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S 000	INITIAL COMMENTS The following citations represent the findings of the licensure resurvey with attached complaint numbers 199210, 199186, 199161, 199027, 199011, 198899, 198836, 198796, 198732, 198733, 198725, 198623, 198439, 198352, 198348, 198299, 198129, 198095, 197490, 197635, 195374, 194731, 194554, and 192937, for the above named facility conducted on 07/20/26 through 07/23/26 and 07/27/26 through 07/29/26, and 08/03/26.	S 000		
S3026 SS=L	26-41-101 (f) (1) Staff Treatment of Residents ANE (f)The administrator or operator shall ensure that all of the following requirements are met: (1) No resident shall be subjected to any of the following: (A) Verbal, mental, sexual, or physical abuse, including corporal punishment and involuntary seclusion; (B) neglect; or (C) exploitation. This REQUIREMENT is not met as evidenced by: K.A.R. 26-41-101 (f) (1) (A) (B) The facility reported a census of 57 residents. The sample included 44 "Residents'" (R)'s, and 7 focused reviews. Based on observation, interview and record review, the facility failed to protect R8 from neglect when staff did not remove a malfunctioning mechanical lift from service. In September 2025 facility staff reported Resident (R)8's mechanical lift was not working appropriately, but the mechanical lift was not removed from service. On 12/09/25 R8, a	S3026		

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

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resident with one-sided paralysis and a history of a nontraumatic brain bleed, fell from the malfunctioning lift during a transfer and hit her head. The facility also failed to protect R16 and R10 from abuse. Certified Nurse Aide (CNA) W forced R16 out of the commons area, and transferred R16 from wheelchair to her bed, against the resident's wishes. Certified Medication Aide (CMA) J restrained R10 in a recliner, by holding the recliner in a reclined position, while R10 tried to get up from the recliner. The facility failed to prevent 38 residents from unintended weight loss, which included R10 who lost 40 pounds in 12 months, R42 who lost 35 pounds, and R46 who lost 29 pounds.

Findings included:

- Record review revealed R8 admitted to the facility on 02/09/22 with diagnoses of unspecified dementia, other cerebral infarction, hemiplegia, unsteadiness on feet, type two diabetes mellitus, hypertension, muscle weakness, aphasia following nontraumatic subarachnoid hemorrhage, and arthritis.

Review of R8's "Functional Capacity Screen" (FCS) dated 08/13/25 revealed R8 required physical assistance with bathing, dressing, walking/mobility, and eating and was unable to perform toileting and transferring. R8 lacked the ability to manager her own medications and medical treatments. R8 was incontinent and had impaired short-term memory, long-term memory, memory/recall, and decision-making. R8 was usually able to make herself understood and usually understood others. R8 used a wheelchair and mechanical lift mobility device.

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S3026	Continued From page 2 The 08/13/25 FCS did not identify the fall risk for R8. [JP1.1] Review of R8's combined "Negotiated Service Agreement" (NSA)/ "Health Service Plan" (HSP) dated 08/19/25 in the section titled "Mechanical Lift" instructed facility staff to transfer R8 with the mechanical lift using two staff members. Review of R8's "Progress Notes" revealed the following entries: The 12/11/25 at 07:53 PM nurse note, signed by Licensed Nurse (LN) K, revealed at 04:45 PM staff notified LN K R8 "had fallen from the lift to the floor." Staff reported the lift malfunctioned during the transfer of R8 from her wheelchair to her bed, and R8 fell and hit her head. R8 was transported by "Emergency Medical Services" to a local hospital for evaluation and treatment. On 12/11/25 at 10:32 PM a nurse note signed by "Registered Nurse" (RN) L revealed she received report on R8 from the nurse at the local hospital. R8 had a cervical strain and would be returning to the facility. Review of the facility provided signed and notarized "Witness Statement" from CMA M dated 12/12/25 revealed she notified LN N in September 2025 that R8's mechanical lift was "broken". CMA M wrote she was instructed to notify "Clinical Service Director" (CSD)/LN G of the broken lift. CMA M documented she took the broken lift to CSD/LN G's office and showed her the bar "hanging" between the legs of the lift. CSD/LN G agreed the lift was broken and instructed CMA M to place a "broken" sign on the lift. CMA M placed the "broken" sign on the lift and returned the broken lift to R8's bathroom.	S3026		

