STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087043	A. BUILDING: _____ B. WING _____	12/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRINGTON AT CHERRY CREEK	8200 E PAWNEE ST WICHITA, KS 67207

(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 represents the findings of a resurvey with attached complaints #191595, #191529, #191364, #191329, #191297, and #191283 at the above named assisted living conducted on 12/02/24 and 12/03/24.	S 000		
S3085 SS=E	26-41-202 (a) Negotiated Service Agreement (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: (1) A description of the services the resident will receive; (2) identification of the provider of each service; and (3) identification of each party responsible for payment if outside resources provide a service. This REQUIREMENT is not met as evidenced by: KAR 26-41-202(a)(1) The facility reported a census of 101 residents with six residents included in the sample. Based on interview and record review the administrator failed to ensure the "Negotiated Service Agreement" (NSA) for Resident (R)103 described the services provided for an indwelling catheter,	S3085		

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
	N087043	A. BUILDING: _____ B. WING _____	12/03/2024

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CARRINGTON AT CHERRY CREEK	8200 E PAWNEE ST WICHITA, KS 67207

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S3085	Continued From page 1	S3085		

and failed to ensure the "NSA" for R101, R103, and R105 identified the provider of services for dressing.

Findings included:

- Record review for R103 revealed an admission date of 06/27/23 with diagnoses of type two diabetes mellitus and hypertension.

The 11/08/24 "FCS" identified R103 required physical assistance with dressing and was incontinent of bladder.

The 11/08/24 "NSA" identified R103 was provided morning and evening assistance with dressing. She had an indwelling unrinary catheter in place with services for maintenance and care provided by home health.

R103's "NSA" failed to identify the provider for assistance with dressing and failed to describe services provided by facility staff for the indwelling urinary catheter.

Review of the 11/2024 "Medication Administration Record" for R103 revealed facility staff documented her indwelling urinary catheter bag was emptied as needed three times daily.

On 12/03/24 at 10:18 AM Administrative Nurse C stated facility staff provided encouragement to R103 to keep her catheter bag below the level of her bladder, emptying of catheter bag every two hours, and reporting to the nurse if they observed sediment in her urine. Administrative Nurse C confirmed these services were not described on R103's "NSA."

On 12/03/24 at 10:33 AM Administrative Staff B

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087043	A. BUILDING: _____ B. WING _____	12/03/2024

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CARRINGTON AT CHERRY CREEK	8200 E PAWNEE ST WICHITA, KS 67207

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S3085	Continued From page 2	S3085		

confirmed R103's "NSA" failed to identify the provider for assistance with dressing.

The administrator failed to ensure the "NSA" for R103 described the services provided for an indwelling catheter and identified the provider of services for dressing.

- Record review for R101 revealed an admission date of 08/15/23 with diagnoses of dementia, bipolar disorder, and alcohol abuse.

The 11/26/24 "FCS" identified R101 required physical assistance with dressing.

The 11/26/24 "NSA" " identified R101 was provided morning and evening assistance with dressing.

The "NSA" failed to to identify the provider for assistance with dressing.

On 12/03/24 at 10:33 AM Administrative Staff B confirmed R101's "NSA" failed to identify the provider for assistance with dressing.

The adminstrator failed to ensure the "NSA" for R101 indentified the provider of services for dressing.
- Record review for R105 revealed an admission date of 08/18/23 with a diagnosis of diabetes mellitus.

The 08/21/24 "FCS" identified R105 required physical assistance with dressing.

The 08/21/24 "NSA" identified R105 was provided assistance with dressing morning and evening.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087043	A. BUILDING: _____ B. WING _____	12/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRINGTON AT CHERRY CREEK	8200 E PAWNEE ST WICHITA, KS 67207

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S3085	Continued From page 3 The "NSA" failed to to identify the provider for assistance with dressing. On 12/03/24 at 10:35 AM Administrative Staff B confirmed R105's "NSA" failed to identify the provider for assistance with dressing. The facility's undated "Negotiated Service Agreement" policy documented the "NSA" shall describe the services provided and indentify the provider of the service or services. The administrator failed to ensure the "NSA" for R103 described the services provided for an indwelling catheter, and failed to ensure the "NSA" for R101, R103, and R105 identified the provider of services for dressing.	S3085		
S3101 SS=E	26-41-202 (h) NSA Signatures (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. This REQUIREMENT is not met as evidenced by: KAR 26-41-202(h) The facility reported a census of 101 residents with six residents included in the sample. Based on interview and record review the administrator failed to ensure designated staff ensured each individual involved in the development of the "Negotiated Service Agreements" (NSA) signed	S3101		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087043	A. BUILDING: _____ B. WING _____	12/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRINGTON AT CHERRY CREEK	8200 E PAWNEE ST WICHITA, KS 67207

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S3101	Continued From page 4	S3101		

the agreements for Residents (R) 101, R103, and R105.

