STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087285	A. BUILDING: _____ B. WING _____	07/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RESIDENCE BEGONIA II AT CRESTVIEW HOUSE 3	1406 N. STRATFORD LN 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 The following citations represent the findings of the licensure resurvey for the above named facility conducted on 07/14/25.	S 000		
S 225 SS=D	26-39-102 (a) Admission Policy (a) Each licensee, administrator, or operator shall develop written admission policies regarding the admission of residents. The admission policy shall meet the following requirements: (1) The administrator or operator shall ensure the admission of only those individuals whose physical, mental, and psychosocial needs can be met within the accommodations and services available in the adult care home. (A) Each resident in a nursing facility or nursing facility for mental health shall be admitted under the care of a physician licensed to practice in Kansas. (B) The administrator or operator shall ensure that no children under the age of 16 are admitted to the adult care home. (C) The administrator or operator shall allow the admission of an individual in need of specialized services for mental illness to the adult care home only if accommodations and treatment that will assist that individual to achieve and maintain the highest practicable level of physical, mental, and psychosocial functioning are available. (2) Before admission, the administrator or operator, or the designee, shall inform the prospective resident or the resident ' s legal representative in writing of the rates and charges for the adult care home's services and of the resident's obligations regarding payment. This information shall include the refund policy of the	S 225		

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
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S 225	Continued From page 1 adult care home.(3) At the time of admission, the administrator or operator, or the designee, shall execute with the resident or the resident ' s legal representative a written agreement that describes in detail the services and goods the resident will receive and specifies the obligations that the resident has toward the adult care home. (4) An admission agreement shall not include a general waiver of liability for the health and safety of residents. (5) Each admission agreement shall be written in clear and unambiguous language and printed clearly in black type that is 12-point type or larger. This REQUIREMENT is not met as evidenced by: K.A.R. 26-39-102 (a) (2) The facility reported a census of 3 "Residents'" (R). Based on record review and interview the Operator failed ensure prior to R2's admission the resident or the residents's legal representative was informed in writing of the rates and charges for the adult care home's services and of R2's obligations regarding payment. Findings included: - Record review for R2 revealed an admission date of 01/03/25 with diagnoses of seizure disorder, anxiety, current smoker, memory loss and hand tremors.	S 225		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S 225	Continued From page 2 Review of the facility provided document titled "Resident Agreement" dated 01/02/25 under section E. "Binding Agreement" "VII. Summary of Charges" lacked documentation of R2's obligation regarding rates and charges for services he would receive from the facility. Interview on 07/14/25 at approximately 04:15 PM with Operator/Registered Nurse B confirmed the "Resident Agreement" lacked documentation of R2's obligation regarding rates and charges for services he would receive from the facility. The Operator failed ensure prior to R2's admission the resident or the residents's legal representative was informed in writing of the rates and charges for the adult care home's services and of R2's obligations regarding payment.	S 225		
S5040 SS=F	26-42-101 (j) Emergency Telephone (j) Emergency telephone. Each administrator or operator shall ensure that the residents and employees have access to a telephone for emergency use at no cost. Each administrator or operator shall ensure that the names and telephone numbers of persons or places commonly required in emergencies are posted adjacent to this telephone. This REQUIREMENT is not met as evidenced by: K.A.R. 26-42-101 (j) The facility reported a census of 3 residents. Based on observation and interview the Operator	S5040		

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S5040	Continued From page 3 failed to ensure the names and numbers of persons or places commonly required in emergencies was posted adjacent to the telephone in the common living room. Findings included: - Observation on 07/14/25 at approximately 09:45 AM of the common living area in the northwest corner of the room next to the sliding glass doors was a desk with a black cordless phone sitting on the right corner of the desk. The area lacked a posting of name and numbers of persons or places commonly required in emergencies. Interview on 07/14/25 at approximately 04:17 PM with Operator/"Registered Nurse" (RN) B and "Certified Nurse Aide" (CNA) A confirmed during the facility tour, the area in the common living room next to the black cordless phone lacked a posting of persons or places commonly required in emergencies was posted, and CNA A further confirmed she placed the names and numbers in the area of the black cordless phone during the survey process. The Operator failed to ensure the names and numbers of persons or places commonly required in emergencies was posted adjacent to the telephone in the common living room.	S5040		
S5171 SS=D	26-42-204 (i) Health Care Services Standards of Practice (i) All health care services shall be provided to residents by qualified staff in accordance with	S5171		

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S5171	Continued From page 4 acceptable standards of practice. This REQUIREMENT is not met as evidenced by: K.A.R. 26-42-204 (i) The facility reported a census of 3 "Residents'" (R). Based on observation, interview, and record review the Operator/Registered Nurse failed to ensure health care services were provided within professional standards of practice when the Operator/Registered Nurse failed to ensure an assessment was performed for R1 showing R1's bed assist device posed no risk for entrapment, was securely attached to the bed, confirmed the device was not a restraint, and R1's ability to safely use the bed assist device. Findings included: - Record review for R1 revealed an admission date of 01/02/25 with diagnoses of Schizophrenia, Rheumatoid arthritis, and diabetes. Review of R1's "Functional Capacity Screen" (FCS) dated 01/02/25 revealed R1 required physical assistance with bathing, dressing, toileting, and supervision with walking and eating. R1 was independent with transferring. R1 lacked the ability to manage her own medications and medical treatments and was incontinent. R1 was marked with impaired short-term memory, long-term memory, memory recall, and decision making. She was usually able to make herself understood and she sometimes understood others. R1 was marked at risk for impaired vision, impaired hearing, socially inappropriate	S5171		

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S5171	Continued From page 5	S5171		

disruptive behavior, and impaired decision making. R1 used a walker or cane mobility device.

