STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087248	A. BUILDING: _____ B. WING _____	04/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMFORTCARE HOMES 29TH #2	8629 W 29TH ST N WICHITA, KS 67205

(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 resurvey with a complaint #190666 at the above named Home Plus conducted 04/21/25 and 04/22/25.	S 000		
S5105 SS=E	26-42-202 (a) Negotiated Service Agreement a) The administrator or operator of each home plus 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: 5105 KAR 26-42-202(a)(1) The facility reported a census of 12 residents with three residents included in the sample. Based on observation, interview, and record review the operator failed to ensure the "Negotiated Service Agreement" (NSA) was fully developed based on the resident's "Functional	S5105		

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

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S5105	Continued From page 1	S5105		

Capacity Screen" (FCS), service needs, and preferences for resident (R)101 and for R102.

Findings included:

- R101's medical record revealed she moved into the facility on 09/25/22 with a diagnosis of Alzheimer's Disease.

The 09/29/24 FCS identified R101 wandered.

The 09/29/24 NSA did not address what services staff provided concerning R101's wandering.

An observation on 04/22/25 at 11:09 AM R101 ambulated without the use of an assistive device wandering around the facility and through the kitchen area.

On 04/22/25 at 11:44 AM "Certified Medication Aide" (CMA) C stated R101 wandered around the facility and at times she went into other resident's rooms if the door was open. CMA C stated some interventions in place for R101's wandering included staff to provide redirection, and take R101 to the bathroom if she seemed anxious or fidgety.

On 04/22/25 at 02:30 PM Licensed Nurse B stated R101's NSA did not address what services staff provided concerning R101's wandering.

The operator failed to ensure R101's NSA was fully developed to include all items that triggered in the FCS.

- R102's medical record revealed he moved into

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S5105	Continued From page 2 the facility on 01/14/25 with a diagnosis of dementia. The 01/14/25 FCS required physical assistance with transfers. The 01/14/25 NSA did not address the use of a bed rail for transfers. The 01/14/25 "Bed Rail/ Assist Bar Evaluation" documented the use of a bed rail to help R102 rise from a supine position to a sitting/standing position with staff assistance. An observation on 04/21/25 at 02:25 PM of R102's room revealed there was a bed rail properly attached to the resident's bed that was found to be within FDA guidelines. On 04/22/25 at 02:12 PM Licensed Nurse B acknowledged a bed rail assessment was completed for R102 but was not included on his NSA. The operator failed to ensure R102's NSA was fully developed to include service needs and preferences for the use of a bed rail.	S5105		
S5116 SS=F	26-42-202 (d) NSA revisions (d) Each administrator or operator shall ensure the review and, if necessary, revision of each negotiated service agreement according to the following requirements: (1) At least once every 365 days;(2) following any significant change in condition, as defined in K.A.R. 26-39-100; (3) at least quarterly if the resident receives	S5116		

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S5116	Continued From page 3	S5116		

assistance with eating from a paid nutrition assistant; and
(4) if requested by the resident or the resident ' s legal representative, staff, the case manager, or, if agreed to by the resident or the resident ' s legal representative, the resident ' s family.

This REQUIREMENT is not met as evidenced by:
5116
KAR 26-42-202(d)(4)

The facility reported a census of 12 residents. The sample included three residents. Based on observation, interview, and record review the operator failed to ensure the "Negotiated Service Agreement" (NSA) for resident (R)101and R102 where revised to include services staff provided for fall prevention and failed to include services staff provided for R103 concerning her inappropriate behaviors and wandering.

Findings included:

- R101's medical record revealed she moved into the facility on 09/25/22 with a diagnosis of Alzheimer's Disease.

The 09/29/24 "Functional Capacity Screen" (FCS) indicated R101 was independent with transfers and ambulation without the use of an assistive device and did not identify R101 as a fall risk and did not indicate R101 wandered.

The 09/29/24 NSA was not revised to address

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S5116	Continued From page 4	S5116		

what services staff provided R101 concerning fall prevention.

The 02/22/25 "Fall Nurse Note" documented, the nurse was notified by staff that R101 had a fall that resulted in her getting a "goose egg" to the right side of her forehead. The nurse reminded staff to keep a close eye on R101 to help keep her safe and free from falls.

The 03/27/25 "Hospice Note- Fall Follow-up Provider Note" documented R101 slid out of a leather chair located in the common area.

