed to ensure each residents medication regimen was reviewed at least quarterly by a licensed pharmacist or licensed nurse.	S5325		