

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175407	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/24/2025
NAME OF PROVIDER OR SUPPLIER Life Care Center of Wichita		STREET ADDRESS, CITY, STATE, ZIP CODE 622 N Edgemoor Street Wichita, KS 67208	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>51334</p> <p>The facility reported a census of 117 residents with 24 residents selected for review. Based on observation, interview, and record review, the facility failed to accurately complete the Minimum Data Set for three Residents (R), which included R11's pressure injury and R18's use of a foley catheter.</p> <p>Findings included:</p> <ul style="list-style-type: none"> - Review of the Electronic Health Record (EHR) documented R11 had pertinent diagnoses of dependence on dialysis treatment, end-stage renal disease (ESRD-a terminal disease of the kidneys), diabetes mellitus (DM-when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), morbid obesity, unspecified malnutrition, and hypotension (low blood pressure). <p>The 09/27/24 Annual Minimum Data Set (MDS) documented a brief interview for mental status (BIMS) score of 15, indicating intact cognition. R11 did not have a risk for pressure ulcers.</p> <p>The 09/27/24 Pressure Ulcer/Injury Care Area Assessment CAA documented R11 had impaired bed mobility.</p> <p>The 03/02/25 Quarterly MDS documented a brief interview for mental status (BIMS) of 15, indicating intact cognition. The assessment documented R11 as on a parenteral/IV feeding (administration of nutritional products directly into the bloodstream, bypassing the usual process of eating and digestion). The assessment also documented R11 did not have any pressure ulcers.</p> <p>During an interview on 03/20/25 at 09:57 AM, Licensed Nurse (LN) Q stated R11 had a wound on her buttock that was identified as a stage three pressure area.</p> <p>During an interview on 03/20/25 at 09:07 AM, Administrative Nurse H confirmed R11 did not get intravenous (IV-administered directly into the bloodstream via a vein) fluid or nutrition while she was in the facility. Administrative Nurse H stated it was incorrect and she would complete a correction of the MDS. Administrative Nurse H stated there was some confusion about the resident's pressure ulcer. She coded that there was a pressure ulcer, but there was not one at any stage. She stated the pressure ulcer questions were incorrect and would be corrected. Administrative Nurse H reported the facility followed the Resident Assessment Instrument (RAI) for instructions on how to complete the MDS.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 03/24/25 at 02:49 PM, Administrative Nurse B stated she expected the MDS to be completed correctly.</p> <p>The facility's Certification of Accuracy of the MDS policy dated 09/05/24 documented the MDS assessment must accurately reflect the resident's status.</p> <p>- Review of the Electronic Health Record (EHR) documented R18 had pertinent diagnoses of acute renal failure (sudden onset of severe inability of the kidneys to excrete wastes, concentrate urine and conserve electrolytes that can be treated) and urinary retention (lack of ability to urinate and empty the bladder).</p> <p>The 02/28/25 Admission Minimum Data Set (MDS) documented R18 had a brief interview for mental status (BIMS) of 11, indicating moderately impaired cognition. The MDS lacked documentation regarding R18's urinary catheter (insertion of a catheter into the bladder to drain the urine into a collection bag).</p> <p>During an observation on 03/20/25 at 08:27 AM revealed the resident had an indwelling urinary catheter.</p> <p>During an interview on 03/24/25 at 01:11 PM, Administrative Nurse H confirmed R18 did have a foley catheter that she was admitted with. She stated the MDS was incorrect, and she would complete a correction of the MDS. Administrative Nurse H reported the facility followed the Resident Assessment Instrument (RAI) manual for instructions on how to complete the MDS.</p> <p>During an interview on 03/24/25 at 02:49 PM, Administrative Nurse B stated she expected the MDS to be completed correctly.</p> <p>The facility's Certification of Accuracy of the MDS policy dated 09/05/24 documented the MDS assessment must accurately reflect the resident's status.</p>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36881</p> <p>The facility had a census of 117 residents, the sample included 24 residents. Based on observation, interview, and record review, the facility failed to develop a comprehensive care plan with interventions to address R47's preferences for bathing on the resident's comprehensive care plan.