Findings included:

- Record review for R101 revealed an admission date of 08/15/23 with diagnoses of dementia, bipolar disorder, and alcohol abuse.

The 11/26/24 "Functional Capacity Screen" (FCS) identified R101 required physical assistance with bathing, dressing, management of medications and treatments; and was marked at risk for falls and inappropriate behavior.

The 11/26/24 "NSA" identified facility staff provided R101 stand-by assistance three times a week and as needed for bathing; partial assistance for dressing in the morning and evening; management of medications and treatments; encouragement to use proper footwear to prevent injury from falls; and monitoring and redirection as needed when under the influence of alcohol.

The "NSA" documented one electronic signature by Administrative Nurse D and lacked signatures by all others involved including the resident or her legal representative.

On 12/03/24 at approximately 10:35 AM Administrative Nurse D confirmed R101's "NSA" lacked the signatures of each individual involved in its development.

The administrator failed to ensure designated staff ensured each individual involved in the development of R101's "NSA" signed it.

- Record review for R103 revealed an admission

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087043	A. BUILDING: _____ B. WING _____	12/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRINGTON AT CHERRY CREEK	8200 E PAWNEE ST WICHITA, KS 67207

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S3101	Continued From page 5	S3101		

date of 06/27/23 with diagnoses of type two diabetes mellitus and hypertension.

The 11/08/24 "FCS" identified R103 required physical assistance with bathing, dressing, toileting, management of medications and treatments; was incontinent of bladder; and she was marked at risk for falls.

The 11/08/24 "NSA" identified facility staff provided R103 assistance three times and as needed for bathing; assistance as needed for toileting; management of medications and treatments; an indwelling catheter was in place for bladder incontinence; and staff encouraged the use of a walker to prevent injury from falls.

The "NSA" documented one electronic signature by Administrative Nurse D and lacked signatures by all others involved including the resident or her legal representative.
On 12/03/24 at approximately 10:35 AM Administrative Nurse D confirmed R103's "NSA" lacked the signatures of each individual involved in its development.

The administrator failed to ensure designated staff ensured each individual involved in the development of R103's "NSA" signed it.
- Record review for R105 revealed an admission date of 08/18/23 with a diagnosis of type two diabetes mellitus.

The 08/21/24 "FCS" identified R105 required physical assistance with bathing, dressing, management of medications and treatments, and was marked at risk for falls, inappropriate behavior, and impaired decision-making.

The 08/21/24 "NSA" identified facility staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087043	A. BUILDING: _____ B. WING _____	12/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRINGTON AT CHERRY CREEK	8200 E PAWNEE ST WICHITA, KS 67207

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S3101	Continued From page 6 provided R105 assistance with bathing; assistance with dressing; management of medications and treatments; and staff encouraged the use of a walker, cane or wheelchair for long distance to prevent injury from falls; provided redirection when he displayed inappropriate behaviors and with decision-making. The "NSA" documented one electronic signature by Administrative Nurse D and lacked signatures by all others involved including the resident or her legal representative. On 12/03/24 at approximately 10:35 AM Administrative Nurse D confirmed R105's "NSA" lacked the signatures of each individual involved in its development. The administrator failed to ensure designated staff ensured each individual involved in the development of R105's "NSA" signed it. The facility's undated "Negotiated Service Agreement" documented "each individual involved in the development of the negotiated service agreement shall sign the agreement." The administrator failed to ensure designated staff ensured each individual involved in the development of the "NSA" signed the agreements for R101, R103, and R105.	S3101		
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	S3186		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087043	A. BUILDING: _____ B. WING _____	12/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRINGTON AT CHERRY CREEK	8200 E PAWNEE ST WICHITA, KS 67207

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S3186	Continued From page 7	S3186		

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.

This REQUIREMENT is not met as evidenced by:
KAR 26-41-205(b)

The facility reported a census of 101 residents with six residents included in the sample. Based on observation, interview, and record review the administrator failed to ensure Resident (R) 102, R103, R105, and R106's "Negotiated Service Agreements" (NSA) identified who was responsible for the administration and management of select medications.

