STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087075	A. BUILDING: _____ B. WING _____	C 06/04/2026

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THE OXFORD GRAND	3051 N PARKDALE CIRCLE WICHITA, KS 67205

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S 000	INITIAL COMMENTS The following citations represent the findings of the licensure resurvey with attached complaint number 197318,197846,198944,198927, for the above named facility conducted on 06/03/26, 06/04/26 and 06/08/26.	S 000		
S3085 SS=F	26-41-202 (a) Negotiated Service Agreement (a) The administrator or operator of each assisted living facility or residential health care facility shall ensure the development of a written negotiated service agreement for each resident, based on the resident ' s functional capacity screening, service needs, and preferences, in collaboration with the resident or the resident ' s legal representative, the case manager, and, if agreed to by the resident or the resident ' s legal representative, the resident ' s family. The negotiated service agreement shall provide the following information: (1) A description of the services the resident will receive; (2) identification of the provider of each service; and (3) identification of each party responsible for payment if outside resources provide a service. This REQUIREMENT is not met as evidenced by: KAR 26-41-202(a)(1) The facility reported a census of 80 residents with six residents included in the sample and one focused record review resident. Based on interview and record review, the administrator failed to ensure the "Negotiated Service Agreements" (NSA) for Residents (R) 1, R2, R3,	S3085		

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

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S3085	Continued From page 1	S3085		

R4, R5, R6, and R7 described the services they received based on their "Functional Capacity Screens" (FCS).

Findings included:

- Record review for R1 revealed and admission date of 11/01/23 with diagnoses of Alzheimer's disease, transient cerebral ischemic attack unspecified, unspecified dementia unspecified severity without behavioral disturbance psychotic disturbance mood disturbance and anxiety.

The 10/31/25 "FCS" identified R1 required physical assistance with management of treatments.

The 10/31/25 "NSA" failed to describe the services for R1's management of treatments.

On 06/08/26 at 02:55 PM Administrative Nurse B confirmed the "NSAs" for all residents in the facility failed to describe the services each resident received for management of treatments.

- Record review for R2 revealed an admission date of 05/18/26 with diagnoses of dementia, acquired absence of right leg above knee, and restlessness and agitation.

The 05/18/26 "FCS" identified R2 required supervision with management of medications and treatments.

The 05/18/26 "NSA" failed to describe the services R2 received for management of medications and treatments.

On 06/08/26 at approximately 03:11 PM

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S3085	Continued From page 2 Administrative Nurse B confirmed R2's "NSA" failed to describe the services R2 received based on her "FCS" for management of medications. - Record review for R3 revealed an admission date of 06/07/24 with diagnoses of paroxysmal atrial fibrillation, mild cognitive impairment of uncertain or unknown etiology, radiculopathy, paresthesia of skin. The 06/03/26 "FCS" identified R3 required supervision with management of medication and treatments and was independent with toileting. R3 was marked as having impaired hearing. The 06/03/26 "NSA" failed to describe services R3 received for changing the catheter tubing every 30 days and services for impaired hearing. On 06/08/26 at approximately 02:37 PM Administrative Nurse B confirmed R3's "NSA" failed to describe the services he received based on his "FCS" for a suprapubic catheter and impaired hearing. - Record review for R4 revealed an admission date of 10/16/24 with diagnosis of dementia. The 09/22/25 "FCS" identified R4 required physical assistance with management of treatments. The 09/22/25 "NSA" failed to describe the services R4 received for management of treatments. On 06/08/26 at 02:55 PM Administrative Nurse B confirmed the "NSAs" for all residents in the facility failed to describe the services each resident received for management of treatments.	S3085		

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S3085	Continued From page 3 - Record review for R5 revealed an admission date of 12/09/24 with a diagnosis of cerebral infarction. The 05/04/26 "FCS" identified R5 required physical assistance with toileting, management of treatments, was occasionally incontinent of bladder, and had memory recall and decision-making cognitive difficulties. The 05/04/26 "NSA" failed to describe the services R5 received for toileting, management of treatments, bladder incontinence, and cognitive difficulties. On 06/08/26 at 02:55 PM Administrative Nurse B confirmed the "NSAs" for all residents in the facility failed to describe the services each resident received for management of treatments. On 06/08/26 at approximately 03:16 PM Administrative Nurse B confirmed R5's "NSA" failed to describe the services she received based on her "FCS" for toileting, bladder incontinence, and cognitive difficulties. - Record review for R6 revealed and admission date of 05/01/21 with diagnosis of history of falls, type 2 diabetes mellitus with unspecified diabetic retinopathy without macular edema. The 04/30/26 "FCS" identified R6 required physical assistance with management of treatments. The 05/28/25 "NSA" failed to describe the services for R6 management of treatments. On 06/08/26 at 02:55 PM Administrative Nurse B	S3085		

