STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087058	A. BUILDING: _____ B. WING _____	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRINGTON HOUSE CENTRAL	1432 N WACO STREET WICHITA, KS 67230

(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 the licensure resurvey with attached complaint numbers 187692, 187380, 183855, and 182318, for the above named facility conducted on 05/21/24, 05/22/24, and 05/23/24.	S 000		
S3026 SS=D	26-41-101 (f) (1) Staff Treatment of Residents ANE (f)The administrator or operator shall ensure that all of the following requirements are met: (1) No resident shall be subjected to any of the following: (A) Verbal, mental, sexual, or physical abuse, including corporal punishment and involuntary seclusion; (B) neglect; or (C) exploitation. This REQUIREMENT is not met as evidenced by: K.A.R. 26-41-101 (f) (1) (B) The facility reported a census of 41 residents. The sample included 5 "Residents'" (R)'s 1, 2, 3, 4 and 5. Based on interview and record review the Administrator failed to protect R5 from neglect of nursing services, when he reported to the "Licensed Nurse" (LN) he was having trouble breathing and she asked the resident to wait for 30 minutes after his medications were administered before she would recheck his vitals. R5 then call emergency medical services for himself, he was transported to the local emergency room for evaluation and returned to the facility with a new order for Potassium 20 milli equivalents twice daily for five days.	S3026		

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
	N087058	A. BUILDING: _____ B. WING _____	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRINGTON HOUSE CENTRAL	1432 N WACO STREET WICHITA, KS 67230

(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
S3026	Continued From page 1 Findings included: - Record review for R5 revealed an admission date of 06/01/23 with diagnoses of edema, chronic atrial fibrillation, heart failure, anemia, acute respiratory failure with and hypoxia. Review of R5's "Functional Capacity Screen" (FCS) dated 12/01/23 revealed R5 required physical assistance with bathing, toileting, transferring, walking/mobility and eating. He was incontinent, and his cognition was intact. He was able to make himself understood and he understood others. He was marked with falls and impaired vision. He used a prothesis and wheelchair mobility device. Review of R5's "Negotiated Service Agreement" (NSA) dated 06/01/23 identified the following health services for R5 Bathing assistance three to four times a week, assist R5 as needed with mobility, and Certified/Licensed facility staff would manage his medications and medical treatments. Review of R5's "Health Service Plan" instructed certified facility staff to provide partial assistance with bathing, administering R5's medications, assist resident with propelling his wheelchair, and remind resident of mealtimes. Review of R5's electronic "Medical Record" under the "Progress Notes" tab revealed the following entry: On 05/07/24 Executive Director LN A entered the following: "On 05/06/24 resident c/o (complained of) unable to breath." She continued to enter R5's oxygen saturation level was 87%. His vitals were obtained and his medications were administered.	S3026		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087058	A. BUILDING: _____ B. WING _____	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRINGTON HOUSE CENTRAL	1432 N WACO STREET WICHITA, KS 67230

(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
S3026	Continued From page 2	S3026		

At approximately 09:30 AM R5 was asked to wait for "30 minutes for re-check on vitals" after his medication was administered. R5 then went and called "911" emergency services himself and was transported by ambulance to the local hospital for evaluation and treatment. He returned to the facility with new orders for Potassium 20 milli equivalents twice daily for 5 days. "Will continue to monitor with report to "MD" (Medical Doctor)/ "APRN" (Advanced Practice Registered Nurse) as needed.

R5's electronic "Progress Notes" lacked any entries after the entry on 05/07/24.

Review of R5's electronic "Medical Records" under the "Miscellaneous" tab revealed the discharge instructions from the local hospital dated 05/06/24 with the diagnoses of Hypokalemia.
Under the signs and symptoms of Hypokalemia it listed skipped heartbeats or irregular heartbeat. On page 11 of 13 of the discharge instructions it was printed "ECG (Electrocardiogram) 12 lead " 05/06/24 was performed and it was an "Abnormal" Electrocardiogram.

Interview on 05/23/24 at approximately 0930 AM with Executive Director/LN A confirmed R5 called emergency services and did go to the local hospital for evaluation and treatment.