</p> <p>Findings included:</p> <ul style="list-style-type: none"> - Review of Resident (R)47's Electronic Health Records (EHR) Physician Orders (POS), dated 02/25/25 documented diagnoses which included hemiplegia (paralysis or complete loss of movement on one side of the body), hemiparesis (muscle weakness on one side of the body) following cerebral infarction (stroke-when blood flow to the brain is blocked causing tissue death in the brain) affecting the non-dominant side, lack of coordination and need for assistance for personal care. <p>The 10/08/24 Minimum Data Set (MDS) documented a brief interview for mental status (BIMS) score of 14 indicating intact cognition. She reported choosing her bath type was very important to her. The resident required partial/moderate assistance of staff with bathing. The resident had no functional limitations in range of motion for upper or lower extremities.</p> <p>The Quarterly MDS dated [DATE] documented an improved BIMS score of 15, indicating intact cognition.</p> <p>The Care Plan dated 01/28/25 documented the resident had an activities of daily living (ADL) self-care performance deficit related to her need for one staff assistance in part of bathing activity. The care plan lacked direction to the staff regarding the resident's bathing schedule and/or the resident's preferences.</p> <p>Review of the resident's Electronic Medical Record (EMR) for Tasks revealed the residents bathing preferences included the use of a whirlpool two days a week on Monday and Thursday during the day shift. The staff offered the resident four bathing opportunities during the 30-day period of 02/24/25 through 03/23/25. Review of the resident's bath sheets, and task bathing indicated the resident was offered bathing 2/24/25 through 3/24/25 and on 02/27/25 the resident had a shower, on 03/03/25 she refused, on 03/16/25 a shower was given, and on 03/17/25 the resident refused. The documentation lacked indication of any baths offered at any other time during the 30-day period reviewed.</p> <p>On 03/18/25 01:51 PM revealed R47 in her chair, in her room and she stated she did not get the baths like she wanted. The staff gave her showers, but they were not given as scheduled.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 03/20/25 at 09:53 AM, Certified Nurse Aide (CNA) GG confirmed the resident required assistance of staff for all of her ADLs. CNA GG reported the resident should receive at least two baths a week, but she could have a bath as she preferred. The facility had a bath schedule that was based on the resident's preferences. The preferences and schedule should be listed in the resident's care plan to guide the staff on the resident's preferences a well. CNA GG reported the CNAs completed a bath sheet when they offered the resident a shower or when they give a them a bath. The nurse should be notified if resident's refused their baths. Then the nurse would check with a resident to determine if there was a scheduling problem and try to work it out.</p> <p>On 03/24/25 at 02:39 PM, Administrative Nurse E confirmed the above findings. She confirmed the staff did not offer bathing opportunities for the resident in accordance with her preference. Additionally, the resident's preferences were not documented in the care plan to guide the staff in providing cares for the resident.</p> <p>On 03/24/25 at 02:03 PM, Administrative Nurse B confirmed the above findings and stated she would expect the staff to offer bathing opportunities in accordance with the bathing schedule and resident's preferences which should be noted in the resident's care plan.</p> <p>On 03/24/25 at 02:37 PM, Administrative Nurse B confirmed preferences were not on the resident's care plan.</p> <p>The facility policy titled Comprehensive Care Plans and Revisions, dated 09/11/24, documentation included the facility will ensure that the comprehensive care plan is developed to include the resident's requests and preferences.</p> <p>The facility failed to develop a comprehensive care plan to direct the staff in the provision of care and services in accordance with the resident's preferences in accordance with the resident's bathing preferences.</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36881</p> <p>The facility reported a census of 117 residents. The 24 sampled residents included four dependent residents reviewed for activities of daily living (ADLs). Based on observation, interview, and record review the facility failed to provide scheduled baths in accordance with the residents scheduled bathing schedule to ensure necessary services to maintain good personal hygiene for Resident (R) 47.