STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N007005	(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
MAPLE HEIGHTS NURSING & REHABILITATIVE CENTER	302 E IOWA STREET , HIAWATHA, Kansas, 66434

(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 for the above named facility conducted on 04/08/26.	S0000		
S0140 SS = E	Resident Right Privacy and Confidentiality CFR(s): 26-39-103 (i) (i) Privacy and confidentiality. The administrator or operator shall ensure that each resident is afforded the right to personal privacy and confidentiality of personal and clinical records. (1) The administrator or operator shall ensure that each resident is provided privacy during medical and nursing treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups. (2) The administrator or operator shall ensure that the personal and clinical records of the resident are maintained in a confidential manner. (3) The administrator or operator shall ensure that a release signed by the resident or the resident's legal representative is obtained before records are released to anyone outside the adult care home, except in the case of transfer to another health care institution or as required by law. This LICENSURE REQUIREMENT is NOT MET as evidenced by: KAR 26-39-103(i) The facility reported a census of nine residents with three residents included in the sample. Based on interview and record review the administrator failed to ensure each resident privacy and confidentiality of their personal and clinical records. Findings included: - Observation on 04/08/26 at 12:10 PM revealed a	S0140		

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

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S0140 SS = E	Continued from page 1 computer on the medication cart signed into Licensed Nurse C's account and R4's medication administration page open. Observation on 04/08/26 at 12:46 PM revealed Licensed Nurse C left the medication cart in the west hall and entered into closed doors in the east hall of the attached skilled nursing facility. The computer on the medication cart was signed into Licensed Nurse C's account with R2's medication administration page open. The page contained information regarding R2's medications, allergies, and her date of birth. On 04/08/26 at 05:17 PM Administrative Staff A confirmed her expectation was for staff to lock or shut the computer screen when not attended. The facility's "HIPAA & Medical Records" training listed staff responsibilities to keep information private and secure, log out and protect passwords, and report breaches immediately. The administrator failed to ensure each resident privacy and confidentiality of their personal and clinical records.	S0140		
S3081 SS = E	Functional Capacity Screen Reassessment CFR(s): 26-41-201 (c) (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 LICENSURE REQUIREMENT is NOT MET as evidenced by: KAR 26-41-201(c)(1) The facility reported a census of nine residents with three residents included in the sample. Based on interview and record review the administrator failed to	S3081		

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S3081 SS = E	Continued from page 2 ensure designated staff completed a "Functional Capacity Screen" (FCS) for Resident (R)2 and R3 upon change of condition as defined in K.A.R. 26-39-100. Findings included: - Record review for R2 revealed an admission date of 07/14/25 with a diagnosis of urinary incontinence. The 07/14/25 (most recent) FCS identified R2 required supervision with bathing; physical assistance with management of medications and treatments; was independent with dressing, transfers, mobility, and toileting; no cognitive difficulties; and was at risk of falls. The 07/14/25 Negotiated Service Agreement (NSA) identified facility staff would provide R2 standby assistance for bathing, R2 toileted self, and the facility provided grab bars and brakes on her walker to prevent falls. The 02/05/26 Service Plan Report which is the facility's Healthcare Service Plan (HSP) indicated on 12/23/25 R2 was incontinent of bladder. The 12/16/25 at 09:48 AM "Nurses Notes" documented R2 received a diagnosis of urinary incontinence in order to obtain pullup supplies. R2's record lacked evidence of an FCS since 07/14/25. On 04/08/26 at 04:08 PM Administrative Nurse B confirmed R2's FCS was not completed on change of condition. - Record review for R3 revealed an admission date of 11/25/23 with a diagnosis of unsteadiness on feet. The 04/09/25 (most recent) FCS identified R3 required physical assistance with bathing and management of medications and treatments; required supervision with dressing; was independent with transfers, mobility, and toileting; had short-term memory, memory recall, and decision-making cognitive difficulties; had impaired	S3081		

