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	N096011	A. BUILDING: _____ B. WING _____	10/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S 000	INITIAL COMMENTS The following citations represent the findings of the licensure resurvey with attached complaint number 191889 for the above named facility conducted on 10/01/25 and 10/02/25.	S 000		
S3026 SS=J	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) (B) The facility reported a census of 31 residents. The sample included 3 Residents(R) and 1 focused record review. Based on interview and record review the facility nurse neglected to do a "Functional Capacity Screening" (FCS) that accurately reflected R4 when he had a change of cognition. The facility staff further neglected to acknowledge the facility door alarm system and R4 left the facility without staff knowledge on 11/16/24 at 06 :54 AM, confirmed by the review of the facility camera footage. R4 was found by another resident walking down a residential street near a convenience store approximately 1. 2 miles from the facility, and was returned to the	S3026		

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

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S3026	Continued From page 1	S3026		

facility at approximately 07:45 AM. This placed R4 in immediate jeopardy for approximately 50 minutes.

Findings included:

- Record review for R4 revealed an admission date of 07/08/24 with diagnoses of unspecified atrial fibrillation, anxiety disorder, other amnesia, transient cerebral ischemic attack, and mild cognitive impairment.

Review of R4's "Functional Capacity Screen" (FCS) dated 07/08/24 revealed R4 was independent with all activities of daily living and lacked the ability to manage his own medications and medical treatments. R4 had impaired short term memory and impaired memory/recall. R4 was able to make himself understood and understood others. R4 was at risk for falls and used no mobility device.

Review of R4's "Negotiated Service Agreement" (NSA) dated 07/08/24 identified the facility staff would administer R4's medications and medical treatments. Under the section titled "Cognition/Memory Recall" it was documented that R4 had "Moderate cognition impairment" and facility would reorient and redirect R4 as needed. The NSA lacked interventions for elopement.

Review of R4's "Health Service Plan" (HSP) dated 07/08/24 instructed facility staff to administer R4's medications and medical treatments. Under the section titled "Cognition/Memory Recall" it was documented that R4 had "Moderate cognition impairment" and

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facility would reorient and redirect R4 as needed.

Review of R4's electronic "Medical Record" under the forms tab, a document titled "Wandering Risk Assessment" dated 07/08/24 revealed R4's "Orientation" was "Forgetful/short attention span", and R4 was taking antidepressants. Under the section titled "Diagnoses" three choices were listed for the diagnoses; "Early dementia, Alzheimer's disease, and Dementia with Psychosis". The section lacked which diagnoses applied.

Review of R4's electronic "Medical Record" under the "Progress Notes" tab revealed the following entries:

On 08/21/24 at 12:44 PM a "Nurse Note" revealed R4 tested positive for COVID-19.

On 08/22/24 at 07:01 PM a "Nurse Note " revealed R4 was noted to have increased confusion and difficulty with activities of daily living. "Resident was placed on two-hour checks for safety".

08/24/24 at 02:33 PM a "Nurse Note" revealed that R4 was "very confused and came out of the room twice and was observed walking in his room naked." R4 was administered Tylenol for fever.

On 08/26/25 at 09:45 AM a "Nurse Note" revealed R4's confusion increased from being isolated in his apartment.

On 08/27/24 at 12:25 PM a "Nurse Note" revealed R4 remained very confused due to the

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S3026	Continued From page 3 COVID -19 virus. On 08/27/25 at 09:00 PM a "Nurse Note" revealed that another resident came to the nurse and reported that R4 had gone outside. The facility staff went outside to look for him and R4 was found "in the tree line near the garden area." R4 was placed on 30-minute checks and his family came to sit with him. On 08/28/24 at 09:14 AM a "Nurse Note" revealed R4 was "easily redirected" and "confusion remains increased due to isolation". On 08/31/24 at 05:49 PM a "Nurse Note" revealed R4 was not in his room when his meal was served. Staff searched the facility and found R4 in another resident's room. On 09/01/24 at 02:34 PM a "Nurse Note" revealed R4 tested negative for COVID - 19. On 10/0 2/24 at 04:35 PM a "Nurse Note" revealed R4 was "Very confused" and an order for a urinalysis was obtained. On 10/23/24 at 04:32 PM a "Nurse Note" revealed R4 was seen by the medical provider for increased anxiety. Escitalopram Oxalate (a medication to treat anxiety and major depressive disorder), 20 milligrams daily was ordered. On 10/26/24 at 08:32 AM a "Nurse Note" revealed R4 was "very weepy" at breakfast. R4 seemed "very upset and distraught". R4 was easily redirected. On 11/07/24 at 12:00 PM a "Behavior Note"	S3026		

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revealed staff was assisting R4 in getting ready for lunch and R4 was having hallucinations.