</p> <p>Findings included:</p> <ul style="list-style-type: none"> - Review of Resident (R) 47's Electronic Health Records (EHR) Physician Orders (POS), dated 02/25/25 documented diagnoses which included hemiplegia (paralysis or complete loss of movement on one side of the body), hemiparesis (muscle weakness on one side of the body) following cerebral infarction (stroke-when blood flow to the brain is blocked causing tissue death in the brain) affecting the non-dominant side, lack of coordination and need for assistance for personal care. <p>The 10/08/24 Minimum Data Set (MDS) documented a brief interview for mental status (BIMS) score of 14 indicating intact cognition. She reported choosing her bath type was very important to her. The resident required partial/moderate assistance of staff with bathing. The resident had no functional limitations in range of motion for upper or lower extremities.</p> <p>The Quarterly MDS dated [DATE] documented an improved BIMS score of 15, indicating intact cognition.</p> <p>The Care Plan dated 01/28/25 documented the resident had an activities of daily living (ADL) self-care performance deficit related to her need for one staff assistance in part of bathing activity. The care plan lacked direction to the staff regarding the resident's bathing schedule and/or the resident's preferences.</p> <p>Review of the resident's Electronic Medical Record (EMR) for Tasks revealed the residents bathing preferences included the use of a whirlpool two days a week on Monday and Thursday during the day shift. The staff offered the resident four bathing opportunities during the 30-day period of 02/24/25 through 03/23/25. Review of the resident's bath sheets, and task bathing indicated the resident was offered bathing 2/24/25 through 3/24/25 and on 02/27/25 the resident had a shower, on 03/03/25 she refused, on 03/16/25 a shower was given, and on 03/17/25 the resident refused. The documentation lacked indication of any baths offered at any other time during the 30-day period reviewed.</p> <p>On 03/18/25 01:51 PM revealed R47 in her chair, in her room and she stated she did not get the baths like she wanted. The staff gave her showers, but they were not given as scheduled.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 03/20/25 at 09:53 AM, Certified Nurse Aide (CNA) GG confirmed the resident required assistance of staff for all of her ADLs. CNA GG reported the resident should receive at least two baths a week, but she could have a bath as she preferred. The facility had a bath schedule that was based on the resident's preferences. The preferences and schedule should be listed in the resident's care plan to guide the staff on the resident's preferences a well. CNA GG reported the CNAs completed a bath sheet when they offered the resident a shower or when they give a them a bath. The nurse should be notified if resident's refused their baths. Then the nurse would check with a resident to determine if there was a scheduling problem and try to work it out.</p> <p>On 03/24/25 at 02:39 PM, Administrative Nurse E confirmed the above findings. She confirmed the staff did not offer bathing opportunities for the resident in accordance with her preference. Additionally, the resident's preferences were not documented in the care plan to guide the staff in providing cares for the resident.</p> <p>On 03/24/25 at 02:03 PM, Administrative Nurse B confirmed the above findings and stated she would expect the staff to offer bathing opportunities in accordance with the bathing schedule and resident's preferences which should be noted in the resident's care plan.</p> <p>On 03/24/25 at 02:37 PM, Administrative Nurse B confirmed preferences were not on the resident's care plan.</p> <p>The facility policy titled Comprehensive Care Plans and Revisions, dated 09/11/24, documentation included the facility will ensure that the comprehensive care plan is developed to include the resident's requests and preferences.</p> <p>The facility failed to develop a comprehensive care plan to direct the staff in the provision of care and services in accordance with the resident's preferences in accordance with the resident's bathing preferences.</p>

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident's drug regimen must be free from unnecessary drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51334</p> <p>The facility reported a census of 117 residents with 24 residents sampled. Based on observation, interview, and record review revealed the facility failed to hold hypotension (low blood pressure) medication for Resident (R)11.</p> <p>Findings included:</p> <ul style="list-style-type: none"> - Review of Resident (R)11's Electronic Medical Record (EMR) revealed a diagnosis of hypotension (low blood pressure BP). <p>The Annual Minimum Data Set (MDS), dated [DATE], documented the resident had a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS indicated R11 had a diagnosis of hypotension.