The comments section of R1's FCS lacked documentation of a bed assist device.

Review of R1's "Negotiated Service Agreement" (NSA) dated 01/03/25 identified the facility would provide health care services for physical assistance with bathing, dressing, toileting and physically assist as needed for walking/mobility. The facility staff would provide reorientation, cueing or redirection as needed and manage R1's medications.

Review of R1's "Health Service Plan" dated 01/03/25 identified R1 used a walker and a cane.

R1's NSA and HSP lacked a description of the device, its purpose and any special instructions on use and monitoring of the device.

Review of the facility provided document titled "Side-Rail Use Assessment Form" was dated 07/14/25.

Observation on 07/14/25 at approximately 12:30 PM of R1's room revealed the head of her bed was next to the southeast wall of the room and the left side of the bed was on the east wall. On the right side of the bed was an inverted "U" shaped bed assist device that slid under the mattress and freely moved. The device measured 20.5 inches in width, with a large opening between the two down bars that measured from the top of the device to the bed frame approximately 16 inches.

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S5171	Continued From page 6 Interview on 07/14/25 at approximately 04:16 PM with Operator/Registered Nurse B confirmed the bed assist device assessment was performed on 07/14/25, and the maintence man secured the device to the bed on 07/14/25. The FDA (food and drug administration) "Bedrails in Assisted Living, Residential Health Care and Home Plus Facilities" recommended the following: Complete an assessment of the resident to confirm that the device is not a restraint. Complete an assessment of the resident to determine the purpose of the device and the resident's ability to safely use the device and document the findings in the resident's record. Complete an assessment of the device using the recommendations in the FDA guidance to ensure the device is securely attached to the bed or bedframe and poses no risk for entrapment and document the findings in the resident record. If the purpose of the device is to assist the resident with transfers, the FCS should document the resident's functional capacity based on the use of the device and should be listed in the comments section. Include a description of the device, its purpose and special instructions on use and monitoring in the resident's NSA. Document periodic reassessments of the resident's use of the device and their ability to	S5171		

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S5171	Continued From page 7 use it safely and reassessment of the safety of the device in the resident's record. The Operator/Registered Nurse failed to ensure health care services were provided within professional standards of practice when the Operator/Registered Nurse failed to ensure an assessment was performed for R1 showing R1's bed assist device posed no risk for entrapment, was securely attached to the bed, confirmed the device was not a restraint, and R1's ability to safely use the bed assist device.	S5171		
S5215 SS=F	26-42-104 (d) Disaster and Emergency Preparedness Education (d) Each administrator or operator shall ensure disaster and emergency preparedness by ensuring the performance of the following: (1) Orientation of new employees at the time of employment to the home ' s emergency management plan; (2) education of each resident upon admission to the home regarding emergency procedures; (3) quarterly review of the home ' s emergency management plan with employees and residents; and (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. This REQUIREMENT is not met as evidenced by: K.A.R. 26-42-104 (d) (1) (2) (3)	S5215		

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S5215	Continued From page 8 The facility reported a census of 3 "Residents'" (R) and 4 newly hired employees. Based on record review and interview the Operator failed ensure disaster and emergency preparedness by ensuring the performance of the following; Orientation of new employees a the time of employment to the home's emergency management plan; Education of each resident upon admission to the home regarding emergency procedures; and a quarterly review of the home's Emergency Management Plan with employees and residents. Findings included: - Record review for R1 revealed an admission date of 01/02/25 with diagnoses of Schizophrenia, Rheumatoid arthritis, and diabetes. Review of R1's facility provided document titled "Resident Agreement" dated 01/02/25 revealed the following, Section "G. Security and Fire Protection/Natural Disasters and Emergencies"; "The house will be furnished with smoke detectors and extinguishers in appropriate locations deemed necessary by the State Fire Marshall'. The facility would conduct routine drills for fire and tornado. Escape systems will be displayed in a common location for residents, visitors, family, and any outside agencies to view for their safety. In the event of a natural disaster facility staff will be able to assist you outside the home or to a point of safety "according to its Emergency Management Plan". - Record review for R2 revealed an admission	S5215		

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S5215	Continued From page 9 date of 01/03/25 with diagnoses of seizure disorder, anxiety, current smoker, memory loss and hand tremors. Review of R2's facility provided document titled "Resident Agreement" dated 01/02/25 revealed the following, Section "G. Security and Fire Protection/Natural Disasters and Emergencies"; "The house will be furnished with smoke detectors and extinguishers in appropriate locations deemed necessary by the State Fire Marshall'. The facility would conduct routine drills for fire and tornado. Escape systems will be displayed in a common location for residents, visitors, family, and any outside agencies to view for their safety. In the event of a natural disaster facility staff will be able to assist you outside the home or to a point of safety "according to its Emergency Management Plan". - Record review for R3 revealed an admission date of 01/02/25 with diagnoses of acquired hemolytic anemia, bipolar disorder, adjustment disorder with anxiety, and insomnia. Review of R3's facility provided document titled "Resident Agreement" dated 01/02/25 revealed the following, Section "G. Security and Fire Protection/Natural Disasters and Emergencies"; "The house will be furnished with smoke detectors and extinguishers in appropriate locations deemed necessary by the State Fire Marshall'. The facility would conduct routine drills for fire and tornado. Escape systems will be displayed in a common location for residents, visitors, family, and any outside agencies to view for their safety. In the event of a natural disaster facility staff will be able to assist you outside the	S5215		