The Administrator failed to protect R5 from neglect of nursing services, when he reported to the LN he was having trouble breathing, and she asked the resident to wait for 30 minutes after his medications were administered before she would recheck his vitals. R5 then call emergency medical services for himself, he was transported to the local emergency room for evaluation and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087058	A. BUILDING: _____ B. WING _____	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRINGTON HOUSE CENTRAL	1432 N WACO STREET WICHITA, KS 67230

(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
S3026	Continued From page 3 returned to the facility with a new order for Potassium 20 milli equivalents twice daily for five days.	S3026		
S3081 SS=D	26-41-201 (c) Functional Capacity Screen Reassessment (c) Designated facility staff shall conduct a screening to determine each resident ' s functional capacity according to the following requirements: (1) At least once every 365 days; (2) following any significant change in condition as defined in K.A.R. 26-39-100; and (3) at least quarterly if the resident receives assistance with eating from a paid nutrition assistant. This REQUIREMENT is not met as evidenced by: K.A.R. 26-41-201 (c) (1) (2) The facility reported a census of 41 residents. The sample included 5 "Residents'" (R)'s 1, 2, 3, 4 and 5. Based on interview and record review the Administrator failed to ensure a new "Functional Capacity Screening" (FCS) was performed determining R1's functional capacity every 365 days, and the Administrator further failed to ensure a screening determining R1's functional capacity after he experienced a significant change of condition. Findings included: - Record review for R1 revealed an admission date of 10/23/20 with diagnoses of other general symptoms and signs, essential primary	S3081		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087058	A. BUILDING: _____ B. WING _____	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRINGTON HOUSE CENTRAL	1432 N WACO STREET WICHITA, KS 67230

(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
S3081	Continued From page 4	S3081		

hypertension, and unspecified dementia with behavioral disturbances.

Review of R1's combined "Functional Capacity Screen" (FCS)/" Negotiated Service Agreement" (NSA)/" Health Service Plan" dated 05/05/23 revealed facility staff would provide R1 with physical assistance with bathing, dressing, toileting, and staff to assist R1 to dining room and set up his meals. He was independent with transfers and walking/mobility, and staff were to provide a one person assist for transfers. He lacked the ability to manage his own mediations, and had impaired short-term memory, impaired long-term memory, impaired memory recall, and impaired decision making. He was marked with wandering and used not mobility assistive devices. He was marked as a full resuscitation, and it stated R1 wandered around the facility frequently day and evening. Staff were to monitor R1 every two hours.

Record review of R1's electronic "Medical Record" under the "Progress Notes" tab revealed the following entries:

Entry on 04/9/24 revealed R1 was seen by the "Advanced Practice Registered Nurse" (APRN) on 04/02/24 "without new orders and continue all hospice meds" (medications).

Entry on 03/06/24 revealed R1 returned from a local hospital on 04/04/24 at approximately 01:30 PM with medication changes and a hospice consultation with readmission. The resident had a Foley catheter in place and the note identified the local hospice agency.

The combined FCS/NSA/HSP was greater then 365 days old, and the combined FCS/NSA/HSP

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087058	A. BUILDING: _____ B. WING _____	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRINGTON HOUSE CENTRAL	1432 N WACO STREET WICHITA, KS 67230

(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
S3081	Continued From page 5 was not performed upon R1 having a significant change of condition. Observation of R1 on 05/22/24 at approximately 08:30 AM R1 was sitting in a wheelchair and rubbing his hands together. He spoke very softly and nonsensical words. He would look up when approximately 50% of the time when he was spoken to. He had minimal responses to attempts at communication. He was unable to self-propel his wheelchair and made no attempts to stand. Interview on 05/23/24 at approximately 09:46 AM with Executive Director A, Administrator B, and Director of Operations C confirmed R1's combined FCS/NSA/HSP was greater then 365 days old and was not done when R1 experienced a change of condition. The Administrator failed to ensure a new FCS was performed determining R1's functional capacity every 365 days, and the Administrator further failed to ensure a screening determining R1's functional capacity after he experienced a significant change of condition.	S3081		
S3092 SS=E	26-41-202 (d) Negotiated Service Agreement Revisions (d) Each administrator or operator shall ensure the review and, if necessary, revision of each negotiated service agreement according to the following requirements:(1) At least once every 365 days; (2) following any significant change in condition, as defined in K.A.R. 26-39-100; (3) at least quarterly, if the resident receives assistance with eating from a paid nutrition assistant; and	S3092		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087058	A. BUILDING: _____ B. WING _____	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRINGTON HOUSE CENTRAL	1432 N WACO STREET WICHITA, KS 67230

