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S 000	INITIAL COMMENTS The following citations represent the findings of an abbreviated survey for complaints #'s 199199, 199082, 199041, 199009, 198910, 19876, 198656, at the above named facility conducted on 06/30/26, 07/01/26, and 07/08/26.	S 000		
S 115 SS=D	26-39-103 (d) Resident Right Inspection of Records (d) Inspection of records. (1) The administrator or operator shall ensure that each resident or resident's legal representative is afforded the right to inspect records pertaining to the resident. The administrator or operator, or the designee, shall provide a photocopy of the resident's record or requested sections of the resident's record to each resident or resident's legal representative within two working days of the request. If a fee is charged for the copy, the fee shall be reasonable and not exceed actual cost, including staff time. (2) The administrator or operator shall ensure access to each resident ' s records for inspection and photocopying by any representative of the department. This STANDARD is not met as evidenced by: K.A.R. 26-39-103 (d) (2) The facility reported a census of 53 residents. The sample included 5 "Residents'" (R)'s and one focused review. Based on interview, the Operator failed to ensure that R1's legal representative was provided with a photocopy of R1's records within two working days of the request. Findings included:	S 115		

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

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S 115	Continued From page 1 - Interview on 06/30/26 at approximately 11:00 AM with R1's legal representative revealed a request was made for a copy of R1's fall documentation for falls on the following dates: 03/17/26 04/08/26 04/19/26 05/26/26 05/28/26 06/09/26 06/10/26 06/13/26. R1's legal representative continued to state that the information requested would need to include the dates and times of the falls and the information would need to be on the facility letterhead. R1's legal representative stated the information was needed by the outside provider so the outside provider would continue to pay for the service of an individual to come and sit with R1. R1's legal representative confirmed the request for the medical records began around 06/16/26. Interview on 07/01/26 at approximately 11:15 AM with Cooperate Nurse A, Regional Executive Director B, Operator C, and Licensed Nurse D confirmed that R1's legal representative was not provided the requested records for R1 within two working days of the request. The Operator failed to ensure that R1's legal representative was provided with a photocopy of R1's records within two working days of the request.	S 115		
S3026 SS=F	26-41-101 (f) (1) Staff Treatment of Residents ANE	S3026		

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S3026	Continued From page 2 (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 53 residents. The sample included 5 "Residents'" (R)'s and one focused review. Based on observation, interview, and record review the Operator neglected to ensure each resident was provided services which were reasonably necessary to ensure the safety and well-being for R1 and R2, and the Operator further failed to ensure all residents were not involuntary secluded. Findings included: Record review for R1 revealed an admission date of 03/05/26 with diagnoses of dementia, hypotension, insomnia, and Parkinson's disease. Review of R1's "Functional Capacity Screen" (FCS) dated 03/05/26 and signed on 04/28/26 revealed R1 required physical assistance with bathing, dressing, toileting, walking mobility, and eating. R1 had impaired short-term memory, long-term memory, memory/recall, and decision making. R1 was usually able to make himself understood and R2 usually understood others. R1	S3026		

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was identified at risk for falls, impaired vision, and impaired decision making. R1 used a walker mobility device.

Review of R1's unsigned combined "Negotiated Service Agreement" (NSA)/"Health Service Plan" (HSP) dated 03/05/26 was attached to a fax cover page that included a handwritten note from R1's legal representative that instructed facility staff to let her know when the changes were made to the combined NSA/HSP so she could sign the NSA/HSP. The combined NSA/HSP instructed facility staff to provide the following health care services; under the section titled "Bladder" facility staff were instructed to provide R1 assistance with toileting "due to vision loss". Under the section titled "Behaviors" it was handwritten to "Identify restlessness as a sign" R1 needed to "Use the bathroom". Under the section titled "Safety" it was typed "Safety Check: every 2 to 3 hours". The 2 to 3 hours had a line drawn through it and handwritten was "30 minutes when alone in room". Under the section titled "Falls" the document lacked any typed information. Handwritten in the box was the following: R1 preferred to "sleep in his recliner-please recline per the preset buttons". Checks on R1 every 30 minutes, and R1 had a call light that he might forget to use. Under the section titled "Cognition" it was typed R1 required reminders, and R1 had mild to moderate disorientation or difficulty recalling/retaining information. R1 displayed deficits in judgement. R1 required "hand over hand" and "verbal/non-verbal cuing due to vision" was very poor.