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S5215	Continued From page 10 home or to a point of safety "according to its Emergency Management Plan". Record review of the facility provided document titled "Employee Safe Working Practices Agreement" revealed the employee agreed to follow established "Home/Operator safety policies and procedures." Record review of the facility provided binder titled Policies and Procedures dated 03/18/24, revealed the facility's "Emergency/Natural Disaster" plan. The plan/policy lacked documentation of the required frequency of education/orientation of the Emergency Management Plan. Interview on 07/14/25 at approximately 04:16 PM with Operator/Registered Nurse B and "Certified Nurse Aide" (CNA) A, confirmed the facility lacked documentation of the facility's emergency management plan education being provided to residents upon admission to the facility, CNA A continued to confirm the facility lacked documentation of orientation to the facility's emergency management plan upon hire, and she further confirmed the facility had not had a quarterly review of the facility's emergency management plan since the facility had admitted the residents on 01/02/25. The Operator failed ensure disaster and emergency preparedness by ensuring the performance of the following; Orientation of new employees a the time of employment to the home's emergency management plan; Education of each resident upon admission to the home regarding emergency procedures; and a	S5215		

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S5215	Continued From page 11 quarterly review of the home's Emergency Management Plan with employees and residents.	S5215		
S5265 SS=D	26-42-205 (a) (1) Medication Self Administration Assessment (a) Self-administration of medication. Any resident may self-administer and manage medications independently or by using a medication container or syringe prefilled by a licensed nurse or pharmacist or by a family member or friend providing this service gratuitously, if a licensed nurse has performed an assessment and determined that the resident can perform this function safely and accurately without staff assistance. (1) An assessment shall be completed before the resident initially begins self-administration of medication, if the resident experiences a significant change of condition, and annually. This REQUIREMENT is not met as evidenced by: K.A.R. 26-42-205 (a) The facility reported a census of 3 "Residents'" (R). Based on observation, interview, and record review the Operator/Registered Nurse failed to ensure an assessment was performed for R1 that determined she could safely and without staff assistance self-administer her provider prescribed treatment of Triamcinolone 0.1%	S5265		

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S5265	Continued From page 12 cream to be applied every morning. Findings included: - Record review for R1 revealed an admission date of 01/02/25 with diagnoses of Schizophrenia, Rheumatoid arthritis, and diabetes. Review of R1's "Functional Capacity Screen" (FCS) dated 01/02/25 revealed R1 required physical assistance with bathing, dressing and toileting. R1 was independent with transferring and required supervision with Walking and eating. R1 lacked the ability to manage her own medications and medical treatments. R1 was incontinent and had impaired short-term memory, long term memory, memory recall and decision making. She was usually able to make herself understood and she sometimes understood others. R2 was marked with impaired vision, impaired hearing, socially inappropriate disruptive behavior and impaired decision making. R1 used a cane or walker mobility devices. Review of R1's "Negotiated Service Agreement" (NSA) dated 01/03/25 under the section titled "Health Care Services;" R1's medications were to be administered by the "Certified Mediation Aide" (CMA), "Licensed Nurse" (LN) or the "Registered Nurse" (RN). The management of "Medical Treatments" was to be performed by "staff and outside agency". Record review of the facility provided "Medication Administration Record" (MAR)	S5265		

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S5265	Continued From page 13	S5265		

revealed the following; an order for Triamcinolone 0.1% cream to be applied every morning.

The record included CMA initials as being administered.

Record review of the facility provided document titled "Active Medications" for R1 revealed the following order; Triamcinolone 0.1% cream, apply a thin layer of cream to the affected area every morning.

The order lacked documentation from the provider for R1 to self-administer this treatment.

Observation on 07/14/25 at approximately 01:15 PM of R1's bed, the head of the bed was in the southeast corner of the room and the left side of the bed was against the east wall of the room, and sitting next to the wall on the bed were two jars of Triamcinolone cream 0.1% that included the pharmacy label sitting next to the wall.

Interview on 07/14/25 at approximately 04:16 PM with Operator / Registered Nurse B confirmed the medical record for R1 lacked an assessment determining R1 could safely and without staff assistance self-administer the provider ordered Triamcinolone 0.1% cream.

Review of the facility provided binder titled Policy and Procedures dated 03/18/24, revealed the following on page 6;

"Self - administration of Medications K.A.R. 26-41-205(a) Resident may self-administer and manage medications independently or by using a

