STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087137	A. BUILDING: _____ B. WING _____	06/05/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS The following citations represent the findings of a Re-Licensure Survey with complaint investigations 183790 and 188114 for the above named Home Plus facility conducted on 06/04/24 and 06/05/24.	S 000		
S5095 SS=D	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 include three residents. Based on interview, and record review the operator failed to ensure designated staff completed one (R5) of three sampled resident's "Functional Capacity Screen" accurately to reflect the resident's functional ability related to Findings Included: - Review of R5's medical record revealed she moved into the facility on 05/03/24 with diagnoses of hypertension and emphysema. R5's "Functional Capacity Screen" (FCS) dated 05/03/24 failed to address eating, falls, vision, hearing, and other possible current risks/problems.	S5095		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087137	A. BUILDING: _____ B. WING _____	06/05/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5095	Continued From page 1 On 06/05/24 at 11:29 AM Licensed Nurse B reviewed R5's FCS and confirmed she had not completed it accurately to include all areas of screening. The operator failed to ensure designated staff completed R3's FCS accurately and completely to show R3's functional needs related to medications, and home health therapy services.	S5095		
S5215 SS=F	26-42-104 (d) Disaster and Emergency Preparedness Education (d) Each administrator or operator shall ensure disaster and emergency preparedness by ensuring the performance of the following: (1) Orientation of new employees at the time of employment to the home ' s emergency management plan; (2) education of each resident upon admission to the home regarding emergency procedures; (3) quarterly review of the home ' s emergency management plan with employees and residents; and (4) an emergency drill, which shall be conducted at least annually with staff and residents. This drill shall include evacuation of the residents to a secure location. This REQUIREMENT is not met as evidenced by: KAR 26-42-104 (d)(3) The facility reported a census of eight residents. Based on record review and interview the operator failed to ensure disaster and emergency	S5215		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087137	A. BUILDING: _____ B. WING _____	06/05/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5215	Continued From page 2 preparedness by the failure to conduct quarterly reviews of the home's emergency management plan with all residents. Findings included: - Review of the Emergency anagement reviews with Operator/Certified Medication Aide A on 06/04/24 at 10:04 AM revealed completion of the quarterly reviews for 2023 but did not have any for 2024. On 06/04/24 at 10:06 AM Operator/Certified Medication Aide A reported they had not done any emergency preparedness reviews with residents for 2024 The operator failed to ensure disaster and emergency preparedness by the failure to conduct quarterly reviews of the emergency management plan with all facility residents.	S5215		
S5251 SS=E	26-42-105 (f) (11) Resident Records 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 26-42-105(f)(11) The facility reported a census of eight residents(R). The sample included three residents. Based on interview and record review	S5251		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087137	A. BUILDING: _____ B. WING _____	06/05/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5251	Continued From page 3 the operator failed to ensure the medical record contained documentation of all incidents, symptoms, and other indications of illness or injury including the date and time, action taken, and results of the action for three (R3, R4, R5) of three sampled residents. Findings included: R3's medical record revealed he moved into the facility on 09/29/23 with diagnoses of Alzheimer's dementia and diabetes type II. R3's "Functional Capacity Screen" dated 11/26/23 revealed R3 had impaired cognition, needed supervision with mobility and transfers and had a current risk/problem with falls and impaired decision making. R3's "Negotiated Service Agreement" dated 11/26/23 included the services and interventions related to safety and fall risk: Review of R3's "Observation" nursing notes included documentation of the resident having falls without follow-up documentation if the resident had any latent injuries or other concerns post fall on the following dates: 10/3/23, 10/16/23, 11/7/23, 12/9/23, and 03/08/24. On 01/19/24 he had a growth removed from right had with no follow up related to skin condition and healing. On 02/12/24 an Hospice documented the resident had a skin tear to left elbow and cut above right eye but the record lacked facility nurse documentation in record of how resident got skin tear on elbow or follow-up on healing. Interview on 06/05/24 at 11:44 AM Licensed Nurse B acknowledged the need to follow up on situations or incidents every three days	S5251		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087137	A. BUILDING: _____ B. WING _____	06/05/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5251	Continued From page 4	S5251		

depending on the situation to make sure not additional concerns arise.

The operator failed to ensure R3's documentation included proper follow up after a fall and after removal of a growth on R3's right hand.

- R4 moved into the facility on 06/12/20 with diagnosis of senile degeneration of the brain.

R4's "Functional Capacity Screen dated 05/14/24 revealed she needed physical assistance with all activities of daily living, and had current problem with falls.

R4's "Negotiated Service Agreement" dated 05/14/24 included interventions for fall risk as well as direction for staff to provide assistance with walking and transfers.

R4's "Observation" nursing notes included documentation of the resident having falls without follow-up documentation if the resident had any latent injuries or other concerns post fall on the following dates: 06/15/23 had two falls, 07/19/23, 09/19/23, 01/26/24, 03/26/24, 05/13/24, and 06/03/24.
On 06/21/23 resident eating less, two falls in past week, scheduled Ativan (antianxiety) discontinued but will continue with as needed dosage. The record lacked follow up if the change in medications improved residents falls or eating.

Interview on 06/05/24 at 11:23 AM Licensed Nurse B reported she would expect there to be follow-up on situations every three days or so depending on the situation.

The operator failed to ensure R4'srecord included documentation for follow-up after R4 had multiple

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087137	A. BUILDING: _____ B. WING _____	06/05/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5251	Continued From page 5	S5251		

falls.

- R5's record revealed she moved into the facility on 05/03/24 with diagnoses of hypertension and emphysema.

R5's "Functional Capacity Screen" dated 05/03/24 revealed she needed physical assistance with activities of daily living.

R5's "Negotiated Service Agreement dated 05/03/24 included interventions for fall risk and for staff to provide her assistance with activities of daily living. It also directed staff to reposition the resident every two hours because she had a stage II coccyx ulcer.

R5's "Observation" nursing notes included the following documentation from 05/03/24 to 06/04/24:
05/03/24 - stage II pressure ulcer to her coccyx approximately two centimeters in diameter. The record lacked additional documentation with a description of the wound, measurements, treatment and results of the treatment.
05/13/24 - resident with increased confusion thinking there is a bomb in the facility and ran out the back door and off the back porch. The record lacked follow-up regarding the resident's increased behaviors and diving off the back porch for any injuries.

Interview on 06/05/24 at 11:30 AM Licensed Nurse B reported she would expect there to be follow-up documentation on situations every three days or so depending on the situation including falls.

The operator failed to ensure R5's record included documentation for follow-up related to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087137	A. BUILDING: _____ B. WING _____	06/05/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5251	Continued From page 6 pressure ulcers and falls.	S5251		