(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
S3092	Continued From page 6 (4) if requested by the resident or the resident ' s legal representative, facility staff, the case manager, or, if agreed to by the resident or the resident ' s legal representative, the resident ' s family. This REQUIREMENT is not met as evidenced by: K.A.R. 26-41-202 (d) (1) (2) The facility reported a census of 41 residents. The sample included 5 "Residents'" (R)'s 1, 2, 3, 4 and 5. Based on interview and record review the Administrator failed to ensure the review and, if necessary, the revision of each "Negotiated Service Agreement" (NSA) at least every 365 days and following a significant change of condition for R1 and R5. Findings included: - Record review for R1 revealed an admission date of 10/23/20 with diagnoses of other general symptoms and signs, essential primary hypertension, and unspecified dementia with behavioral disturbances. Review of R1's combined "Functional Capacity Screen" (FCS)/" Negotiated Service Agreement" (NSA)/" Health Service Plan" dated 05/05/23 revealed facility staff would provide R1 with physical assistance with bathing, dressing, toileting, and staff to assist R1 to dining room and set up his meals. He was independent with transfers and walking/mobility, and staff were to provide a one person assist for transfers. He lacked the ability to manage his own mediations, and had impaired short-term memory, impaired long-term memory, impaired memory recall, and	S3092		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087058	A. BUILDING: _____ B. WING _____	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRINGTON HOUSE CENTRAL	1432 N WACO STREET WICHITA, KS 67230

(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
S3092	Continued From page 7	S3092		

impaired decision making. He was marked with wandering and used not mobility assistive devices. He was marked as a full resuscitation, and it stated R1 wandered around the facility frequently day and evening. Staff were to monitor R1 every two hours.

Record review of R1's electronic "Medical Record" under the "Progress Notes" tab revealed the following entries:

Entry on 04/9/24 revealed R1 was seen by the "Advanced Practice Registered Nurse" (APRN) on 04/02/24 "without new orders and continue all hospice meds" (medications).

Entry on 03/06/24 revealed R1 returned from a local hospital on 04/04/24 at approximately 01:30 PM with medication changes and a hospice consultation with readmission. The resident had a Foley catheter in place and the note identified the local hospice agency.

Observation of R1 on 05/22/24 at approximately 08:30 AM R1 was sitting in a wheelchair and rubbing his hands together. He spoke very softly and nonsensical words. He would look up when approximately 50% of the time when he was spoken to. He had minimal responses to attempts at communication. He was unable to self-propel his wheelchair and made no attempts to stand.

The combined FCS/NSA/HSP was greater then 365 days old, and the combined FCS/NSA/HSP was not performed upon R1 having a significant change of condition. The document further lacked the identification of, the description of, and who was paying for the hospice outside provider.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087058	A. BUILDING: _____ B. WING _____	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRINGTON HOUSE CENTRAL	1432 N WACO STREET WICHITA, KS 67230

(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
S3092	Continued From page 8	S3092		

- Record review for R5 revealed an admission date of 06/01/23 with diagnoses of edema, chronic atrial fibrillation, heart failure, anemia, acute respiratory failure with and hypoxia.

Review of R5's "Functional Capacity Screen" (FCS) dated 12/01/23 revealed R5 required physical assistance with bathing, toileting, transferring, walking/mobility and eating. He was incontinent, and his cognition was intact. He was able to make himself understood and he understood others. He was marked with falls and impaired vision. He used a prothesis and wheelchair mobility devices.

Review of R5's "Negotiated Service Agreement" (NSA) dated 06/01/23 identified the following health services for R5 Bathing assistance three to four times a week, assist R5 as needed with mobility, and Certified/Licensed facility staff would manage his medications and medical treatments.

Review of R5's "Health Service Plan" instructed certified facility staff to provide partial assistance with bathing, administering R5's medications, assist resident with propelling his wheelchair, and remind resident of mealtimes.

R5's electronic "Medical Record" lacked documentation of the Review of R5's NSA when a new FCS was performed on 12/01/23.

