STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087137	A. BUILDING: _____ B. WING _____	06/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLSPRINGS OF WICHITA LLC	6311 E MARJORIE ST WICHITA, KS 67208

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S 000	INITIAL COMMENTS The following citations represent the findings of the licensure resurvey for the above named facility conducted on 06/24/25 and 06/25/25.	S 000		
S3026 SS=J	26-41-101 (f) (1) Staff Treatment of Residents ANE (f)The administrator or operator shall ensure that all of the following requirements are met: (1) No resident shall be subjected to any of the following: (A) Verbal, mental, sexual, or physical abuse, including corporal punishment and involuntary seclusion; (B) neglect; or (C) exploitation. This REQUIREMENT is not met as evidenced by: K.A.R. 26-41-101 (f) (1) (B) The facility reported a census of 8 residents. The sample included 3 "Residents'" (R)Based on interview and record review the Operator failed to protect cognitively impaired R1 from neglect, when facility staff failed to physically observe R1 after dinner at approximately 05:00 PM on 05/30/25 until approximately 08:00 AM on 05/31/25 when facility staff were unable to find him for the morning meal. Local law enforcement notified the facility on 05/31/25 at 01:45PM reporting R1 had been found and was being taken to the local hospital for evaluation and treatment. This placed R1 in immediate jeopardy for neglect, when for approximately for 20.75 hours, until R1 was located approximately 2	S3026		

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

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S3026	Continued From page 1	S3026		

miles from the facility.

Findings included:

- Record review for R1 revealed an admission date of 10/09/24 with diagnoses of dementia, altered mental status, and self-care deficit.

R1's "Functional Capacity Screen" dated 10/09/24 revealed R1 required supervision with bathing and dressing and physical assistance with toileting. R1 was independent with transferring, walking/mobility and eating. R1 lacked the ability to manage his own medications and was occasionally incontinent. R1 was identified to have impaired short-term memory, impaired long-term memory, impaired memory recall and decision making. R1 was usually able to make himself understood and he usually understood others. R1 was marked at risk for impaired decision making and used no walking assistive device.

R1's "Negotiated Service Agreement" (NSA) dated 10/09/24 identified the facility would provide moderate physical assistance with bathing and toileting, reminders for meals, and management of medications. Under the section titled "Safety" "1" resident was identified to be "disoriented and confused at times or always" and "5" Resident required status checks. Under the Section titled "Wandering/Elopement Assessment" R1 was not identified as an elopement risk.

R1's "Health Service Plan" (HSP) dated 10/09/24 instructed facility staff to "Spot Check" R1; "Resident will remain safe and accounted for

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within the premises. Staff will check on resident to promote safety and ensure resident's needs are being met.

Review of the facility provided document titled "Report of Examination and Evaluation for Guardian and/or Conservatorship" dated 05/22/24 and signed by the medical provider revealed R1 had a diagnosis of dementia and had been at a local homeless shelter. The provider assessed R1 was "disheveled" in appearance, easily confused, and a risk to himself. Under the assessor's findings it was marked that R1 did not have the capacity to meet essential needs for his physical health, safety or welfare and was an adult with impairment.

Review of the facility provided, electronic "Medical Record" "Observation Notes" revealed the nurse entered a note on 05/31/25 at 09:45 PM that R1 had returned to the facility via non emergent transport. He had been seen at the hospital for a fall and altered mental stats. "Resident had eloped the evening prior (05/30/25).

Facility provided, undated document, titled "Complaint Investigation Witness Statement of Facts" signed by "Certified Nurse Aide" (CNA) A revealed that around 05:00 PM he observed R1 "take a few bites" at dinner time, and "headed off back to his room", CNA A continued to write "I assumed" R1 "was in his room sleeping".

Facility provided, untitled document, that was handwritten and signed by CNA B dated 05/31/25 revealed CNA B arrived to work at approximately 08:00 PM and it was reported to

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her that R1 was asleep in his bed. She wrote "at 09:00PM checked on all residents. Everyone was still asleep" except two residents who needed assistance to go to the bathroom. CNA B continued to write that when the night shift person arrived, she reported to them that all residents were asleep.

