STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087273	A. BUILDING: _____ B. WING _____	08/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMFORTCARE HOMES WEST 3	8649 W 29TH STREET N WICHITA, KS 67205

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S 000	INITIAL COMMENTS The following citations represent the findings of the licensure resurvey with attached complaint numbers 195439, 195352, 192876, and 188971, for the above named facility conducted on 08/13/2025 and 08/14/25.	S 000		
S5026 SS=D	26-42-101 (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. 26-42-101 (f) (1) (B) The facility reported a census of 12 residents. The sample included 6 "Residents'" (R). Based on observation, interview, and record review the Operator failed to protect R2 from neglect, when staff failed to see R2 standing on the right side of the secured interior door when the staff answered the door, then turned and walked away without ensuring the interior door to the secured specialty unit shut and engaged. This failure allowed R2 to prevent the door from closing and walk out to the front yard of the home unobserved by staff.	S5026		

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

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S5026	Continued From page 1 Findings included: - Record review for R2 revealed an admission date of 10/31/24 with diagnoses of dementia, anxiety, and restlessness. Review of R2's "Functional Capacity Screen" (FCS) dated 10/31/24 revealed R2 was independent with bathing, dressing, toileting, transferring, walking/mobility, and eating. R2 lacked the ability to manage her own medications and was scored with impaired short-term memory, long-term memory, memory/recall, and decision making. R2 was identified to be at risk for falls and impaired decision making and she used no mobility device. Review of R2's "Negotiated Service Agreement" (NSA) dated 10/15/24 under the section titled "12. Wandering" the NSA lacked the identification of services to be provided for wandering behavior. Review of R2's "Health Service Plan" (HSP) dated 10/15/24 under the section titled "Mental Attitude" R2 was identified as an elopement risk, and the intervention was "30 minutes checks implemented". Under the section titled "Behaviors" R2 was identified to wander, and the intervention was "30-minute checks implemented to help keep resident safe." Review of the facility provided document titled "Resident Notes" revealed a "Nurse Note" entered on 05/12/25 at 08:39 PM that revealed the nurse received a call at 08:07 PM from the	S5026		

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S5026	Continued From page 2	S5026		

homes staff who noticed R2 was not in the home. One of the staff members looked out the window and saw R2, staff went to the door and was opening the door just as R2 opened the door to return to the home. Staff reported that they had opened the door to get a drink from the other caregiver and R2 "must have slipped by her".

Review of the facility provided video dated 12/05/25 at 04:43:21 revealed the following:

At 04:43:28 two staff members entered the secured specialty unit and do not ensure the door lock engaged.

At 04:43:31 the two staff members are in the home and R2 can be seen pushing the door to keep it from closing and at 16:43:34 R2 is past the secured interior door to the home.

Review of the facility provided investigation revealed the following from the outside cameras:

R2 was observed walking south to parking lot and turn left, and headed north and walked a quarter way down the driveway. She turned around and walked back toward the front parking area and then to the front door of the home at 16:46

Ongoing observation that started on 08/13/25 at approximately 09:15 AM of R2 revealed every time the doorbell rang R2 went to the door. Every time someone entered or left the home R2 was at the front door. R2 would pace from the front door to different areas of the home and go back to the front door. R2 declined going out on the back patio with other residents.

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S5026	Continued From page 3 Interview on 08/13/25 at approximately 11:35 AM with "Licensed Nurse" (LN) B confirmed the time stamp on the video was wrong and the time charted at 08:07 PM was the time staff reported the occurrence to her. The Operator failed to protect R2 from neglect, when staff failed to see R2 standing on the right side of the secured interior door when the staff answered the door, then turned and walked away without ensuring the interior door to the secured specialty unit shut and engaged. This failure allowed R2 to prevent the door from closing and walk out to the front yard of the home unobserved by staff.	S5026		
S5085 SS=E	26-42-201 (c) Functional Capacity Screen Reassessment (c) Designated staff shall conduct a screening to determine each resident ' s functional capacity 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; and (3) at least quarterly if the resident receives assistance with eating from a paid nutrition assistant. This REQUIREMENT is not met as evidenced by: K.A.R. 26-42-201 (c) (1) The facility reported a census of 12 residents. The sample included 6 "Residents'" (R)'s. Based on record review and interview the Operator	S5085		

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S5085	Continued From page 4	S5085		

failed to ensure the screening determining the functional capacity was performed at least every 365 days for R5 and R6.