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S5265	Continued From page 14 medication container or syringe prefilled by a licensed nurse or pharmacist or by a family member or friend providing this service gratuitously, if a licensed nurse has performed an assessment and determined that the resident can perform this function safely and accurately without staff assistance. Resident clinical record shall contain documentation of the assessment and the determination. The Operator/Registered Nurse failed to ensure an assessment was performed for R1 that determined she could safely and without staff assistance self-administer her provider prescribed treatment of Triamcinolone 0.1% cream to be applied every morning.	S5265		
S5286 SS=D	26-42-205 (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 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: K.A.R. 26-42-205 (b) The facility reported a census of 3 "Residents'" (R). Based on observation, interview, and record review the Operator/Registered Nurse failed to	S5286		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087285	A. BUILDING: _____ B. WING _____	07/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RESIDENCE BEGONIA II AT CRESTVIEW HOUSE 3	1406 N. STRATFORD LN 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
S5286	Continued From page 15 ensure R1's "Negotiated Service Agreement" (NSA) identified who was responsible for the administration of the provider prescribed treatment of Triamcinolone 0.1% cream to be applied every morning. Findings included: - Record review for R1 revealed an admission date of 01/02/25 with diagnoses of Schizophrenia, Rheumatoid arthritis, and diabetes. Review of R1's "Functional Capacity Screen" (FCS) dated 01/02/25 revealed R1 required physical assistance with bathing, dressing and toileting. R1 was independent with transferring and required supervision with Walking and eating. R1 lacked the ability to manage her own medications and medical treatments. R1 was incontinent and had impaired short-term memory, long term memory, memory recall and decision making. She was usually able to make herself understood and she sometimes understood others. R1 was marked with impaired vision, impaired hearing, socially inappropriate disruptive behavior, and impaired decision making. R1 used a cane or walker mobility devices. Review of R1's NSA dated 01/03/25 under the section titled "Health Care Services;" R1's medications were to be administered by the "Certified Mediation Aide" (CMA), "Licensed Nurse" (LN) or the "Registered Nurse" (RN). The management of "Medical Treatments" was to be performed by "staff and outside agency".	S5286		

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S5286	Continued From page 16 Record review of the facility provided "Medication Administration Record" (MAR) revealed the following; an order for Triamcinolone 0.1% cream to be applied every morning. The record included CMA initials as being administered. Record review of the facility provided document titled "Active Medications" for R1 revealed the following order; Triamcinolone 0.1% cream, apply a thin layer of cream to the affected area every morning. The order lacked documentation from the provider for R1 to self-administer this treatment. Observation on 07/14/25 at approximately 01:15 PM of R1's bed, the head of the bed was in the southeast corner of the room and the left side of the bed was against the east wall of the room, and sitting next to the wall on the bed were two jars of Triamcinolone cream 0.1% that included the pharmacy label sitting next to the wall. Interview on 07/14/25 at approximately 04:16 PM with Operator / Registered Nurse B confirmed the NSA for R1 lacked identification of who was responsible for administering the Triamcinolone 0/1% cream. Review of the facility provided binder titled Policy and Procedures dated 03/18/24, revealed the following on page 6; "Self -administration of Medications K.A.R.	S5286		

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S5286	Continued From page 17 26-41-205(a) Resident may self-administer and manage medications independently or by using a medication container or syringe prefilled by a licensed nurse or pharmacist or by a family member or friend providing this service gratuitously, if a licensed nurse has performed an assessment and determined that the resident can perform this function safely and accurately without staff assistance. Resident clinical record shall contain documentation of the assessment and the determination. The Operator/Registered Nurse failed to ensure R1's "Negotiated Service Agreement" (NSA) identified who was responsible for the administration of the provider prescribed treatment of Triamcinolone 0.1% cream to be applied every morning.	S5286		
S5300 SS=F	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 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.	S5300		

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S5300	Continued From page 18 This REQUIREMENT is not met as evidenced by: K.A.R. 26-42-205 (d) The facility reported a census of 3 "Residents'" (R). Based on interview and record review the Operator/Registered Nurse failed to ensure that all medications were administered to each resident in accordance with a medical care providers written order and within professional standards of practice for R1, R2, and R3 when the electronic "Medication Administration Record" (MAR)s lacked documentation of the mediations being administered as prescribed, and the documentation further lacked the nurse being notified prior to R2 receiving 800 milligrams of Ibuprofen for pain in his foot on 07/01/25 and 07/08/25, and for R3 receiving Albuterol HCF 90 microgram inhaler for "feeling a bit difficult to breath" on 07/08/25, Mucinex 600 milligrams on 07/01/25 and 07/08/25 and Cyclobenzaprine a muscle relaxer on 07/08/25. Findings included: - Record review for R1 revealed an admission date of 01/02/25 with diagnoses of Schizophrenia, Rheumatoid arthritis, and diabetes. Review of R1's "Functional Capacity Screen" (FCS) dated 01/02/25 revealed R1 lacked the ability to manage her own medications and medical treatments.	S5300		

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S5300	Continued From page 19 Review of R1's "Negotiated Service Agreement" (NSA) dated 01/03/25 under the section titled "Health Care Services;" R1's medications were to be administered by the "Certified Mediation Aide" (CMA), "Licensed Nurse" (LN) or the "Registered Nurse" (RN). The management of "Medical Treatments" was to be performed by "staff and outside agency". Review of the facility provided electronic "Medication Administration Record" (MAR) dated 07/2025 revealed the following; Clonazepam 0.125 milligrams by mouth to be administered twice daily was documented as administered only one time on 07/03/25, 07/07/25 and 07/13/25. 07/10/25 lacked documentation of being administered. Calcium CIT 315 milligram vitamin with D3 5 micrograms by mouth to be administered by mouth twice daily was documented as administered only one time on 07/03/25, 07/07/25 and 07/13/25. 07/10/25 lacked documentation of being administered. Ferrous Sulfate 325 milligrams 1 tablet by mouth daily was not documented on 07/10/25 as being administered. Metformin HCL 850 milligrams 1 tablet by mouth 3 times daily was administered one time on 07/03/25, 07/07/25, 07/13/25 and 07/14/25. On 07/12/25 the medication was documented as being administered twice, and on 07/10/25 the document lacked documentation of the medication being administered.	S5300		

