STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087043	A. BUILDING: _____ B. WING _____	09/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRINGTON AT CHERRY CREEK	8200 E PAWNEE ST WICHITA, KS 67207

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S 000	INITIAL COMMENTS The following represent the findings of an abbreviated survey with review of facility report #196922, 196846, 196764, 196587, 194873, 195269, 196936 and complaint # 196660, 196595, 196218, 195824, 195738, 195703, 195480, 195409, and 195412 at the above assisted living conducted on 09/03/25 & 09/04/25.	S 000		
S3025 SS=E	26-41-101 (f) STAFF TREATMENT OF RESIDENTS (f) Staff treatment of residents. Each administrator or operator shall ensure the development and implementation of written policies and procedures that prohibit the abuse, neglect, and exploitation of residents by staff. This REQUIREMENT is not met as evidenced by: KAR 26-41-101(f) The facility reported a census of 95 residents with 15 resident focused record reviews. Based on observation, interview, and record review the administrator failed to ensure the implementation of written policies and procedures that prohibit the exploitation of residents by staff when staff did not ensure medication cards were unaltered or report discrepancies immediately. Findings included:	S3025		

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

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S3025	Continued From page 1 - Record review for R14 revealed an admission date of 06/11/21 with diagnosis of schizophrenia. The 06/17/25 Functional Capacity Screen (FCS) identified R14 required physical assistance with management of medications and treatments. The 06/17/25 Negotiated Service Agreement (NSA) identified facility staff would administer medications and treatments to R14. Review of R14's August medication administration record revealed an order for oxycodone 7.5 milligrams (mg) with acetaminophen 325 mg to be given every six hours for pain. Review of facility's investigation submitted 09/03/25 revealed oxycodone tablets were replaced with acetaminophen tablets in a medication card for R14. Review of Certified Medication Aide (CMA) G's witness statement revealed on 08/28/25 she found a medication card of narcotics altered with a different medication placed in the bubbles. She reported it "to the nurse." Review of 08/13/25 "Medication Storage Audit" revealed controlled substances were not checked for proper count or unaltered cards by pharmacy staff. Observation on 09/03/25 at 12:14 PM of medication card for R14's oxycodone/acetaminophen revealed ten pieces of white medical tape applied to the back where medications were popped from card including	S3025		

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S3025	Continued From page 2	S3025		

bubbles numbered seven, eight, 13, 14, 20, 27, 28, 34, 47, and 48.

Observation on 09/04/25 at 11:11 AM of the Hall 100 cart revealed CMA G unlocked the controlled substances drawer. The following medication cards were found:

clonazepam 1 mg with a punctured hole in bubble #1
oxycodone/acetaminophen 7.5mg (milligrams)/325mg, 60 tablets with a tablet missing from bubble #3
Phenobarbital 97.2mg, 60 tablets with a puncture in bubble #11

On 09/04/25 at 11:14 AM Administrative Nurse D confirmed the medications in the cards were not secured or had a missing medication tablet and it was not reported to her or Licensed Nurse C.

On 09/03/25 at 08:37 AM Licensed Nurse C stated tape was not allowed on the back of medication cards. Bubbles that have cuts were to have the medication properly wasted with two staff members.

On 09/03/25 at 11:50 AM Administrative Nurse D and Licensed Nurse C confirmed the tape to the back of the oxycodone card for R14 was scattered around the different bubbles which would mean the card had been altered intermittently since 08/17/25.