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S3026	Continued From page 3 CMA M wrote she instructed the facility staff on the next shift to not use the lift. Review of the facility provided signed and notarized "Witness Statement" from CNA O dated 12/11/25[JP2.1] revealed on 12/09/25 he assisted another staff member to transfer R8 and the legs of the mechanical lift were "hard to open". CNA O and the other staff member continued to use the lift for the transfer of R8 from her wheelchair to her bed. CNA O reported the malfunction of the mechanical lift to LN N who told CNA O to "put in a work order" to "Maintenance". CNA O wrote that CNA P "put in the work order". Review of the facility provided signed and notarized "Witness Statement" revealed the following: The "Witness Statement" from CNA P dated 12/11/25 revealed on 12/09/25 she and CNA O had trouble opening the legs of the mechanical lift. CNA P documented the legs of the lift were "at first not moving but eventually opened up" and [SV3.1]LN N instructed her to put in a "work order" for "Maintenance". CNA P noted she asked Maintenance Staff Q if R8's mechanical lift had been fixed on 12/11/25. CNA P documented Maintenance Staff Q's response was, he reported the work order to CSD/LN G because he did not take care of the mechanical lifts, and CNA P should have informed the nurse on duty. CNA P documented she then informed LN B of the "situation". The "Witness Statement" from CNA R dated 12/11/25 revealed she and another staff member were operating the mechanical lift to transfer R8. CNA R documented, as staff turned the lift to place the resident into her wheelchair, the leg of	S3026		

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the lift went inwards and caused the lift to "tip over". CNA R documented she was not notified of the mechanical lift leg being "defective".

The "Witness Statement" from CNA S dated 12/11/25[JP4.1] revealed the leg of the lift folded inward when she and CNA R were transferring R8. CNA S documented she was not notified of R8's lift being broken, and she and CNA R did not "suspect" the mechanical lift was broken. "When the leg folded inwards it tipped over and the resident landed on her back".

The "Witness Statement" from LN K dated 12/11/26 revealed she was unaware R8's mechanical lift "had a malfunction". LN K documented Maintenance Staff Q [SV5.1]informed her the lift needed sent to a local "Durable Medical Equipment" (DME) company for repair.

The "Witness Statement" from LN N revealed during the "first week of December 2025" she was asked if she was aware of R8's mechanical lift being "loose at the bottom". LN N wrote she was not informed by the off going nurse of any issues, and she asked a CNA to put in a work order for maintenance to repair the mechanical lift.

Review of the facility provided "Electronic Mail" (email) from Maintenance Staff Q revealed the following: On 12/10/25 he went to R8's room to look at a "lift that was not working properly". He found a "control rod" was not attached to the bottom leg of the lift and seemed to be missing parts. He was unable to locate any of the missing parts on the floor, and he noticed a local DME tag on the mechanical lift. Maintenance Staff Q documented, he "closed the shower curtain and

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went immediately to the nurse office" where he spoke to CSD/LN G and stated the local DME company would need to repair or replace the mechanical lift. He continued to write that a nurse would need to call the DME company due to some of the questions they asked were nursing questions. [SV7.1]On 12/11/25 at about 06:00 PM he inquired with a staff member about the status of the lift and was informed the lift remained broken. He then told the staff member to not use the lift and he would follow up "the next morning". Review of the facility provided investigation revealed a document titled "Employee Questionnaire" dated 12/19/25 and answered by CSD/LN G. The document revealed CSD/LN G claimed Maintenance Staff Q notified her regarding the malfunctioning mechanical lift the "day before the fall occurred". CSD/LN G answered she was very busy on the day she and Maintenance Staff Q had the conversation, and she forgot to call the DME company to repair the mechanical lift. CSD/LN G claimed she was unaware the lift was unsafe to use.

Review of the facility provided undated document titled "Supporting Safe Transfers: Hoyer / Hydraulic Lift" revealed facility staff were to "Familiarize" themselves with the device and "review the device manual"[SV8.1]

The facility failed to protect R8 from neglect when staff did not remove a malfunctioning mechanical lift from service in September 2025, after facility staff reported the malfunctioning lift, and on 12/09/25 R8 fell from the malfunctioning lift during a transfer.

- Record review for R16 revealed an admission date of 03/24/25 with diagnoses of major

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depressive disorder, Parkinson's disease, heart failure, polyneuropathy, psychotic disorder with delusions, and chronic atrial fibrillation.

Review of R16's FCS dated 06/19/25 [LM9.1]revealed R16 required physical assistance with bathing, dressing, toileting, transferring, walking, mobility, and supervision with eating. R16 lacked the ability to manage her own medication and medical treatments. R16 was incontinent and had impaired short-term memory, long-term memory, memory/recall, and decision-making. R16 was usually able to make herself understood and she usually understood others. R16 was identified at risk for falls and wandering.

Review of R16's combined NSA/HSP dated 06/19/25 documented R16 had the ability to express/communicate her needs, likes, and dislikes to staff and "may miss some part or intent of the message" but comprehended most of it. R16 generally demonstrated her comprehension by responding in words or actions. R16 was able to perform some of the activities of daily living and noted she would be slow in performing the task. Staff were instructed to assist the resident when needed and allow R16 to take her time to complete the task. Staff were instructed to provide physical assistance with guided maneuvering of limbs or weight bearing and engage R16 in conversation and an activity of her choice to assist and lessen R16's moments of anxiety. R16 was to do as much of the toileting task as possible.

Review of R16's "Progress Notes" revealed an entry dated 11/20/25. LN B documented that she attempted to perform a skin assessment following reports of an incident regarding resident care and

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resident rights reported by Hospice Nurse U. LN B documented the facility administrator was notified of an allegation.