</p> <p>The Cognitive Loss/Dementia Care Area Assessment (CAA), dated 09/27/24, did not trigger.</p> <p>The Quarterly MDS, dated [DATE], documented the resident had a BIMS score of 15, indicating intact cognition. She had a diagnosis of hypotension.</p> <p>The care plan, revised 04/26/25, lacked staff instruction regarding the use of Midodrine (hypotension medication) medication.</p> <p>Review of the resident's EMR revealed the following physician's order:</p> <p>Midodrine (medication used to treat low blood pressure/hypotension), 5 milligrams (mg), by mouth (po), twice daily (BID), for a diagnosis of hypotension. Staff were to monitor the resident's BP and hold the medication if her systolic blood pressure (SBP-the top number) was greater than 110 millimeters of Mercury (mmHg), BID, ordered 02/28/25.</p> <p>Review of the resident's blood pressures in her EMR, from 02/15/25 through 03/20/25, revealed the following instances where staff administered R18's Midodrine when the resident's SBP was greater than the ordered parameter of 110 mmHg:</p> <ul style="list-style-type: none"> On 02/12/25, the resident's SBP was 112 mmHg, and staff administered the medication. On 02/21/25, the resident's SBP was 113 mmHg, and staff administered the medication. On 02/26/25, the resident's SBP was 114 mmHg, and staff administered the medication. On 03/06/25, the resident's SBP was 112 mmHg, and staff administered the medication. On 03/20/25, the resident's SBP was 157 mmHg, and staff administered the medication. On 03/22/25, the resident's SBP was 131 mmHg, and staff administered the medication. <p>(continued on next page)</p>		

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 03/24/25 at 02:49 PM, Administrative Nurse B stated it was the expectation for staff to hold medications when the vital signs were outside of the ordered parameters.</p> <p>The facility policy, Administration of Medications, dated 09/16/24, included: Staff will follow the 10 rights of medication administration while administering medications to the residents.</p> <p>The facility failed to ensure staff held the hypotension medication, as ordered, for R18 on multiple occasions.</p>

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>Deficiency Text Not Available</p>

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>52154</p> <p>The facility census totaled 117 residents, eleven medication carts and three medication storage rooms. Based on observation, interview, and record review, the facility failed to ensure the staff had dated multiple dose vials of injectable medication. This deficient practice placed residents at risk of receiving outdated injectable medication.</p> <p>Findings included:</p> <p>- On 03/20/25 at 01:49 PM, observation in the medication room revealed a multiple dose vial of Purified Protein Derivative (PPD) solution (substance used in a skin test to diagnose tuberculosis [TB] infection) had been opened and was not marked with the opened date.</p> <p>During an interview on 03/20/25 at 01:50 PM, Administrative Nurse G replied that she believed multiple-dose vials are good for 28 days and that some insulin pens could be good for use longer than 28 days. Administrative Nurse G replied that the opened pen or vial should have been dated once it had been opened with the open date; labeled on the pen, box or vial.</p> <p>During an interview on 03/20/25 at 02:30 PM, Administrative Nurse B reported that PPD solutions should have been labeled when it was opened. Administrative Nurse B stated the PPD solution was good for 28 days and it had now been disposed of.</p> <p>Administrative Nurse C provided the undated facility policy Omnicare Medication Storage Guidance. The facility policy guidance indicated that multiple-dose vials for injection are to be dated when opened. It also indicated that the unused portion were to be discarded after 28 days or in accordance with the manufacturer's recommendations.</p> <p>The facility failed to ensure the safe and secure storage of multiple-dose injectable medication when observation onsite revealed staff had failed to date multiple-dose injectable medication once it had been opened.</p>