Interview on 05/23/24 at approximately 09:46 AM with Executive Director A, Administrator B, and Director of Operations C confirmed R1's combined FCS/NSA/HSP was greater then 365 days old and was not done when R1 experienced a change of condition, and lacked identification of the outside hospice provider, a description of the services of the outside hospice provider and who

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087058	A. BUILDING: _____ B. WING _____	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRINGTON HOUSE CENTRAL	1432 N WACO STREET WICHITA, KS 67230

(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
S3092	Continued From page 9 was going to pay for the outside hospice provider. They further confirmed R5's electronic "Medical Record" lacked documentation of a review being performed on his NSA with a new FCS was performed on 12/01/23. The Administrator failed to ensure the review and, if necessary, the revision of each "Negotiated Service Agreement" (NSA) at least every 365 days and following a significant change of condition for R1 and R5.	S3092		
S3177 SS=E	26-41-205 (a) (2) Self Administration Assessment Content (2) Each assessment shall include an evaluation of the resident ' s physical, cognitive, and functional ability to safely and accurately self-administer and manage medications independently or by using a prefilled medication container or prefilled syringe. This REQUIREMENT is not met as evidenced by: K.A.R. 26-41-205 (a) (2) The facility reported a census of 41 residents. The sample included 5 "Residents'" (R)'s 1, 2, 3, 4 and 5. Based on interview and record review the Administrator failed to ensure the "Licensed Nurse" (LN) performed an assessment for R4 which determined that he was able to safely and accurately without staff assistance self-inject his insulin.	S3177		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087058	A. BUILDING: _____ B. WING _____	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRINGTON HOUSE CENTRAL	1432 N WACO STREET WICHITA, KS 67230

(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
S3177	Continued From page 10 Findings included: - Reveiw of the facility provided resident roster revealed R4 was marked with "Insulin Injeciton" - Record review for R4 revealed an admission date of 11/01/23 with diagnoses of chronic obstructive pulmonary disease, acute and chronic respiratory failure with hypoxia, and type two diabetes mellitus. Review of R4's combined "Functional Capacity Screen (FCS)/Negotiated Service Agreement (NSA)/Health Service Plan (HSP)" dated 04/21/24 revealed R4 required physical assistance with bathing, supervision with dressing, toileting and transferring. He was unable to walk and was independent with eating. He lacked the ability to manage his own medications and medical treatments, was sometimes incontinent, and his cognition was intact. He was usually able to make himself understood, and he usually understood others. He was marked as at risk for falls and used a wheelchair mobility device. Review of R4's "electronic Medication Administration Record" (eMAR) revealed a document titled "Self Medication Assessment" which included the following comment; "Certified/Qualified Staff to Administer Medications" Review of the facility provided undated document titled "Medication Management" revealed the following: The resident may self-administer and manage	S3177		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087058	A. BUILDING: _____ B. WING _____	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRINGTON HOUSE CENTRAL	1432 N WACO STREET WICHITA, KS 67230

(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
S3177	Continued From page 11 their own medications if an assessment by a "Licensed Nurse" (LN) or a physician that determined that the resident could perform the function safely and accurately. The assessments "shall be performed when the resident is admitted and before the resident begins to self-administer medications with assistance; assessments shall also be performed following a significant change in condition and at least annually. Each assessment shall e maintained in the resident's clinical record." Interview on 05/23/24 at approximately 09:45 AM with Executive Director /LN A, Administrator B, and Director of Operations C confirmed R4 did self inject his insulin, and they further confirmed R4's electronic "Medical Record" lacked an assessment which determined that he was able to safely and accurately without staff assistance able to self-inject his insulin. The Administrator failed to ensure the LN performed an assessment for R4 which determined that he was able to safely and accurately without staff assistance self-inject his insulin.	S3177		
S3186 SS=E	26-41-205 (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.	S3186		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087058	A. BUILDING: _____ B. WING _____	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRINGTON HOUSE CENTRAL	1432 N WACO STREET WICHITA, KS 67230

(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
S3186	Continued From page 12	S3186		

This REQUIREMENT is not met as evidenced by:
K.A.R. 26-41-205 (b)

The facility reported a census of 41 residents. The sample included 5 "Residents'" (R)'s 1, 2, 3, 4 and 5. Based on interview and record review the Administrator failed to ensure R4's combined "Functional Capacity Screen (FCS)/Negotiated Service agreement (NSA)/Health Service Plan (HSP)" identified who was responsible for dialing R4's insulin pen.