The 03/31/25 "Fall Nurse Note" documented R101 was observed walking around prior to hearing one of the residents yell that a resident had fallen. The nurse observed R101 to have two separate gashes to the frontal part of her forehead and was bleeding very heavily. The nurse asked staff to keep a close eye on R101 for safety.

On 04/22/25 at 11:09 AM the resident ambulated without the use of an assistive device wandering around the facility and through the kitchen area.

On 04/22/25 at 11:44 AM "Certified Medication Aide" (CMA) C stated staff have provided more standby assistance when R101 ambulated due to her unsteadiness.

On 04/22/25 at 02:30 PM "Licensed Nurse" (LN) B stated R101's NSA was not revised to include fall prevention interventions.

The operator failed to ensure designated staff revised the NSA to include fall prevention

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S5116	Continued From page 5 interventions after R101 experienced falls. - R102's medical record revealed he moved into the facility on 01/14/25 with a diagnosis of dementia. The 01/14/25 FCS indicated R102 required physical assistance with transfers and ambulation and did not identify R102. The 01/14/25 NSA was not revised to address what services staff provided R102 concerning fall prevention. The 01/20/25 "Fall follow up Nurse Note" documented the nurse reminded staff to keep a close eye on R102 and do frequent checks to help keep him safe and free from falls. The 04/14/25 "Fall Nurse Note" documented R102 was found on the floor on a fall mat in his room. His bed was in low position and the fall mat was on the floor next to his bed. The 04/15/25 "Fall follow-up Nurse Note" documented the facility nurse added a baby monitor with a video screen to the care plan to help staff be able to see if R102 was in need of help when he was in his room. An observation on 04/21/25 at 02:25 PM revealed there was a fall mat and video monitor located in R102's room. On 04/22/25 at 02:17 PM Administrative Nurse A stated R102's NSA was not revised until 04/22/25 to include interventions for falls.	S5116		

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S5116	Continued From page 6 The operator failed to ensure designated staff revised the NSA to include fall prevention interventions after R102 experienced falls. - R103's medical record revealed she moved into the facility on 03/26/25 with a diagnosis of Alzheimer's Disease. The 03/26/25 FCS indicated R103 was independent with transfers and ambulation and had severe cognitive impairment. R103 did not trigger for wandering or inappropriate behaviors. The 03/36/25 NSA was not revised to address R103's wandering or inappropriate behaviors. The 03/28/25 "New admit follow-up note" documented staff reported R103 came out of her room without clothing on and when staff tried to assist resident, she hit staff in the face. The 04/09/25 "Behavior Nurse Note" documented staff redirected R103 from trying to open the outside door when she hit and kicked at the staff. Staff notified the nurse that R103 tried to open doors to the outside at the end of the hall and at the front door. R103 had also entered other resident rooms and went through their jewelry and personal belongings. The 04/13/25 at 12:40 PM "Behavior Nurse Note" documented staff observed R103 walking behind a visitor in the home and put both fists up in the air as if she was going to hit the visitor. The 04/13/25 at 01:42 PM "Behavior Nurse Note" documented another resident's daughter showed staff a video of R103 in another resident's room	S5116		

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S5116	Continued From page 7 and attempted to get the resident out of her own room. R103 went up behind the other resident and hit her on the back. The other resident continued to tell R103 to get out of her room, R103 pushed the other resident to get out of the room. An observation on 04/21/25 at 12:19 PM revealed staff redirected R103 as she was wandering around the facility and going down hallways that did not correspond to her room. Staff redirected R103 to sit down to eat lunch. On 04/22/25 at 11:38 AM CMA C stated R103 was able to ambulate independently without any assistive devices. CMA C stated R103 tended to wander around the facility and tried to get into other resident rooms as well as the laundry room and had slapped staff in face. CMA C stated R103 required constant redirection. On 04/22/25 at 02:06 PM LN B stated R103's NSA had not been revised to include services staff provided concerning inappropriate behaviors and wandering. The operator failed to ensure designated staff revised R103's NSA to include services staff provided to address inappropriate behaviors and wandering.	S5116		
S5300 SS=E	26-42-205 (d) (1-2) Facility Administration of Medications (d) Home administration of resident ' s medications. If a home is responsible for the administration of a resident ' s medications, the administrator or operator shall ensure that all	S5300		

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S5300	Continued From page 8 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 home has responsibility. (2) Medication aides shall not administer medication through the parenteral route. This REQUIREMENT is not met as evidenced by: 5300 KAR 26-42-205(d) The facility reported a census of 12 residents with three included in the sample. Based on interview, and record review the operator failed to ensure staff followed physician instructions by not ensuring the availability and administration of medications as ordered for resident (R)101 and failed ensure designated staff adhered to professional standards of practice for medication administration when staff failed to identify the right medication and failed to correctly document medications administered for R102. Findings included: - R101's medical record revealed she moved into the facility on 09/25/22 with a diagnosis of Alzheimer's Disease.	S5300		

