| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | N087083 | A. BUILDING: _____ B. WING _____ | 10/15/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CREDO MEMORY CARE OF WICHITA | 6887 E ROCKHILL STREET WICHITA, KS 67206 |

| (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<br><br>The following represents the findings of a resurvey with attached complaints #190324, #189309, #188686, and #183245 at the above named assisted living conducted on 10/14/24 and 10/15/24. | S 000 | | |
| S3026 SS=J | 26-41-101 (f) (1) Staff Treatment of Residents ANE<br><br>(f)The administrator or operator shall ensure that all of the following requirements are met:<br>(1) No resident shall be subjected to any of the following:<br>(A) Verbal, mental, sexual, or physical abuse, including corporal punishment and involuntary seclusion;<br>(B) neglect; or<br>(C) exploitation.<br><br>This REQUIREMENT is not met as evidenced by:<br>KAR 26-41-101(f)(1)(B)<br><br>The facility reported a census of 10 residents with three residents included in the sample. Based on observation, interview, and record review the operator failed to protect one resident from neglect by the failure to secure all exit doors and courtyard gates; the failure to implement a system to ensure exit doors and courtyard gates were locked and alarms functioned; the failure to ensure facility staff accounted for an at-risk resident every 30 minutes per facility policy; and the failure to ensure designated staff conducted reviews of the "Emergency Management Plan" including how to manage a missing resident emergency every quarter. Cognitively impaired Resident (R) 2 exited the facility through an | 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 |
|---|---|---|---|
| | N087083 | A. BUILDING: _____ B. WING _____ | 10/15/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CREDO MEMORY CARE OF WICHITA | 6887 E ROCKHILL STREET WICHITA, KS 67206 |

| (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 | S3026 | | |

unlocked and non-alarmed door outside to the courtyard and went out an unsecured gate without staff knowledge. A security guard found R2 approximately 0.4 miles from the facility in a grocery store parking lot. This placed the resident in Immediate Jeopardy.

Findings included:

- Record review for R2 revealed an admission date of 07/10/24 with a diagnosis of dementia.

The 07/10/24 "Functional Capacity Screen" (FCS) identified R2 had short-term and long-term memory, memory/recall, and decision-making cognitive difficulties; and was identified at risk for wandering and inappropriate behavior.

The 07/10/24 combined "Negotiated Service Agreement/Healthcare Service Plan" (NSA/HSP) identified facility staff provided reminders for cognitive difficulties; 24-hour supervision in a secured community, frequent safety checks, encouragement to participate in activities and conversation for wandering; and encouragement to participate in activities and decisions regarding care and activities of daily living (ADL's) for inappropriate behavior.

The "NSA/HSP" failed to describe/inform designated staff how frequently to provide safety checks for R2.

The 07/10/24 admission "Elopement Risk Screening" documented R2 was at risk for elopement.

The 07/10/24 nursing "Progress Note" documented R2 admitted to the facility. He was alert to self only, ambulated independently with no

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | N087083 | A. BUILDING: _____ B. WING _____ | 10/15/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CREDO MEMORY CARE OF WICHITA | 6887 E ROCKHILL STREET WICHITA, KS 67206 |

| (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 | | |

devices, and occasionally exhibited wandering and exit-seeking behavior. R2 stated multiple times he wanted to go home.

The 07/16/24 nursing "Progress Note" documented the following:

At 09:15 PM facility staff notified the on-call nurse they were unable to locate R2 inside the facility.

At 09:25 PM a security guard found R2 in a grocery store parking lot near the facility. The Certified Medication Aide (CMA) on duty drove to the parking lot, identified R2, and returned him to the facility.

At 09:40 PM the nurse arrived to the facility and performed a head-to-toe assessment. R2's vital signs were within normal limits with no injuries reported. When the nurse asked R2 to show her how he exited the building, he pointed at the west courtyard doors. The nurse found the west courtyard gate unlatched.

The facility's "Investigation Report" documented R2 dressed appropriately for the weather. Facility staff last saw him inside the facility sometime during the hour of 08:00 PM. The report documented the nurse implemented the following interventions:

On 07/16/24 at 09:30 PM - facility staff initiated 15-minute safety checks for R2 which continued until 07/17/24 at 12:00 AM.

On 07/16/24 following R2's elopement, the nurse provided re-education to the maintenance director to keep the courtyard gates securely latched.