On 09/03/25 at 12:11 PM Administrative Staff A confirmed the staff have not been retrained on abuse, neglect, and exploitation reporting or proper counting of controlled substances since

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S3025	Continued From page 3 08/28/25. The facility's undated "Administration of Controlled Substances" policy instructed staff to ensure the medication cards were unaltered and report any discrepancy immediately to administration. The administrator failed to ensure the implementation of written policies and procedures that prohibit the exploitation of residents by staff when staff did not ensure medication cards were unaltered or report discrepancies immediately.	S3025		
S3081 SS=D	26-41-201 (c) Functional Capacity Screen Reassessment (c) Designated facility 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: KAR 26-41-201(c)(1) The facility reported a census of 95 residents. The sample included 15 abbreviated record reviews. Based on interview and record review the administrator failed to ensure designated	S3081		

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S3081	Continued From page 4 staff completed a Functional Capacity Screen (FCS) for resident (R)15 at least once every 365 days. Findings included: - R15's medical record revealed she moved into the facility on 05/01/23 with a diagnosis of Paranoid Schizophrenia. The most current FCS available in R15's medical record was dated 10/03/23 with no documentation to show a FCS was completed since this date. On 09/04/25 at 10:30 AM Administrative Nurse D confirmed an FCS was not completed annually for R15 in 2024. The administrator failed to ensure designated staff completed a FCS for R15 at least once every 365 days.	S3081		
S3092 SS=E	26-41-202 (d) Negotiated Service Agreement 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, facility staff, the case	S3092		

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S3092	Continued From page 5	S3092		

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:
KAR 26-41-202(d)(1)(4)

The facility reported a census of 95 residents. The sample included 95 abbreviated record reviews. Based on interview, and record review the administrator failed to ensure the "Negotiated Service Agreement" (NSA) for Resident (R)1 was revised to include new behavior monitoring interventions and R15's NSA was revised at least once every 365 days.

Findings included:

- R1's medical record revealed he moved into the facility on 10/02/24 with diagnoses of major depressive disorder and generalized anxiety.

The most current NSA available in R1's medical records was dated 04/17/25 with no documentation to show his NSA was revised to include behavioral monitoring interventions implemented since this date.

R1's medical record revealed a physician's order dated 05/08/25 for "Room Checks for Behavior/Aggression every hour for Behavior/Aggression. Notify Resident Director/Nurse if resident becomes a nuisance, aggressive and combative."

On 09/04/25 at 10:32 AM Administrative Staff A

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S3092	Continued From page 6 confirmed R1's NSA was not updated to include hourly behavior checks completed by facility staff. The administrator failed to ensure R1's NSA was revised to include new behavioral monitoring interventions implemented by staff. - R15's medical record revealed she moved into the facility on 05/01/23 with a diagnosis of Paranoid Schizophrenia. The most current NSA available in R15's medical records was dated 10/03/23 with no documentation to show a NSA was completed since this date. On 09/04/25 at 10:30 AM Administrative Nurse D confirmed an NSA was not completed annually for R15 in 2024. The administrator failed to ensure designated staff completed an NSA for R15 at least once every 365 days.	S3092		
S3216 SS=E	26-41-205 (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 facility in 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	S3216		

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S3216	Continued From page 7 (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: KAR 26-41- 205(i) The facility reported a census of 95 residents. Based on observation and interview the administrator failed to ensure licensed nurses and medication aides maintained records of the disposition of all medications in sufficient detail for accurate reconciliation. Findings included: Observation on 09/03/25 at 12:14 PM of medication card for R14's oxycodone 7.5 milligram (mg)/acetaminophen 325 mg revealed 13 white tablets. 8 of the 13 tablets were original medications to the card. 5 of the 13 tablets had different markings indicating it was acetaminophen 325mg tablets. Observation on 09/04/25 at 11:11 AM of the Hall 100 cart revealed CMA G unlocked the controlled	S3216		

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S3216	Continued From page 8 substances drawer. A card of oxycodone/acetaminophen 7.5mg/325mg had a tablet missing from bubble #3 which made the total tablets left in the card 40. On 09/04/25 at 11:14 AM Administrative Nurse D confirmed the card had a missing medication tablet, the quantity on the log read 41, and it was not reported to her or Licensed Nurse C. The administrator failed to ensure licensed nurses and medication aides maintained records of the disposition of all medications in sufficient detail for accurate reconciliation.	S3216		