Review of the facility provided document titled "Statement", signed by Hospice Nurse U, revealed on 11/18/25 at approximately 11:14 AM she spoke with LN V and stated she needed to provide wound care to R16's buttocks. LN V informed Hospice Nurse U that R16 refused skin assessments. LN V then called CNA W who informed LN's U and V that R16 was continent of bowel and bladder and stated she only assisted R16 to transfer to and from the toilet. CNA W then told Hospice Nurse U that she could get R16 to agree to an assessment. Hospice Nurse U wrote that she observed CNA W go to the common area of the facility and inform R16 they were going to R16's room to be "changed". R16 replied to CNA W that she "did not want go" and stated she knew when she "had to go". When CNA W attempted to push R16 forward R16's feet bent under her wheelchair as there were no foot pedals in place on the wheelchair. Hospice Nurse U continued documented she told CNA W it was ok if R16 did not want to go. CNA W then told Hospice Nurse U that R16 "needed to be changed", CNA W continued to tell Hospice Nurse U that R16 had not been checked since she got up that morning. CNA W attempted approximately three times to push R16's wheelchair forward bending her feet under the wheelchair. Hospice Nurse U wrote that she told CNA W the assessment could be done another day. CNA W then mobilized R16 out of the common area "backwards". While in the hallway CNA W turned R16's wheelchair around and R16 planted her feet on the ground again stating to "stop" and that she did not want to go. CNA W informed R16 a second time she was going to her

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room and "needed changed". Hospice Nurse U documented R16 was crying and stating "no", "help me she is forcing me". Hospice Nurse U documented she continued to ask CNA W to stop. CNA W placed R16's wheelchair next to her bed and R16 stated "stop" and she knew when she needed to go. CNA W "bear hugged" R16 and attempted to transfer R16 to her bed. R16 gripped her wheelchair and the transfer was unsuccessful. CNA W transferred R16 with force on the second transfer attempt. R16 attempted to sit up on the bed and CNA W placed one hand on R16's right shoulder to make R16 lay down on the bed, and CNA W's other hand pulled R16's brief down. CNA W stated she thought she smelled fecal matter and thought R16's brief needed to be changed. Hospice Nurse U again asked CNA W to stop. Hospice Nurse U wrote R16 had no visible wound and R16's brief was dry and not soiled. Hospice Nurse U wrote CNA W did not inform R16 of what she was doing when CNA W provided peri-care and changed R16's brief. When CNA W finished providing forced cares to R16 she then fixed R16's hair and apologized to Hospice Nurse U stating that she knew it was "a little rough" and that R16 did not know what she needed. Hospice Nurse U noted the incident lasted approximately one hour and fifteen minutes. Hospice Nurse U reported the incident to LN V who stated that R16 did not know what she needed. Hospice Nurse U wrote she reported the incident to CSD/LN G on 11/18/25 at 02:30 PM.

Review the facility provided undated and unnotarized "Witness Statement" signed by LN V revealed Hospice Nurse U reported R16 was resistant with cares and "was made to stand up".

Review of the facility provided undated and

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unnotarized "Witness Statement" signed by CNA W revealed R16 "expressed she did not want the nurse to look at her".

Review of the facility provided investigation revealed an "electronic mail" (e-mail) dated 11/20/25 at 08:45 PM which confirmed Hospice Nurse U reported the incident to LNHA F and LN B on 11/20/25.

The facility failed to investigate an allegation of abuse when CMA W forcibly provided care to R16 after R16 and Hospice Nurse U requested CMA W to stop. LN V and CSD/LN G further failed to report to LNHA F a reported allegation of abuse on 11/18/25.

- Record review for R10 revealed an admission date of 06/18/25 with diagnoses of dementia with behavioral disturbances, depression, Sundown syndrome, type two diabetes mellitus, cerebral vascular accident, dilated cardiomyopathy, congestive heart failure, generalized anxiety disorder, and hypertensive heart disease.

Review of R10's FCS dated 02/10/26 revealed R10 required physical assistance with bathing, dressing, and toileting. R10 was independent with transferring and required supervision with walking, mobility, and eating. R10 lacked the ability to manage his own medications and medical treatments. R10 was incontinent and had impaired short-term memory, memory/recall, and decision making. R10 was usually able to make himself understood and he understood others. R10 was identified at risk for falls, wandering, socially inappropriate behaviors, impaired decision making, and at risk for elopement. R10 used a walker and wheelchair mobility device.

