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	N087046S	A. BUILDING: _____ B. WING _____	09/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK WEST PLAZA	505 N MAIZE ROAD WICHITA, KS 67212

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S 000	INITIAL COMMENTS The following citations represent the findings of a Re-Licensure Survey with complaint investigations 180870, 181251, 185598, and 187228 for the above named Assisted Living Facility conducted on 09/11/24, 09/12/24 and 09/16/24.	S 000		
S3082 SS=D	26-41-201 (d) Functional Capacity Screen Accurate d) Designated facility 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: K.A.R 26-41-201 (d) The facility reported a census of 44 residents(R). The sample included three residents and three closed record reviews. Based on observation, interview and record review, the executive director failed to ensure designated staff completed one (R3) of three sampled residents "Functional Capacity Screen" accurately to reflect their functional ability and need for health care services. Findings Included: - R3's Medical Record revealed she moved into the facility on 08/15/24 with diagnoses of fracture left inferior pubis ramus and left radial fracture, and hypertension. R3's "Functional Capacity Screen" (FCS) dated 08/15/24 coded R3 as unable to participate in	S3082		

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

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S3082	Continued From page 1	S3082		

walking/mobility and independent with eating.

R3's "Negotiated Service Agreement /Health Care Service Plan" (NSA/HCSP) directed that the resident was toe touch weight bearing on Left Lower Extremity and used a wheelchair for mobility. It directed staff to escort her in the wheelchair to meals and to assist her with opening packets and cutting up foods.

Observation on 09/12/24 at 07:15 AM Certified Nurse Aide (CNA) E went to R3's room to assist her with getting dressed for the day. R3 stood from a sitting position on the side of the bed with stand-by assistance, and then CNA E pushed her via wheelchair into the restroom and R3 reached for the grab bar and stood up and was able to complete the task of getting onto the toilet without staff assistance. When R3 had finished getting ready for the day CNA E pushed her down to the breakfast table and helped her get set up for breakfast. R3 had on a splint to her left wrist.

Interview on 09/12/24 at 06:38 AM Certified Medication Aide (CMA) F reported R3 needed assist with transfers in and out of the wheelchair and we take her to meals. If she needs help with things she will ask.

Interview on 09/12/24 at 10:35 AM Administrative Licensed Nurse B reviewed the FCS and NSA/HCSP for R3 and acknowledged that they did not match and after reviewing the FCS manual agreed she should have coded a "2" for walking/mobility and a "2" for eating.

The executive director failed to ensure designated staff completed R3's FCS accurately to identify her functional ability and need for health care services related to mobility using a

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S3082	Continued From page 2 wheelchair and need for assistance with opening packages or cutting food with meals.	S3082		
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: (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: KAR 26-41-205 (d) The facility reported a census of 44 residents (R). The sample included three residents and three closed record reviews. Based on interview and record review the executive director failed to ensure facility staff administered medications according to standards of practice for two (R3 and R4) of three sampled residents and one (R7) of three closed records, whom the facility was responsible for administering medications.	S3200		

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S3200	Continued From page 3 Findings included: - R3's Medical Record revealed she moved into the facility on 08/15/24 with diagnoses of fracture left inferior pubis ramus and left radial fracture, and hypertension. R3's "Functional Capacity Screen" (FCS) dated 08/15/24 coded R3 as unable to participate in management of medications. R3's "Negotiated Service Agreement /Health Care Service Plan" (NSA/HCSP) revealed Certified Medication Aide (CMA) and nurses would administer and order medications. Review of R3's September 2024 "Medication Administration Record" (MAR) from 09/01/24 to 09/11/24 revealed four days staff administered scheduled medications between 30 minutes and almost two hours past the standard medication administration window time of an hour before or an hour after scheduled. Interview on 09/12/24 at 02:24 PM Administrative Licensed Nurse B reported medications are to be administered by qualified staff within an hour before or an hour after the scheduled time. The executive director failed to ensure staff administered medications for R3 within the standard time frame window to ensure staff met standards of practice for medication administration. - Review of R4's medical record revealed she moved into the facility on 04/15/24 with diagnoses of diabetes type II and chronic venous insufficiency.	S3200		

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S3200	Continued From page 4 R4's "Functional Capacity Screen" dated 05/15/24 identified she needed physical assistance with medication management. R4's "Negotiated Service Agreement/Health Care Service Plan" dated 05/15/24 identified Certified Medication Aides and Nurses would administer medications. Review of R4's September 2024 "Medication Administration Record" (MAR) from 09/01/24 to 09/11/24 revealed three days staff administered R4's medications 15 minutes prior to or 45 minutes after the standard medication administration window time of an hour before or an hour after the scheduled time. Interview on 09/12/24 at 02:24 PM Administrative Licensed Nurse B reported medications are to be administered by qualified staff within an hour before or an hour after the scheduled time. The executive director failed to ensure staff administered medications for R4 within the standard time frame window to ensure staff met standards of practice for medication administration. - Review of R7's medical record revealed she moved into the facility on 05/02/23 with diagnoses of Parkinson's and bipolar disorder. R7's "Functional Capacity Screen dated 06/12/24 identified she required physical assistance with management of medications and had impaired memory recall and decision-making ability. R7's "Negotiated Service Agreement/Negotiated Service Agreement" identified Certified	S3200		