The NSA/HSP lacked healthcare services to be provided for the cognitively impaired resident, the combined NSA/HSP further lacked specific

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healthcare services to be provided to reduce the risk for falls for R1.

Review of R1's electronic "Medical Record" under the "Misceallanous" tab revealed a document titled "Clinical Discharge Summary" dated 03/05/26 revealed the following:

Diagnoses listed were: coronary artery disease, chronic atrial fibrillation, chronic hypotension, History of Parkinson's disease, long term use of anticoagulants, Multiple falls and prostate cancer.

Under the section titled "Discharge instructions Given" it was typed "suture, staples, or adhesive wound closure, ...fall preventions in the home, Adult".

Review of R1's electronic "Medical Record" under the "Miscellaneous" tab revealed the following NSA Addendums:

An NSA Addendum dated 03/19/26 that revealed the addition of "Specialized Physical Therapy Services" to be added to R1's healthcare services to be coordinated.

An NSA Addendum dated 04/19/26 that revealed the facility staff were instructed to turn R1's television off "30 minutes after" R1 had gone to sleep.

An NSA Addendum dated 04/19/26 that revealed R1 had fallen twice and had a small abrasion to the left buttocks and a skin tear to the left elbow. Facility staff were instructed to obtain a urinalysis and check on resident every one to two hours during the night.

Interview on 06/30/26 at approximately 11:00 AM

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with R1's legal representative revealed R1 had falls on 03/17/26, 04/08/26, 04/19/26, 05/26/26, 05/28/26, 06/09/26, 06/10/26, and 06/13/26. R1's legal representative continued to confirm a local outside provider pays for R1 to have a private sitter through the night time hours and that was set up and organized by the legal representative for R1.

Review of R1's FCS dated 03/05/26 and signed on 05/18/26 revealed that R1 required physical assistance with bathing, dressing, toileting, walking mobility, and eating. R1 had impaired short-term memory, long-term memory, memory/recall, and decision making. R1 was usually able to make himself understood and R2 usually understood others. R1 was identified at risk for falls, impaired vision, and impaired decision making. R1 used a walker and wheelchair mobility device.

Review of R1's combined NSA/HSP dated 04/30/26 and signed by R1's legal representative on 05/18/26 lacked documentation of health care services to be provided for R1's impaired cognition.". Under the section titled "Safety" it was typed "Safety Check: every 2 to 3 hours". The 2 to 3 hours had a line drawn through it and handwritten was "every 1 to 2 hours" while R1 was alone in his room. Under the section titled falls facility staff were instructed to remove safety hazards "such as making sure all walkway areas in room" were clear of any items that posed a fall risk, and handwritten was "always use walker or wheelchair".

Interview on 06/30/26 at approximately 11:00 AM with Cooperate Nurse A, Regional Executive Director B, Operator C, and Licensed Nurse D confirmed that R1's had falls on 03/17/26,

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S3026	Continued From page 6 04/08/26, 04/19/26, 05/26/26, 05/28/26, 06/09/26, 06/10/26, and 06/13/26. They further confirmed that the facility did not add any other health care services to reduce R1's risk of falls. They continued to confirm that R1's family has a paid sitter provided by an outside provider comes into the facility to sit with R1during the over night hours, and that the medical record for R1 lacked documentation of R1 being checked on every 1 to 2 hours on 04/19/26 after a fall. Observation on 06/30/26 at approximately 03:15 PM of the facility common area, two male residents were observed sitting in the electronic recliners. R1 was observed sitting in the electronic recliner on the west side of the room. R1's recliner was in the reclined position and R1 had slid himself to the end of the footrest. The footrest appeared to be resting about halfway down from the top of R1's buttocks. There were no staff present in the common area. When asked, R1 he was getting up. Operator C entered the building and went to R1's electronic recliner and attempted to use the control to put the recliner in the down position. The electronic chair would not operate with the control. R1 was assisted by Operator C to his wheelchair. Facility staff then came into the common area and were asked how the recliner was made to be put into the down position. Facility staff responded there was only one electronic cord for the electronic recliners and that the cord had been removed from R1's recliner and placed it on the recliner on the east side of the room. They confirmed that R1 would be unable to put the chair in the down position with out the chair having electronic cord attached to his chair. - Record review for R2 revealed an admission	S3026		

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date of 04/15/26 with diagnoses of hypertension, dementia, folate deficiency anemia, and falls.