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S3085	Continued From page 4 confirmed the "NSAs" for all residents in the facility failed to describe the services each resident received for management of treatments. - Record review for R7 revealed an admission date of 04/14/26 with a diagnosis of dementia. The 04/14/26 "FCS" identified R7 required physical assistance with management of treatments. The 04/14/26 "NSA" failed to describe the services R7 received for management of treatments. On 06/08/26 at 02:55 PM Administrative Nurse B confirmed the "NSAs" for all residents in the facility failed to describe the services each resident received for management of treatments. On 06/08/26 at 04:03 PM a "Negotiated Service Agreement" policy was requested which the facility failed to provide. The administrator failed to ensure the "NSAs" for R1, R2, R3, R4, R5, R6, and R7 described the services they received based on their "FCSs."	S3085		
S3102 SS=E	26-41-202 (i) Negotiated Service Agreement Service Received (i) Each administrator or operator shall ensure that each resident receives services according to the provisions of that resident ' s negotiated service agreement This REQUIREMENT is not met as evidenced by: KAR 26-41-202(i)	S3102		

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S3102	Continued From page 5 The facility reported a census of 80 residents with six included in the sample and one focused review. Based on interview and record review the administrator failed to ensure Resident (R) 1, R2, and R7 received the services described in their "Negotiated Service Agreements" (NSA) for safety checks. Findings included: - Record review for R1 revealed an admission date of 11/01/23 with a diagnosis of dementia. The 10/31/25 "Functional Capacity Screen" identified R 1had short-term and long-term memory, memory/recall, and decision-making cognitive difficulties and was at risk for falls/ unsteadiness and wandering. The 10/31/25 "NSA" identified R1 received reminders for cognitive difficulties, assistance to get up in the mornings and used an assistive device while ambulating for falls, and observation of her location in the community and safety checks every two to three hours for wandering. Review of R1's record lacked evidence of documentation staff checked her every two to three hours for safety. - Record review for R2 revealed an admission date of 05/1/26 with diagnoses of dementia and restlessness and agitation. The 05/18/26 "FCS" identified R2 had short-term and long-term memory, memory/recall, and decision-making cognitive difficulties and was at risk for inappropriate behavior.	S3102		

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S3102	Continued From page 6 The 05/18/26 "NSA" identified R2 received explanation of care activities prior to and as they occurred for cognitive difficulties, and observation of her location in the community at all times for wandering, and safety checks every two to three hours. Review of R2's record lacked evidence of documentation staff checked her every two to three hours for safety. - Record review for R7 revealed an admission date of 04/14/26 with diagnoses of dementia, muscle weakness, and abnormalities of gait and mobility. The 04/14/26 "FCS" identified R7 had short-term and long-term memory, memory/recall, and decision-making cognitive difficulties. The 04/14/26 "NSA" identified R7 received checks every two to three hours for safety. Review of R7's record lacked evidence of documentation staff checked her every two to three hours for safety. The 05/28/26 "Intake" report to the department reported R7 suffered a bruise of unknown origin sometime during the night of 05/27/26 to 05/28/26. Direct care staff found R7 in her bed with a bruise on her forehead the morning of 05/28/26 and notified the nurse. The nurse performed an assessment and R7 was unable to open her eyes. R7 was transported to the hospital and found to have more bruises on multiple areas of her body. On 06/03/26 Administrative Nurse C stated a day shift Certified Nurse Aide (CNA) checked on R7,	S3102		

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S3102	Continued From page 7 saw a bruise on R7's forehead and notified the nurse. The nurse assessed R7 and found she was lethargic and not at her baseline level of consciousness. Administrative Nurse C stated CNA D was assigned to work in R7's unit that night. CNA D had been accused of sleeping while at work and was currently suspended. On 06/03/26 at approximately 11:56 AM CNA D stated she worked in all areas of the facility including the memory care unit where R7 lived. She had been suspended because someone said she slept while on duty which she did not do. She had arrived to work at the facility "more than once" and saw staff sleeping on the couch, which she did not report to her supervisors. CNA D stated she provided rounds every two hours. R7's door remained open during the night and CNA D did not hear anything unusual from her room. R7 often forgot to use her walker when she walked and had fallen and got back up by herself in the past "plenty of times." On 06/03/26 at approximately 01:23 PM via speaker phone call with several unidentified family members of R7, an unidentified family member stated a facility nurse told them the CNA on duty during the night when R7 suffered a bruise and a change in level of consciousness was suspended because she did not check R7 like she was supposed to. On 06/04/26 at approximately 04:20 PM Administrative Nurse C confirmed the residents' records lacked evidence of documentation staff checked them every two to three hours for safety. The administrator failed to ensure R1, R2, and R7 received the services described in their "NSAs" for safety checks.	S3102		

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S3261 SS=D	26-41-105 (f) (11) Resident Record Documentation of Incidents (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: K.A.R. 26-41-105 (f)(11) The facility reported a census of 80 residents. The sample included six "Residents'" (R)'s and included one focus review. Based on interview and record review the administrator failed to ensure all resident records contained documentation of all incidents, symptoms, and other indications of illness or injury including the date, time of occurrence, action taken and results of the actions for R1. Findings Included: -Record Review of R1 revealed an admission date of 11/01/23 with diagnoses of hypertension, hyperlipidemia, Alzheimer's disease, transient cerebral ischemic attack, unspecified dementia unspecified severity without behavioral disturbance psychotic disturbance mood disturbance and anxiety. Review of R1's "Functional Capacity Screen" (FCS) dated 10/31/25 revealed R1 required supervision with transferring, walking and mobility. R1 required physical assistance with	S3261		