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S5300	Continued From page 20 Pioglitazone HCL 30 milligram tablet for diabetes was started on 07/09/25. The document lacked documentation of the medication being administered on 07/10/25. Vitamin B12 1,000 micrograms 1 tablet mouth daily. 07/10/25 lacked documentation of being administered. Atorvastatin 40 milligrams 1 tablet by mouth daily. 07/15/2025 lacked documentation of being administered. Farxiga 10 milligrams 1 tablet by mouth daily for diabetes. 07/10/25 lacked documentation of being administered. Levothyroxine 100 micrograms tablet one time daily. 07/10/25 lacked documentation of being administered. Olanzapine 15 milligrams one time daily lacked documentation of being administered on 07/03/25, 07/07/25, 07/10/25, and 07/13/25. Oxybutynin 5 milligrams tablet take 2 tablets by mouth twice daily. 07/03/25, 07/07/25, 07/13/25 and 07/14/25 lacked documentation of being administered twice daily. 07/10/25 lacked documentation of the medication being administered. Famotidine 20 milligrams one table by mouth daily lacked documentation of being administered on 07/10/25. Sertraline Hydrochloride 100 milligrams lacked documentation of being administered on	S5300		

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S5300	Continued From page 21 07/10/25. Record review of the facility provided electronic "Observation Notes" for R1 revealed the last entry was on 05/27/25. The "Observation Notes" lacked documentation of the medications not being administered. - Record review for R2 revealed an admission date of 01/03/25 with diagnoses of seizure disorder, anxiety, current smoker, memory loss and hand tremors. Review of R2's FCS dated 01/03/25 revealed R2 lacked the ability to manage his own medications and medical treatments. Review of R2's NSA dated 01/03/25 under the section titled "Health Care Services"; R2's medications were to be administered by the CMA, LN, or RN. Review of the facility provided electronic "MAR" dated 07/25 revealed the following; Tizanidine HCL 4 milligram take one tablet by mouth every day wans not documented as being administered on 07/03/25 and 07/12/25. Levetiracetam 750 milligrams twice daily. 07/03/25, 07/07/25, 07/10/25, and 07/13/25 the medication was documented as being administered one time. Buspirone HCL 10 milligram tablet; 1 tablet by mouth 3 times daily was documented as being	S5300		

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S5300	Continued From page 22 administered twice on 07/03/25, 07/07/25, and 07/13/25. Ibuprofen 800 milligrams 1 tablet by mouth every 8 hours as needed for pain. Was administered on 07/01/25 and 07/08/25. Review of the "As Needed" (PRN) Medications Log dated 07/25 revealed CMA E documented on 07/01/25 and 07/08/25 that she administered Ibuprofen 800 milligrams for pain in R2's foot. She documented "No" that the nurse was not notified and the "Pain Level" area lacked documentation, and the note further lacked documentation of which foot had pain. Review of the facility provided electronic "Observation Notes" for R2 revealed the last entry was made on 02/23/25. The record lacked documentation of R2 having pain in his foot and receiving Ibuprofen 800 milligrams for the pain. Review of the facility provided binder titled Policies and Procedures dated 03/18/24 under the section titled "PRN Medication Documentation" on page 6 revealed the following; "1. If a PRN mediation is to be given, on call nurse must be notified prior to resident being given medication." "2. If a PRN is given, you must document on back of medication sheet when given and effectiveness, with 30 minutes to 1 hour after". - Record review for R3 revealed an admission	S5300		

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S5300	Continued From page 23 date of 01/02/25 with diagnoses of acquired hemolytic anemia, bipolar disorder, adjustment disorder with anxiety, and insomnia. Review of R3's FCS dated 01/02/25 revealed R3 lacked the ability to manage her own mediations and medical treatments. Review of R3's NSA dated 01/03/25, under the section titled "Health Care Services"; R2's medications were to be administered by the CMA, LN, or RN. Review of the facility provided electronic "MAR" dated 07/25 for R3 revealed the following; Alprazolam 0.25 milligrams 1 tablet twice daily was documented as being administered one time on 07/03/25, and 07/10/25 lacked documentation of the medication being administered. Alprazolam 0.5 milligram tablet at bedtime was not documented as being administered on 07/02/25. Paliperidone Extended Release 6 milligram tablet; 1 tablet daily was not documented as being administered on 07/11/25 and 07/13/25. Acetaminophen 500 milligram tablet; 1 tablet 3 times a day for pain. On 07/03/25 and 07/10/25 the medication was documented as being administered two times. Trazadone 100 milligram 1 tablet every night at bedtime was not documented as being administered on 07/02/25.	S5300		

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S5300	Continued From page 24 Ducosate-Senn 8.6/50 milligrams take 2 tablets by mouth twice daily was documented as being administered one time on 07/11/25 and 07/13/25. Breztri Aerosphere Inhaler; Inhale 2 puffs two times a day for "Chronic Obstructive Pulmonary" Disease (COPD) was not documented as being administered twice on 07/10/25 and 07/13/25. The medication was not documented as being administered on 07/11/25 and 07/12/25. Albuterol HFA 90 micrograms Inhale 2 puffs every 4 hours as needed for COPD was documented as being administered on 07/08/25. Cyclobenzaprine 5 milligram tablet by mouth two times a day as needed was administered on 07/08/25. Mucinex Extended Release 600 milligram tablet ; 1 tablet by mouth every 12 hours as needed for COPD/Cough for 10 days was administered on 07/01/25 and 07/08/25. Record of the PRN Medication Log dated 07/25 revealed the following entries; On 07/01/25 CMA E documented she administered Mucinex 600 milligrams to R3 and she did not notify the nurse. On 07/08/25 CMA E documented she administered Albuterol HFA 90 microgram Inhaler to R3 for R3 stating she was "feeling a bit difficult to breath", and CMA E further documented she did not notify the nurse. The PRN Mediation Log dated 07/25 for R3	S5300		

