STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087290	A. BUILDING: _____ B. WING _____	09/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVENANT AT 11TH STREET	6617 E 11TH ST N 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 09/29/25 and 09/30/25.	S 000		
S 135 SS=D	26-39-103 (h) Resident Right Notification of Changes (h) Notification of changes. (1) The administrator or operator shall ensure that designated facility staff inform the resident, consult with the resident's physician, and notify the resident's legal representative or designated family member, if known, upon occurrence of any of the following: (A) An accident involving the resident that results in injury and has the potential for requiring a physician's intervention; (B) a significant change in the resident's physical, mental, or psychosocial status; (C) a need to alter treatment significantly; or (D) a decision to transfer or discharge the resident from the adult care home. (2) The administrator or operator shall ensure that a designated staff member informs the resident, the resident's legal representative, or authorized family members whenever the designated staff member learns that the resident will have a change in room or roommate assignment. This STANDARD is not met as evidenced by: K.A.R. 26-39-103 (h)(1) (A)	S 135		

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

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S 135	Continued From page 1 The facility reported a census of 5 residents. The sample included 3 "Residents'" (R)'s1, 2, and 3. Based on record review and interview the operator failed to ensure the facility nurse notified R1's medical care provider when the facility "Certified Medication Aide" (CMA) administered R1's narcotic twice in approximately 37 minutes. Findings included: - Record review for R1 revealed an admission date of 05/27/25 with diagnoses of end stage renal disease, chronic pain, atrial fibrillation, anemia, and heart failure with preserved ejection fraction. Review of R1's "Functional Capacity Screen" (FCS) dated 05/27/25 revealed R1 required physical assistance with bathing, dressing, toileting, transferring, walking/mobility, and supervision with eating. R1 lacked the ability to manage her own mediations/medical treatments, and had impaired short-term memory, long-term memory, memory/recall, and decision making. R1 was usually able to make herself understood and she usually understood others. R1 was at risk for falls, impaired decision making and used a walker and wheelchair mobility device. Review of R1's "Negotiated Service Agreement" dated 05/27/25 under the section titled "Medication and Medical Treatments" identified the facility staff would be provided by qualified facility staff. Review of R1's "Health Service Plan" (HSP)	S 135		

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S 135	Continued From page 2 instructed the facility "Certified Medication Aides'" (CMA)'s would administer all of R1's medications. Review of R1's medical record under the "Nurse Notes" tab revealed the following entry made on 06/27/25 (the entry lacked a time of entry). Registered Nurse B documented that she received a call from the third shift CMA stating that "an additional Oxycodone dosage may have been given in error." Registered Nurse B documented that she instructed the facility CMA to get a set of vital signs immediately and to obtain another set of vital signs in 30 minutes, and to repeat every thirty minutes with first shift continuing to monitor for the next three to four hours. Registered Nurse B documented that she notified R1's family about the "medication error". The note lacked the documentation of R1's medical care provider being notified of the CMA administering R1's Oxycodone twice in approximately 37 minutes. Review of R1's signed orders dated 06/25 revealed an order for Oxycodone HCL 5 milligram tablets to be administered twice daily for pain. Interview on 09/30/25 at approximately 02:40 PM with Registered Nurse B confirmed she did not notify the medical care provider until 03:05 PM on 05/27/25 when she requested an order for Narcan due to the medication error that happened on 05/27/25. The operator failed to ensure the facility nurse notified R1's medical care provider when the facility CMA administered R1's narcotic twice in	S 135		

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S 135	Continued From page 3 approximately 37 minutes.	S 135		
S5028 SS=D	26-42-101 (f) (3) Staff Treatment of Residents Reporting (f) (3) Each allegation of abuse, neglect, or exploitation shall be reported to the administrator or operator of the home as soon as staff is aware of the allegation and to the department within 24 hours. The administrator or operator shall ensure that all of the following requirements are met: (A) An investigation shall be started when the administrator or operator, or the designee, receives notification of an alleged violation. (B) Immediate measures shall be taken to prevent further potential abuse, neglect, or exploitation while the investigation is in progress. (C) Each alleged violation shall be thoroughly investigated within five working days of the initial report. Results of the investigation shall be reported to the administrator or operator. (D) Appropriate corrective action shall be taken if the alleged violation is verified. (E) The department ' s complaint investigation report shall be completed and submitted to the department within five working days of the initial report. (F) A written record shall be maintained of each investigation of reported abuse, neglect, or exploitation. This REQUIREMENT is not met as evidenced by: K.A.R. 26-42-101 (f) (3)	S5028		

