STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087178	A. BUILDING: _____ B. WING _____	08/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWLARK CHIPPER	10001 W 12TH STREET NORTH WICHITA, KS 67212

(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 with attached compliant numbers 191051 and 187002 for the above named facility conducted on 08/11/25 and 08/12/25.	S 000		
S5105 SS=D	26-42-202 (a) Negotiated Service Agreement a) The administrator or operator of each home plus shall ensure the development of a written negotiated service agreement for each resident, based on the resident ' s functional capacity screening, service needs, and preferences, in collaboration with the resident or the resident ' s legal representative, the case manager, and, if agreed to by the resident or the resident ' s legal representative, the resident ' s family. The negotiated service agreement shall provide the following information: (1) A description of the services the resident will receive; (2) identification of the provider of each service; and (3) identification of each party responsible for payment if outside resources provide a service. This REQUIREMENT is not met as evidenced by: K.A.R. 26-42-202 (a) (1) The facility reported a census of 9 residents. The sample included 3 "Residents'" (R)'s . Based on record review and interview the Operator failed to ensure R3's "Negotiated Service Agreement" (NSA) contained a description of healthcare services for a diagnosis of Suicidal Ideations.	S5105		

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
	B087178	A. BUILDING: _____ B. WING _____	08/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWLARK CHIPPER	10001 W 12TH STREET NORTH WICHITA, KS 67212

(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
S5105	Continued From page 1 Findings included: - Record review for R3 revealed an admission date of 04/11/25 with diagnoses of Schizophrenia, Suicidal Ideations, and Type 2 Diabetes Mellitus. Review of R3's "Functional Capacity Screen" (FCS) dated 04/11/25 revealed he was independent with bathing, dressing, toileting, transferring, walking/mobility, and eating. R3 required physical assistance with management of his medications and medical treatments. R3 was marked at risk for falls and his cognition was intact. R3 was able to make himself understood and he understood others. R3 used a cane mobility device. Review of R3's NSA dated 04/11/25 instructed facility staff to provide health care services for management of his oral medications and medical treatments. R3 would self-inject his own insulin. The section titled "Behavior management" lacked any documentation. Review of R3's "Health Service Plan" (HSP) dated 04/11/25 in the column titled "Problem" the diagnoses of "Schizophrenia" was handwritten in. In the column titled "Interventions" the following instructions to staff were listed: Redirect resident using positive a positive and calm voice. Provide resident with verbal cues to guide appropriate behavior.	S5105		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087178	A. BUILDING: _____ B. WING _____	08/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWLARK CHIPPER	10001 W 12TH STREET NORTH WICHITA, KS 67212

(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
S5105	Continued From page 2 Reduce environmental stimulation. Allow resident to talk about what is making them upset. Interview on 08/12/25 at approximately 12:45 PM with "Licensed Nurse" (LN) C confirmed the NSA for R3 lacked a description of health services for R3's diagnoses of Suicidal ideation. The Operator failed to ensure R3's NSA contained a description of healthcare services for a diagnosis of Suicidal Ideations.	S5105		
S5315 SS=F	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 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	S5315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087178	A. BUILDING: _____ B. WING _____	08/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWLARK CHIPPER	10001 W 12TH STREET NORTH WICHITA, KS 67212

(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
S5315	Continued From page 3 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) The facility reported a census of 9 residents. Based on observation and interview the Operator failed to ensure that all medications were 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. Findings included: - Observation on 08/11/25 at approximately 02:30 PM of the facility medication cart located in the common resident dining room on the east wall, revealed 3 brown bags with pharmacy labels stapled to the brown bags. Interview on 08/11/25 at approximately 02:30 PM with "Certified Nurse Aide" (CNA) A confirmed the pharmacy did deliver the bags that contained	S5315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087178	A. BUILDING: _____ B. WING _____	08/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWLARK CHIPPER	10001 W 12TH STREET NORTH WICHITA, KS 67212

(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
S5315	Continued From page 4 resident medications, and that she was the only staff in the home. CNA A further confirmed she was not a "Certified Medication Aide" (CMA). Interview on 08/11/25 at approximately 03:00 PM with Operator B confirmed all medications should be in a locked cabinet or cart. The Operator failed to ensure that all medications were 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.	S5315		