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S5300	Continued From page 25 lacked documentation of the following PRN medication administrations; On 07/01/25 Mucinex 600 milligrams On 07/08/25 Cyclobenzaprine 5 milligrams Review of the facility provided binder titled Policies and Procedures dated 03/18/24 under the section titled "PRN Medication Documentation" on page 6 revealed the following; "1. If a PRN mediation is to be given, on call nurse must be notified prior to resident being given medication." "2. If a PRN is given, you must document on back of medication sheet when given and effectiveness, with 30 minutes to 1 hour after". Review of the facility provided "Observation Notes" for R3 revealed the last entry was on 06/10/25. The record lacked documentation of R3 being having symptoms of " felling a bit difficult to breath", and the document further lacked documentation of the effectiveness of the Cyclobenzaprine and Albuterol Inhaler PRN medication administrations. Interview on 07/14/25 at approximately 04:16 PMwith Operator/Registered Nurse B confirmed the missing documentation on the electronic "MARS" for R1, R2, and R3. The Operator/Registered Nurse failed to ensure that all medications were administered to each resident in accordance with a medical care	S5300		

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S5300	Continued From page 26 providers written order and within professional standards of practice for R1, R2, and R3 when the electronic "Medication Administration Record" (MAR)s lacked documentation of the mediations being administered as prescribed, and the documentation further lacked the nurse being notified prior to R2 receiving 800 milligrams of Ibuprofen for pain in his foot on 07/01/25 and 07/08/25, and for R3 receiving Albuterol HCF 90 microgram inhaler for "feeling a bit difficult to breath" on 07/08/25, Mucinex 600 milligrams on 07/01/25 and 07/08/25 and Cyclobenzaprine a muscle relaxer on 07/08/25.	S5300		
S5313 SS=F	26-42-205 (g) (3) Over the counter medication (g) (3) A licensed nurse or medication aide may accept over-the-counter medication only in its original, unbroken manufacturer ' s package. A licensed pharmacist or licensed nurse shall place the full name of the resident on the package. If the original manufacturer ' s package of an over-the-counter medication contains a medication in a container, bottle, or tube that can be removed from the original package, the licensed pharmacist or a licensed nurse shall place the full name of the resident on both the original manufacturer ' s medication package and the medication container. This REQUIREMENT is not met as evidenced by: K.A.R. 26-42-205 (g) (3) The facility reported a census of 3 "Residents'" (R). Based on observation and interview the	S5313		

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S5313	Continued From page 27 Operator/Registered Nurse failed to ensure all "Over the Counter" (OTC) mediations located in the facility's only medication cart contained the full name of the resident Findings included: - Observation on 07/14/25 at approximately 10:45 AM of the facility medication cart located in the northwest corner of the common dining room in the second drawer revealed the following OTC medication bottles that lacked the residents full name; 1 bottle of Natures Bounty Vitamin D3 50 micrograms 1 bottle of Natures Bounty Vitamin B-12 1000 micrograms 2 bottles of Complete Multivitamin Women 50 plus 1 bottle of Spring Vally Hair, Nail, and Skin supplement 1 bottle of Equate Allergy Relief 25 milligrams Interview on 07/14/25 with Operator/Registered Nurse B confirmed all OTC bottles should be labeled with the resident's full name. The Operator/Registered Nurse failed to ensure all OTC medications located in the facility's only mediation cart contained the full name of the resident.	S5313		
S5315 SS=F	26-42-205 (h) Medication Storage (h) Storage. Licensed nurses and medication aides shall ensure that all medications and	S5315		

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RESIDENCE BEGONIA II AT CRESTVIEW HOUSE 3	1406 N. STRATFORD LN WICHITA, KS 67206

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S5315	Continued From page 28 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. (1) Licensed nurses or medication aides shall store non-controlled medications and biologicals managed by the home in a locked medication room, cabinet, or medication cart. Licensed nurses and medication aides shall store controlled medications managed by the home 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. (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. (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 stored by the home. (4) A licensed nurse or medication aide shall not administer medication beyond the manufacturer ' s or pharmacy provider ' s recommended date of expiration. This REQUIREMENT is not met as evidenced by: K.A.R. 26-42-205 (h) (1) The facility reported a census of 3 "Residents'"	S5315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087285	A. BUILDING: _____ B. WING _____	07/14/2025

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S5315	Continued From page 29 (R). Based on observation, interview, and record review the Operator/Registered Nurse failed to ensure all non-controlled medications managed by the home were in a locked medication room, cabinet, or medication cart. Only "Licensed Nurses" (LN) or "Certified Medication Aides" (CMA) shall have access to the stored medications. Findings included: - Record review for R1 revealed an admission date of 01/02/25 with diagnoses of Schizophrenia, Rheumatoid arthritis, and diabetes. Review of R1's "Functional Capacity Screen" (FCS) dated 01/02/25 revealed R1 required physical assistance with bathing, dressing and toileting. R1 was independent with transferring and required supervision with Walking and eating. R1 lacked the ability to manage her own medications and medical treatments. R1 was incontinent and had impaired short-term memory, long term memory, memory recall and decision making. She was usually able to make herself understood and she sometimes understood others. R1 was marked with impaired vision, impaired hearing, socially inappropriate disruptive behavior, and impaired decision making. R1 used a cane or walker mobility devices. Review of R1's NSA dated 01/03/25 under the section titled "Health Care Services;" R1's medications were to be administered by the "Certified Mediation Aide" (CMA), "Licensed Nurse" (LN) or the "Registered Nurse" (RN). The	S5315		

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S5315	Continued From page 30	S5315		

management of "Medical Treatments" was to be performed by "staff and outside agency".

