STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087043	A. BUILDING: _____ B. WING _____	10/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRINGTON AT CHERRY CREEK	8200 E PAWNEE ST WICHITA, KS 67207

(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 following represents the findings of a resurvey with attached complaints #182971, #182741, #182641, #182530, #182186, #182116, #181661, #181408, #181141, #181099, and #181066 at the above named assisted living facility conducted on 10/17/23 and 10/18/23.	S 000		
S3085 SS=D	26-41-202 (a) Negotiated Service Agreement (a) The administrator or operator of each assisted living facility or residential health care facility 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 26-41-202(a)(1) The facility reported a census of 103 residents with six residents included in the sample and four closed record reviews. Based on interview and	S3085		

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
	N087043	A. BUILDING: _____ B. WING _____	10/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRINGTON AT CHERRY CREEK	8200 E PAWNEE ST WICHITA, KS 67207

(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
S3085	Continued From page 1	S3085		

record review the operator failed to ensure the "Negotiated Service Agreements" (NSA) for Resident (R) 3, R6, R9, and R10 described the services they received based on their "Functional Capacity Screens" (FCS).

Findings included:

- Record review for R3 revealed an admission date of 10/14/22 with a diagnosis of alcohol dependence.
The 09/29/23 "FCS" identified R3 was independent with using a wheelchair for walking/mobility and was marked for falls.

The 09/29/23 "NSA" identified facility staff would encourage R3 to use a wheelchair. The "NSA" failed to identify the services provided R3 to prevent injury from falls.

- Record review for R6 revealed an admission date of 03/13/23 with diagnoses of schizophrenia and alcohol abuse.
The 03/13/23 "FCS" identified R6 was marked for falls.

The 03/13/23 "NSA" failed to identify the services provided R6 to prevent injury from falls.

- Record review for R9 revealed an admission date of 05/11/22 with a diagnosis alcohol abuse.

The 02/03/23 "FCS" identified R9 was marked for falls.

The 02/03/23 "NSA" failed to identify the services provided R9 to prevent injury from falls.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087043	A. BUILDING: _____ B. WING _____	10/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRINGTON AT CHERRY CREEK	8200 E PAWNEE ST WICHITA, KS 67207

(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
S3085	Continued From page 2 - Record review for R10 revealed an admission date of 10/05/22 with a diagnosis of paraplegia. The 04/10/23 "FCS" identified R10 was marked for falls. The 04/10/23 "NSA" failed to identify the services provided R10 to prevent injury from falls. On 10/18/23 at approximately 03:41 PM Administrative Staff A confirmed R3, R6, R9 and R10's "NSA's" failed to describe the services provided for falls based on their "FCS's" The operator failed to ensure the "NSA's" for R3, R6, R9 and R10 described the services provided to prevent injury from falls based on their "FCS's".	S3085		
S3145 SS=D	26-41-203 (e) Routine Maintenance (e) Maintenance. Designated staff shall provide routine maintenance, including the control of pests and rodents, and repairs in each resident's bedroom and common areas inside and outside the facility as specified in the admission agreement. This REQUIREMENT is not met as evidenced by: KAR 26-41-203(e) The facility reported a census of 103 residents with six residents included in the sample and four closed record reviews. Based on interview and record review the operator failed to ensure	S3145		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087043	A. BUILDING: _____ B. WING _____	10/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRINGTON AT CHERRY CREEK	8200 E PAWNEE ST WICHITA, KS 67207

(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
S3145	Continued From page 3	S3145		

designated staff provided bed bug treatment to Resident (R) 1's room when R1 was present in her room during the treatment, was exposed to insecticide chemicals, and developed a reaction on her forehead and in her eyes.

Findings included:

- Record review R1 revealed an admission date of 10/30/14 with diagnoses of dementia and schizophrenia.

The 02/02/23 "Functional Capacity Screen" (FCS) identified R1 required physical assistance with bathing, dressing, toileting, and management of medications and treatments; was incontinent of bladder and was marked for impaired vision and impaired hearing.

The 02/02/23 "Negotiated Service Agreement" (NSA) identified facility staff would provide R1 assistance three times weekly with bathing, assistance morning and evening with dressing; certified or licensed staff would manage medications and treatments; staff would encourage her to change her briefs and assist with peri care for bladder incontinence and she wore glasses for impaired vision. Impaired hearing was not addressed on the "NSA."

The facility's investigation provided to the department documented on 09/15/23 R1 went to the nurse's station with red and irritated eyes. The Advanced Registered Nurse Practitioner (ARNP) was notified and gave orders for Benadryl and loratadine. On 09/20/23 R1 had peeling skin on her forehead and the ARNP was notified and gave orders for Silvadene cream. On

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087043	A. BUILDING: _____ B. WING _____	10/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRINGTON AT CHERRY CREEK	8200 E PAWNEE ST WICHITA, KS 67207

(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
S3145	Continued From page 4	S3145		

09/21/23 R1 reported when her room was treated for bed bugs last week, she was sprayed with insecticide. R1's physician and guardian were notified.

Review of the facility's bed bug task checklist completed for apartment 406 dated 09/19/23 (four days after the treatment) revealed four columns which were labeled "Department," "Step," "Task," and "Initials of person completing the task." Step one to be completed by the nursing department read "Remove resident. . . Do not let them return to the apartment until task list is completed" and was initialed completed by Housekeeping Staff B and C. Steps three-five to be completed by the maintenance department were initialed by Housekeeping Staff B and C. Step ten to be completed by nursing department read "Return resident to apartment" and was not initialed as completed.