Findings included:

- Record review for R4 revealed an admission date of 11/01/23 with diagnoses of chronic obstructive pulmonary disease, acute and chronic respiratory failure with hypoxia, and type two diabetes mellitus.

Review of R4's combined "Functional Capacity Screen (FCS)/Negotiated Service Agreement (NSA)/Health Service Plan (HSP)" dated 04/21/24 revealed R4 required physical assistance with bathing, supervision with dressing, toileting and transferring. He was unable to walk and was independent with eating. He lacked the ability to manage his own medications and medical treatments, was sometimes incontinent, and his cognition was intact. He was usually able to make himself understood, and he usually understood others. He was marked as at risk for falls and used a wheelchair mobility device.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087058	A. BUILDING: _____ B. WING _____	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRINGTON HOUSE CENTRAL	1432 N WACO STREET WICHITA, KS 67230

(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
S3186	Continued From page 13 Review of R4's "electronic Medication Administration Record" (eMAR) Under the assessments tab revealed an assessment titled "Functional Capacity Screen with Negotiated Service Agreement", NSA portion of the document lacked the documentation of who was responsible for dialing R4's insulin pen. Review of the facility provided undated document titled "Medication Management" revealed the following: A resident who self-administers medications may select medications to be administered by a licensed nurse employed be the facility. The negotiated service agreement shall identify who will be responsible for management of the selected medications. Interview on 05/23/24 at approximately 09:45 AM with Executive Director /LN A, Administrator B, and Director of Operations C confirmed R4's NSA lacked the documentation of the management of who was responsible for dialing R4's insulin pen.	S3186		
S3200 SS=E	26-41-205 (d) (1-2) Facility Administration of Medications (d) Facility administration of resident ' s medications. If a facility 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:	S3200		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087058	A. BUILDING: _____ B. WING _____	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRINGTON HOUSE CENTRAL	1432 N WACO STREET WICHITA, KS 67230

(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
S3200	Continued From page 14 (1) Only licensed nurses and medication aides shall administer and manage medications for which the facility has responsibility. (2) Medication aides shall not administer medication through the parenteral route. This REQUIREMENT is not met as evidenced by: K.A.R. 26-41-205 (d) The facility reported a census of 41 residents. The sample included 5 "Residents'" (R)'s 1, 2, 3, 4 and 5. Based on interview and record review the Administrator failed to ensure all medications and biologicals were administered to R4 in accordance with the medical care provider's written order and within professional standards of practice when the facility's "Certified Medication Aides'" (CMA)'s failed to follow the written provider order for R4's Insulin Glargine-agir 100 "units/milliliter" (U/ml) inject 25 units subcutaneously at bedtime for Diabetes Mellitus. The order included the instruction of notifying the nurse if R4's blood glucose level was below 150 milligrams/deciliter (mg/dl). Findings included: - Record review for R4 revealed an admission date of 11/01/23 with diagnoses of chronic obstructive pulmonary disease, acute and chronic respiratory failure with hypoxia, and type two diabetes mellitus. Review of R4's combined "Functional Capacity	S3200		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087058	A. BUILDING: _____ B. WING _____	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRINGTON HOUSE CENTRAL	1432 N WACO STREET WICHITA, KS 67230

(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
S3200	Continued From page 15 Screen (FCS)/Negotiated Service Agreement (NSA)/Health Service Plan (HSP)" dated 04/21/24 revealed R4 required physical assistance with bathing, supervision with dressing, toileting and transferring. He was unable to walk and was independent with eating. He lacked the ability to manage his own medications and medical treatments, was sometimes incontinent, and his cognition was intact. He was usually able to make himself understood, and he usually understood others. He was marked as at risk for falls and used a wheelchair mobility device. Review of R4's "electronic Medication Administration Record" (eMAR) revealed the following order: Insulin Glargine -agir Subcutaneous Solution Pen-injector 100 units/milliliter. Inject 25 unit subcutaneously at bedtime for diabetes mellitus "Hold If Blood suger Less Than 150" "Call Nurse" The following dates revealed R4's blood sugar was lower then 150: 05/02/24 a blood sugar result of 108 was recorded 05/03/24 a blood sugar result of 98 was recorded with an "RF" (drug Refused) above the CMA's initials 05/04/24 there was an "x" placed in the result box with an "RF" (drug Refused) above the CMA's initials 05/05/24 a blood sugar result of 146 was recorded with an "RF" (drug Refused) above the CMA's initials 05/06/24 a blood sugar result of 128 was recorded 05/08/24 there was an "x" placed in the result box with a "9" (see nurse notes) above the CMA's initials	S3200		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087058	A. BUILDING: _____ B. WING _____	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRINGTON HOUSE CENTRAL	1432 N WACO STREET WICHITA, KS 67230