Record review of the facility provided "Medication Administration Record" (MAR) revealed the following; an order for Triamcinolone 0.1% cream to be applied every morning.

The record included CMA initials as being administered.

Observation on 07/14/25 at approximately 09:30 AM of the common dining room, the facility medication cart sat in the northwest corner of the room. On the top of the medication cart was a small black metal box which had a small silver key inserted into the lock on the top of the box. "Certified Nurse Aide" (CNA) A got up from the desk located on the southwest wall of the common dining room and removed the keys from the lock on the small black metal box which sat on top of the medication cart.

Interview on 07/14/25 at approximately 09:30 AM with CNA A confirmed the box on top of the medication cart were the medication cart keys, she further confirmed she was the only staff in the home at the time.

Observation on 07/14/25 at approximately 12:37 PM of the common dining room revealed R2 and R3 were eating their lunch and sitting approximately 5 feet away from the facility medication cart, CMA C was standing at the medication cart, and turned and walked to the front living room of the facility. CMA C did not engage the locking bolt on the medication cart

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S5315	Continued From page 31 and at approximately 12:40 PM Operator/RN B went over and locked the medication cart. Observation on 07/14/25 at approximately 01:15 PM of R1's bed, the head of the bed was in the southeast corner of the room and the left side of the bed was against the east wall of the room, and sitting next to the wall on the bed were two jars of Triamcinolone cream 0.1% that included the pharmacy label sitting next to the wall. Review of the facility provided binder titled Policy and Procedures dated 03/18/24, revealed the following on page 5; Under the section titled "Medication Administration" "2. Medications be in order of resident in a locked cabinet, narcotics have to be double locked." Interview on 07/14/25 at approximately 04:16 PM with Operator/Registered Nurse B confirmed all medications are to be in the secured medication cart. The Operator/Registered Nurse failed to ensure all non-controlled medications managed by the home were in a locked medication room, cabinet, or medication cart. Only LN's or CMA's shall have access to the stored medications.	S5315		
S5316 SS=D	26-42-205 (i) Disposition of Medication (i) Accountability and disposition of medications. Licensed nurses and medication aides shall maintain records of the receipt and disposition of all medications managed by the home in	S5316		

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S5316	Continued From page 32 sufficient detail for an accurate reconciliation. (1) Records shall be maintained documenting the destruction of any deteriorated, outdated, or discontinued controlled medications and biologicals according to acceptable standards of practice by one of the following combinations: (A) Two licensed nurses; or (B) a licensed nurse and a licensed pharmacist. (2) Records shall be maintained documenting the destruction of any deteriorated, outdated, or discontinued non-controlled medications and biologicals according to acceptable standards of practice by any of the following combinations: (A) Two licensed nurses; (B) a licensed nurse and a medication aide; (C) a licensed nurse and a licensed pharmacist; or (D) a medication aide and a licensed pharmacist. This REQUIREMENT is not met as evidenced by: K.A.R. 26-42-205 (i) The facility reported a census of 3 "Residents'" (R). Based on observation, interview, and record review the Operator/Registered Nurse failed to ensure the accountability and disposition of medications by maintaining records of the receipt and disposition of all medications managed by the home in sufficient detail for an accurate reconciliation of R1's Clonazepam, a Schedule IV controlled substance in the Benzodiazepine	S5316		

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S5316	Continued From page 33 drug class for anxiety, seizures, panic disorder and acute mania. Findings included: - Record review for R1 revealed an admission date of 01/02/25 with diagnoses of Schizophrenia, Rheumatoid arthritis, and diabetes. Review of R1's "Functional Capacity Screen" (FCS) dated 01/02/25 revealed R1 lacked the ability to manage her own medications and medical treatments. Review of R1's "Negotiated Service Agreement" (NSA) dated 01/03/25 under the section titled "Health Care Services;" R1's medications were to be administered by the "Certified Mediation Aide" (CMA), "Licensed Nurse" (LN) or the "Registered Nurse" (RN). The management of "Medical Treatments" was to be performed by "staff and outside agency". Review of the facility provided document from the electronic "Medical Record" titled Medication Count Log for Clonazepam 0.125 milligrams dated 07/14/25 revealed the "Quantity currently on hand was "-83". Review of the facility provided document titled "Individual Residents Controlled Substance Record: dated 6/10/25 revealed the only reconciliation documentation was performed on 06/11/25 with an ending quantity of 57 tablets, and 06/17/25 with and ending quantity of 46 tablets.	S5316		

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S5316	Continued From page 34 Observation on 07/14/25 at approximately 10:45 AM of the facility medication cart located in the northwest corner of the common dining room in the secured metal box for controlled medications revealed a box labeled with R1's name for Clonazepam 0.125 milligrams to be administered twice daily for anxiety disorder. The box contained two tablets in the manufacturers foil wrapped packaging. Review of the facility provided binder titled Policies and Procedures dated 03/18/24, on page five Under the section titled "Medication Administration", "4. All narcotics must be counted for all shifts and signed by on coming staff that count is correct. 5. If count is not correct, supervisor must be notified immediately". Interview on 07/14/25 at approximately 04:16 PM with Operator/Registered Nurse B confirmed she was unaware of the facility not using the pharmacy provided count sheets with he controlled medication for R1, she stated that Chief Executive Officer/Owner stated the counts were verified in the electronic system. Operator/Registered Nurse B confirmed the electronic verification system was not accurate for R1. The Operator/Registered Nurse failed to ensure the accountability and disposition of medications by maintaining records of the receipt and disposition of all medications managed by the home in sufficient detail for an accurate reconciliation of R1's Clonazepam, a Schedule IV controlled substance in the Benzodiazepine drug class for anxiety, seizures, panic disorder and acute mania.	S5316		