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S3261	Continued From page 9	S3261		

dressing, toileting, bathing, management of medications, and management of treatments. R1 was occasionally incontinent and had impaired short term, long term, memory/recall and decision making. R1 was usually able to make herself understood and could usually understand others. R1 was identified at risk for falls, wandering, socially inappropriate disruptive behavior and impaired decision making. R1 used a walker and a wheelchair mobility device.

Review of R1's electronic "Medical Record" revealed a document titled "Service Plan" dated 10/31/25 and instructed staff to manage R1's medications and instructed staff to provide assistance with bathing, dressing, toileting. R1 was independent with transferring and independently walked with a walker. Facility staff were instructed to provide reminders to assist with cognition and to perform safety checks every two to three hours.

Review or R1's electronic Medical Record under the "Progress Note" tab revealed the following entries:

05/27/26 Alprazolam 0.5 milligram as needed was administered, and results were ineffective

05/15/26 Alprazolam 0.5 milligram as needed was administered, and results were ineffective

R1's medical record lacked evidence of documentation of direct care staff notifying the nurse prior to administration. The record further lacked evidence of documentation of the actions taken when the medication was ineffective.

Interview on 06/08/26 at approximately 03:06PM with Administrative Nurse B confirmed the lack of

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S3261	Continued From page 10 documentation on two separate occasions of actions taken and results of actions when as needed alprazolam was ineffective for R1. The administrator failed to ensure all resident records contained documentation of all incidents, symptoms, and other indications of illness or injury including the date, time of occurrence, action taken and results of the actions for R1.	S3261		
S3298 SS=F	26-41-206 (d) Food Preparation (d) Food preparation. Food shall be prepared using safe methods that conserve the nutritive value, flavor, and appearance and shall be served at the proper temperature. (1) Food used by facility staff to serve to the residents, including donated food, shall meet all applicable federal, state, and local laws and regulations. (2) Food in cans that have significant defects, including swelling, leakage, punctures, holes, fractures, pitted rust, or denting severe enough to prevent normal stacking or opening with a manual, wheel-type can opener, shall not be used. (3) Food provided by a resident ' s family or friends for individual residents shall not be required to meet federal, state, and local laws and regulations. This REQUIREMENT is not met as evidenced by: K.A.R. 26-41-206(d) The facility reported a census of 80 residents. The sample included six residents and one	S3298		

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S3298	Continued From page 11 focused review. Based on record review and interview the administrator failed to ensure food was served at the proper temperature. Findings Included: - Record review on 06/04/26 of facility document titled "Food Temp Log" located in memory care one revealed no entries for the months of 05/2026 and 06/2026 Interview on 06/04/26 at approximately 10:04 AM with CNA E confirmed the food temperature log was blank for the months of 05/2026 and 06/2026. Record review on 06/04/26 of facility document titled "Food Temp Log" located in memory care two revealed four meal entries for the months of 05/2026 and 06/2026. Interview on 06/04/26 at approximately 10:14 AM confirmed with CMA F the food temperature logs only had four meal entries for the months of 05/2026 and 06/2026. Interview on 06/04/2026 at approximately 10:23 AM revealed and confirmed there were no food temperature logs completed for the months of 05/2026 and 06/2026 in the main kitchen. The administrator failed to ensure food was served at the proper temperature.	S3298		
S3299 SS=F	26-41-206 (e) (1) Facility Food Storage (e) Food storage. Facility staff shall store all food under safe and sanitary conditions.	S3299		

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S3299	Continued From page 12 (1) Containers of poisonous compounds and cleaning supplies shall not be stored in the areas used for food storage, preparation, or serving. This REQUIREMENT is not met as evidenced by: K.A.R. 26-41-206(e) The facility reported a census of 80 residents. The sample included 6 residents and 1 focused review. Based on record review and interview the administrator failed to ensure all food would be stored under safe and sanitary conditions. Findings Included: - Record Review on 06/04/26 of facility document titled "Temp Logs" for the refrigerator and freezer located in memory care one revealed no entries for the month of 05/2026 and 06/2026. Interview on 06/04/26 at approximately 10:04 AM with CNA E confirmed the fridge and freezer temperature log was blank for the months of 05/2026 and 06/2026. Record Review on 06/04/26 of facility document titled "Temp Logs" for the refrigerator and freezer located in memory care two revealed three entries. The rest of the document was blank for the month of 06/2026. Interview on 06/04/26 at approximately 10:14 AM with CMA F confirmed the fridge and freezer temperature log was blank except three entries for the month of 06/2026.	S3299		

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S3299	Continued From page 13 The administrator failed to ensure all food would be stored under safe and sanitary conditions.	S3299		