Kansas State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N087084	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AZRIA HEALTH WICHITA	7057 WEST VILLAGE CIRCLE , WICHITA, Kansas, 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
S0000	INITIAL COMMENTS The following citations represent the findings of the licensure resurvey with attached complaint number 2601109 for the above named facility conducted on 04/07/26 and 04/08/26.	S0000		
S3085 SS = D	Negotiated Service Agreement CFR(s): 26-41-202 (a) (a) The administrator or operator of each assisted living facility or residential health care facility 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 LICENSURE REQUIREMENT is NOT MET as evidenced by: K.A.R. 26-41-202 (a) The facility reported a census of 24 residents. The sample included 3 "Residents'" (R)'s, and 1 focused review. Based on interview and record review the Administrator failed to ensure the development of the "Negotiated Service Agreement" (NSA) for R4 was based on his preferences and was in collaboration with the resident or the resident's legal representative. Findings included: -Record review for R4 revealed an admission date of 02/19/25 with diagnoses of hypertension, tissue	S3085		

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

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S3085 SS = D	Continued from page 1 perfusion alteration, Parkinson's disease, dementia, agitation, sundowners, and congestive heart failure. Review of R4's FCS dated 07/22/25 revealed R4 required physical assistance with bathing, dressing, and eating. R4 was independent with transferring, walking/mobility and eating. R4 lacked the ability to manage his own medications and medical treatments. R4 was incontinent and had impaired short-term memory and memory recall. R4 was able to make himself understood and he sometimes understood others. Review of R4's combined NSA/HSP (Negotiated Service agreement/Health care Service Plan) dated 07/22/25 under the section titled 'Medication Assist" instructed facility staff to assist with medication management and reordering medications. Review of the facility provided electronic mail dated 05/18/25 revealed R4's legal representative had a concern that R4 could not be provided his scheduled medications "any earlier than 09:00PM". Review of the facility provided letter from R4's legal representative dated 06/16/25, that revealed that R4 saw his neurologist and set his medication time at 07:30 PM , "which allows medication administration to be administered between the hours of 06:30PM and 08:30PM. Review of the facility provided administration audit dated 08/12/25 to 08/26/25 for Melatonin oral tablet 10 milligrams scheduled for 08:00 PM was documented as administered five times greater then one hour before or one hour after the scheduled 08:00 PM time. Review of the facility provided administration audit dated 08/12/25 to 08/26/25 for Trazodone HCl oral tablet scheduled for 08:00 PM was documented as administered five times greater then one hour before or one hour after the scheduled 08:00 PM time. Interview on 04/08/26 at approximately 04:00 PM with Licensed Nurse A, Administrator B, and Director of Nursing C, confirmed R4's NSA was based on the preferences of R4 and his legal representative. The Administrator failed to ensure the development of the NSA for R4 was based on his preferences and was in collaboration with the resident or the resident's legal representative.	S3085		
S3200 SS = E	Facility Administration of Medications	S3200		

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S3200 SS = E	Continued from page 2 CFR(s): 26-41-205 (d) (1-2) (d) Facility administration of resident ' s medications. If a facility is responsible for the administration of a resident ' s medications, the administrator or operator shall ensure that all medications and biologicals are administered to that resident in accordance with a medical care provider ' s written order, professional standards of practice, and each manufacturer ' s recommendations. The administrator or operator shall ensure that all of the following are met: (1) Only licensed nurses and medication aides shall administer and manage medications for which the facility has responsibility. (2) Medication aides shall not administer medication through the parenteral route. This LICENSURE REQUIREMENT is NOT MET as evidenced by: K.A.R. 26-41-205 (d) The facility reported a census of 24 residents. The sample included 3 "Residents'" (R)'s and 1 focused review. Based on record review and interview the Administrator failed to ensure that all medications administered to R1 were administered in accordance with a medical care providers written order and professional standards of practice. The Administrator further failed to ensure medications managed by the facility were administered within professional standards of practice when the documented administration times exceeded one hour before or one hour after the scheduled administration times for R1, R2, R3, and R4. Findings included: -Record review for R1 revealed an admission date of 01/06/26 with diagnoses of cellulitis of the left lower limb, chronic pain syndrome, edema, sever morbid obesity, hypertension, and type two diabetes. Review of R1's "Functional Capacity Screen" (FCS) dated 01/06/26 revealed R1 required physical assistance with bathing and dressing. R1 was independent with toileting, transferring, walking/mobility, and eating. R1 lacked the ability to manage her own medications and medical treatments. R1 was cognitively intact, continent, was able to make herself understood and she understood others. R1 used a walker and wheelchair mobility device.	S3200		