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S3026	Continued From page 10 Review of R10's combined NSA/HSP dated 08/13/25 under the section titled "Expression" instructed facility staff R10 was able to make his needs known and he would ask for help if needed. Under the section titled "Communication" facility staff were instructed R10 clearly comprehended the speaker's message and demonstrated comprehension by words, actions, and behaviors. Under the section titled Decision Making, staff were instructed to assist R10 with decision as needed "without telling him what to do". Under the section titled "Transfer" facility staff were instructed R10 was able to transfer from sitting to standing independently with "no issues noted". LN B confirmed R10 lacked a combined NSA/HSP dated 02/10/26. Review of R10's progress notes dated 04/19/26 lacked documentation of an allegation of R10 having an allegation of abuse. Review of the facility provided undated and unnotarized document titled "Witness Statement" signed by CMA H revealed on 04/19/26 between 06:30 PM and 06:45 PM she observed CMA J in the facility's common television (t.v.) area and CMA J was "forcefully reclining back the recliner" R10 was sitting in. This action prevented R10 from placing the recliner into an upright position. CMA H continued to write when CMA J "noticed" her CMA J stated using profanity and indicated she was tired of being in the common t.v. area. CMA J continued to state to CMA H if she allowed R10 to "sit up, he was going to fall" on his face. CMA H wrote that she observed other residents in the t.v. area became "upset" while CMA J continued "yelling". CMA H wrote she reported the	S3026		

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incident to the oncoming facility nurse.

CMA H's Witness Statement lacked documentation of the time the incident was reported to the facility nurse.

Review of the facility provided unnotarized witness statement dated 04/19/26 signed by LN N revealed on 04/19/25 at approximately 07:50 PM and allegation of CMA J physically restraining R10's chair in a reclined position and not allowing R10 to "get up". LN N wrote "investigation initiated/pending".

CMA H's observation of CMA J preventing R10 from freely moving was not reported to LN until 07:50 PM. This is approximately 70 minutes from the time of CMA H's observation of the alleged abuse.

Review of the facility provided undated policy titled "Elder Abuse" revealed the following staff are to immediately notify the Clinical Services Director or the Executive Director.

The facility failed to protect R10 from abuse when CMA J restrained R10 in a recliner, by holding the recliner in a reclined position, while R10 tried to get up from the recliner. The facility staff further failed to notify the facility LN when staff observed the CMA J physically holding R10's recliner in the reclined position preventing R10 from placing the recliner into the sitting position.

- Record review revealed R10 admitted to the facility on 06/18/25, with diagnoses of dementia with behavioral disturbances, depression, Sundown syndrome, type two diabetes mellitus, cerebral vascular accident, dilated

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cardiomyopathy, congestive heart failure, generalized anxiety disorder, and hypertensive heart disease.

Review of R10's FCS dated 02/10/26 revealed R10 was independent with transferring and required supervision with walking, mobility, and eating.

Review of R10's combined NSA/HSP dated 08/13/25 instructed facility staff to "bring food tray" to R10 and noted R10 did not like to be crowded at any time and "may need to eat in his room or small dining room". Facility staff were instructed that Dietician X would monitor R10's weights and diets and "make educated recommendations" to R10's medical care provider, power of attorney, and to facility staff.

The combined NSA/HSP lacked any further interventions related to R10's nutritional status, weight, and/or potential weight loss.

Review of R10's facility provided weights revealed the following:

July 2025, R10 weighed 189.5 pounds (lbs.)

November 2025, R10 weighed 173 lbs.

January 2026, R10 weighed 166 lbs.

April 2026, R10 weighed 155 lbs.

July 2026, R10 weighed 149.5 lbs. [LM10.1]

R10's record lacked evidence that the facility put additional interventions in place when R10 had a 40 lb. weight loss in twelve months.

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S3026	Continued From page 13 Review of R10's "Notes and Incidents" revealed an entry on 06/09/26 at 09:11 PM by Licensed Nurse (LN) C, which documented R10 weighed 148.5 pounds and noted the facility reported the weight loss to the local hospice nurse. The hospice nurse would notify the provider. The "Notes and Incidents" documentation lacked interventions for monitoring R10's nutritional intake and the notes further lacked documentation of follow up on the weight loss from R10's medical care provider. Review of R10's "Progress Notes" lacked documentation from the dietician regarding R10's weight loss. An interview on 07/22/26 at approximately 10:48 AM with Licensed Nursing Home Administrator (LNHA) A confirmed the facility dietician came to the facility "quarterly and toured the kitchen", and LNHA further confirmed the dietician did not document in the facility resident records. - Record review revealed R42 admitted to the facility on 10/25/23 with diagnoses of Alzheimer's disease, hypertension, celiac disease (an immune reaction to eating gluten), arthritis, depression, gastro-esophageal reflux disease, unspecified dementia, agitation, and unspecified convulsions. Review of R42's combined NSA/HSP dated 02/25/26 revealed facility staff were instructed to feed R42 and provide a pureed diet to R42. R42's NSA/HSP lacked further interventions to assist in maintaining her weight. Review of R42's facility provided weights revealed	S3026		

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the following:

June 2025, R42 weighed 113 lbs.

December 2025, R42 weighed 86 lbs.

July 2026, R42 weighed 78 lbs.

R42 lost a total of 35 lbs. in thirteen months.