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S3200	Continued From page 5 Medication Aides and Nurses ordered and administered medications. Review of R7's May 2024 "Medication Administration Record" (MAR) provided by Executive Director A on 09/12/24 at 08:40 AM revealed 23 out of 31 days R7's scheduled medications were administered 30 minutes to almost 2 hours past the standard medication administration window time of an hour before or an hour after the scheduled time. Review of R7's MAR included why medications were not administered or why as needed medications were administered but did not include documentation as to why medications were administered late. Interview on 09/12/24 at 02:24 PM Administrative Licensed Nurse B reported medications are to be administered by qualified staff within an hour before or an hour after the scheduled time. Administrative Licensed Nurse B reported R7 would ask Certified Medication Aide to come back later, had a lot of behaviors during this time frame. Administrative Licensed Nurse B also reported the MAR should include notes as to why it was given late. The executive director failed to ensure staff administered medications for R7's within the standard medication time frame window to ensure staff met standards of practice for medication administration.	S3200		
S3201 SS=D	26-41-205 (d) (3) Facility Administration of Medication (3) A licensed nurse or medication aide shall perform the following: (A) Administer only the medication that the	S3201		

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S3201	Continued From page 6 licensed nurse or medication aide has personally prepared; (B) identify the resident before medication is administered; (C) remain with the resident until the medication is ingested or applied; and (D) document the administration of each resident ' s medication in the resident ' s medication administration record immediately before or following completion of the task. If the medication administration record identifies only time intervals or events for the administration of medication, the licensed nurse or medication aide shall document the actual clock time the medication is administered. This REQUIREMENT is not met as evidenced by: KAR 26-41-205 (d)(3)(C) The facility reported a census of 44 residents (R). The sample included three residents and three closed record reviews. Based on observation, interview, and record review the executive director failed to ensure facility staff followed professional standards of practice while administering medications for one (R3) of three sampled residents by the failure of the medication aide to remain with the resident until the medication is ingested. Findings included: - R3's Medical Record revealed she moved into the facility on 08/15/24 with diagnoses of fracture left inferior pubis ramus and left radial fracture, and hypertension.	S3201		

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S3201	Continued From page 7 R3's "Functional Capacity Screen" (FCS) dated 08/15/24 coded R3 as unable to participate in management of medications. R3's "Negotiated Service Agreement /Health Care Service Plan" (NSA/HCSP) revealed Certified Medication Aide (CMA) and nurses would administer and order medications. Observation on 09/12/24 at 07:33 AM Certified Nurse Aide E pushed R3 down to the dining room in a wheelchair and stopped at the medication cart. R3 asked CMA F if she would bring her medications pretty soon and let her take them herself during her breakfast meal. CMA F stated she would. Observation on 09/12/24 at 07:45 AM R3 sat at the breakfast table and CMA F brought R3's medications to her in a plastic medication cup and sat them on the table in front of her and left the dining room. Observation on 09/12/24 at from 07:55 AM to 08:28 AM, R3 would take a pill out of the cup, take a drink and then eat a little bit of food. She continued this process until she had taken all of her medications. Interview on 09/12/24 at 08:30 AM CMA F reported R3 is the only resident that we leave medications at the table for and had asked Administrative Licensed Nurse B about it and as long as it wasn't eye drops it was OK. Interview on 09/12/24 at 02:24 PM Administrative Licensed Nurse B reported staff were not supposed to leave the medications sitting at the table for residents to take later, they are supposed to observe the resident take the	S3201		

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S3201	Continued From page 8 medications and document. Review of the "Medication Administration" policy dated 04/30/19 revealed the person responsible for administering medications shall "observe swallowing of oral medication". The executive director failed to ensure medications that were the responsibility of the facility to manage and administer, were administered by qualified staff according to professional standards of practice when staff failed to remain with the resident until the medication was ingested.	S3201		
S3211 SS=E	26-41-205 (g) (3) OVER THE COUNTER DRUGS (3) A licensed nurse or medication aide may accept over-the-counter medication only in its original, unbroken manufacturer ' s package. A licensed pharmacist or licensed nurse shall place the full name of the resident on the package. If the original manufacturer ' s package of an over-the-counter medication contains a medication in a container, bottle, or tube that can be removed from the original package, the licensed pharmacist or a licensed nurse shall place the full name of the resident on both the original manufacturer ' s medication package and the medication container. This REQUIREMENT is not met as evidenced by: KAR 26-41-205 (g)(3) The facility reported a census of 44 residents(R).	S3211		

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S3211	Continued From page 9 Based on observation and interview, the executive director failed to ensure a licensed nurse or pharmacist included the residents full name on all over-the-counter medications, including the original manufacturer's medication package and the medication container/tube. Findings included: - Observation on 09/11/24 at 01:18 PM Licensed Nurse C unlocked the 300-medication cart for inspection. Observations revealed the following medication containers without a resident's full name on them: bottles of acetaminophen, magnesium, calcium, PreserVision, stool softener, two bottles of glucosamine, vitamin D3, and a bottle of multivitamins. On 09/12/24 at 04:59 PM Administrative Nurse D acknowledged over-the-counter medications needed to include the full name of the resident on the medication container. The executive director failed to ensure a licensed nurse or pharmacist wrote the residents full name on all over-the-counter medications, including the medication package and container.	S3211		