Findings included:

- Record review for R5 revealed an admission date of 05/17/24 with diagnoses of Alzheimer's disease and mood disorder.

Review of R5's "Functional Capacity Screen" (FCS) dated 05/20/24 revealed R5 required supervision with bathing, dressing and toileting. R5 was independent with transferring, walking/mobility, and eating. She lacked the ability to manage her own medications and was scored with impaired short-term memory, long-term memory, memory/recall, and decision making.

Review of R5's medical record lacked a FCS performed 365 days of 05/20/24.

Interview on 08/14/25 at approximately 09:45 AM with "Licensed Nurse" (LN) A confirmed R5's medical record lacked a FCS being performed 365 days of 05/20/24.

Record Review for R6 revealed an admission date of 04/25/24 with diagnoses of Dementia, congestive heart failure, depression, and irregular heart rhythm.

Review for R6's FCS dated 04/25/24 revealed R6 required supervision with bathing and dressing. She was independent with toileting, transferring, walking/mobility, and eating. R6

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	B087273	A. BUILDING: _____ B. WING _____	08/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S5085	Continued From page 5 lacked the ability to manage her own medications and she was scored with impaired short-term memory, long-term memory, memory/recall, and decision making. Review of R6's medical record lacked a FCS performed 365 days of 04/25/24. Interview on 08/14/25 at approximately 09:45 AM with LN A confirmed R6's medical record lacked a FCS being performed 365 days of 04/25/24. The Operator failed to ensure the screening determining the functional capacity was performed at least every 365 days for R5 and R6.	S5085		
S5116 SS=E	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 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:	S5116		

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S5116	Continued From page 6 KAR 26-42-202 (d)(1) The facility reported a census of 12 residents. The sample included 6 "Residents'" (R)'s. Based on record review and interview the Operator failed to ensure the "Negotiated Service Agreements'" (NSA)s were reviewed and if necessary revised at least once every 365 days for R5 and R6. Findings included: - Record review for R5 revealed an admission date of 05/17/24 with diagnoses of Alzheimer's disease and mood disorder. Review of R5's "Functional Capacity Screen" (FCS) dated 05/20/24 revealed R5 required supervision with bathing, dressing and toileting. R5 was independent with transferring, walking/mobility, and eating. She lacked the ability to manage her own medications and was scored with impaired short-term memory, long-term memory, memory/recall, and decision making. Review of R5's NSA dated 05/24/24 identified the facility would provide health care services for bathing, dressing, toileting, and the management of R5's medications. Review of R5's medical record lacked documentation of a review and if necessary, the revision of R5's NSA. Interview on 08/14/25 at approximately 09:45 AM with "Licensed Nurse" (LN) A confirmed R5's	S5116		

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S5116	Continued From page 7 medical record lacked a review and if necessary, the revision of R5's NSA every 365 days. Record Review for R6 revealed an admission date of 04/25/24 with diagnoses of Dementia, congestive heart failure, depression, and irregular heart rhythm. Review for R6's FCS dated 04/25/24 revealed R6 required supervision with bathing and dressing. She was independent with toileting, transferring, walking/mobility, and eating. R6 lacked the ability to manage her own medications and she was scored with impaired short-term memory, long-term memory, memory/recall, and decision making. Review of R6's NSA dated 04/25/24 revealed the facility would provide health care services for bathing, dressing and the management of R6's mediations. Review of R6's medical record lacked a review and if necessary, the revision of R6's NSA every 365 days. Interview on 08/14/25 at approximately 09:45 AM with LN A confirmed R6's medical record lacked review and if necessary, the revision of R6's NSA every 365 days. The Operator failed to ensure the NSAs were reviewed and if necessary revised at least once every 365 days for R5 and R6.	S5116		
S5265 SS=D	26-42-205 (a) (1) Medication Self Administration Assessment	S5265		