R42's medical record lacked interventions to assist in maintaining her weight.

Observation on 07/28/26 at approximately 12:00 PM revealed there were 23 residents in the dining room with four residents in "Broda" wheelchairs (specialized, highly adjustable tilt-in-space positioning wheelchair) at the table on the east side of the dining room. There was one staff member in the dining room and at approximately 12:13 PM an exit door alarm sounded, and one staff member left the dining room. At approximately 12:23 PM staff served food to residents who were seated at the dining room tables. At approximately 12:30 PM the facility staff member sat down at the north end of the dining room table next to R42. R42's plate contained three medium scooped servings of soft food that appeared to be of "mashed potato" like texture, and the staff member proceeded to feed R42.

Interview on 07/22/26 at approximately 11:59 AM with Speech Therapist X revealed the facility Kitchen Manager was responsible for training dietary staff on the International Dysphagia Diet Standard initiative (IDDSI -a global system that standardizes food textures and drink thicknesses for people with swallowing difficulties). Speech Therapist X stated she informed the facility dietary staff on the required tools to cut the food

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into quarter inch pieces. Speech Therapist X confirmed she had not met the facility dietician. CSD/LN G had been responsible for ordering the appropriate levels for residents who required IDDSI diet.

Interview on 07/22/26 at approximately 09:07 AM with LN B confirmed she did not know who the facility dietician was and further stated "Speech Therapy" gave the orders regarding resident diets.

Interview on 07/22/26 at approximately 08:52 AM with Dietary Staff Y revealed he did not know where the pureed diet instructions were. He continued to state that he was trained on pureed diets and prepared them in the blender for this morning's breakfast, but he did not follow any specific instructions. He continued to confirm the facility had four or five residents currently on pureed diets.

An interview on 07/22/26 at approximately 10:48 AM with LNHA A confirmed the facility dietician came to the facility "quarterly and toured the kitchen", and the LNHA further confirmed the dietician did not document in the facility resident records.

- Record review revealed R46 admitted to the facility on 12/31/25 with diagnoses of senile dementia, type two diabetes mellitus with hyperglycemia, generalized anxiety disorder, hypertension, dysphagia, depression, and insomnia.

Review of R46's FCS dated 03/17/26 revealed R46 was independent with eating.

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S3026	Continued From page 16 Review of R46's combined NSA/HSP dated 03/19/26 instructed facility staff to provide a "minced and moist" diet for the resident. Facility staff were instructed that R46 was independent with eating and R46 did not require cuing, oversight or encouragement. Staff were instructed to provide R46 with a list of meals that would be provided. Record review of R46's facility provided weights revealed the following: January 2026, R46 weighed 140 lbs. February 2026, R46 weighed 130.5 lbs. March 2026, R46 weighed 122.5 lbs. April 2026, R46 weighed 112 lbs. May 2026, R46 weighed 111.lbs. R46 lost a total of 29 lbs. in five months. Review of R46's "Progress Notes" revealed the following entries: On 12/31/25 at 06:21 PM a "Nurse's Note signed by LN K revealed upon admission R46 ate a regular diet with thin liquids and did best with finger foods. On 02/01/26 at 11:29 AM a "Nurse's Note" signed by LN Z revealed R46's weight upon return from her recent hospital stay was 131 pounds. R46's medical record lacked documentation of interventions or acknowledgement of the resident's weight loss.	S3026		

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S3026	Continued From page 17 An interview on 08/03/26 at approximately 10:45 AM with LNHA administrator A confirmed the facility scales were calibrated on 06/08/26. The facility failed to prevent unintended weight loss for R10 who lost 40 pounds in 12 months, R42 who lost 35 pounds in thirteen months, and R46 who lost 29 pounds in five months. The failure to have a system to monitor resident's nutritional status, including weight loss/potential for weight loss placed all 38 residents at risk for unintended weight loss.	S3026		
S3155 SS=E	26-41-204 (a) Health Care Services . (a) The administrator or operator in each assisted living facility or residential health care facility shall ensure that a licensed nurse provides or coordinates the provision of necessary health care services that meet the needs of each resident and are in accordance with the functional capacity screening and the negotiated service agreement. This REQUIREMENT is not met as evidenced by: K.A.R. 26-41-204 (a) The facility reported a census of 57 residents. The sample included 44 "Residents'" (R)'s and 7 focused reviews. Based on observation, interview, and record review, the facility failed to provide or coordinate the provision of necessary health care services that met the needs for R1's aggression towards his peers, and the facility	S3155		