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S3081 SS = E	Continued from page 3 hearing; and was at risk of falls and unsteadiness. The 04/09/25 Negotiated Service Agreement (NSA) identified facility staff would provide R3 assistance for bathing. R3 toileted, dressed, and walked with walker by self. Staff were to monitor R3 for unsteadiness. R3 was listed as alert and cheerful for cognition. The 02/05/26 HSP indicated R3 was independent with cognition, had no memory loss, was able to recall information, and made safe judgements. The HSP failed to “specify” fall interventions. R3's record lacked evidence of an FCS since 04/09/25. On 04/08/26 at 03:17 PM R3 recalled his most recent meal accurately according to the food menu. He was able to indicate who he would report an issue or concern to, the location of her desk, and the town where she lived. On 04/08/26 at 04:08 PM Administrative Nurse B confirmed R3’s FCS was not completed on change of condition. The administrator failed to ensure designated staff completed a FCS for R2 and R3 upon change of condition as defined in K.A.R. 26-39-100.	S3081		
S3092 SS = E	Negotiated Service Agreement Revisions CFR(s): 26-41-202 (d) (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 manager, or, if agreed to by the resident or the resident ' s	S3092		

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S3092 SS = E	Continued from page 4 legal representative, the resident ' s family. This LICENSURE REQUIREMENT is NOT MET as evidenced by: KAR 26-41-202(d)(2) The facility reported a census of nine residents with three residents included in the sample. Based on interview and record review the administrator failed to ensure facility staff reviewed and revised the Negotiated Service Agreement (NSA) for Resident (R) 2 and R3 upon significant change in condition, as defined in K.A.R. 26-39-100. Findings included: - Record review for R2 revealed an admission date of 07/14/25 with a diagnosis of urinary incontinence. The 07/14/25 (most recent) Functional Capacity Screen (FCS) identified R2 required supervision with bathing; physical assistance with management of medications and treatments; was independent with dressing, transfers, mobility, and toileting; no cognitive difficulties; and was at risk of falls. The 07/14/25 NSA identified facility staff would provide R2 standby assistance for bathing, R2 toileted self, and the facility provided grab bars and brakes on her walker to prevent falls. The NSA included a handwritten and unsigned note dated 08/28/25 and documented a grab bar was applied to the bed after a fall. The NSA failed to include a note dated 01/06/26 for an additional grab bar applied to bed. The NSA failed to indicate services provided to R3 and the provider of the service for bladder incontinence. The 02/05/26 Service Plan Report which is the facility’s Healthcare Service Plan (HSP) indicated on 01/06/26 a grab bar was applied to the right side of R2’s bed. Review of 08/28/25 at 07:35 PM “Nurses Note” revealed R2 decided to have a grab bar applied to her bed. Review of 01/06/26 at 01:02 PM “IDT Note” revealed a bar was moved from the left side of bed to the right	S3092		

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S3092 SS = E	Continued from page 5 The 12/16/25 at 09:48 AM “Nurses Notes” documented R2 received a diagnosis of urinary incontinence in order to obtain pullup supplies. Observation on 04/08/26 at 03:29 PM of R2’s bed revealed a white approximately 4.5 inches wide rail to the left side of the bed and a black device placed on the right. On 04/08/26 at 03:34 PM R2 stated one of her bed assistive devices was placed one month after her admission and the other about a month ago. R2 stated her bladder “goes all the time” and had difficulty holding urine in the mornings. On 04/08/26 at 04:08 PM Administrative Nurse B confirmed R2’s NSA failed to include changes related to the grab bars on her bed and her bladder incontinence. - Record review for R3 revealed an admission date of 11/25/23 with a diagnosis of unsteadiness on feet. The 04/09/25 (most recent) FCS identified R3 required physical assistance with bathing and management of medications and treatments; required supervision with dressing; was independent with transfers, mobility, and toileting; had short-term memory, memory recall, and decision-making cognitive difficulties; had impaired hearing; and was at risk of falls and unsteadiness. The 04/09/25 NSA identified facility staff would provide R3 assistance for bathing. R3 toileted, dressed, and walked with walker by self. Staff were to monitor R3 for unsteadiness. R3 was listed as alert and cheerful for cognition. The 02/05/26 HSP indicated R3 failed to “specify” fall interventions. Review of 12/09/25 at 02:03 AM “Fall” note revealed R3 fell while trying to get to the bathroom. The “intervention/prevention to prevent recurrence” was for staff to encourage R3 to use his call light for assistance.	S3092		