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S3200 SS = E	Continued from page 3 Review of R1's combined "Negotiated Service Agreement" (NSA)/ "Health Service Plan" (HSP) Under the section titled "Medication/Treatment" identified facility staff were to assist with the medication management and any needed physician ordered treatments. Facility staff would reorder medications and treatments supplies as needed. Review of R1's electronic "Medication Administration Record" (eMAR) dated 04/26 revealed an order for Lisinopril Oral tablet 10 milligrams. Give one tablet by mouth one time a day for hypertension. The order date was 11/18/25. Review of R1's electronic "Medical Record" under the "Miscellaneous" tab revealed a document titled "Prescription / Pharmacy Orders" dated 01/01/26, and signed by "Advanced Practice Registered Nurse" (APRN) revealed an order for Lisinopril Oral Tablet give 5 milligrams by mouth one time a day for hypertension. The signed "Prescription / Pharmacy Orders" dated 01/01/26 lacked documentation of an order for Lisinopril 10 milligrams. Give one tablet by mouth one time a day. R1's electronic 'Medical Record" lacked documentation of a signed order for Lisinopril 10 milligrams, give one tablet by mouth one time a day. Interview on 04/08/26 at approximately 04:00 PM with Licensed Nurse A, Administrator B, and Director of Nursing/Registered Nurse D confirmed R1's medical record lacked documentation of a signed order from R1's provider for Lisinopril 10 milligrams. They further confirmed the signed order provided by R1's medical provider contained the order for Lisinopril 5 milligrams one tablet by mouth one time daily. Review of the facility provided report titled "Medication Administration Audit Report" dated 04/01/26 - 04/08/26 revealed the following; On 04/01/26 the following medications were scheduled to be administered at 06:00 AM and were documented as administered at 08:32 AM: Multivitamin-Minerals oral tablet, Lisinopril oral tablet, Loratadine oral tablet, Clopidogrel Bisulfate oral tablet, Aspirin oral tablet, and Colchicine oral tablet. An order for Levothyroxine Sodium was scheduled to be administered at 07:00 AM and was documented as	S3200		

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S3200 SS = E	Continued from page 4 administered at 08:32 AM. Review of the facility provided report titled "Medication Administration Audit Report" dated 04/01/26-04/08/26 revealed eight out of eight days had scheduled medications that were documented as administered greater then one hour after the scheduled administration time. -Record review for R2 revealed an admission date of 12/15/21 with diagnoses of anemia, hypothyroidism, anxiety, dementia with anxiety, and hypertension. Review of R2's FCS dated 03/03/26 revealed R2 required physical assistance with bathing, dressing, toileting, transferring, and walking/mobility. R2 required supervision with eating and lacked the ability to manage her own medications and medical treatments. R2 was incontinent and had impaired long-term memory. R2 was usually able to make herself understood and she understood others. Review of R2's combined NSA/HSP dated Under the section titled "Medication Assist/Healthcare Supplies" identified certified/licensed staff were to manage and store medications and treatments as ordered by the physician. R2 was able to swallow pill one at a time and required the pill to be placed on a spoon and then staff were to "feed it to her". Review of the facility provided report titled "Medication Administration Audit Report" dated 04/01/26 - 04/08/26 revealed the following. On 04/01/26 the following medications were scheduled to be administered at 06:00 AM and were documented as administered at 09:09 AM: Ensure and Fexofenadine HCl tablet. Review of the facility provided report titled "Medication Administration Audit Report" dated 04/01/26-04/08/26 revealed eight out of eight days had scheduled medications that were documented as administered greater then one hour after the scheduled administration time. -Record review for R3 revealed an admission date of 02/10/25 with diagnoses of hypo-osmolality and hyponatremia, depression, atherosclerotic heart disease of native coronary artery, muscle weakness, anemia, and urine retention. Review of R3's FCS dated 01/10/25 revealed R3 required	S3200		