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S3155	Continued From page 18 further failed to provide or coordinate the provision of necessary health care services that met the needs for R15 for falls. Findings included: - Record review revealed R15 admitted to the facility on 02/10/26 with diagnoses of memory impairment, anemia, malignant neoplasm of unspecified site of unspecified female breast, hypertension, anxiety disorder, lack of coordination, difficulty in walking, and muscle weakness. Review of R15's "Functional Capacity Screen" (FCS) dated 02/10/26 revealed R15 required physical assistance with bathing and toileting. R15 required supervision with dressing, transferring, walking, and mobility. R15 lacked the ability to manager her own medications and medical treatments. R15 had impaired short-term memory, long-term memory, memory/recall, and decision-making, and was frequently incontinent. R15 was able to make herself understood and she understood others. R15 was at risk for impaired vision, impaired hearing, impaired decision making, and was an elopement risk. R15 used a walker and wheelchair mobility devices. R15's FCS did not identify R15 at risk for falls. Review of R15's combined "Negotiated Service Agreement" (NSA)/"Health Service Plan" (HSP) instructed facility staff to provide one staff assistance with bathing and walking/mobility. Staff were instructed to provide supervision with dressing, walking and transferring. Facility staff were instructed to provide safety/elopement checks and toileting assistance every two hours.	S3155		

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R15's combined NSA/HSP lacked interventions to reduce R15's risk for falls.

Review of R15's medical record revealed a document titled "Fall Risk" dated 02/13/26 that scored R15 with 13 points. The Fall Risk revealed "Total Score of 10 or More = Risk of Falls", with a referral to physical therapy services on 02/02/26.

Review of R15's "Progress Notes" revealed the following entries:

On 02/10/26 at 03:46 PM a note signed by LN revealed that R15 arrived at the facility at approximately 02:40 PM.

On 02/12/26 at 10:41 AM a note signed by LN Z revealed R15 was found on the floor in her bathroom at approximately 08:15 AM. Staff reported to LN Z R15 was observed in her bed at around 07:50 AM.

On 02/13/26 at 02:35 AM a note signed by LN N revealed at 01:10 AM R15 was found on the floor in front of her recliner.

On 02/17/26 at 09:58 AM a note signed by LN Z revealed at 08:10 AM R15 was found lying on the floor next to her bed. R15 had a hematoma to the right side of her forehead and a bruise to her right temple. R15 was sent to the local hospital by emergency medical services for evaluation and treatment.

On 02/18/26 at 08:46 AM a note signed by LN CC revealed R15 had been admitted to the local hospitals critical care unit with a "head injury".

On 02/21/26 at 05:20 PM a note signed by LN B

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revealed R15 had passed away that day at the local hospital at 02:53 PM.

Interview on 07/29/26 at approximately 05:55 PM with Licensed Nursing Home administrator A, LN's B, C, and Regional directors AA and BB confirmed R15's combined NSA/HSP lacked specific interventions to reduce her risk of falls.

Record review revealed R1 admitted to the facility on 05/01/24 with diagnoses of other amnesia, adjustment disorder with depressed mood, anxiety disorder, depression, atrial fibrillation, type two diabetes mellitus, Parageusia (a distorted sense of taste), alcohol abuse, and unspecified dementia.

Review of R1's FCS dated 02/10/26 revealed R1 required physical assistance with toileting. R1 was independent with transferring, walking/mobility, and eating. R1 lacked the ability to manage his own medications and medical treatments. R1 was usually continent and had impaired short-term memory, long-term memory, memory/recall, and decision making. R1 was able to make himself understood and he understood others. R1 was identified to be at risk for falls, wandering, socially inappropriate disruptive behavior, and had difficulty making decisions. R1 used no mobility device.

Review of R1's combined NSA/HSP dated 02/10/26 instructed facility staff to provide safety checks every two hours and provide redirection away from exit doors. When R1 became "threatening" staff were instructed to "keep distance" from him and calmly redirect R1 back to a "calm state". Under the section titled "Behavior Management Plan" the following interventions

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S3155	Continued From page 21 were listed: On 04/04/26 R1 was sent to the local behavioral health unit. On/02/24/26 an order was obtained for a urinalysis to be performed due to "increased aggression/altered mental status". R15's combined NSA/HSP lacked health care services to be provided by facility staff when R1 showed physical aggression towards other residents. Review of R1's "Progress Notes" revealed the following entries: On 02/24/26 at 09:00 PM a note signed by LN K revealed R1 had been in an altercation with two other residents. On 02/13/26 at 02:44 PM a note signed by LN CC revealed at approximately 01:50 PM facility staff reported R2 grabbed R52's right arm "tightly" and started shaking R52's right arm with both of his hands due to a disagreement over a box of chocolates that belong to another resident. On 02/15/26 at 10:35 AM a note signed by LN Z revealed R52 was walking down a facility hall and reached to take something off of a tray that was in the hall. R1 became "visibly angry and approached" R52. Staff was able to intervene before "anything happened". On 02/16/26 at 04:10 PM a note signed by LN CC revealed R1 "punched" R52 in the left hip/abdomen area after R52 took a roll off of R1's plate in the dining area.	S3155		