On 07/16/24 following R2's elopement, the nurse

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | N087083 | A. BUILDING: _____ B. WING _____ | 10/15/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CREDO MEMORY CARE OF WICHITA | 6887 E ROCKHILL STREET WICHITA, KS 67206 |

| (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 | S3026 | | |

re-educated all facility staff via a group text program keep the courtyard gates securely latched.

The maintenance department installed alarms on the east, west, and south courtyard gates to alert staff each time a door or gate opened. The code to disarm the alarms would be known only to employees.

Facility staff checked alarms on the east, west, and south courtyard gates each shift during shift change.

On 10/15/24 at approximately 03:31 PM the state surveyor requested documentation to verify the staff checked the facility's exit doors, gate locks, and alarms each shift, which the facility failed to provide.

Review of facility's "Emergency Management Plan" log revealed designated staff conducted quarterly reviews during the first quarter for on 02/15/24 for facility staff and on 02/29/24 for residents. Designated staff conducted a quarterly review during the third quarter with staff and residents on 08/21/24. The "Emergency Management Plan" quarterly review log lacked evidence and/or documentation that designated staff conducted a quarterly review for staff and residents during the second quarter of 2024. The review log also lacked evidence and/or documentation that designated staff included how to manage a missing resident emergency in the quarterly emergency management plan reviews.

On 10/14/24 at 03:02 PM Administrative Staff A stated facility staff reviewed elopement training annually in September and October, which was after R2 exited the facility without staff knowledge

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | N087083 | A. BUILDING: _____ B. WING _____ | 10/15/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CREDO MEMORY CARE OF WICHITA | 6887 E ROCKHILL STREET WICHITA, KS 67206 |

| (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 4<br>on 07/16/24. She confirmed the "Emergency Management Plan" reviews lacked documentation designated staff included how to manage a missing resident emergency.<br><br>On 10/15/24 at 02:19 PM Administrative staff A stated the doors to the courtyards were not alarmed or locked during the day for residents to walk in the courtyard, but the doors should have been locked during the night.<br><br>On 10/15/24 at 02:22 PM during a phone interview, Administrative Staff C stated at the time R2 exited the facility without staff knowledge, facility staff did not keep exit doors to the courtyard locked or alarmed. The maintenance man was the last one to go through the gate and left it unlocked but was not sure how long he left the gate unlocked. Signs on each courtyard gate read "Please make sure gate is locked at all times" were present from time of ownership of the facility.<br><br>On 10/15/24 at 03:31 PM Administrative Staff A stated a staff member informed her he checked all doors and gate locks daily by text message. She confirmed there was no other documentation to indicate designated staff verified if doors and gates were locked and alarms functioned.<br><br>Review of Google Maps accessed online on 10/15/24 revealed the grocery store parking lot where a security guard found R2 was approximately 0.4 miles away from the facility and estimated to take nine minutes to walk if he stayed on or near the street.<br><br>The weather on 07/16/24 according to Wunderground.com was 87 degrees Fahrenheit with a wind speed of 14 MPH at 08:53 PM. | S3026 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | N087083 | A. BUILDING: _____ B. WING _____ | 10/15/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CREDO MEMORY CARE OF WICHITA | 6887 E ROCKHILL STREET WICHITA, KS 67206 |

| (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 5<br><br>Observation on 10/14/24 at 12:58 PM revealed R2 ambulated independently with no devices through the common area to Administrative Staff A's office without difficulty. Administrative Staff A told R2 she had to leave for a few minutes and asked him to sit and wait for her to return. 12 minutes later Administrative Staff returned to her office and R2 remained seated in her office.<br><br>Observation on 10/15/24 at approximately 04:23 PM of east, west, and south courtyard gates revealed they were keypad locked and alarmed. The alarm activated when staff unlocked and opened each gate. A sign on each gate read "Please make sure gate is locked at all times."<br><br>The facility's revised 2022 "Elopement Prevention" policy documented residents identified at risk for elopement were to be accounted for every 30 minutes until reassessment and transferred to a more appropriate setting if necessary.<br><br>The operator failed to protect one resident from neglect by the failure to secure all exit doors and courtyard gates; the failure to implement a system to ensure exit doors and courtyard gates were locked and alarms functioned; the failure to ensure facility staff accounted for an at-risk resident every 30 minutes per facility policy; and the failure to ensure designated staff conducted reviews of the "Emergency Management Plan" including how to manage a missing resident emergency every quarter. This failure resulted in immediate jeopardy when cognitively impaired R2 exited the facility through an unlocked and non-alarmed door outside to the courtyard and went out an unsecured gate without staff knowledge. A security guard found R2 | S3026 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | N087083 | A. BUILDING: _____ B. WING _____ | 10/15/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CREDO MEMORY CARE OF WICHITA | 6887 E ROCKHILL STREET WICHITA, KS 67206 |

