STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087119	A. BUILDING: _____ B. WING _____	02/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER LIVING BY WARDEN LLC	234 S ANNA STREET 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 following citations represent the findings of a Re-Licensure Survey for the above named facility conducted on 02/29/24.	S 000		
S5314 SS=D	26-42-205 (g) (4) Sample & Indigent Medication Program Meds (g) (4) Licensed nurses and medication aides may administer sample medications and medications from indigent medication programs if the administrator or operator ensures the development of policies and implementation of procedures for receiving and identifying sample medications and medications from indigent medication programs that include all of the following conditions: (A) The medication is not a controlled medication. (B) A medical care provider ' s written order accompanies the medication, stating the resident ' s name; the medication name, strength, dosage, route, and frequency of administration; and any cautionary instructions regarding administration. (C) A licensed nurse or medication aide receives the medication in its original, unbroken manufacturer ' s package. (D) A licensed nurse documents receipt of the medication by entering the resident ' s name and the medication name, strength, and quantity into a log. (E) A licensed nurse places identification information on the medication or package containing the medication that includes the medical care provider ' s name; the resident ' s name; the medication name, strength, dosage, route, and frequency of administration; and any cautionary instructions as documented on the	S5314		

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

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S5314	Continued From page 1 medical care provider ' s order. Staff consisting of either two licensed nurses or a licensed nurse and a medication aide shall verify that the information on the medication matches the information on the medical care provider ' s order. (F) A licensed nurse informs the resident or the resident ' s legal representative that the medication did not go through the usual process of labeling and initial review by a licensed pharmacist pursuant to K.S.A. 65-1642 and amendments thereto, which requires the identification of both adverse drug interactions or reactions and potential allergies. The resident ' s clinical record shall contain documentation that the resident or resident ' s legal representative has received the information and accepted the risk of potential adverse consequences. This REQUIREMENT is not met as evidenced by: KAR 26-42-205(g)(4)(B)(D)(E)(F) The facility reported a census of twelve residents (R). The sample included three residents. Based on observation, interview and record review the operator failed to ensure one (R3) of one resident that received sample medications included the following: 1. a care providers written order with the medication that included the name, strength, dosage, route, and frequency of administration and any cautionary instructions; 2. License Nurse document receipt of medication with appropriate information into a log; 3. Licensed Nurse failed to included required information on each box/container and indicate verification of such information.; 4. A licensed	S5314		

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S5314	Continued From page 2	S5314		

nurse failed to inform the resident or resident's legal representative the medications were not received through a pharmacy and were not reviewed by a pharmacist.

Findings included:

- Review of R3's medical record revealed she moved into the facility on 12/21/22 with diagnosis of history of deep vein thrombosis (potentially life-threatening blood clot, usually in the legs).

R3's "Functional Capacity Screen" dated 12/21/23 identified she was unable to manage her medications or medical treatments.

R3's 12/21/23 "Negotiated Service Agreement" identified qualified premier living staff would administer R3 her medications.

Review of R3's medical record lacked evidence that the facility informed the resident/legal representative that the medication did not go through a pharmacy so it did not have the same reviews such as possible adverse reactions or drug interactions as a regular prescription.

Observation on 02/29/24 at 09:27 AM Certified Medication Aide (CMA) C unlocked the medication cabinet to get R3's Eliquis (blood thinner). She unlocked the bottom drawer and got a paper sack that had two unopened boxes of Eliquis 5 milligram (mg) tablets and another unopened box of Eliquis 5mg tablets laid in the drawer. In the top medicine cabinet CMA C got another box of Eliquis that had been opened which contained three tablets. Each box was labeled with the resident's name. Boxes lacked a

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S5314	Continued From page 3 physician's order label for the medicine that included the resident's name, medication name, strength, dosage, route, frequency or any cautionary instructions regarding administration. There was no documentation recording when the medication was brought into the facility, who received it and how many boxes were brought in. On 02/29/24 at 10:20 PM Licensed Nurse B confirmed they did not have the physician's order with the medication but had an order in the chart. Licensed Nurse B also acknowledged they did not have a record for when the family brought in the Eliquis, did not have all of the required information written on the package, and did not have evidence of informing the resident the medications were not obtained through a pharmacy and thus lacked comparison of medications for potential adverse reactions and interactions. The operator failed to ensure the appropriate information regarding the administration of sample medications for R3 was received when brought into the facility, including a written physician's order with specified instructions and any cautionary instructions, the license nurse documentation of receipt of medication, the appropriate information on the box/container along with verification from another licensed nurse or medication aide to verify such information. The operator also failed to include information that the resident and/or legal representative was informed the medications were not received through a pharmacy and not reviewed by a pharmacist.	S5314		