Findings included:

- Record review for R102 revealed an admission date of 08/28/24 with diagnoses of bipolar disorder and hepatitis C.

The 11/06/24 "Functional Capacity Screen" (FCS) identified R102 required physical assistance with management of medications.

The 11/06/24 "NSA" identified facility staff provided management of medications.

The 08/28/24 "Physician's Order" documented give Zenpep two capsules by mouth three times a day for hepatitis C unsupervised

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087043	A. BUILDING: _____ B. WING _____	12/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRINGTON AT CHERRY CREEK	8200 E PAWNEE ST WICHITA, KS 67207

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S3186	Continued From page 8	S3186		

self-administration.

The Medication Administration Record (MAR) for the month of November 2024 documented R102 self-administered her own Zenpep.

Observation on 12/03/24 at approximately 11:04 AM revealed a bottle of Zenpep in R102's apartment.

On 12/03/24 at approximately 11:04 AM R102 stated that she administered her own protonix and Zenpep which she stored in her room.

On 12/28/24 at approximately 10:07 AM Administrative Nurse C confirmed R103's "NSA" failed to identify who was responsible for administration of Zenpep medication.

The administrator failed to ensure R103's "NSA" identified who was responsible for the administration of select medications.

- Record review for R103 revealed an admission date of 06/27/23 with diagnoses of type two diabetes mellitus and hypertension.

The 11/08/24 "FCS" identified R103 required physical assistance with management of medications.

The 11/08/24 "NSA" identified facility staff provided management of medications.

The 11/08/24 "Self-Administration of Medications Assessment ALF" documented R103 self-injected insulin after a Certified Medication Aide (CMA) dialed the pen to the correct dose.

On 12/03/24 at 10:07 AM Administrative Nurse C

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087043	A. BUILDING: _____ B. WING _____	12/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRINGTON AT CHERRY CREEK	8200 E PAWNEE ST WICHITA, KS 67207

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S3186	Continued From page 9	S3186		

confirmed R103's "NSA" failed to identify who was responsible for administration of insulin.

The administrator failed to ensure R103's "NSA" identified who was responsible for the administration of select medications.

- Record review for R105 revealed an admission date of 08/18/23 with a diagnosis of diabetes mellitus.

The 08/21/24 "Functional Capacity Screen" (FCS) documented R105 required physical assistance from staff with the management of his medications.

The 08/21/24 "Negotiated Service Agreement " documented staff administered R105's medications.

The 08/21/24 "Self Administration of Medications Assessment ALF" documented R105 self-injected insulin after a Certified Medication Aide (CMA) dialed the pen to the correct dose.

On 12/03/24 at 10:35 AM Administrative Nurse C confirmed R103's "NSA" failed to identify who was responsible for administration of insulin.

The administrator failed to ensure R105's "NSA" identified who was responsible for the administration of select medications.

- Record review for R106 revealed an admission date of 04/29/20 with a diagnosis of diabetes mellitus.

The 11/12/24 "Functional Capacity Screen" (FCS) documented R106 required physical assistance from staff with the management of his

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087043	A. BUILDING: _____ B. WING _____	12/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRINGTON AT CHERRY CREEK	8200 E PAWNEE ST WICHITA, KS 67207

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S3186	Continued From page 10	S3186		

medications.

The 11/12/24 "Negotiated Service Agreement " documented staff administered R106's medications and staff dialed-up the insulin pen and gave to R106 to self-inject insulin. The NSA did not indicate R106 self-administered her Calmoseptine topical ointment.

Review of R106's record revealed a physician's order dated 11/19/24 for Calmoseptine external ointment, apply to affected areas topically every eight hours as needed for redness. Resident to self apply to affected areas, may keep in room, nursing staff to apply as needed.

Review of R106's records failed to locate a "Self Administration of Medications Assessment ALF" completed for Calmoseptine.

On 12/03/24 at 10:22 AM Administrative Nurse C confirmed R106's "NSA" failed to identify who was responsible for administration of Calmoseptine.

The administrator failed to ensure R106's "NSA" identified who was responsible for the administration of select medications.

The facility's undated "Medication Management" policy documented the "NSA" shall identify who was responsible for the management of selected medications.