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.</p> <p>52154</p> <p>The facility reported a census of 117 residents. The facility failed to provide the appropriate vegetarian diet selection sheet for a resident (R)13 who was vegetarian with orders for a vegetarian diet.</p> <p>Findings included:</p> <ul style="list-style-type: none"> - Review of R13's diagnoses from the Electronic Health Record (EHR) documented, anemia due to enzyme disorder (occurs when red blood cells break down faster than the body can replace them, often due to inherited enzyme deficiencies like G6PD or pyruvate kinase deficiency), schizophrenia (a chronic brain disorder that affects how a person thinks, feels, and behaves, often characterized by disruptions in thought processes, perceptions, and emotional responsiveness, leading to hallucinations, delusions, and disorganized thinking). <p>The 10/02/24 Annual Minimum Data Set (MDS) documented a BIMS score of 15, which indicated intact cognition. R13 was independent for eating and had no weight loss indicated on the assessment.</p> <p>The 01/02/25 Quarterly Minimum Data Set (MDS) documented a BIMS score of 15, which indicated intact cognition. R13 was independent for eating and had no weight loss indicated on the assessment.</p> <p>Review of R13's Care Area Assessment (CAA) revealed no concerns to dietary needs.</p> <p>An observation on 03/20/25 revealed R13 received the same dietary selection sheet as the other residents to select her meals for the day. Administrative Nurse E assisted R13 to cross out the non-vegetarian protein options and write in her vegetarian selections. The dietary sheet had only and egg protein option for breakfast and there were not any additional protein selections for the lunch or supper meals.</p> <p>During an interview on 03/18/25 at 11:52 AM, R13 stated she was a vegetarian and the facility had not provided many options for her dietary requirements. R13 reported the facility told her they would provide her protein choices, and they have not done so and R13 stated she has had to spend part of her monthly income to buy groceries.</p> <p>During an interview on 03/19/25 at 11:05 AM, Administrative Nurse E reported R13's diet was on a regular vegetarian diet and stated R13 crossed out menu items on the dietary sheet provided to her. R13 wrote in her vegetarian choices and often did not eat or order breakfast.</p> <p>During an interview on 03/20/25 at 09:25 AM, Dietary Staff I stated some vegetarian options were provided on the daily dietary sheet that the residents filled out. Alternate protein options were available, and the residents were allowed to write their choices. She reported that the same dietary sheet was provided to all of the residents.</p> <p>(continued on next page)</p>		

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a phone interview on 03/20/25 at 10:54 AM, with Dietitian KK she stated it was not appropriate for a vegetarian resident to receive the same dietary meal selection list as the other residents. He reported a vegetarian resident should have received a dietary selection list that was specific to their diet. He further stated that it was not appropriate for a resident to have to spend their own money on groceries to ensure they received necessary protein. Dietitian KK also indicated that there should have been protein options available for a vegetarian at every meal.</p> <p>The facility policy Food and Nutrition Services Manual dated 03/05/24, has nothing documented in it with regards to meeting requirement for alternative ordered diets.</p> <p>The facility failed to follow the ordered alternative menu to ensure proper nutrition for resident 13 that had a vegetarian diet ordered.</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>50659</p> <p>The facility reported a census of 117 residents with 24 in the sample. Based on observation, interview, and record review, the facility failed to store, prepare, and serve food to prevent possible food-borne illness among the facility's residents.</p> <p>Findings included:</p> <p>- On 03/18/25 at 07:55 AM, during the initial tour of the central kitchen and refrigerator storage areas, the following areas of concern were identified:</p> <p>One undated opened one-gallon jug of honey mustard dressing, one undated gallon jug of base BBQ sauce, approximately 33 slices of cheese in cellophane wrap undated, a five-pound tub of sour cream is opened and undated. And one pitcher with an orange substance in it that is undated and unlabeled in the walk-in refrigerator.</p> <p>Four unsealed opened and undated bags of food stuff, one bag of Italian zucchini in the freezer.</p> <p>The tour also documented the freezer temperature logs had nothing noted for 03/17/25, the refrigerator temperature log had blanks for 03/15/25, 03/16/25, and 03/17/25. The sanitizer log documents blank from 03/12/25 through 03/17/25.</p> <p>On 03/18/25 at 08:04 AM, an interview with Dietary staff J revealed the facility policy was to reseal and date all opened foods. She confirmed the above as not being properly dated, sealed, and labeled. Dietary staff J stated the logs should be filled out each shift each day and confirmed the open areas were not correct.</p> <p>On 03/19/25 at 04:15 PM, three cutting boards noted with many scratches making an uncleanable surface.</p> <p>On 03/19/25 at 04:15 PM, Certified Dietary Manager (CDM) I confirmed the scratches and reported that she would buy new ones.