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S5265	Continued From page 8 (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 12 residents. The sample included 6 "Residents'" (R)'s. Based on record review and interview the Operator failed to ensure the "Licensed Nurse" (LN) performed an assessment for R1 that determined that he could perform the self-administration of insulin safely, accurately and without staff assistance. Findings included:	S5265		

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S5265	Continued From page 9 - Record review for R1 revealed an admission date of 05/14/25 with diagnoses of atherosclerotic heart disease, Alzheimer's disease, depression, and Diabetes. Review of R1's "Functional Capacity Screen" (FCS) dated 05/15/25 revealed R1 required supervision with bathing, and he was independent with dressing, toileting, transferring, walking/mobility, and eating. R1 lacked the ability to manage his own medications and medical treatments. R1 was occasionally incontinent and had impaired short-term memory, long-term memory, memory/recall, and decision making. R1 was able to make himself understood and he usually understood others. Review of R1's "Negotiated Service Agreement" (NSA) dated 05/15/25 under the section titled "23. Medication Administration and Documentation:" identified the facility would have qualified staff administer and document all prescription and over-the-counter medications as ordered by the physician or primary care practitioner. Review of R1's "Health Service Plan" dated 05/15/25 identified R1 took his medications "willingly" and that he took his medications "whole". Review of the facility provide "Medication Administration Record" (MAR) dated 08/25 for R1 revealed the following orders; NovoLog (Daily) Administer 5 units subcutaneously with breakfast and lunch; "Dial up 5 units and put the needle on the insulin and	S5265		

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	B087273	A. BUILDING: _____ B. WING _____	08/14/2025

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S5265	Continued From page 10 hand to the resident to inject by himself". Toujeo (Daily) Administer 12 units subcutaneously at 05:00 PM; "Dial up 12 units and put the needle on the insulin and hand to the resident to inject by himself". Review of R1's medical record revealed it lacked an assessment determining he could safely, accurately and without staff assistance self-inject his own insulin. Interview on 08/13/25 at approximately 04:30 PM with LN A confirmed R1's medical record lacked an assessment determining he could safely, accurately and without staff assistance self-inject his own insulin. The Operator failed to ensure the LN performed an assessment for R1 that determined that he could perform the self-administration of insulin safely, accurately and without staff assistance.	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	S5286		

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	B087273	A. BUILDING: _____ B. WING _____	08/14/2025

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S5286	Continued From page 11 by: K.A.R 26-42-205 (b) The facility reported a census of 12 residents. The sample included 6 "Residents'" (R)'s. Based on record review and interview the Operator failed to ensure the "Negotiated Service Agreement" (NSA) for R1 reflected who was responsible for the administration of select medications. Findings included: - Record review for R1 revealed an admission date of 05/14/25 with diagnoses of atherosclerotic heart disease, Alzheimer's disease, depression, and Diabetes. Review of R1's "Functional Capacity Screen" (FCS) dated 05/15/25 revealed R1 required supervision with bathing, and he was independent with dressing, toileting, transferring, walking/mobility, and eating. R1 lacked the ability to manage his own medications and medical treatments. R1 was occasionally incontinent and had impaired short-term memory, long-term memory, memory/recall, and decision making. R1 was able to make himself understood and he usually understood others. Review of R1's NSA dated 05/15/25 under the section titled "23. Medication Administration and Documentation:" identified the facility would have qualified staff administer and document all prescription and over-the-counter medications as ordered by the physician or primary care practitioner.	S5286		