(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
S3200	Continued From page 16 05/09/24 a blood sugar result of 84 was recorded with an "RF" (drug Refused) above the CMA's initials 05/10/24 a blood sugar result of 127 was recorded with an "RF" (drug Refused) above the CMA's initials 05/11/24 a blood sugar result of 106 was recorded with an "RF" (drug Refused) above the CMA's initials 05/14/24 a blood sugar result of 139 was recorded with an "RF" (drug Refused) above the CMA's initials 05/15/24 there was an "x" placed in the result box with an "RF" (drug Refused) above the CMA's initials 05/16/24 a blood sugar of 99 was recorded 05/18/24 a blood sugar of 99 was recorded with an "RF" (drug Refused) above the CMA's initials 05/20/24 a blood sugar of 100 was recorded Review of R4's electronic "Medical Record" under the "Progress Notes" tab for the dates of 05/01/24 to 05/21/24 revealed the following: The record lacked a "Medication Administration" note for a blood glucose level below 150 for the following dates: 05/02/24, 05/03/24, 05/04/24, 05/05/24, 05/06/24, 05/09/24, 05/10/24, 05/11/24, 05/15/24, 05/16/24, 05/18/24 and 05/20/24. The following note was entered on 05/08/24 at 09:35 PM; R4's blood sugar at 07:00 PM was 60. R4's blood sugar was rechecked at 09:31 PM and was 90. The CMA documented that the night shift CMA was notified to monitor the blood sugar for the administration of the Glargine insulin. The record lacked the documentation of the LN	S3200		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087058	A. BUILDING: _____ B. WING _____	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRINGTON HOUSE CENTRAL	1432 N WACO STREET WICHITA, KS 67230

(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
S3200	Continued From page 17 being called. The following note was entered on 05/14/24 at 09:34 PM; R4 refused, his blood sugar was 107. The record lacked the documentation of the LN being called. Interview on 05/23/24 at approximately 09:30 AM with Executive Director / LN A, Administrator B, and Director of Operations C confirmed the resident records lacked documentation of the LN being notified of R4's blood sugar readings below 150, and Executive Director / LN A further confirmed that the facility CMA's have not called her regarding R4's blood sugar readings below 150. The Administrator failed to ensure all medications and biologicals were administered to R4 in accordance with the medical care provider's written order and within professional standards of practice when the facility's CMA's failed to follow the written provider order for R4's Insulin Glargine-agir 100 U/ml, inject 25 units subcutaneously at bedtime for Diabetes Mellitus. The order included the instruction of notifying the nurse if R4's blood glucose level was below 150 mg/dl.	S3200		
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	S3261		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087058	A. BUILDING: _____ B. WING _____	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRINGTON HOUSE CENTRAL	1432 N WACO STREET WICHITA, KS 67230

(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 18 results of the action This REQUIREMENT is not met as evidenced by: K.A.R. 26-41-105 (f) (11) The facility reported a census of 41 residents. The sample included 5 "Residents'" (R)'s 1, 2, 3, 4 and 5. Based on interview and record review the Administrator failed to ensure the "Licensed Nurse" (LN) documented in R5's resident record all indications of symptoms, and other indications of illness, including the date, the time, actions taken and results of the action taken when R5 reported he was having trouble breathing. R5 called emergency medical services and was transported for evaluation and treatment. Findings included: - Record review for R5 revealed an admission date of 06/01/23 with diagnoses of edema, chronic atrial fibrillation, heart failure, anemia, acute respiratory failure with and hypoxia. Review of R5's "Functional Capacity Screen" (FCS) dated 06/01/23 revealed R5 required physical assistance with bathing, toileting, transferring, walking/mobility and eating. He was incontinent, and his cognition was intact. He was able to make himself understood and he understood others. He was marked with falls and impaired vision. He used a prothesis and wheelchair mobility devices. Review of R5's "Negotiated Service Agreement"	S3261		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087058	A. BUILDING: _____ B. WING _____	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRINGTON HOUSE CENTRAL	1432 N WACO STREET WICHITA, KS 67230