</p> <p>(continued on next page)</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 03/20/25 at 12:00 PM, noted that there was an unidentified man on a ladder with a roof tile open by the dishwashing room that was several feet away from the tray line, while staff were starting the tray line for lunch. There was then water noticed leaking from a ceiling tower approximately eight feet away from the meal line prep area. The water intensified the maintenance man came over to that area with an outside vendor, as water was pouring out of the ceiling above the sink area where a microwave and small freezer were plugged in, and tray caddy with six trays set up for meal pass with silverware wrapped in a paper napkin and the dessert cup that was covered on the trays were noted to be sprayed with the water that came out of the ceiling as the dark blue trays had several water spots on them, CDM I unplugged the microwave, moved a large dish storage container, that was covered, towards the dishwasher room and told Dietary staff J to take the one tray caddy that was splashed with the water to the dishwasher room, another dietary staff moved that tray caddy and it sat out of the way and never made it to the dishwasher. Those trays were used on the last trays set up for the meal that the test tray was on. The divided dishes that were set up on a table where the temperature base was placed on were splashed with the water from the ceiling also and they were used to serve the food to the residents.</p> <p>On 03/20/25 at 12:07 PM, Maintenance Staff EE reported that there was a leak noted above that area earlier today and this was the first time the outside worker could get to the facility to fix the leak and reported this was not his call, to do the job during a meal service.</p> <p>On 03/20/25 at 12:30 PM, CDM I reported that maintenance staff did not normally work in the kitchen during the meal prep and pass time.</p> <p>On 03/20/25 at 12:34 PM, Administrative Staff A reported that maintenance should not have been working in the kitchen during mealtimes and reported that the outside vendor shut off the wrong valve and that was what caused the water to leak.</p> <p>The facility's Food Safety Requirements dated 04/26/23 documented that the facility must store, prepare, distribute, and serve food in accordance with professional standards for food service safety.</p> <p>The facility's Food Safety policy dated 04/26/23 documented food would be stored and maintained in a clean, safe, and sanitary manner following federal, state, and local guidelines to minimize contamination and bacterial growth.</p> <p>The facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety to prevent possible food borne illness in the facility's resident population.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide and implement an infection prevention and control program.</p> <p>51334</p> <p>The facility reported a census of 117 residents. The sample included 24 residents. Based on observation, interview, and record review, the facility failed to maintain an effective infection control program related to improper hand hygiene care by facility staff during incontinent care and catheter (a flexible tube inserted through a narrow opening into a body cavity, particularly the bladder, for removing fluid) care. The facility staff also failed to follow infection control policies for respiratory care and failed to follow proper enhanced barrier precautions (EBP- a set of infection control measures that use gowns and gloves to reduce the spread of multidrug-resistant organisms (MDRO) in nursing homes). This deficient practice had the potential to spread possible infections to the residents in the facility.</p> <p>Findings included:</p> <ul style="list-style-type: none"> - During an observation on 03/18/25 at 09:33 AM, Resident (R)18 was in her bed. Her wheelchair had an oxygen tank on the back of it with tubing wrapped around it and not in a bag. She had a cough and reported she thinks she may need to go to the hospital. <p>During an observation on 03/18/25 at 02:09 PM, R93's oxygen tubing nasal cannula was hung on the wheelchair and touched the wheel.