| (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 6 | S3026 | | |

approximately 0.4 miles from the facility in a grocery store parking lot.

Jeopardy was removed on 07/16/24 at 09:30 PM when 15-minute safety checks were initiated for R2 after he returned to the facility and the nurse provided re-education to all staff the same evening. The following actions were documented by the facility in the "Abatement Plan" and accepted by the department on 10/15/24 at approximately 06:10 PM.

On 07/16/24 at 09:35 PM facility staff implemented 15-minute checks immediately after R2 returned to the facility and continued until the end of 07/17/24.

On 07/16/24 in the evening, Administrative Staff C re-educated facility staff via a group text program regarding resident elopement procedures. Re-education provided to maintenance director on proper gate locking procedures.

On 07/17/24 at 11:47 AM, Administrative Staff C purchased an alarm system for all the gates, ensured staff installed and tested them.

On 07/17/24 at 12:00 AM staff discontinued 15-minute checks for R2.

On 07/17/24 the maintenance director resigned without notice.

On 07/18/24 at 03:00 PM Administrative Staff provided mandatory all-staff safety meeting and elopement training.

On 07/18/24 Administrative Staff promoted a staff member who already worked at the facility to the

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | N087083 | A. BUILDING: _____ B. WING _____ | 10/15/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CREDO MEMORY CARE OF WICHITA | 6887 E ROCKHILL STREET WICHITA, KS 67206 |

| (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 7<br>Security/Maintenance Department. He provided daily perimeter checks, alarm checks, and lock checks.<br><br>On 07/20/24 at 04:00 Administrative Staff performed an elopement drill and planned for quarterly elopement drills conducted by facility's designated staff. | S3026 | | |
| S3085 SS=E | 26-41-202 (a) Negotiated Service Agreement<br><br>(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:<br>(1) A description of the services the resident will receive;<br>(2) identification of the provider of each service; and<br>(3) identification of each party responsible for payment if outside resources provide a service.<br><br>This REQUIREMENT is not met as evidenced by:<br>KAR 26-41-202(a)(1)<br><br>The facility reported a census of 10 residents with three residents included in the sample and one closed record review. Based on interview and | S3085 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | N087083 | A. BUILDING: _____ B. WING _____ | 10/15/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CREDO MEMORY CARE OF WICHITA | 6887 E ROCKHILL STREET WICHITA, KS 67206 |

| (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 8 | S3085 | | |

record review the operator failed to ensure the "Negotiated Service Agreement" (NSA) for Resident (R)2 and R3 described the services they received based on their "Functional Capacity Screen" (FCS).

Findings included:

- Record review for R2 revealed an admission date of 07/10/23 with a diagnosis of dementia.

The 07/10/24 "FCS" identified R2 was sometimes understandable and rarely or never understood others during communication.

The 07/10/24 "NSA" identified R2 was "independent" with communication. The "NSA" failed to describe services provided to R2 for communication.

- Record review for R3 revealed an admission date of 04/22/24 with a diagnosis of dementia.

The 06/26/24 "FCS" identified R3 required physical assistance with toileting and transfers; was unable to perform management of medications and treatments; and was marked at risk for falls, impaired hearing, impaired decision-making, and inappropriate behavior.

The 04/22/24 "NSA" failed to describe services provided to R3 for toileting, transfers, and management of medications and treatments; and to keep him safe from falls, impaired hearing, impaired decision-making, and inappropriate behavior.