Review of R2's FCS dated 04/15/26 revealed R2 required physical assistance with bathing, dressing, toileting, and eating. R2 was independent with transferring and walking. R2 was incontinent and had impaired short-term memory, long-term memory, memory/recall, and decision making. R2 was rarely or never understandable and he rarely or never understood others. R2 was identified at risk for wandering, having socially disruptive behavior, and had difficulty making decisions which were harmful or potentially harmful to the R2.

R2's FCS lacked documentation of R2 being at risk for falls.

Review of R2's unsigned and combined NSA/HSP dated 04/15/26 instructed facility staff to provide assistance with toileting. Under the section titled "Behaviors" it was documented that staff were to manager behavior episodes. R2 would become angry at times and yell out words such as "cattle". R2 would take other residents' food and would try and to into other residents' rooms. R2 would need redirections and monitored for behavior and medication management when appropriate. Under the section titled "Reluctance to Accept Cares" staff were instructed to stop, ensure safety, and resume/reapproach at a later time. Known triggers for resisting care were dressing and toileting. The resistive behavior was de-escalated by the staff members taking their time and explaining to R2 the process. Staff were instructed to allow time for R2 to process the request. Under the section titled "Falls" the intervention was to start physical therapy for

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strengthening. Under the section titled "Cognition" it was documented that R2 demonstrated inappropriate judgement, behavior, and ability to function in social settings and R2 required assistance. Under the section titled "Communication" it was documented that R2 required assistance with mode of expression, speech, or writing: word seeking. Facility staff were instructed to provide assistance.

R2's NSA/HSP lacked a description of services for R2 when; R2 would take other residents' food, go into other residents' rooms, fall interventions until R2 started physical therapy services, instructions to facility staff on how to manage R2's inappropriate judgement and behaviors, and the combined NSA/HSP further failed to provide a full description of services for R2's impaired communication.

Review of R2's electronic "Medical Record" under the "Progress Notes" tab revealed the following entries:

On 04/15/26 at 11:43 AM R2 moved into the facility.

On 04/16/26 at 06:45 AM a "Behavior Note" revealed that R2 had been up all night wondering into other resident's rooms and R2 was hard to redirect and became agitated and raised his fist to staff when R2 was redirected out of another resident's room. R2 cornered the staff member and started yelling "cattle" at her. The medical care provider was going to be notified in the "morning".

R2's "Progress Notes" lacked documentation of the results of actions taken to related to R2's inappropriate socially disruptive behavior.

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S3026	Continued From page 9 On 04/19/26 at 11:03 AM an "Incident Note" revealed R2 had been standing in the living room of the facility and fell asleep while standing and "fell over to floor". R2 fell on his right side without hitting "anything but the floor". R2's "Progress Notes" lacked documentation of actions taken to protect resident after the fall, and the note further lacked results of the actions taken after R2 fell asleep while standing. On 04/20/26 at 11:56 AM an "Incident Note" revealed that at 09:45 AM the facility Certified Medication Aide (CMA) notified the nurse that R2 had a non injury fall. Staff reported that they had just finished assisting R2 with toileting and R2 sat on the shower bench, and R2 appeared to have fallen off of the shower bench to his right side. "Upon assessment" staff had placed a pillow under R2's head. R2 had his left arm up under his head and was falling asleep. "Noted resident did not sleep last night per staff report ...about 05:30 AM a new order for right hip and pelvis x ray to be obtained. Medical provider will be in "tomorrow to review medications on behaviors and lack of sleep" ... On 04/21/26 at 08:00 PM a "Late Entry" revealed that staff reported that R2 was wandering most of the shift, exit seeking, going into and out of other resident rooms, and was hard to redirect. On 04/21/26 at 08:01 PM an "Incident" Note revealed that R2 was agitated and anxious. R2 wandered into other resident's rooms and staff continued to redirect. R2 was not "receptive to redirection". R2 had been started on Seroquel for behaviors, "however; family did not want" R2 to take the Seroquel. R2 approached another	S3026		