</p> <p>During an observation 03/19/25 10:35 AM, R72 received incontinent care by Certified Nurse Aide (CNA) T and</p> <p>Certified Medication Aide (CMA) X. CNA T and CMA X failed to complete hand washing prior to applying gloves when donning personal protective equipment (PPE- gowns, face shields and/or eyeglasses/goggles, and gloves). CNA T and CMA X used their gloved hands to close the blinds on the window, opened the closet door, and opened the drawer on the nightstand and neither aide changed gloves and then CMA X provided peri care to R72's perineum (the area between the genitals and the anus) she used one disposable wipe three strokes before disposing the wipe. CMA X did not change the area of the wipe when she washed perineum front to back. With the first stroke CMA X pulled the wipe back and a noted light brown colored spot was on the wipe. CMA X used the same area on the wipe for two more strokes. R72 was assisted onto her left side, CNA T provided care to R72's buttocks, CNA T removed her glove on her right hand applied a new glove then applied barrier cream to R72's buttocks. CMA X removed her gloves and applied new gloves, but the staff did not perform hand hygiene between doffing and donning gloves.</p> <p>During an interview on 03/19/25 at 11:05 AM, CNA T reported that she should have removed both gloves and</p> <p>performed hand hygiene, she also reported she did not realize she had touched surfaces in R72's room with gloves before she performed peri care.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During an interview on 03/19/25 at 11:10 AM, CMA X reported that she should have washed her hands each time after she removed her gloves. CMA X reported that she knew to not use a wipe more than one stroke when peri care was provided CMA X reported that she thought the light-colored brown area on the wipe after the first stroke was barrier cream. She reported that R72 did have a smear of soft bowel movement in her brief.</p> <p>During an observation on 03/20/25 at 08:19 AM, R18 was in bed with the call light on. Her bilevel positive airway pressure (BiPAP-medical device which helps with breathing) mask was laying on top of items on the bed side table. Her incentive spirometer was on the overbed table with the mouthpiece laying on the table adjacent to two dried spots of coffee and other items.</p> <p>During an interview on 03/19/25 at 10:41 AM, CNA U stated oxygen tubing should always be placed in a bag when not in use.</p> <p>During an interview on 03/19/25 at 01:29 PM, Licensed Nurse (LN) M stated oxygen tubing and BiPAP masks should always be in a bag when not in use. LN M said the nebulizer should be washed out and laid open on a paper towel when a treatment is completed.</p> <p>During an observation on 03/20/25 at 08:27 AM, CNA F entered the room and put on gloves. LN M and the therapy aide were in the room with gloves on. She put on a gown and handed a gown to LN M. The therapy aide went over and got one and put it on. The OT aide lowered the head of the bed, but the legs of the bed would not lower. CNA F wiped the front of R18's peri area with several swipes with the same wipe, then rolled R18 to her side and wiped with a new wipe every wipe on the bottom. Took off her soiled gloves and put on clean gloves without hand hygiene. CNA F applied cream and again removed soiled gloves and applied new gloves without hand hygiene. CNA F placed the catheter drainage bag on the bed beside R18's legs that were raised at least 6 inches above her bladder. CNA F picked up the catheter several times lifting it far above the foot of the bed to adjust the covers off R18's feet. This Nurse reminded her to keep the bag below the bladder. She stated she was worried it would pull on the tubing if she left it down, but she did attach it to the bed below the level of the bladder. CNA F lifted the catheter drainage bag up again over the level of the bladder several more times in the process of dressing R18, also lifted it up and handed it over the other staff member to the other side of the bed at her shoulder height. CNA F and LN M removed their gown to transfer R18 to her wheelchair. CNA F attached the catheter drainage bag to the sling but removed it prior to the transfer. During the transfer with the hoier lift, CNA F handed the catheter drainage bag to LN M, who then kept the bag below the level of the bladder. Then CNA F went to the bed and remade the bed by spreading out the bed pad and taking off the soiled turn sheet. LN M took the sling out of the room as CNA F got R18 set up for breakfast.</p> <p>During an interview on 03/20/25 at 08:52 AM, LN M stated the Foley catheter drainage bag should be kept below the level of the bladder. Also, hand hygiene should be performed prior to putting on gloves and between glove changes.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During an observation on 03/20/25 at 01:25 PM R71 was assisted off unit with other facility staff for activities. Leg bag was not emptied, and pant leg was soiled with urine.</p> <p>During an interview on 03/19/25 at 02:04 PM, CNA DD revealed that R71's catheter had been leaking and that she had fixed it to stop the leak. CNA DD revealed that R71 was able to change her clothes when it is needed.