On 10/15/24 at appproximately 03:21 PM Administrative Nurse B confirmed R3's "NSA" failed to describe services provided based on his

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | N087083 | A. BUILDING: _____ B. WING _____ | 10/15/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CREDO MEMORY CARE OF WICHITA | 6887 E ROCKHILL STREET WICHITA, KS 67206 |

| (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 9<br>"FCS."<br><br>The facility's revised 2022 "Negotiated Service Agreement/Health Care Plan Policy" documented the "NSA" would contain a description of health care services to be provided by the facility.<br><br>The operator failed to ensure the "NSA" for R2 and R3 described the services they received based on their "FCS." | S3085 | | |
| S3101 SS=E | 26-41-202 (h) NSA Signatures<br><br>(h) Each individual involved in the development of the negotiated service agreement shall sign the agreement. The administrator or operator shall ensure that a copy of the initial agreement and any subsequent revisions are provided to the resident or the resident's legal representative.<br><br>This REQUIREMENT is not met as evidenced by:<br>KAR 26-41-202(h)<br><br>The facility reported a census of 10 residents with three residents included in the sample and one closed record review. Based on interview and record review the operator failed to ensure that each individual involved in the development of the "Negotiated Service Agreement" (NSA) signed the agreement for Resident (R) 1, R2, and R3.<br><br>Findings included:<br><br>- Record review for R1 revealed an admission date of 08/22/24 with a diagnosis of dementia. | S3101 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | N087083 | A. BUILDING: _____ B. WING _____ | 10/15/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CREDO MEMORY CARE OF WICHITA | 6887 E ROCKHILL STREET WICHITA, KS 67206 |

| (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 |
|---|---|---|---|---|
| S3101 | Continued From page 10<br><br>The 05/22/24 "Functional Capacity Screen" (FCS) identified R1 was unable to perform management of medications and treatments; was occasionally incontinent of bladder; had short-term and long-term memory, memory/recall, and decision-making cognitive impairments; and was identified at risk for falls.<br><br>The 05/22/24 "NSA" identified facility staff provided R1 management of medications and treatments; reminders for toileting; reminders for cognitive difficulties; and ensured her environment was clutter free and assistive devices were available and in good repair to prevent injury from falls.<br><br>The 05/22/24 "NSA" for R1 lacked signatures.<br><br>- Record review for R2 revealed an admission date of 07/10/24 with a diagnosis of dementia.<br><br>The 07/10/24 "FCS" identified R2 was unable to perform dressing, toileting, management of medications and treatments; was frequently incontinent of bladder; had short-term and long-term memory, memory/recall, and decision-making cognitive impairments; was sometimes understandable and rarely or never understood others during communication; and was marked at risk for falls, impaired hearing, impaired decision-making, wandering, and inappropriate behavior.<br><br>The 07/10/24 "NSA" identified facility staff provided R2 set up assistance and reminders with bathing; reminders to toilet and assistance to change incontinence products for toileting and bladder incontinence, and management of medications and treatments; reminders for cognitive difficulties; ensure glasses were on and | S3101 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | N087083 | A. BUILDING: _____ B. WING _____ | 10/15/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CREDO MEMORY CARE OF WICHITA | 6887 E ROCKHILL STREET WICHITA, KS 67206 |

| (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 |
|---|---|---|---|---|
| S3101 | Continued From page 11 | S3101 | | |

clean for impaired vision; assistance to place bilateral hearing aids for impaired hearing; a durable power of attorney (DPOA) for impaired decision-making; 24-hour supervision in a secured community, frequent safety checks, encouragement to participate in activities and conversation for wandering; and encouragement to participate in activities and decisions regarding care and activities of daily living (ADL's) for inappropriate behavior.

The 07/10/24 "NSA" for R2 lacked signatures.

- Record review for R3 revealed an admission date of 04/22/24 with a diagnosis of dementia. The 06/26/24 "FCS" identified R3 was unable to perform bathing, dressing, management of medications and treatments; was occasionally incontinent of bladder; had short-term memory, memory/recall, and decision-making cognitive difficulties; and was identified at risk for falls, impaired hearing, impaired decision-making, and inappropriate behavior.

The 04/22/24 (most recent) "NSA" identified facility staff would provide assistance with bathing, dressing, walking/mobility; he wore briefs mainly at night for bladder incontinence; and reminders for cognitive difficulties. The "NSA" failed to describe services provided for toileting, transfers, management of medications and treatments; and to prevent injury from falls, impaired hearing, impaired decision-making, and inappropriate behavior.

The 04/22/24 "NSA" for R3 lacked signatures.