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S5028	Continued From page 4 The facility reported a census of 5 residents. The sample included 3 "Residents'" (R)'s1, 2, and 3. Based on record review and interview the operator failed to report to the department within 24 hours an allegation of neglect for R1 when the facility "Certified Medication Aide" reported to the Registered Nurse that the CMA failed to document the administration of Oxycodone at the time of administration and administered the medication twice in approximately 37 minutes. Findings included: - Record review for R1 revealed an admission date of 05/27/25 with diagnoses of end stage renal disease, chronic pain, atrial fibrillation, anemia, and heart failure with preserved ejection fraction. Review of R1's "Functional Capacity Screen" (FCS) dated 05/27/25 revealed R1 required physical assistance with bathing, dressing, toileting, transferring, walking/mobility, and supervision with eating. R1 lacked the ability to manage her own mediations/medical treatments, and had impaired short-term memory, long-term memory, memory/recall, and decision making. R1 was usually able to make herself understood and she usually understood others. R1 was at risk for falls, impaired decision making and used a walker and wheelchair mobility device. Review of R1's "Negotiated Service Agreement" dated 05/27/25 under the section titled "Medication and Medical Treatments" identified	S5028		

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S5028	Continued From page 5 the facility staff would be provided by qualified facility staff. Review of R1's "Health Service Plan" (HSP) instructed the facility "Certified Medication Aides'" (CMA)'s would administer all of R1's medications. Review of R1's medical record under the "Nurse Notes" tab revealed the following entry made on 06/27/25 (the entry lacked a time of entry). Registered Nurse B documented that she received a call from the third shift CMA stating that "an additional Oxycodone dosage may have been given in error." Registered Nurse B documented that she instructed the facility CMA to get a set of vital signs immediately and to obtain another set of vital signs in 30 minutes, and to repeat every thirty minutes with first shift continuing to monitor for the next three to four hours. Registered Nurse B documented that she notified R1's family about the "mediation error". Review of R1's signed orders dated 06/25 revealed an order for Oxycodone HCL 5 milligram tablets to be administered twice daily for pain. Interview on 09/30/25 at approximately 02:40 PM with Registered Nurse B confirmed she did not notify the department of the medication error within 24 hours of being notified of the incident. The operator failed to report to the department within 24 hours an allegation of neglect for R1 when the facility "Certified Medication Aide" reported to the Registered Nurse that the CMA failed to document the administration of	S5028		

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S5028	Continued From page 6 Oxycodone at the time of administration and administered the medication twice in approximately 37 minutes.	S5028		
S5029 SS=F	26-42-101 (g) Availability of policies and procedures (g) Availability of policies and procedures. Each administrator or operator shall ensure that policies and procedures related to resident services are available to staff at all times and are available to each resident, legal representatives of residents, case managers, and families during normal business hours. A notice of availability shall be posted in a place readily accessible to residents. This REQUIREMENT is not met as evidenced by: K.A.R. 26-42-101 (g) The facility reported a census of 5 residents. The sample included 3 "Residents'" (R)'s. Based on observation and interview the operator failed ensure the facility's policies and procedures related to resident services were available to staff at all times. The Operator further failed to post in a notice in a place readily accessible to residents the availability of the facility's policy and procedures during normal business hours. Findings included: - Observation on 09/29/25 at approximately 02:30 PM during the facility tour, the facility lacked a posting of the availability of the facility's policy and procedures.	S5029		

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S5029	Continued From page 7 Interview on 09/30/25 at approximately 04:00 PM with Operator A and Registered Nurse B confirmed the facility lacked a posting of the availability of the facility's policies and procedures during normal business hours. Operator B further confirmed the facility policies were being reviewed and revised during the survey process and the policy and procedure manual had been located at the main business office. The operator failed ensure the facility's policies and procedures related to resident services were available to staff at all times. The Operator further failed to post in a notice in a place readily accessible to residents the availability of the facility's policy and procedures during normal business hours.	S5029		
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 5 residents. The	S5040		