Review of Housekeeping C's New Hire Packet "Acceptance of Policies" revealed she initialed she understood her responsibility to understand and abide by the facilities policies and procedures. Her signature at the bottom verified that she had received training on all the topics, was obligated to follow the policies and procedures, and agreed to abide by the policies.

Observation on 10/18/23 at 01:32 PM revealed Housekeeping Staff B showed a one-pint bottle of Bayer Suspend SC insecticide concentrate used in bed bug treatment of residents' rooms. The bottle had a label which read "Hazards to humans and domestic animals. Caution. Harmful if inhaled. Avoid breathing vapor of spray mist. Contact with product may result in transient

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087043	A. BUILDING: _____ B. WING _____	10/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRINGTON AT CHERRY CREEK	8200 E PAWNEE ST WICHITA, KS 67207

(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
S3145	Continued From page 5	S3145		

tingling and reddening of the skin. Remove contaminated clothing and wash before reuse."

On 10/18/23 at 01:22 PM Housekeeping Staff B stated she was present when R1's room was treated for bed bugs. Housekeeping Staff C called Housekeeping Staff B to go to R1's with her to spray for bed bugs. When Housekeeping Staff B arrived, Housekeeping Staff C was already spraying the room. The room still contained all R1's personal items and R1 was present in the room. Housekeeping Staff C took R1's purse from her, sprayed it with insecticide and handed it back to R1 still wet. She then sprayed R1's pants and shoes.

Housekeeping Staff B stated she was not trained on bed bug treatment procedure upon hire because maintenance department staff performed bed bug treatment of rooms in the facility. When bed bugs were found, the resident was removed from the room and a checklist was used to ensure the treatment procedure steps were followed.

On 10/18/23 at approximately 03:41 PM Administrative Staff A confirmed the facility's policy/task checklist was not followed by Housekeeping Staff C who had been terminated following investigation of the incident.

The operator failed to ensure designated staff provided bed bug treatment to R1's room when R1 was present in her room during the treatment, was exposed to insecticide chemicals, and developed a reaction on her forehead and in her eyes.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087043	A. BUILDING: _____ B. WING _____	10/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRINGTON AT CHERRY CREEK	8200 E PAWNEE ST WICHITA, KS 67207

(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
S3261	Continued From page 6	S3261		
S3261 SS=D	26-41-105 (f) (11) Resident Record Documentation of Incidents (f) (11) documentation of all incidents, symptoms, and other indications of illness or injury including the date, time of occurrence, action taken, and results of the action This REQUIREMENT is not met as evidenced by: KAR 26-41-105(f)(11) The facility reported a census of 103 residents with six residents included in the sample and four closed record reviews. Based on interview and record review the operator failed to ensure licensed staff documented when Resident (R) 1 developed peeling skin on her forehead and reported she was sprayed in the face with an insecticide. Findings included: - Record review R1 revealed an admission date of 10/30/14 with diagnoses of dementia and schizophrenia. The 02/02/23 "Functional Capacity Screen" (FCS) identified R1 required physical assistance with bathing, dressing, toileting, and management of medications and treatments; was incontinent of bladder and was marked for impaired vision and impaired hearing. The 02/02/23 "Negotiated Service Agreement"	S3261		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087043	A. BUILDING: _____ B. WING _____	10/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRINGTON AT CHERRY CREEK	8200 E PAWNEE ST WICHITA, KS 67207

(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
S3261	Continued From page 7	S3261		

(NSA) identified facility staff would provide R1 assistance three times weekly with bathing, assistance morning and evening with dressing; certified or licensed staff would manage medications and treatments; staff would encourage her to change her briefs and assist with peri care for bladder incontinence and she wore glasses for impaired vision. Impaired hearing was not addressed on the "NSA."

The facility's investigation provided to the department documented on 09/15/23 R1 went to the nurse's station with red and irritated eyes. The Advanced Registered Nurse Practitioner (ARNP) was notified and gave orders for Benadryl and loratadine. On 09/20/23 R1 had peeling skin on her forehead and the ARNP was notified and gave orders for Silvadene cream. On 09/21/23 R1 reported when her room was treated for bed bugs last week, she was sprayed with insecticide. R1's physician and guardian were notified.

The 09/15/23 "Health Status Note" documented R1 went to the nurse's office with red, swollen, itchy eyes. The APRN was notified, and orders received to administer one Benadryl 25 milligrams (mg) tablet now, start loratadine 10 mg daily for two weeks, and eye drops to both eyes twice daily for two weeks.

The 09/25/23 (next nursing progress note) documented continued Silvadene cream to forehead for R1 and will continue to monitor.

The nursing progress notes for R1 lacked evidence of documentation of her forehead skin peeling and her report that she was sprayed with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087043	A. BUILDING: _____ B. WING _____	10/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRINGTON AT CHERRY CREEK	8200 E PAWNEE ST WICHITA, KS 67207

(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
S3261	Continued From page 8 insecticide. On 10/18/23 at approximately 03:41 PM Administrative Staff A confirmed R1's record lacked evidence of documentation of her forehead skin peeling and her report that she was sprayed with insecticide. The operator failed to ensure licensed staff documented when R 1 developed peeling skin on her forehead and reported she was sprayed in the face with an insecticide.	S3261		