On 10/15/24 at approximately 01:50 PM Administrative Nurse B confirmed R1, R2, and R3's "NSAs" lacked signatures.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | N087083 | A. BUILDING: _____ B. WING _____ | 10/15/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CREDO MEMORY CARE OF WICHITA | 6887 E ROCKHILL STREET WICHITA, KS 67206 |

| (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 |
|---|---|---|---|---|
| S3101 | Continued From page 12<br><br>The facility's revised 2022 "Negotiated Service Agreement/Health Care Plan Policy" documented all individuals involved in the development of the "NSA" shall sign the agreement.<br><br>The operator failed to ensure that each individual involved in the development of the "NSAs" for R1, R2, and R3 signed the agreements. | S3101 | | |
| S3215 SS=F | 26-41-205 (h) Medication Storage<br><br>(h) Storage. Licensed nurses and medication aides shall ensure that all medications and biologicals are securely and properly stored in accordance with each manufacturer ' s recommendations or those of the pharmacy provider and with federal and state laws and regulations.<br>(1) Licensed nurses or medication aides shall store non-controlled medications and biologicals managed by the facility in a locked medication room, cabinet, or medication cart. Licensed nurses and medication aides shall store controlled medications managed by the facility in separately locked compartments within a locked medication room, cabinet, or medication cart. Only licensed nurses and medication aides shall have access to the stored medications and biologicals.<br>(2) Each resident managing and self-administering medication shall store medications in a place that is accessible only to the resident, licensed nurses, and medication aides.<br>(3) Any resident who self-administers medication and is unable to provide proper storage as recommended by the manufacturer or pharmacy provider may request that the medication be | S3215 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | N087083 | A. BUILDING: _____ B. WING _____ | 10/15/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CREDO MEMORY CARE OF WICHITA | 6887 E ROCKHILL STREET WICHITA, KS 67206 |

| (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 |
|---|---|---|---|---|
| S3215 | Continued From page 13<br>stored by the facility.<br>(4) A licensed nurse or medication aide shall not administer medication beyond the manufacturer ' s or pharmacy provider ' s recommended date of expiration.<br><br>This REQUIREMENT is not met as evidenced by:<br>KAR 26-41-205(h)<br><br>The facility reported a census of 10 total residents. Based on observation and interview, the operator failed to ensure designated staff stored controlled medications in a locked compartment within the medication room.<br><br>Findings included:<br><br>- Observation on 10/14/24 at approximately 11:30 AM revealed Administrative Nurse B unlocked and opened the medication room. The room had a small, unlocked refrigerator which contained five containers of liquid lorazepam.<br><br>On 10/14/24 at approximately 11:30 AM Administrative Nurse B confirmed five containers of liquid lorazepam were in an unlocked refrigerator within the medication room.<br><br>The facility's revised 2022 "Medication Management" policy documented controlled medications would be kept under double lock in the medication room in a locked cabinet.<br><br>The operator failed to ensure designated staff stored controlled medications in a locked compartment within the medication room. | S3215 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | N087083 | A. BUILDING: _____ B. WING _____ | 10/15/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CREDO MEMORY CARE OF WICHITA | 6887 E ROCKHILL STREET WICHITA, KS 67206 |

| (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 14 | S3261 | | |
| S3261 SS=D | 26-41-105 (f) (11) Resident Record Documentation of Incidents<br><br>(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<br><br>This REQUIREMENT is not met as evidenced by:<br>KAR 26-41-105(f)(11)<br><br>The facility reported a census of 10 residents with three residents included in the sample and one closed record review. Based on interview and record review the operator failed to ensure licensed staff documented all incidents, symptoms, and other indications of illness or injury including the date and time of occurrence, action taken, and results of the action for Resident (R)1 when she exited out of the facility through a window without staff knowledge.<br><br>Findings included:<br><br>- Record review for R1 revealed an admission date of 08/22/24 with diagnoses of dementia and cachexia.<br>The 08/22/24 "Functional Capacity Screen" (FCS) identified R1 was independent with transfers and walking/mobility; and had short-term and long-term memory, memory/recall, and decision-making cognitive difficulties.<br><br>The 05/22/24 "Negotiated Service Agreement" NSA identified facility staff provided R1 reminders | S3261 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | N087083 | A. BUILDING: _____ B. WING _____ | 10/15/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CREDO MEMORY CARE OF WICHITA | 6887 E ROCKHILL STREET WICHITA, KS 67206 |