</p> <p>During an interview on 03/19/25 at 01:52 PM, Certified Medication Aide (CMA) R revealed staff are responsible for R71's catheter care and switching it from the night drainage bag to the leg bag for daytime use as well as the emptying of the catheter.</p> <p>During an observation on 03/20/25 at 09:09 AM, LN N prepared R93's medications. During the medications preparation LN N dropped the cap off the Lactulose (a synthetic sugar used to treat constipation) bottle onto the ground. LN N picked the cap back up off the floor with her left hand applied a glove to her right hand and retrieved a sanitation wipe from the cart. LN N wiped the cap off and placed it back onto the bottle. LN N removed the glove off her right hand and finished the medication preparation for the remainder of six more medications. LN N failed perform hand hygiene after she cleansed the cap.</p> <p>During an interview on 03/20/25 at 10:05 AM, LN N reported that there was no hand sanitizer on the medication cart, and she should have washed her hands. She reported that she normally would not wash her hands every time she removed her gloves.</p> <p>During an interview on 03/24/25 at 10:03 AM, Administrative Nurse D expected staff to perform hand hygiene after they pick up an object off the floor before they provide resident care or tasks.</p> <p>During an interview on 03/24/25 at 11:29 AM, Administrative Nurse E stated that it was her expectations for nursing staff to empty R71's leg bag prior to her leaving the unit to attend activities. R71 was reported to be able to notify the nurse on shift if this care had been completed or not when asked.</p> <p>During an interview on 03/24/25 at 02:48 PM, Administrative Nurse B stated that it was her expectations for CNA to be completing catheter care. When the Nurse documents the completion of the task on the administration record (MAR) that verified that nurse confirmed the CNAs preformed the catheter care.</p> <p>Administrative Nurse B revealed she expected staff to complete catheter care at least once a shift and more if necessary.</p> <p>During an interview on 03/20/25 at 01:23 PM, Administrative Nurse F stated she expected staff to perform hand</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>hygiene prior to applying gloves and when taking off gloves prior to putting them back on. Administrative Nurse F IC nurse stated that she expected the oxygen tubing and BiPaP mask to be in a bag when not in use. The nebulizers were to be washed out with water and left to air dry on a paper towel. Administrative Nurse F expected staff to follow the EBP guidelines by wearing proper PPE when performing ADL care. They do not have to wear PPE when going in to ask a question, but if they were going to touch the resident or their items in their room. Staff were expected to wear PPE if transferring, toileting, anything that is body contact, or changing sheets.</p> <p>Administrative Nurse F had not had a chance to spot check staff on catheter care or incontinent care. She expected staff to perform hand hygiene and don gloves to provide incontinent care or catheter care. Perform hand hygiene and don new gloves before touching clean items. She expected staff to only wipe one time with a cloth then throwing it away and getting a new cloth.</p> <p>During an interview on 03/24/25 at 02:48 PM, Administrative Nurse B stated that it was her expectations for CNA to be completing catheter care. When the Nurse documents the completion of the task on the MAR that verified that nurse confirmed the CNAs performed the catheter care. Administrative Nurse B revealed she expected staff to complete catheter care at least once a shift and more if necessary.</p> <p>During an interview on 03/24/25 at 02:49 PM, Administrative Nurse B stated it was her expectation that staff use good infection control measures including hand hygiene before and between gloving, use proper infection control measures with Foley catheter including using the proper PPE according to the EBP policy, and cleaning the nebulizers and taking them apart to dry on a paper towel.</p> <p>The facility's Enhanced Barrier Precautions policy dated 06/03/24 documented EBP was required during high-contact care activities for residents with wounds, indwelling medical devices including urinary catheters.</p> <p>Examples of high-contact resident care activities requiring gown and gloves include dressing, transferring, changing linens, and device care.</p> <p>The facility lacked a policy of Incontinent Care</p> <p>The facility failed to maintain an effective infection control program related to improper incontinent care, improper hand hygiene after removal of soiled gloves and failed to wear the proper PPE when staff cared for residents on EBP to prevent cross contamination in the facility.</p>		