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S3092 SS = E	Continued from page 6 Review of 12/19/25 at 10:32 PM “Fall” note revealed R3 fell while trying to get to the bathroom. His oxygen tubing and comforter were tangled with him causing his fall. Staff encouraged R3 to call for assistance when transferring. On 04/08/26 at 04:08 PM Administrative Nurse B confirmed R3’s NSA failed to be revised with fall interventions when his needs changed. The administrator failed to ensure facility staff reviewed and revised the NSA for R2 and R3 upon change in condition.	S3092		
S3165 SS = F	Health Care Services CFR(s): 26-41-204 (d) (d) The negotiated service agreement shall contain a description of the health care services to be provided and the name of the licensed nurse responsible for the implementation and supervision of the plan. This LICENSURE REQUIREMENT is NOT MET as evidenced by: KAR 26-41-204(d) The facility reported a census of nine residents with three residents included in the sample. Based on record review and interview the administrator failed to ensure the Negotiated Service Agreement (NSA) for all residents listed the licensed nurse responsible for implementing and supervising their Healthcare Service Plans (HSP). Findings included: - Record review for Resident (R)1, R2, and R3 revealed the NSAs failed to name the licensed nurse responsible for implementing and supervising the HSPs. On 04/08/26 at approximately 11:00 AM Administrative Staff A stated during the entrance interview Administrative Nurse B was the licensed nurse who completed the NSAs and was responsible for the HSPs.	S3165		

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S3165 SS = F	Continued from page 7 On 04/08/26 at 02:29 PM Administrative Staff A confirmed the NSAs for all residents were not updated with Administrative Nurse B being responsible for the HSPs. The administrator failed to ensure all residents' NSAs named the licensed nurse responsible for implementing and supervising their HSPs.	S3165		
S3171 SS = D	Health Care Services Standards of Practice CFR(s): 26-41-204 (i) (i) All health care services shall be provided to residents by qualified staff in accordance with acceptable standards of practice. This LICENSURE REQUIREMENT is NOT MET as evidenced by: KAR 26-41-204(i) The facility reported a census of nine residents with three included in the sample. Based on observation, interview, and record review the administrator failed to ensure a licensed nurse completed an assessment for the purpose to use a bed assist device, ability to use a bed assist safely without risk of entrapment, and to confirm the bed assist device was not a restraint for Residents (R) 2. Findings included: - Record review for R2 revealed an admission date of 07/14/25 with a diagnosis of urinary incontinence. The 07/14/25 Functional Capacity Screen (FCS) identified R2 was independent with transfers and was marked for falls. The 07/14/25 Negotiated Service Agreement (NSA) identified R2 transferred herself and a grab bar was used to prevent falls. R2's record lacked evidence of documentation of a bed assist device assessment. Observation on 04/08/26 at 03:29 PM revealed a white	S3171		

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S3171 SS = D	Continued from page 8 bed assist device was attached to the left side of R2's bed and a black bed assist device was attached to the right side. There was a 12-inch gap between the rails of the black bed assist that lacked a cover to prevent entrapment between the rails. On 04/08/26 at 03:34 PM R2 stated she had the first bed assistive device placed one month after admission and the second one was in the last month. She stated she used them to get up and to reposition. On 04/08/26 at approximately 04:44 PM Administrative Nurse B confirmed R2's record lacked evidence of documentation a bed rail assessment was completed. The facility's undated "Proper Use of Bed Rails" policy defined bed rails with examples of grab bars and assist bars. The policy specified a nurse will complete an assessment and reassess in accordance with the facility's assessment schedule at no less than quarterly, upon significant change in condition, or a change in the type of bed, mattress, or rail. The administrator failed to ensure a licensed nurse completed an assessment for the purpose to use a bed assist device, ability to use a bed assist safely without risk of entrapment, and to confirm the bed assist device was not a restraint for R2. The administrator further failed to ensure a gap greater than 4.5 inches between the rails of a bed assist device was covered to prevent entrapment.	S3171		