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S3200 SS = E	Continued from page 5 physical assistance with bathing and dressing. R3 was independent with toileting, transferring, walking/mobility, and eating. R3 lacked the ability to manage his own medications, and was continent. R3 was cognitively intact and was able to make himself understood and he understood others. Review of R3's combined NSA/HSP dated 10/20/25 under the section titled "Medication Assist" identified the R3 required facility staff assistance with medication management. Review of the facility provided report titled "Medication Administration Audit Report" dated 04/01/26 - 04/08/26 revealed the following. On 04/01/26 the following medications were scheduled to be administered at 06:00 AM and were documented as administered at 07:38 AM: Polyethylene Glycol Powder, Citalopram Hydrobromide oral tablet, Dulcolax oral tablet, and Fluocinonide External ointment. Review of the facility provided report titled "Medication Administration Audit Report" dated 04/01/26-04/08/26 revealed eight out of eight days had scheduled medications that were documented as administered greater then one hour after the scheduled administration time. -Record review for R4 revealed an admission date of 02/19/25 with diagnoses of hypertension, tissue perfusion alteration, Parkinson's disease, dementia, agitation, sundowners, and congestive heart failure. Review of R4's FCS dated 07/22/25 revealed R4 required physical assistance with bathing, dressing, and eating. R4 was independent with transferring, walking/mobility and eating. R4 lacked the ability to manage his own medications and medical treatments. R4 was incontinent and had impaired short-term memory and memory recall. R4 was able to make himself understood and he sometimes understood others. Review of R4's combined NSA/HSP dated 07/22/25 under the section titled 'Medication Assist" instructed facility staff to assist with medication management and reordering medications. Review of the facility provided administration audit dated 08/12/25 to 08/26/25 for Melatonin oral tablet 10 milligrams scheduled for 08:00 PM was documented as administered five times greater than one hour before or	S3200		

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S3200 SS = E	Continued from page 6 one hour after the scheduled 08:00 PM time. Review of the facility provided administration audit dated 08/12/25 to 08/26/25 for Trazodone HCl oral tablet scheduled for 08:00 PM was documented as administered five times greater than one hour before or one hour after the scheduled 08:00 PM time. Interview on 04/08/26 at approximately 04:00 PM with Licensed Nurse A, Administrator B, and Director of Nursing C, confirmed the documented medication administrations for R's 1, 2, 3, and 4 were greater then one hour before or one hour after the scheduled administration times. Review of the "Certified Medication Aide Curriculum" dated 05/10/2013, page 172 "10. Always follow the 7 Rights of Medication Administration...6. Right time...Routine medications are to be administered within an hour before or an hour after the scheduled time unless there are specific instructions ordered by the physician." The Administrator failed to ensure that all medications administered to R1 were administered in accordance with a medical care providers written order and professional standards of practice. The Administrator further failed to ensure medications managed by the facility were administered within professional standards of practice when the documented administration times exceeded one hour before or one hour after the scheduled administration times for R1, R2, R3, and R4.	S3200		
S3201 SS = E	Facility Administration of Medication CFR(s): 26-41-205 (d) (3) (3) A licensed nurse or medication aide shall perform the following: (A) Administer only the medication that the licensed nurse or medication aide has personally prepared; (B) identify the resident before medication is administered; (C) remain with the resident until the medication is ingested or applied; and (D) document the administration of each resident ' s medication in the resident ' s medication administration record immediately before or following completion of the task. If the medication administration record identifies only time intervals or	S3201		

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S3201 SS = E	Continued from page 7 events for the administration of medication, the licensed nurse or medication aide shall document the actual clock time the medication is administered. This LICENSURE REQUIREMENT is NOT MET as evidenced by: K.A.R. 26-41-205 (d) (3) (D) The facility reported a census of 24 residents. The sample included 3 "Residents'" (R)'s and 1 focused review. Based on record review and interview the Administrator failed to ensure the "Licensed Nurse" (LN) and the "Certified Medication Aides" (CMA)'s documented the administration of each residents medications in the residents "Medication Administration Record" (MAR) immediately before or following the completion of the task for R2 and R3. Findings included: -Record Review for R2 revealed an admission date of 12/15/21 with diagnoses of anemia, hypothyroidism, anxiety, dementia with anxiety, and hypertension. Review of R2's "Functional Capacity Screen" (FCS) dated 03/03/26 revealed R2 required physical assistance with bathing, dressing, toileting, transferring, and walking/mobility. R2 required supervision with eating, and she lacked the ability to manage her own medications and medical treatments. R2 had impaired long-term memory. R2 was incontinent and was usually able to make herself understood and she understood others. R2 used a wheelchair mobility device. Review of R2's combined "Negotiated Service Agreement" (NSA)/"Health Service Plan" (HSP) dated 01/20/26, under the section titled "Medication Assist" instructed the facility's certified/licensed staff to manage and store R2's medications and treatments as ordered by the physician. Review of R2's "electronic Medication Administration Record" (eMAR) dated 04/26 revealed the following: An order to check resident for incontinences episodes and change as needed at night two times a day for incontinence management at 04:00AM and 11:00PM. R2's eMAR lacked documentation on 04/02/26 at 11:00PM and 04/03/26 at 04:00AM of R2 being checked and changed as needed for incontinence management. -Record review for R3 revealed an admission date of 02/10/25 with diagnoses of other cervical disc	S3201		