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S3155	Continued From page 22 On 02/17/26 at 02:34 PM a note signed by LN Z revealed R1 got agitated very quickly when R1 observed "another resident attempting to steal people's food". As soon as the other resident would approach another residents table R1 became visibly agitated and got up and tried to prevent the other resident from removing items from other residents plates. On 04/04/26 at 04:14 PM a note signed by LN CC revealed that R1 pushed his roommate/ R20 out of their bedroom door while the roommate was sitting on his walker. R1 admitted to pushing R20 out of the room. On 04/04/26 at 08:31 PM a note signed by LN B revealed a new order to send R1 out to the local behavioral hospital for evaluation and treatment. On 04/30 26 at 03:33 PM a note signed by LN DD revealed R1 returned from his stay at the local behavioral health unit. On 04/30/26 at 06:51 PM a note signed by LN DD revealed R1 attempted to hit staff and he began to follow and chase the staff member around the facility. R1 was administered his scheduled medications and was redirected. On 07/06/26 at approximately 10:00 PM a note signed by LN DD revealed R1 entered the common television room with a small amount of blood beneath his left eye from a superficial laceration. R1 reported that he struck R2 because R2 had stolen his dog, and that R2 had struck R1 back. R2 was located by staff on the floor next to his wheelchair. R2 reported to staff that R1 had struck him causing him to fall from his wheelchair.	S3155		

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S3155	Continued From page 23 Review of the facility reported investigation on resident-to-resident abuse involving R1 and R2 dated 07/15/26 revealed when R1 struck R2, R2 stated he fell from his wheelchair and resulted in R2 having a fractured right femoral neck. Interview on 07/29/26 at approximately 05:55 PM with Licensed Nursing Home administrator A, LN's B, C, and Regional directors AA and BB confirmed R15's combined NSA/HSP lacked specific interventions for staff to follow when R1 showed physical aggression towards other residents, and to reduce the risk of R1 showing aggression towards other residents.	S3155		
S3171 SS=D	26-41-204 (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) The facility reported a census of 57 residents. The sample included 44 "Residents'" (R)'s and 7 focused reviews. Based on observation, interview, and record review, the facility failed to provide healthcare services for R32 in accordance with professional standards of practice when the facility failed to conduct an assessment of R32's bed assist device to ensure the device posed no risk for entrapment, confirmed the device was not a restraint, ensured	S3171		

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the bed assist device was securely attached to the bed, and R32's ability to safely use the bed assist device. The facility continued to fail to ensure the bed assist device for R32 was listed in the comment section of the "Functional Capacity Screen" (FCS), and the facility further failed to include a description of the bed assist device, the purpose of the device, and any special instructions on use and monitoring of the bed assist device in 32's "Negotiated Service Agreement'" (NSA).

Findings included:

- Record review revealed R32 admitted to the facility on 11/11/24 with a diagnoses of adrenogenital disorders, hypertension, Parkinson's disease, and osteoarthritis.

Review of R1's FCS dated 02/08/26 revealed R32 required physical assistance with bathing, dressing, toileting, transferring, walking, mobility, and eating. R32 lacked the ability to manage his own medications and medical treatments. R32 was frequently incontinent, and had impaired short-term memory, long-term memory, memory/recall, and decision-making. R32 was usually able to make himself understood and he usually understood others. R32 was at risk for falls and had difficulty making decisions. R32 used a walker and wheelchair mobility devices.

R32's FCS lacked documentation of the bed assist device in the comments section.

Review of R32's combined NSA/"Health Service Plan" (HSP) dated 07/03/26 facility staff were instructed to provide a one person assist with transferring, walking, and to propel his

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S3171	Continued From page 25 wheelchair. R32's NSA lacked a description of the bed assist device, the purpose of the device, and any special instructions on use and monitoring of the bed assist device. Observation 07/29/26 at approximately 02:00 PM with "Licensed Nurse" (LN) C of R32's room revealed the head of his bed sat in the southeast corner of the room with the foot of the bed facing the west of the room. One side of the bed sat against the southeast wall of the room. On the side of the bed that was opened to the northeast side of the room was a bed assist device that slid under the mattress, was squared in shape at the top, and had legs that extended to the floor. The device measured approximately 16.5 inches in width at the top of the device, and approximately 28.75 inches from the top of the device to the floor. There were two vertical bars in the squared section of the device that did not measure greater than 4 inches. The device was not securely attached to the bed and slid freely from under the mattress. Interview on 07/29/26 at approximately 02:00 PM with LN C confirmed the bed assist device was not secured to the bed. Interview on 07/29/26 at approximately 05:55 PM with Licensed Nursing Home administrator A, LN's B, C, and Regional directors AA and BB confirmed R32's record lacked an assessment of R32's bed assist device to ensure the device posed no risk for entrapment, confirmed the device was not a restraint, ensured the device was securely attached to the bed, and R32's ability to safely use the bed assist device, listed the device in the comment section of the FCS,	S3171		

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and included a description of the bed assist device, the purpose of the device, and any special instructions on use and monitoring of the bed assist device in R32'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.