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S5286	Continued From page 12 R1's NSA lacked documentation of who was responsible for the administration of his insulin. Review of R1's "Health Service Plan" dated 05/15/25 identified R1 took his medications "willingly" and that he took his medications "whole". Review of the facility provide "Medication Administration Record" (MAR) dated 08/25 for R1 revealed the following orders; NovoLog (Daily) Administer 5 units subcutaneously with breakfast and lunch; "Dial up 5 units and put the needle on the insulin and hand to the resident to inject by himself". Toujeo (Daily) Administer 12 units subcutaneously at 05:00 PM; "Dial up 12 units and put the needle on the insulin and hand to the resident to inject by himself". Interview on 08/13/25 at approximately 04:30 PM with "Licensed Nurse" (LN) A confirmed R1's NSA lacked the identification of who was responsible for the administration of his insulin. The Operator failed to ensure the NSA for R1 reflected who was responsible for the administration of select medications.	S5286		
S5315 SS=E	26-42-205 (h) Medication Storage (h) Storage. Licensed nurses and medication aides shall ensure that all medications and biologicals are securely and properly stored in accordance with each manufacturer ' s recommendations or those of the pharmacy	S5315		

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S5315	Continued From page 13 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) (4) The facility reported a census of 12 residents. The sample included 6 "Residents'" (R)'s. Based on observation and interview the Operator failed to ensure the facility "Licensed Nurse" (LN)s and	S5315		

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S5315	Continued From page 14 "Certified Medication Aides" (CMA)s did not administer medication beyond the manufacturer's or pharmacy provider's recommended date of expiration. Findings included: - Observation on 08/13/25 at approximately 10:30 AM LN A entered the code into the locked medication room. In the cabinet on the northeast side of the wall were the resident medication baskets. In the baskets were the following insulin pens which lacked a date of expiration after being opened: 1 Toujeo Solo Star pen 1 Novolog Pen 1 Basaglar Pen Review of the manufacturer's recommendation for the Toujeo Solo Star pen revealed the pen could be stored for up to 56 days at room temperature after its first use. Review of the manufacturer's recommendation for the Novolog Pen revealed after 28 days the Novolog Pen should be thrown away in the trash even if there was leftover insulin. Review of the manufacturer's recommendation for the Basaglar Pen revealed after 28 days to throw Basaglar Pen away even if it had insulin left in the pen. Interview on 08/13/25 at approximately 10:30 AM with LN A confirmed the insulin pens lacked the beyond use dates.	S5315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087273	A. BUILDING: _____ B. WING _____	08/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S5315	Continued From page 15 The Operator failed to ensure the facility LNs and CMAs did not administer medication beyond the manufacturer's or pharmacy provider's recommended date of expiration.	S5315		
S5335 SS=F	28-39-437 Construction (a) Each home-plus facility shall be designed, constructed, equipped, and maintained to protect the health and safety of residents, personnel, and the public. (b) All new construction, renovation, remodeling, and changes in building use in existing buildings shall comply with building and fire codes, ordinances, and regulations enforced by city, county, and state jurisdictions, including the state fire marshal. This REQUIREMENT is not met as evidenced by: K.A.R. 28-39-437 (a) The facility reported a census of 12 residents. Based on record observation and interview the Operator failed to ensure the secured specialty unit was maintained to protect the safety of residents. Findings included: - Observation on 08/13/25 at approximately 10:00 AM during the facility tour of the common area of the home revealed a public bathroom located in the northeast corner of the home. The cabinet under the sink freely opened and there was a container of Sani Wipes. In the common	S5335		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S5335	Continued From page 16 dining room, there was an island with cabinets on the north end. The north cabinet door opened freely and there was a spray container of Super Odor eliminator. Interview on 08/13/25 with "Licensed Nurse" (LN) A confirmed all chemical were to be stored in a locked cabinet or closet. The Operator failed to ensure the secured specialty unit was maintained to protect the safety of residents.	S5335		