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resident and was shaking his fist at the other resident and the other resident's family, saying "get the hell out of here". R2 was redirected. R2's medical provider was notified and at 04:00 PM R2 received 2.5 milligrams of Zyprexa and "another" 2.5 milligrams of Seroquel. R2 was less agitated and remained uncooperative. Staff will continue to monitor R2 throughout the night and lock any doors to keep all other residents safe.

On 04/22/26 at 03:07 PM an "Incident Note" revealed that R2 went into another resident's room and urinated and defecated in the other resident's room. R2 was redirected and uncooperative. At approximately 02:40 PM R2 was observed going into his own rooms and was visible soiled with urine. When the staff approached R2 he became aggressive and grabbed the staffs wrist and shoved the CMA making the CMA fall to the ground where R2 proceeded to spit on the CMA and kick her in the stomach. Another staff member tried to redirect R2 and R2 remained uncooperative and grabbed the staff member causing a "skin tear". R2 continued to "fight and kick at staff while they changed his pants form the incontinence episode". Family and the medical care provider were notified and contact to be made with the local behavioral health hospital will be made for possible admission.

On 04/22/26 at 07:15 PM a "Communication" note revealed R2's medications and behaviors were discussed with his medical care provider. It was reported to the medical care provider that R2 continued to be agitated and aggressive with staff, and his behaviors had been uncontrolled with the as needed dose of Olanzapine.

On 04/22/26 at 08:30 PM an "Communication"

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note revealed that the nurse spoke to R2's family and the family reported they had provided R2 with two Good Bye Stress gummies at 07:09 PM.

On 04/23/26 at 11:00 PM a "Behavior" note revealed that R2 had gotten up and was pacing the halls. R2's family walked into his path and told R2 that he needed to listen to the staff and R2 half yelled and half mumbled something to his family member. R2's family member raised her voice at R2 and told R2 not to cuss at her and R2's family members voice got louder and she told R2 to not "talk to her that way". R2's family then grabbed his shoulder and told R2 again to listen to staff. R2 then "swung" and hit his family member in the chest. R2's family member then raised her fist at R2 and asked R2 "What are you going to do to me? What are you going to do?" A staff member stepped between R2 and his family member and asked them to try something different. The staff member redirected R2 towards his room and R2 continued to pace while the other staff member told the family member to step away and let R2 calm down.

On 04/24/26 at 11:05 an "Orders" note read "Behavioral Health Unit" BHU.

Review of R2's electronic "Medical Record" under the "Census" tab revealed that R2's status was "Hospital/Medical Leave".

Interview on 06/30/26 at approximately 11:00 AM with Cooperate Nurse A, Regional Executive Director B, Operator C, and Licensed Nurse D confirmed that there was an occasion when all residents were placed in their rooms due to R2's behavior. Regional Executive Director B stated that when the residents are in their rooms the residents can freely open their door if they are

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S3026	Continued From page 12 cognitively/physically able, she continued to state that the rooms require a key to open the door if the door is closed and one is trying to enter the room. They continued to confirm that all residents were unable to cognitively or physically open the door to exit their rooms. The Operator neglected to ensure each resident was provided services which were reasonably necessary to ensure the safety and well-being for R1 and R2, and the Operator further failed to ensure all residents were not involuntary secluded.	S3026		
S3080 SS=E	26-41-201 (a) (b) Functional Capacity Screen on Admission a) On or before each individual ' s admission to an assisted living facility or residential health care facility, a licensed nurse, a licensed social worker, or the administrator or operator shall conduct a screening to determine the individual ' s functional capacity and shall record all findings on a screening form specified by the department. The administrator or operator may integrate the department ' s screening form into a form developed by the facility, which shall include each element and definition specified by the department. (b) A licensed nurse shall assess any resident whose functional capacity screening indicates the need for health care services. This REQUIREMENT is not met as evidenced by: KAR 26-41-201(a) The facility reported a census of 53 residents.	S3080		