The administrator failed to ensure Resident (R) 102, R103, R105, and R106's "NSA's" identified who was responsible for the administration and management of select medications.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087043	A. BUILDING: _____ B. WING _____	12/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRINGTON AT CHERRY CREEK	8200 E PAWNEE ST WICHITA, KS 67207

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S3200	Continued From page 11	S3200		
S3200 SS=D	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 101 residents. Based on interview and record review the administrator failed to ensure facility staff administered all medications to resident (R)105 in accordance with his medical care provider's orders written order. Findings included: - R105's medical record revealed he moved into the facility on 08/18/23 with a diagnosis of diabetes mellitus.	S3200		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087043	A. BUILDING: _____ B. WING _____	12/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRINGTON AT CHERRY CREEK	8200 E PAWNEE ST WICHITA, KS 67207

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S3200	Continued From page 12 The 08/21/24 "Functional Capacity Screen" (FCS) documented R105 required physical assistance from staff with the management of his medications. The 08/21/24 "Negotiated Service Agreement " documented staff administered R105's medications. Review of R105's medical record revealed a physician order dated 07/31/24 for Lantus (insulin glargine), inject five units subcutaneously at bedtime for diabetes. Notify Nurse if blood glucose is less than 60 milligrams/deciliter (mg/dl) or greater than 180 mg/dl. Hold insulin if blood glucose is less than 150 mg/dl. Review of the "Electronic Medication Administration Record" (EMAR) for November 2024 revealed qualified facility staff administered insulin when R105's blood glucose level was less than 150 mg/dl the following times: 11/01/24 at 07:00 PM with a blood glucose level of 131 mg/dl 11/11/24 at 07:00 PM with a blood glucose level of 115 mg/dl 11/16/24 at 07:00 PM with a blood glucose level of 113 mg/dl 11/22/24 at 07:00 PM with a blood glucose level of 103 mg/dl 11/30/24 at 07:00 PM with a blood glucose level of 115 mg/dl On 12/03/24 at 01:00 PM Certified Medication Aide K, after reviewing R105's November 2024 EMAR, acknowledged there were times when staff administered R105 insulin when it should have been held.	S3200		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087043	A. BUILDING: _____ B. WING _____	12/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRINGTON AT CHERRY CREEK	8200 E PAWNEE ST WICHITA, KS 67207

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S3200	Continued From page 13 On 12/03/24 at 01:40 PM Licensed Nurse D confirmed that insulin was administered to R105 when his blood sugar levels were less than 150 mg/dl and should have been held. The undated "Medication Management" policy documented, " ...ensure that all drugs are administered to each resident in accordance with a physician's written order." The administrator failed to ensure staff administered (R)105's insulin in accordance with his medical care provider's orders written order.	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 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	S3201		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087043	A. BUILDING: _____ B. WING _____	12/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S3201	Continued From page 14 by: KAR 26-41-205 (d)(3)(C) The facility reported a census of 101 residents. The sample included six residents. Based on observation, record review and interview the administrator failed to ensure that "Certified Medication Aides" (CMA) administered resident's medication according to professional standards of practice for one of six residents reviewed. This included the failure to remain with resident (R)102 until she ingested her medication. Findings included: - R102's medical record revealed she was admitted to the facility on 08/28/24 with diagnoses of restless leg syndrome and urinary incontinence. R102's "Functional Capacity Screen" (FCS) dated 11/06/24 revealed she required physical assistance with management of medications. R102's "Negotiated Service Agreement (NSA) dated 11/06/24 revealed staff administered her medications. Review of R102's medical revealed the following physician orders: 08/28/24 Ropinirole Hydrochloride 1 milligram (mg), one tablet, by mouth three times a day for restless leg syndrome 08/28/24 Tolterodine tartrate 2 mg., one tablet by mouth, two times a day for urinary incontinence 08/29/24 CMA to watch resident swallow all medications two times a day	S3201		

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	N087043	A. BUILDING: _____ B. WING _____	12/03/2024