The facility failed to provide healthcare services

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	N087071	A. BUILDING: _____ B. WING _____	C 07/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHISHOLM PLACE	1859 N. WEBB ROAD 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
S3171	Continued From page 27 for R32 in accordance with professional standards of practice when the facility failed to conduct an assessment of R32's bed assist device to ensure the device posed no risk for entrapment, confirmed the device was not a restraint, ensured the bed assist device was securely attached to the bed, and R32's ability to safely use the bed assist device. The facility continued to fail to ensure the bed assist device for R32 was listed in the comment section of the FCS, and the facility further failed to include a description of the bed assist device, the purpose of the device, and any special instructions on use and monitoring of the bed assist device in R32's NSA.	S3171		
S3215 SS=F	26-41-205 (h) Medication Storage (h) Storage. Licensed nurses and medication aides shall ensure that all medications and biologicals are securely and properly stored in accordance with each manufacturer ' s recommendations or those of the pharmacy provider and with federal and state laws and regulations. (1) Licensed nurses or medication aides shall store non-controlled medications and biologicals managed by the facility in a locked medication room, cabinet, or medication cart. Licensed nurses and medication aides shall store controlled medications managed by the facility in separately locked compartments within a locked medication room, cabinet, or medication cart. Only licensed nurses and medication aides shall have access to the stored medications and biologicals. (2) Each resident managing and self-administering medication shall store medications in a place that is accessible only to	S3215		

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S3215	Continued From page 28 the resident, licensed nurses, and medication aides. (3) Any resident who self-administers medication and is unable to provide proper storage as recommended by the manufacturer or pharmacy provider may request that the medication be stored by the facility. (4) A licensed nurse or medication aide shall not administer medication beyond the manufacturer ' s or pharmacy provider ' s recommended date of expiration. This REQUIREMENT is not met as evidenced by: K.A.R. 26-41-205 (h) (4) The facility reported a census of 57 residents. The sample included 44 "Residents'" (R)'s and 7 focused reviews. Based on observation and interview the facility failed to ensure the facility "Licensed Nurses" (LN)'s and "Certified Medication Aides" (CMA)'s did not administer medications beyond the manufacturer's or pharmacy provider's recommended date of expiration. Findings included: - Observation on 07/20/26 at approximately 10:30 AM of the facility's two medication carts located in the northeast entrance of the facility dining room revealed the following expired medications: One bag of 30 syringes with a pharmacy label for R32 which contained Morphine sulfate 100 milligrams (mg) / 5 milliliters (ml) (20 mg/ml) oral solution with a discard date of 07/11/26.	S3215		

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S3215	Continued From page 29 One small box with a pharmacy label for R14 which contained Naloxone injection 2 mg/1 ml. The box instructed to "discard unused portion" and on the bottom of the box the expiration date was 06/30/26. One bottled a prescription label with R52's name faded and the prescription information faded of the label. One opened box of Nystatin Cream. The only portion of the prescription label that had not been removed contained R46's last name. Review of the facility provided discharged resident list revealed R46 discharged from the facility on 07/05/26. One box of Hydrocortisone cream with a pharmacy label for R40 with an expiration date of 04/02/26. One bottle of Nitroglycerin 0.4 mg sublingual that contained a pharmacy label for R10 with an expiration date of 06/17/26. One bottle of Betadine Antiseptic solution that had the pharmacy label removed entirely with an expiration date of January 2026. One box of Famotidine 10 mg tablets with a pharmacy label for R10 with an expiration date of 05/07/26. Interview on 07/29/26 at approximately 05:55 PM with Licensed Nursing Home administrator A, LN's B, C, and Regional directors AA and BB confirmed all expired medications should be removed from the facility's medication carts.	S3215		

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S3215	Continued From page 30 The facility failed to ensure the facility "Licensed Nurses" (LN)'s and "Certified Medication Aides" (CMA)'s did not administer medications beyond the manufacturer's or pharmacy provider's recommended date of expiration.	S3215		
S9999	Final Observations K.A.R. 26-39-101 (h) scope/severity of F The facility reported a census of 57 residents. Based on record review and interview the facility failed to notify the department within two working days when there was a change in the Administrator of the facility. Findings included: - Record review of the facility provided untitled document revealed the following; "Licensed Nursing Home Administrator" (LNHA) E terminated from the facility on 10/03/25. LNHA F was hired on 10/29/25 and terminated 03/31/26. LNHA A was hired on 03/23/26. Review of the facility provided document titled "Request for Change of Administrator/Operator" revealed LNHA F started as the LNHA for the facility on 10/29/26 and the document was electronically signed on 03/09/26.	S9999		

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S9999	Continued From page 31 Review of the facility provided document titled "Request for Change of Administrator/Operator" revealed LNHA A started as the LNHA for the facility on 04/01/26 and the document was electronically signed on 03/31/26. Interview on 07/29/26 at approximately 05:55 PM with LNHA A confirmed the facility failed to notify the department within two working days when there was a change in the LNHA and the CSD. The facility failed to notify the department within two working days when there was a change in the Administrator of the facility.	S9999		