STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175563	A. BUILDING _____ B. WING _____	C 03/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AZRIA HEALTH WICHITA	**7057 WEST VILLAGE CIRCLE WICHITA, KS 67205**

(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) COMPLETION DATE
F 000	INITIAL COMMENTS A complaint survey was conducted regarding the allegations in KS00193428, KS00193391, KS00192552, KS0019409 and KS00192221 The investigation revealed noncompliance was found related to the allegations and the following deficiencies were cited. The 2567 was electronically sent on 3/21/25.	F 000		
F 602 SS=D	Free from Misappropriation/Exploitation CFR(s): 483.12 §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: The facility reported a census of 68. The sample included 4 residents in the sample for reviews of misappropriation of medications. Based on observations, interview and record review the facility failed to ensure Resident (R) 1 remained free from misappropriation of medications, when on 02/04/24 Licensed Nurse D removed R1's second card of three with 45 tablets of hydrocodone (medications used for pain) 10-325 milligrams (mg) from the facility. The deficient practice placed R1 at risk for missed medication, unrelieved pain, and further misappropriate of medications. Findings included:	F 602		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 03/13/2025

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.

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F 602	Continued From page 1	F 602		

- The "Physicians Orders" date 03/4/25 for R1 revealed the following diagnosis paraplegia incomplete paralysis characterized by motor or sensory loss in the lower limbs and trunk) muscle spasms (involuntary contractions of a muscle) lupus (autoimmune disease is only condition hat causes the immune system believe the body's tissue are foreign pathogens and attacks the tissues)

The "Quarterly Minimum Data Set" (MDS) dated 10/09/24 revealed a "Brief Interview for Mental Status" (BIMS) score 15 indicating intact cognition. R1 dependent on staff for all "Activities of Daily Living" ADL, use of medications opioid for pain.

The "Annual Minimum Data Set" (MDS) dated 11/30/24 revealed there were no changes from Quarterly MDS.

The "Care Plan" with a revision date of 02/06/25 revealed R1 experienced acute and chonic pain related to lupus and chronic back pain related to vertebral fracture. R1 had a physcians order for hydrocodone with acetaminophen to given as needed for pain. Staff were to monitor and record pain characteristic every shift and as needed.

The "Pain Assessment" dated 02/12/25 revealed R1 had pain rated at a eight a few weeks ago when R1 had a urinary tract infection which was constant for three hours then stopped for about an hour and then started again. The pain does not affect R1's mood.

The "Physicians Medication Orders" dated 10/13/24 indicated hydrocodone- acetaminophen oral tablet 10-325 milligrams (mg) give one tablet

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F 602	Continued From page 2	F 602		

by mouth every six hours as needed for pain that range from six to nine. Fentanyl patch (transdermal patch that provides pain medication through the skin).

Observation on 03/06/25 at 11:35 AM R1 laying in her bed propped on her right sided no facial grimaces of pain. R1 denied she was in pain at this time. R1 stated that she was aware that on her cards of pain medicatins was taken from the facility. She stated that she did recieve her pain medications.

Review of the facility investigation on missing narcotics revealed that LN G had worked on the east unit on 03/01/25 through 03/02/25 on night shift. On 03/05/25 LN G returned to work and noticed a card of hydrocodone was missing. LN H notified the unit manager which then notified Administration Nurse D of the missing pain medication. LN G was placed on suspension pending investigation and notified to come in for a urine drug screening. LNG called the facility and self-confessed to taking the card of hydrocodone 10 mgs and tried to replace it with the 30 tabs of hydrocodone.

02/07/25 Pharmacist GG completed an audit on all scheduled medication in the facility with no other diversion discovered.

An interview on 03/06/25 at 01:10 PM with LN H revealed she had given the last dose on card one on 01/28/25. The resident had three cards of hydrocodone the first card was finished on 01/28/25 and she removed the card and the count sheet gave it to the unit manager. LN H stated she pulled the second card with the count

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F 602	Continued From page 3	F 602		

of 60 tabs with the count sheet placed in the medication cart. LN H stated she was for a couple of days and upon her return on 03/05/25 R1's card was number three not the second card that was started She notified the unit manage regarding the missing second card and a search started for the missing card. LN H revealed she worked the same hall opposite of LN G and noticed a new card of 30 tabs of hydrocodone had been ordered.

An interview on 03/11/25 at 09:40 AM, Administration Nurse D revealed her expectations when a nursing staff suspect missing medication was to report it immediately so an investigation can be completed.

The undated "Administering Medication" policy revealed medications are to be administered in a safe and timely manner and as prescribed. If a resident uses prn (as needed) medication frequently, the attending physician and interdisciplinary care team with support from the consultant pharmacist as needed, shall reevaluate the situation exam the individual as needed, determine if there is a clinical reason for the frequent prn use.

The facility failed to ensure Resident (R) 1 remained free from misappropriation of medications, when Licensed Nurse D removed R1's a card with 45 hydrocodone (medications used for pain) on 02/04/24. The deficient practice place R1 at risk for missed medication, uncontrolled pain and further misappropriate of medications.