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S3080	Continued From page 13 The sample included 5 "Residents' (R)'s and 1 focused review. Based on observation, interview, and record review the operator failed to ensure designated facility staff documented the residents' functional capacity accurately on the functional capacity screening form for Resident R1 and R6. Findings included: - Record review for R1 revealed an admission date of 03/05/26 with the following diagnoses: dementia, hypotension, insomnia, and Parkinson's disease. The 03/05/26 "Functional Capacity Screen" (FCS) identified R1 required physical assistance with bathing, dressing, toileting, transfers, walking/mobility, and eating. He required physical assistance with management of medications and total assistance with management of treatments. R1's FCS was marked for impaired decision making and impaired vision. R1's FCS lacked documentation R1 was at risk for falls. The 05/18/26 "Service Plan Report" revealed R1 had a fall on 03/17/26 intervention was to ask for physical therapy from the local medical provider 04/19/26 intervention was "Remove safety hazards such as making sure all walkway areas in room are clear of any items that pose a risk for falling." The 03/05/26 Fall Risk Assessment had R1 marked as a High Risk for Falling. The 03/05/26 Progress Note revealed R1 had a history of falls and had 6 staples to the right side	S3080		

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S3080	Continued From page 14 of his head that were intact. On 06/30/26 at approximately 11:10 AM Durable Power of Attorney for R1 revealed that R1 was admitted to facility after falling and from the fall had major injuries. The operator failed to ensure designated facility staff documented the residents' functional capacity accurately on the FCS for R1. - Record review for R6 revealed an admission date of 07/30/25 with the following diagnoses: hyperkalemia, hypertension, hyperlipidemia, restlessness, and agitation. The 01/29/26 FCS identified R6 required physical assistance with bathing, dressing, and toileting. Independent with transfers, walking/mobility, and eating. FCS was marked for impaired decision making and impaired vision. The 05/01/26 "Service Plan Report" revealed R6 07/30/25 intervention was "Keep pathways clear and free of clutter." The 07/30/25 Fall Risk Assessment had R6 marked as having recent falls and was a Moderate Risk for Falling. The operator failed to ensure designated facility staff documented the residents' functional capacity accurately on the FCS for R6. The operator failed to ensure designated facility staff documented the residents' functional capacity accurately on the functional capacity screening form for Resident R1 and R6.	S3080		

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S3081	Continued From page 15	S3081		
S3081 SS=E	26-41-201 (c) Functional Capacity Screen Reassessment (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 REQUIREMENT is not met as evidenced by: KAR 26-41-201 (c) (2) The facility reported a census of 53 residents. The sample included 5 "Residents' (R)'s and 1 focused review. Based on interview and record review the operator failed to ensure designated staff completed a "Functional Capacity Screen" (FCS) for Resident (R)1, and R4 upon change of condition as defined in K.A.R. 26-39-100. Findings included: - Record review for R1 revealed an admission date of 03/05/26 with the following diagnoses: dementia, hypotension, insomnia, and Parkinson's. The 03/05/26 FCS identified R1 required physical assistance with bathing, dressing, toileting, transfers, walking/mobility, and eating. He required physical assistance with management of medications and total assistance with management of treatments. FCS was marked for	S3081		