Facility provided copies of a text message dated 05/31/25 from CNA F to Operator revealed upon her arrival to work at 10:00 PM the door was locked, and the alarms were on. CNA F wrote that it was reported to her that R1 was asleep and that she decided not "wake him", and "Didn't look in on him".

Facility provided document titled "Complaint Investigation Witness Statement of Facts" signed by "Certified Nurse Aide" (CNA) C dated 05/31/25 revealed she clocked in at 05:58 AM and the front door was locked, and that the "back gate was not hooked close". CNA C wrote that she physically checked and observed seven residents, and she did not open the door to R1's room to physically observe him. CNA C wrote that after preparing breakfast she went to get R1 from his room and noticed he was not in bed. She looked for R1 in the facility and then outside of the facility. She notified Operator D at 08:07 AM and called 911 at 08:09 AM.

Review of the facility provided investigation revealed the following:
On 05/30/25 R1 was observed by a passerby "falling in the street" approximately 0.6 miles from the facility on a busy 4 lane street with a speed limit of 40 miles per hour. The observer called 911 and the local ambulance service

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transported R1 to a local hospital at approximately 06:45 PM then released from the local emergency room at approximately 11:30 PM "reportedly in stable condition but very confused". He was placed in an Uber by hospital staff and directed the Uber driver to take R1 to a destination that had no specific address. "The Uber driver ultimately returned him to the hospital due to the resident's confusion and the unsafe nature of discharging him to an unknown location at night".

A "Silver Alert" was issued on 05/31/25 at 12:45 PM

On 05/31/25 at approximately 01:45 PM local law enforcement notified the facility that R1 had been located in a local park approximately 2.3 miles from the facility. The outside temperature ranged from 90 degrees Fahrenheit at 04:53 PM on 05/30/25, to 53 degrees Fahrenheit at 05:53 AM on 05/31/25, and to 75 degrees Fahrenheit at 01:53 PM on 05/31/25 per Wunderground.com.

Facility investigation interview with R1 revealed he wanted to go to a local fast-food restaurant that was located down the street from the facility approximately 0.6 miles. He told Operator D that he went out the back sliding glass door. He then pushed on the gate door "very hard" to open the gate.

Operator D was notified on 06/24/25 at approximately 10:20 AM that R1 had been in been placed in immediate jeopardy when facility staff neglected to physically check on resident to promote safety and security when they were unaware that R1 left the facility on 05/30/25

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S3026	Continued From page 5 without staff knowledge at approximately 05:00 PM and his absence was not discovered until approximately 08:00 AM on 05/31/25. Staff neglected to check on R1 for approximately 15 hours. Facility staff were unaware of R1's location from approximately 08:00 AM on 05/31/25 to 01:45 PM on 05/31/25 when the local law enforcement notified the facility, they had found the resident and sent him to the local hospital for evaluation. The immediate jeopardy was removed on 05/31/25 at 01:45 PM based on the facility's removal plan which included the following actions: The facility enlisted the assistance of local law enforcement to help look for R1, local law enforcement found R1 on 05/31/25 at approximately 01:45 PM. The lock on the back door was checked and secured. A motion detector was put in place in R1's room and staff educated on how to use the detector. Empty hamburger wrappers from the local fast-food restaurant were obtained and staff instructed to wrap a hamburger in it for R1 if there was no staff available to go get him a hamburger from the local fast food restaurant. Staff education on performing 10-minute checks on resident R1 for 48 hours and then 20 minutes for 48 hours, then hourly thereafter. All exits were secured with door alarms and audible alerts.	S3026		

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S3026	Continued From page 6 On 06/02/25 staff were educated on the new policy and procedures of "Walking Rounds" to add, every resident must be "seen and touched" during the rounding process.	S3026		