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S5325 SS=F	26-42-205 (l) Medication Regimen Review Frequency (l) Medication regimen review. A licensed pharmacist or licensed nurse shall conduct a medication regimen review at least quarterly for each resident whose medication is managed by the home and each time the resident experiences any significant change in condition. This REQUIREMENT is not met as evidenced by: K.A.R. 26-42-205 (l) The facility reported a census of 3 "Residents'" (R). Based on interview and record review the Operator/Registered Nurse failed to ensure a licensed pharmacist or a licensed nurse conducted a medication regimen review at least quarterly for each resident whose mediation was managed by the home. Findings included: - Record review for R1 revealed an admission date of 01/02/25 with diagnoses of Schizophrenia, Rheumatoid arthritis, and diabetes. Review of R1's "Functional Capacity Screen" (FCS) dated 01/02/25 revealed R1 lacked the ability to manage her own medications and medical treatments.	S5325		

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S5325	Continued From page 36 Review of R1's "Negotiated Service Agreement" (NSA) dated 01/03/25 under the section titled "Health Care Services;" R1's medications were to be administered by the "Certified Mediation Aide" (CMA), "Licensed Nurse" (LN) or the "Registered Nurse" (RN). The management of "Medical Treatments" was to be performed by "staff and outside agency". Review of R1's medical record revealed a document titled "Consultant Pharmacist Drug Regimen Review Log" with the last entry dated 10/03/24. - Record review for R2 revealed an admission date of 01/03/25 with diagnoses of seizure disorder, anxiety, current smoker, memory loss and hand tremors. Review of R2's FCS dated 01/03/25 revealed R2 lacked the ability to manage his own medications and medical treatments. Review of R2's NSA dated 01/03/25 under the section titled "Health Care Services"; R2's medications were to be administered by the CMA, LN, or RN. R2's Medical Record lacked a document titled "Consultant Pharmacist Drug Regimen Review Log". - Record review for R3 revealed an admission date of 01/02/25 with diagnoses of acquired hemolytic anemia, bipolar disorder, adjustment disorder with anxiety, and insomnia.	S5325		

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S5325	Continued From page 37 Review of R3's FCS dated 01/02/25 revealed R3 lacked the ability to manage her own mediations and medical treatments. Review of R3's NSA dated 01/03/25, under the section titled "Health Care Services"; R2's medications were to be administered by the CMA, LN, or RN. R3's Medical Record lacked a document titled "Consultant Pharmacist Drug Regimen Review Log". Interview on 07/14/25 with Operator/Registered Nurse B confirmed the medical record for R1 showed the last pharmacy review date was on 10/03/24 and she further confirmed R2 and R3 had not had a pharmacy review since their admission to the facility. Operator/Registered Nurse B confirmed the pharmacist would be at the facility on 07/22/25. The Operator/Registered Nurse failed to ensure a licensed pharmacist, or a licensed nurse conducted a medication regimen review at least quarterly for each resident whose mediation was managed by the home.	S5325		
S5370 SS=F	28-39-437 Construction (f) Sanitation and maintenance. Each facility shall provide a safe, functional, sanitary, and comfortable environment for residents, staff, and the public. (g) Public telephone. There shall be a public telephone locally accessible to individuals with disabilities in a private area that allows a	S5370		

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S5370	Continued From page 38 resident or another individual to conduct a private conversation. This REQUIREMENT is not met as evidenced by: K.A.R. 28-39-437 (f) The facility reported a census of 3 "Residents'" (R). Based on observation and interview the Operator/Registered Nurse failed to ensure the facility staff provided a safe, functional, and sanitary environment for residents, staff, and the public. Findings included: - Observation on 07/14/25 at approximately 09:40 AM during the homes tour revealed the following; On the top of the file cabinet in the common dining room a small clear plastic container with a white lid, that was greater than half full of a yellow liquid sitting on a blue disposable glove. In the kitchen on the northwest cabinet, on the floor next to the countertop stove, was a cabinet door sitting in front of the cabinet it came off of. In the bathroom located on the southwest side of the home, next to the toilet was a divider wall to the shower. The lower middle portion of the wall was a square opening approximately 12 inches by 12 inches. In the opening were two metal horizontal pipes. The covering for the opening sat leaned against the divider wall.	S5370		

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S5370	Continued From page 39 Interview on 07/14/25 at approximately 09:43 with "Certified Nurse Aide" (CNA) A confirmed the liquid in the container was urine and she continued to confirm she was unaware of when the sample was obtained. Interview on 07/14/25 at approximately 12:45 PM with Operator/Registered Nurse B confirmed the urine sample that sat on the filing cabinet in the common dining room had been obtained "last week". Interview on 07/14/25 at approximately 04:16 PM with Operator/Registered Nurse B and CNA A confirmed the cabinet door in the kitchen had been fixed during the survey process, they continued to confirm the opening in the bathroom dividing wall exposing the pipes, and they further confirmed the residents in the home do use that bathroom. The Operator/Registered Nurse failed to ensure the facility staff provided a safe, functional, and sanitary environment for residents, staff, and the public.	S5370		