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S3201 SS = E	Continued from page 8 degeneration unspecified cervical region, hypo-osmolality and hyponatremia. Review of R3's FCS dated 10/20/25 revealed R3 required physical assistance with bathing and dressing. R3 was independent with toileting, transferring, walking/mobility, and eating. R3 lacked the ability to manage his own medications and medical treatments. R3 was continent, had intact cognition, and was able to make himself understood and he understood others. R3 used a walker mobility device. Review of R3's combined NSA/HSP under the section titled "Medication Assist" instructed facility staff to assist R3 with medication management and reordering his medications. Review of R3's "eMAR" dated 04/26 revealed the following: An order for Tramadol Oral Tablet 50 milligrams; give 50 milligrams by mouth 4 times a day for pain at 05:00 AM, 11:00 AM, 05:00 PM, and 11:00 PM. R3's "eMAR lacked documentation on 04/02/26 at 11:00 PM and 04/03/26 at 05:00 AM of R3 receiving the Tramadol 50 milligram oral tablet. Interview on 04/08/26 at approximately 04:00 PM with Licensed Nurse A, Administrator B, and Director of Nursing/Registered Nurse D, confirmed R2 and R3 "eMARS" lacked documentation on 04/02/26 and 04/03/26 of all facility administered medications and treatments being administered/performed. The Administrator failed to ensure the LN and the CMA's documented the administration of each residents medications in the residents MAR immediately before or following the completion of the task for R2 and R3.	S3201		
S3211 SS = F	OVER THE COUNTER DRUGS CFR(s): 26-41-205 (g) (3) (3) A licensed nurse or medication aide may accept over-the-counter medication only in its original, unbroken manufacturer ' s package. A licensed pharmacist or licensed nurse shall place the full name of the resident on the package. If the original manufacturer ' s package of an over-the-counter medication contains a medication in a container, bottle, or tube that can be removed from the original package, the licensed pharmacist or a licensed nurse shall place the full name of the resident on both the	S3211		

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S3211 SS = F	Continued from page 9 original manufacturer ' s medication package and the medication container. This LICENSURE REQUIREMENT is NOT MET as evidenced by: K.A.R.26-41-205 (g) (3) The facility reported a census of 24 residents. The sample included 3 "Residents'" (R)'s and 1 focused review. Based on observation and interview the Administrator failed to ensure the "Licensed Nurse" (LN) or the Licensed Pharmacist placed the full name of the resident on the "Over-the-Counter" tubes and bottles that were located in the facility's medication cart. Findings included: -Observation on 04/07/26 on the second floor of the facility medication room, on the west wall was the facility medication cart contained the following OTC tube and bottle that lacked the residents' full name: a tube of Remedy Protectant with Zinc and one bottle of Docusate Sodium tablets. Interview on 04/07/26 at approximately10:30 AM with LN A confirmed OTC's tubes and bottles were to contain the full name of the resident. The Administrator failed to ensure the LN or the Licensed Pharmacist placed the full name of the resident on the OTC tube and bottle located in the facility's medication cart.	S3211		
S3299 SS = F	Facility Food Storage CFR(s): 26-41-206 (e) (1) (e) Food storage. Facility staff shall store all food under safe and sanitary conditions. (1) Containers of poisonous compounds and cleaning supplies shall not be stored in the areas used for food storage, preparation, or serving. This LICENSURE REQUIREMENT is NOT MET as evidenced by: K.A.R 26-41-206 (e) The facility reported a census of 24 residents. The sample included 3 "Residents'" (R)'s and 1 focused review. Based on observation and interview the Administrator failed to ensure the food stored in the facility's satellite kitchen was stored under safe and	S3299		

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S3299 SS = F	Continued from page 10 sanitary conditions. Findings included: -Observation on 04/07/26 at approximately 10:15AM with Administrator B of the satellite kitchen located on the second floor revealed a cabinet with a sink on the east side of the kitchen. A note on the cabinet located under the sink had printed "do not store food". The cabinet door freely opened and revealed the drain pipe from the sink and directly under the drain pipe were three bags of what appeared to be dry cereal that had been opened and were closed with a food clip. Interview on 04/07/26 at approximately 10:15AM with Administrator A confirmed the cabinet under the sink was not to be used for food storage. The Administrator failed to ensure the food stored in the satellite kitchen located on the second floor, stored food in a safe and sanitary manner.	S3299		