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S3201	Continued From page 15 Review of the November and December 2024 electronic medication administration records revealed CMA staff documented they stayed with R102 until she had swallowed all her medications. Observation on 12/03/24 at 11:04 AM revealed there was a clear plastic pill cup sitting on a cabinet near the kitchen that contained two unidentified pills. On 12/03/24 at approximately 11:20 AM R102 stated a CMA the previous evening left her evening pills in her apartment since she was not in her room at that time. R102 identified the two pills as being for bladder control and restless leg syndrome. At approximately 01:50 PM Licensed Nurse D stated that it was her expectation that CMAs stay with the resident until they have swallowed their medications. The administrator failed to ensure facility CMA's administered R102's medications according to standards of practice when they failed to remain with R102 until her medication was ingested.	S3201		
S3298 SS=F	26-41-206 (d) Food Preparation (d) Food preparation. Food shall be prepared using safe methods that conserve the nutritive value, flavor, and appearance and shall be served at the proper temperature. (1) Food used by facility staff to serve to the residents, including donated food, shall meet all applicable federal, state, and local laws and regulations. (2) Food in cans that have significant defects,	S3298		

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S3298	Continued From page 16 including swelling, leakage, punctures, holes, fractures, pitted rust, or denting severe enough to prevent normal stacking or opening with a manual, wheel-type can opener, shall not be used. (3) Food provided by a resident ' s family or friends for individual residents shall not be required to meet federal, state, and local laws and regulations. This REQUIREMENT is not met as evidenced by: KAR 26-41-206(d) The facility reported a census of 101 residents. The facility had a main kitchen where food was stored, prepared, and served for the residents. Based on interview and record review, the administrator failed to ensure dietary staff served food at the proper temperature to avoid bacterial growth. Findings included: - Review of the facility's food temperature log for October revealed the last date dietary staff documented a food temperature was for the evening meal on 10/12/24. Dietary staff failed to document food temperatures for the remaining 19 days of October, which was 57 meals. Review of the facility's food temperature log for November revealed dietary staff failed to document food temperatures for 30 days, which was 90 meals. Review of the facility's food temperature log for December revealed dietary staff failed to	S3298		

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S3298	Continued From page 17 document food temperatures for four meals so far in December at the start of the survey. On 12/02/24 at approximately 10:29 AM Dietary Staff G confirmed the food temperature log lacked evidence of documentation of food temperature logs from 10/12/24 to present. The facility's undated "Dietary Services" policy documented hot foods would be held at 140 degrees Fahrenheit (F) or above and would not be served below 115 degrees F. Cold foods would be held and served at no more than 40 degrees F. Food items would be stored, prepared, displayed, distributed, and served to residents, visitors, and staff under sanitary conditions. The Kansas Department of Agriculture's "Focus on Food Safety" booklet documented "minimum hot holding temperature is 135 degrees Fahrenheit (F)." and "maximum cold holding temperature is 41 degrees F. The administrator failed to ensure dietary staff served food at the proper temperature to avoid bacterial growth.	S3298		
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	S3310		

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S3310	Continued From page 18 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: KAR 26-41-207(c) The facility reported a census of 101 residents. The sample included six residents. Based on interview and record review for six residents and five new employee records, the operator failed to ensure the facility remained in compliance with the department's tuberculosis (TB) guidelines for adult care homes adopted by reference in K.A.R. 26-39-105. This failure affected all residents who lived in the assisted living facility. Findings included: - Review of five newly hired employee files revealed the following: Review of facility personnel records revealed the following: Housekeeping staff E was hired on 08/22/24 but lacked evidence a TB Symptom Screen Questionnaire was completed. Dietary staff F was hired on 09/17/24 and did not have a TB Symptom Screen Questionnaire completed till 10/11/24, seventeen days late. Review of the personnel records revealed no	S3310		

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S3310	Continued From page 19 two-step TB skin test (TST) was completed. Certified Medication Aide (CMA) I was hired on 04/09/24 but lacked evidence a TB Symptom Screen Questionnaire was completed. A two-step TB skin test (TST) was administered on 04/29/24, thirteen days late. Certified Nurse Aide (CNA) J was hired on 05/08/24 but did not have a TB Symptom Screen Questionnaire completed until 10/11/24, 149 days late. On 12/02/24 Administrative Staff A acknowledged the personnel records lacked the information described above. The undated, "Mantoux (Tuberculosis)Testing Policy" documented, "Skin test all new ...employees as soon as ...employment begins ...Testing should be performed within seven days of ...employment ..." The policy did not address the completion of a TB Symptom Screen Questionnaire. The June 2013 "Tuberculosis (TB) Guidelines for Adult Care Homes" documented, "Each new ...employee shall have an initial TB symptom screen that includes the components of the Tuberculosis Symptom Screen Questionnaire within 7 days of ...employment. " The administrator failed to ensure the facility remained in compliance with the department's tuberculosis guidelines for adult care homes adopted by reference in K.A.R. 26-39-105.	S3310		