(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 19 (NSA) identified the following health services for R5 Bathing assistance three to four times a week, assist R5 as needed with mobility, and Certified/Licensed facility staff would manage his medications and medical treatments. Review of R5's "Health Service Plan" instructed certified facility staff to provide partial assistance with bathing, administering R5's medications, assist resident with propelling his wheelchair, and remind resident of mealtimes. Review of R5's electronic "Medical Record" under the "Progress Notes" tab revealed the following entry: On 05/07/24 Executive Director LN A entered the following: "On 05/06/24 resident c/o (complained of) unable to breath." She continued to enter R5's oxygen saturation level was 87%. His vitals were obtained, and his medications were administered. At approximately 09:30 AM R5 was asked to wait for "30 minutes for re-check on vitals" after his medication was administered. R5 then went and called "911" emergency services himself and was transported by ambulance to the local hospital for evaluation and treatment. He returned to the facility with new orders for Potassium 20 milli equivalents twice daily for 5 days. "Will continue to monitor with report to "MD" (Medical Doctor)/ "APRN" (Advanced Practice Registered Nurse) as needed. R5's electronic "Progress Notes" lacked any entries after the entry on 05/07/24. Interview on 05/23/24 at approximately 09:30 AM with Executive Director/LN A confirmed R5 called emergency services and did go to the local hospital for evaluation and treatment, and the	S3261		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087058	A. BUILDING: _____ B. WING _____	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRINGTON HOUSE CENTRAL	1432 N WACO STREET WICHITA, KS 67230

(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 20 resident record lacked follow up documentation for the actions taken when R5 returned from the hospital with a new for Potassium 20 milli equivalents two times daily for 5 days. The Administrator failed to ensure LN documented in R5's resident record all indications of symptoms, and other indications of illness, including the date, the time, actions taken, and results of the action taken when R5 reported he was having trouble breathing. R5 called emergency medical services and was transported for evaluation and treatment and returned with a new order for Potassium 20 milli equivalents two times daily for five days.	S3261		
S3310 SS=F	26-41-207 (b) (5-6) (c) Infection Control Policies (b) (5) prohibiting any employee with a communicable disease or any infected skin lesions from coming in direct contact with any resident, any resident ' s food, or resident care equipment until the condition is no longer infectious; (6) providing orientation to new employees and employee in-service education at least annually on the control of infections in a health care setting; and (c) Each administrator or operator shall ensure the facility ' s compliance with the department ' s tuberculosis guidelines for adult care homes adopted by reference in K.A.R. 26-39-105 This REQUIREMENT is not met as evidenced by: K.A.R. 26-41-207 (c)	S3310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087058	A. BUILDING: _____ B. WING _____	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRINGTON HOUSE CENTRAL	1432 N WACO STREET WICHITA, KS 67230

(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
S3310	Continued From page 21 The facility reported a census of 41 residents. The sample included 5 "Residents'" (R)'s 1, 2, 3, 4, 5, and 5 newly hired employees. Based on record review and interview, the Administrator failed to ensure the facility's compliance with the department's "Tuberculosis" (TB) Guidelines for adult care homes adopted by reference in K.A.R. 26-39-105 for R1, maintenance staff D, "Certified Medication Aide" (CMA) E, and "Certified Nurse Aides'" (CNA)'s F and G. Findings included: - Record review on 05/23/24 for newly hired Maintence Staff D revealed he began employment on 04/13/23. His personnel record lacked documentation of the required first step of the two step TB test being administered within seven days of employment. Review of CMA E's personnel record revealed she began employment on 11/21/23. Her personnel record lacked documentation of the required first step of the two step TB test being administered within seven days of employment. Review of CNA F's personnel record revealed she began employment on 10/26/23. Her personnel record lacked documentation of the required first step of the two step TB test being administered within seven days of employment. Review of CNA G's personnel record revealed she began employment on 11/17/23. Her personnel record lacked documentation of the required first step of the two step TB test being administered within seven days of employment.	S3310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087058	A. BUILDING: _____ B. WING _____	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRINGTON HOUSE CENTRAL	1432 N WACO STREET WICHITA, KS 67230

