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 _____	05/07/2025

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 citations represent the findings of an Abbreviated Complaint Survey for complaints 192364, 193262, 193279, 193983, 195052 conducted on 05/05/25, 05/06/25, and 05/07/25.	S 000		
S3028 SS=E	26-41-101 (f) (3) Staff Treatment of Residents Reporting (f) (3) Each allegation of abuse, neglect, or exploitation shall be reported to the administrator or operator of the facility as soon as staff is aware of the allegation and to the department within 24 hours. The administrator or operator shall ensure that all of the following requirements are met: (A) An investigation shall be started when the administrator or operator, or the designee, receives notification of an alleged violation. (B) Immediate measures shall be taken to prevent further potential abuse, neglect, or exploitation while the investigation is in progress. (C) Each alleged violation shall be thoroughly investigated within five working days of the initial report. Results of the investigation shall be reported to the administrator or operator. (D) Appropriate corrective action shall be taken if the alleged violation is verified. (E) The department ' s complaint investigation report shall be completed and submitted to the department within five working days of the initial report. (F) A written record shall be maintained of each investigation of reported abuse, neglect, or exploitation.	S3028		

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

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S3028	Continued From page 1 This REQUIREMENT is not met as evidenced by: KAR 26-41-101(f)(3) The facility reported a census of 100 residents (R). The sample included four residents and two closed record reviews. Based on interview and record review the administrator failed to report allegations of exploitation for (R6) and an allegation of neglect (R8) to the department within 24 hours for two of the four sampled residents. Findings included: - R6 moved into the facility on 06/18/24 with diagnoses of fusion of the spine and pain. Interview on 05/07/25 at 10:27 AM Director A reported the "Functional Capacity Screen", "Negotiated Service Agreement" and the "Health Care Service Plan" were all one document (FCS/NSA/HCSP). R6's FCS/NSA/HCSP dated 12/27/24 revealed he needed physical assistance with management of his medications and medical treatments and had no cognitive impairment. It also identified qualified staff would administer his medications. Review of R6's January 2024 Medication Administration Record included the following Percocet (Narcotic) dosage and administration: Percocet 10-325 milligram tablet four time a day for pain.	S3028		

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S3028	Continued From page 2	S3028		

Review of R6's incident statement revealed he reported on Saturday morning he went to get his medication at approximately 05:00 AM and noticed the cup did not have his Percocet in it and the pill was different. He went back to talk to the "Certified Medication Aide" C and she then gave him the one he was supposed to have.

Review of CMA D's statement revealed CMA C helped her to pop out some of the medications and get them ready for morning pass. When CMA D handed R6 his medications he told her that she changed his medications and did not give him his narcotic. He told her it is the same shape but not the same medication. CMA D said something to CMA C who then reached in her personal bag and got R6 his correct medication.

Interview on 05/06/25 R6 reported he has pain all the time and takes different pain medications. He reported awhile back he noticed his Percocet did not look right and went back to tell the medication aide and then they gave me the Percocet like I am supposed to have.

Interview on 05/06/25 at approximately 03:45 PM Administrative staff A acknowledged the incident occurred on 01/26/25 and he proceeded to complete the investigation and reported the incident on 01/31/25, 5 days after the incident occurred.

The Administrator failed to ensure designated staff reported an allegation of exploitation to the department within 24 hours.

- Review of R8's medical record revealed he moved into the facility on 08/18/23 with a

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S3028	Continued From page 3	S3028		

diagnoses of schizophrenia and diabetes mellitus type II.

Interview on 05/07/25 at 10:27 AM Director A reported the "Functional Capacity Screen", "Negotiated Service Agreement" and the "Health Care Service Plan" were all one document (FCS/NSA/HCSP).

R8's FCS/NSA/HCSP revealed he needed physical assistance with bathing and dressing, was at risk for falls, had inappropriate behaviors and had no cognitive impairment. It identified staff helped with dressing and bathing, encouraged him to use an assistive device for walking, especially when drinking.

R4's record include a Brief Interview for Mental Status score of 14/15 indicating no cognitive impairment.

Review of R8's record revealed on 04/23/25 at approximately 03:30 PM the resident left the facility without telling any staff member. On the morning of 02/24/25 at 05:30 AM Certified Medication Aide E texted Administrative Nurse F and told her that R8 had not been in the facility since she started her sift on 04/23/24 at 06:00 PM. The staff notified the police on 04/24/25 at approximately 02:53 PM that the resident was missing. R8 returned to the facility on his own at 11:30 AM on 04/25/25. The record lacked documentation that the facility notified R8's family that he had left the facility and had not returned.

Interview on 05/05/25 at 04:02 PM with R8 acknowledged he left the facility awhile back and

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S3028	Continued From page 4 was gone for a few days. He stated he went to a friend's house and saw on the news that he was missing and figured he better head back home. Interview on 05/05/25 at 04:55 PM Administrative Staff B reported they got the call that he wasn't back and it had been 24 hours so they called the police and probably should have reported it to the state department. Review of the undated missing resident policy and procedure revealed when a resident is missing staff needed to look for the resident inside and outside of the facility, notify te Resident Director and once 30 minutes had passed, fmaily should be notified and the police should be contacted. The policy failed to identify when staff needed to contact the state department. The Administrator failed to ensure designated staff notified the state department within 24 hours of identifying a missing resident.	S3028		