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S5040	Continued From page 8 sample included 3 "Residents'" (R)'s. Based on observation and interview the operator failed ensure the posting of the names and phone numbers commonly required in emergencies was posted adjacent to the facility phone. Findings included: - Observation on 09/29/25 at approximately 02:30 PM during the facility tour revealed a phone that sat on the counter in the kitchen on the northeast wall under the window. The area adjacent to the phone lacked a posting of the names and phone numbers commonly required in emergencies. Interview on 09/30/25 at approximately 04:00 PM with Operator A and Registered Nurse B confirmed the phone in the kitchen lacked a posting of the names and phone numbers commonly required in emergencies. The operator failed ensure the posting of the names and phone numbers commonly required in emergencies was posted adjacent to the facility phone.	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 acceptable standards of practice. This REQUIREMENT is not met as evidenced by: K.A.R. 26-42-204 (i)	S5171		

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S5171	Continued From page 9 The facility reported a census of 5 residents. The sample included 3 "Residents'" (R). Based on observation, interview, and record review the Operator failed to ensure to provide healthcare services for R2 in accordance with professional standards of practice when the operator failed to complete an assessment to confirm the device was not a restraint, an assessment to determine the purpose of the device and R2's ability to safely use the device, and an assessment to confirm the device posed no risk for entrapment, and document a description of the device, the purpose of the device, and special instructions for use and monitoring of the device in R2's "Negotiated Service Agreement/Health Service Plan"(NSA/HSP). Findings included: Record review for R2 revealed an admission date of 06/06/25 with diagnoses of hypertension, type two diabetes mellitus, Rheumatoid arthritis, chronic obstructive pulmonary disease, insomnia, congestive heart failure, and seizures. Review of R2's "Functional Capacity Screen" (FCS) dated 07/23/25 revealed R2 required physical assistance with bathing, dressing, and toileting. R2 was independent with transferring and required supervision with walking/mobility. R2 lacked the ability to manage her own medications and was incontinent of bladder. R2 was at risk for falls and impaired decision making. R2 used a walker mobility device. Review of R2's "Negotiated Service Agreement"	S5171		

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S5171	Continued From page 10 dated 07/23/25 under the section titled "Bed Cane / Rail: May use bed rail if requested and per Doctor orders". R2's NSA lacked a description of the device, its purpose and special instructions on use and monitoring, Observation on 09/30/25 at approximately 03:30 PM of R2's bed revealed the head of the bed sat against the southeast wall with the left side of the bed against the south wall. On bilateral sides of the bed were rectangular quarter bedrails that measured approximately 32.5 inches in width, and approximately 18 inches width. There devices were securely attached to the bed frame and there were 8 support bars in the opening of the rectangle area closing any risk for entrapment. Interview on 09/30/25 at approximately 03:30 PM with R2 revealed the bedrail on the left side of the bed that sat against the wall was always in the up position, and that she used the rail for repositioning while in bed. She stated that the rail on the right side of the bed is not used and always in the down position. Interview on 09/30/25 at approximately 04:00 PM with Registered nurse B confirmed the medical record for R2 lacked documentation of R2's bilateral bed assist device to confirm the device was not a restraint, an assessment to determine the purpose of the device and R2's ability to safely use the device, and an assessment to confirm the device posed no risk for entrapment, and document a description of the device, the purpose of the device, and special instructions	S5171		

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S5171	Continued From page 11 for use and monitoring of the device in R2's NSA. 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 use it safely and reassessment of the safety of the device in the resident's record. For R2 the Operator failed to ensure to provide healthcare services for R2 in accordance with	S5171		

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S5171	Continued From page 12 professional standards of practice when the operator failed to complete an assessment to confirm the device was not a restraint, an assessment to determine the purpose of the device and R2's ability to safely use the device, and an assessment to confirm the device posed no risk for entrapment, and document a description of the device, the purpose of the device, and special instructions for use and monitoring of the device in R2's "Negotiated Service Agreement/Health Service Plan"(NSA/HSP).	S5171		