| (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 15<br>for cognitive difficulties.<br><br>The 08/27/24 nursing "Behavior Note" documented R1 exhibited exit-seeking behavior. Staff attempted to redirect her with no change. R1 became agitated, put her purse on and said she was leaving. Staff attempted to redirect her again and administered as needed medication for agitation.<br><br>The 08/31/24 nursing "Behavior Note" documented R1 continued to have "verbal behaviors" and threatened staff.<br><br>The 09/03/24 facility's "Intake Information" report to the department documented on 08/30/24 at 02:00 PM R1 walked around the kitchen and down the hall where her room was located. At 02:05 staff began looking for R1. At 02:29 PM Administrative Staff A was notified R1 was found at a gas station nearby. Upon return to the facility, R1 told police she opened the window to get out.<br><br>Review of photos provided by the facility revealed R1's bedroom window was opened to it's maximum of five inches gap width. The screen had a hand-sized hole near the bottom and was ripped from the hole vertically to near the top of the window.<br><br>R1's record lacked evidence of documentation of the incident when exited the facility through her window without staff knowledge, indications of injury, actions taken, and results of the actions.<br><br>On 10/14/24 at approximately 11:53 AM Administrative Staff A stated R1 weighed about 90 pounds and squeezed out through the window that only opened to a five-inch gap. | S3261 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | N087083 | A. BUILDING: _____ B. WING _____ | 10/15/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CREDO MEMORY CARE OF WICHITA | 6887 E ROCKHILL STREET WICHITA, KS 67206 |

| (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 16<br><br>On 10/15/24 at approximately 06:12 PM Administrative Nurse B confirmed R1's record lacked evidence of documentation of the incident when exited the facility through her window without staff knowledge, indications of injury, actions taken, and results of the actions.<br><br>The revised 2022 facility's "Incident Reports" policy documented the director and/or nurse were responsible for documenting incidents in the residents' records.<br><br>The operator failed to ensure licensed staff documented all incidents, symptoms, and other indications of illness or injury including the date and time of occurrence, action taken, and results of the action for Resident (R)1 when she exited out of the facility through a window without staff knowledge. | S3261 | | |
| S3280 SS=F | 26-41-104 (d) Disaster and Emergency Preparedness<br><br>(d) Each administrator or operator shall ensure disaster and emergency preparedness by ensuring the performance of the following:<br>(1) Orientation of new employees at the time of employment to the facility ' s emergency management plan;<br>(2) education of each resident upon admission to the facility regarding emergency procedures;<br>(3) quarterly review of the facility ' s emergency management plan with employees and residents; and<br>(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. | S3280 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | N087083 | A. BUILDING: _____ B. WING _____ | 10/15/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CREDO MEMORY CARE OF WICHITA | 6887 E ROCKHILL STREET WICHITA, KS 67206 |

| (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 |
|---|---|---|---|---|
| S3280 | Continued From page 17 | S3280 | | |

This REQUIREMENT is not met as evidenced by:
KAR 26-41-104(d)(3)

The facility reported a census of 10 residents. Based on interview and record review the operator failed to provide evidence of documentation quarterly reviews of the facility's emergency management plan was completed the second quarter of 2024 with residents and staff.

Findings included:

- Review of the facility's emergency management plan records revealed designated staff conducted quarterly reviews during the first quarter for staff on 02/15/24 and for residents on 02/29/24. Designated staff conducted a quarterly review during the third quarter with staff and residents on 08/21/24.

The emergency management plan records lacked evidence of documentation designated staff conducted a quarterly review for staff and residents during the second quarter of 2024.

On 10/14/24 at approximately 03:02 PM Administrative Staff A confirmed the facility's records lacked evidence of documentation designated staff conducted a quarterly review for staff and residents during the second quarter of 2024.

The operator failed to provide evidence of documentation quarterly reviews of the facility's emergency management plan was completed the

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | N087083 | A. BUILDING: _____ B. WING _____ | 10/15/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CREDO MEMORY CARE OF WICHITA | 6887 E ROCKHILL STREET WICHITA, KS 67206 |

| (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 |
|---|---|---|---|---|
| S3280 | Continued From page 18<br>second quarter of 2024 with residents and staff. | S3280 | | |