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S5300	Continued From page 9 The 09/29/24 "Functional Capacity Screen" (FCS) identified R101 had severely impaired cognition and was unable to manage her medications. The 09/29/24 "Negotiated Service Agreement" (NSA) documented qualified staff administered and documented all medications as ordered by a physician or primary care practitioner. R101 received hospice care services. Review of R101's medical records revealed physician orders for: Levothyroxine 25 micrograms, one tablet, by mouth, daily every morning. Sertraline 100 milligrams, one tablet, by mouth, daily at bedtime for depression. Review of the July 2024 "Electronic Medication Administration Record" (EMAR) revealed staff documented Levothyroxine as being "Declined or Skipped" on: 07/02 - 07/03 07/05 07/07 - 07/08 07/10 - 07/11 07/13 - 07/17 07/19 07/22 - 07/31 for a total of 23 days. Review of the July 2024 "Electronic Medication Administration Record" (EMAR) revealed staff documented Sertraline as being "Declined or Skipped" on: 07/05 07/07 - 07/11 07/13 - 07/19	S5300		

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S5300	Continued From page 10 07/22 - 07/24 07/26 - 07/31 for a total of 22 days. Review of the August 2024 "Electronic Medication Administration Record" (EMAR) revealed staff documented Levothyroxine as being "Declined or Skipped" on: 08/02 08/06 - 08/20 08/22 08/24 - 08/25 08/31 for a total of 20 days. Review of the August 2024 "Electronic Medication Administration Record" (EMAR) revealed staff documented Sertraline as being "Declined or Skipped" on: 08/01 - 08/02 08/05 - 08/15 08/21 for a total of 14 days. On 04/22/25 at 02:39 PM Administrative Nurse A acknowledged designated staff did not ensure R101's medications were available and administered as ordered. Administrative Nurse A stated staff did not follow procedures but instead marked the medications as unavailable and failed to notify the nurse, Director of Nursing, the hospice nurse or pharmacy about this. The "Medication Cycle Fill and Reordering" policy dated 03/10/2022 documented, "When...medications require a refill the hospice needs to be contacted directly." The operator failed to ensure medications for R101 were available and administered as ordered by the physician.	S5300		

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S5300	Continued From page 11 - R102's medical record revealed he moved into the facility on 01/25/25 with a diagnosis of dementia. - R102's medical record revealed he moved into the facility on 01/14/25 with diagnoses of dementia and heart rhythm disorders. The 01/14/25 FCS identified R102 had severely impaired cognition and was unable to manage his medications. The 09/29/24 NSA documented qualified staff administered and documented all medications as ordered by a physician or primary care practitioner. Review of R102's medical records revealed a physician's order dated 01/13/25 for Pacerone 200 milligrams, one tablet daily, by mouth for heart rhythm disorders. Review of the April 2025 "Electronic Medication Administration Record " (EMAR) revealed staff documented R102 did not receive Pacerone on the following dates: 04/03 - 04/09 04/12 04/20 for a total of 11 days. On 04/22/25 at 11:30 AM "Certified Medication Aide" (CMA) C stated when R102 admitted to the facility he brought a bottle of Paceron and when this medication was reordered, the pharmacy sent a card of amiodorone, the generic form of Pacerone. CMA C stated it seemed as though some of the staff did not understand that	S5300		

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S5300	Continued From page 12 amiodorone was the same as Paceron and that some of the staff documented it as being unavailable. CMA C stated that if a medication was unavailable, she would notify the nurse and contact the pharmacy to reorder it. On 04/22/25 at 02:17 PM Administrative Nurse A confirmed there were some CMAs who did not correctly document medication administrations of R102's medications. Administrative Nurse A confirmed CMA staff administered R102's amiodadrone but did not realize it was the same medication as Paceron and documented the Paceron as not available. The "Comfortcare Homes Medication Management and Health Care Services Employee Success Manual" revised 06/28/18 documented, "All medications will be administered following the Eight rights of Medication Administration. Staff will also adhere to the PIP (Punch, Initial, Pass) process as well." The definition of "8 Rights of Medication Administration" included right medication and right documentation. The operator failed to ensure designated staff adhered to professional standards of practice for medication administration.	S5300		