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S3081	Continued From page 16 impaired decision making and impaired vision. On observation of R1's resident records, it revealed he was admitted to Hospice on 06/11/26 per documentation from outside provider. R1's record lacked evidence that a FCS was completed when R1 was admitted to hospice on 06/11/26. - Record review for R4 revealed an admission date of 04/21/26 with the following diagnoses: insomnia, psychotic disturbance, mood disturbance, anxiety, and vascular dementia. The 04/21/26 FCS identified R4 required standby assistance with dressing. Independent with bathing, toileting, transfers, walking/mobility, and eating. The FCS was marked for impaired decision making. Record review of R4's electronic "Medical Records" under the "Progress Notes" tab revealed R4 had a change of condition when he displayed inappropriate behaviors. Behavior Note on 05/13/26 stated R4 was found in another resident's room. R4's record lacked evidence that an FCS was completed when R4 exhibited new behaviors on 05/13/26. The operator failed to ensure designated staff completed an FCS for R1 and R4 upon change of condition as defined in K.A.R. 26-39-100.	S3081		
S3261 SS=E	26-41-105 (f) (11) Resident Record Documentation of Incidents	S3261		

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S3261	Continued From page 17 (f) (11) documentation of all incidents, symptoms, and other indications of illness or injury including the date, time of occurrence, action taken, and results of the action This REQUIREMENT is not met as evidenced by: KAR 26-41-105 (f) (11) The facility reported a census of 53 residents. The sample included 5 "Residents' (R)'s and 1 focused review. Based on interview and record review the operator failed to ensure licensed staff documented all incidents, symptoms, and other indications of illness or injury including the date and time of occurrence, action taken, and results of the action with incidents that occurred with Resident (R)1, R2, R4, and R5. Findings included: - Record review for R1 revealed an admission date of 03/05/26 with the following diagnoses: dementia, hypotension, insomnia, and Parkinson's disease. The 03/05/26 "Functional Capacity Screen" (FCS) identified R1 required physical assistance with bathing, dressing, toileting, transfers, walking/mobility, and eating. He required physical assistance with management of medications and total assistance with management of treatments. R1's FCS was marked for impaired decision making and impaired vision. Behavior Note on 04/15/26 states that R1 is having increased behaviors, exit seeking,	S3261		

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S3261	Continued From page 18	S3261		

refusing to put clothes on, and is very hard to redirect. Will have morning nurse call primary care provider to report behaviors.

R1's record failed to provide details that a follow up from having behaviors on 04/15/26 was completed.

- Record review for R2 revealed an admission date of 04/15/26 with the following diagnoses: hypertension, dementia, insomnia, and mood disorder with depressive features.

The 04/15/26 FCS identified R2 required physical assistance with bathing, dressing, toileting, and eating. He was independent with transfers and walk/mobility. Required physical assistance with management of medications and management of treatments. R2's FCS was marked for impaired decision making, wandering, and inappropriate behavior.

Behavior Note on 04/16/26 states that R2 was up all night wandering into other residents' rooms, hard to redirect, agitated, and raised fist to staff when they were trying to redirect resident. Will inform primary care provider in the morning of behaviors.

R2's record failed to provide details that a follow up from having behaviors on 04/16/26 was completed.

- Record review for R4 revealed an admission date of 04/21/26 with the following diagnoses: insomnia, psychotic disturbance, mood disturbance, anxiety, and vascular dementia.

The 04/21/26 FCS identified R4 required standby assistance with dressing. Independent with

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bathing, toileting, transfers, walking/mobility, and eating. FCS was marked for impaired decision making.

Incident Note on 05/24/26 states that R4 was unable to be found in the facility. R4 was found and was to have 15-minute checks done until solution becomes available.

R4's record failed to provide details that a follow up from the elopement on 05/24/26 was completed.

- Record review for R5 revealed an admission date of 04/20/26 with the following diagnoses: degeneration of the brain, neuralgia, diabetes mellitus, and anxiety.

The 05/01/26 FCS identified R5 required physical assistance with bathing, dressing, and toileting. Required standby assistance with transfers and walk/mobility. She was independent with eating. Required physical assistance with management of medications and management of treatments.

R5's FCS was marked for impaired decision making, impaired hearing, impaired vision, and falls.

Incident Note on 05/28/26 states that R5 lost her balance and fell to the floor. R5's record failed to provide details that a follow up from having fall on 05/28/26 was completed.

The operator failed to ensure licensed staff documented all incidents, symptoms, and other indications of illness or injury including the date and time of occurrence, action taken, and results of the action with incidents that occurred with Resident (R)1, R2, R4, and R5.

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