(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
S3310	Continued From page 22 Interview on 05/23/24 at approximately 09:50 AM with "Licensed Nurse" (LN) A, Administrator B, and Director of Operations C confirmed the newly hired personnel records for Maintence Staff D, CMA E, and CNA's F and G lacked documentation the required first step of the two step TB test being administered within seven days of employment. - Record review for R1 revealed an admission date of 10/23/23 with diagnoses of essential primary hypertension and unspecified dementia with behavioral disturbances. Review of R1's electronic "Medical Record" under the assessments tab revealed an electronic form titled "TB Annual Review Questionaire" that was dated and signed electronically on 03/16/23. Interview on 05/23/24 at approximately 09:50 AM with "Licensed Nurse" (LN) A, Administrator B, and Director of Operations C confirmed R1's electronic "Medical Record" lacked the required annual TB symptom screening. Review of the facility provided undated document titled "Mantoux (Tuberculosis) Testing Policy revealed the following All new residents and employees were to have the skin test as soon as their residency or employment began using the two-step method unless there was documentation of a previous significant reaction. Testing should have been performed within seven days of admission or employment. The Administrator failed to ensure the facility's	S3310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087058	A. BUILDING: _____ B. WING _____	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRINGTON HOUSE CENTRAL	1432 N WACO STREET WICHITA, KS 67230

(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
S3310	Continued From page 23 compliance with the department's TB Guidelines for adult care homes adopted by reference in K.A.R. 26-39-105 for R1, maintenance staff D, CMA E, and CNA's F and G.	S3310		
S3320 SS=D	28-39-254 CONSTRUCTION (a) The assisted living facility or residential health care facility shall be designed, constructed, equipped and maintained to protect the health and safety of residents, personnel and the public. (b) All new construction, renovation, remodeling and changes in building use in existing buildings shall comply with building and fire codes, ordinances and regulations enforced by city, county, and state jurisdictions, including the state fire marshal. (c) New construction, modifications and equipment shall conform to the following codes and standards: (1) Title III of the Americans with disabilities act, 42 U.S.C. 12181, effective as of January 26, 1992; and (2) "Food Service Sanitation Manual," health, education, and welfare (HEW) publication no. FDA 78-2081, as in effect on July 1, 1981. This REQUIREMENT is not met as evidenced by: K.A.R. 28-39-254 (a) The facility reported a census of 41 residents. The sample included 5 "Residents'" (R)'s. Based on observation and interview the Administrator	S3320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087058	A. BUILDING: _____ B. WING _____	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRINGTON HOUSE CENTRAL	1432 N WACO STREET WICHITA, KS 67230

(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
S3320	Continued From page 24 failed to ensure the facility was maintained to protect the safety of residents, personnel and the public when the door to R2's room was damaged and not repaired. Findings included: - Observation on 05/21/24 at approximately 04:30 PM revealed a door to a resident's apartment opened freely, and an area approximately 5 inches by 3 inches next to the handle of the door was missing the paint, the door latch, and an area of wood approximately 1 inch at the width of the base to 0.25 inches at the top of the missing section, which created a jagged edge. The damage was not covered. On the door frame the strike plate was missing. Interview on 05/21/24 at approximately 04:30 PM with R2 revealed the damage occurred approximately two weeks ago. R2 stated that he had been unable to open his door on two different occasions. He stated the first-time staff were able to enter, and the second time the door damage occurred. Interview on 05/21/24 at approximately 04:30 PM with "Licensed Nurse" (LN)/Executive Director A revealed she was unaware of the damage to the door. Interview on 05/21/24 at approximately 04:30 PM with Administrator B and Director Of Operations C confirmed the damage to the door had not been reported to them and Director of Operations C opened an immediate investigation. The Administrator failed to ensure the facility was maintained to protect the safety of residents,	S3320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087058	A. BUILDING: _____ B. WING _____	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRINGTON HOUSE CENTRAL	1432 N WACO STREET WICHITA, KS 67230

(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
S3320	Continued From page 25 personnel and the public when the door to R2's room was damaged and not repaired.	S3320		