On 11/12/24 at 05:26 PM a "Nurse Note" revealed R4 was noted with increased confusion and an order for a urinalysis was obtained.

On 11/13/24 at 09:16 PM a "Nurse Note" revealed R4's uranalysis was negative for infection and R4 was seen by his medical provider for increased confusion. A new order for Donepezil (a medication to treat dementia) was provided by the medical care provider.

On 11/16/24 at 07:45 AM a "Nurse Note" revealed that another resident, who was driving, found R4 walking near a local convenience store. The resident who found R4 stated he pulled his car over and R4 got into the car and the other resident returned him to the facility.

On 11/22/24 at 09:32 AM a "Nurse Note" revealed R4 moved to a secured memory care assisted living facility.

Record review of R4's electronic "Treatment Administration Record" (TAR) revealed The "Certified Medication Aide" (CMA) documented at 06:00 AM that she performed the two hour check on R4 .

The facility provided witness statements lacked documentation of the time R4 was last seen .

Review of the facility provided investigation revealed that R4 was wearing slacks, a jacket, tennis shoes, ball cap and was carrying a walking stick. The temperature was 59 degrees

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S3026	Continued From page 5 Fahrenheit. Based on the witness statement provided by the resident who returned R4 to the facility, R4 walked down a two-lane residential street and was found approximately two blocks from a busy two lane street that ran in front of the local school. Interview on 10/02/25 at approximately 11:15 AM with Operator A confirmed the electronic record for R4 lacked documentation of a FCS being performed when R4 had a change in cognition, she further confirmed the facility doors alert the staff pagers when the doors are opened and closed. Operator A confirmed the quarterly Emergency Preparedness Training reviews with all staff and residents included the facility elopement procedures and prior to the elopement were performed quarterly. On 10/02/25 at approximately 11:20 AM Operator A was informed that R4 had been placed in jeopardy when the facility staff failed to check the door alarms when their pagers were activated and R4 left the facility without staff knowledge, Operator A was further informed that the facility nurse neglected to perform the FCS at the time R4 experienced a change in cognition. At the time of the incident on 11/16/24 the facility implanted the following. 11/16/24 One on One staff was implemented immediately for R4 until the time of discharge. 11/16/24 Monthly Inservice meetings now include elopement training. 11/16/24 Alarms on the facility doors are checked monthly.	S3026		

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S3026	Continued From page 6 11/16/24 Monthly elopement drills conducted.	S3026		
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. 26-41-204 (i) The facility reported a census of 31 residents. The sample included 3 "Residents'" (R) and 1 closed record review. Based on observation, interview, and record review the Operator failed to ensure to provide healthcare services for R3 in accordance with professional standards of practice when the operator failed to perform an assessment to confirm the device posed no risk for entrapment, and document a description of the device, the purpose of the device, and special instructions for use and monitoring of the device in R2's "Negotiated Service Agreement/Health Service Plan"(NSA/HSP). Findings included: - Record review for R3 revealed an admission date of 05/15/24 with diagnoses of type one diabetes mellitus, hypertension, muscle weakness, need for assistance with personal car and atrial fibrillation.	S3171		

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S3171	Continued From page 7 Review of R3's "Functional Capacity Screen" (FCS) dated 05/02/25 revealed R3 required physical assistance with bathing. R3 was incontinent and lacked the ability to manage her own medications and medical treatments. R3 was cognitively intact and used a walker mobility device. The comment section of the FCS lacked documentation of the bed assist device. Review of R3's NSA dated 05/02/25 identified that R3 was independent with transfers. R3 was independent with toileting with the assistance of an over the toilet commode to assist R3 in getting off and on the toilet. R3 was independent with ambulation with the assistance of a four wheeled walker. R3's NSA lacked a description the bed assist device, its purpose and instructions for use and monitoring. Review of R3's "Health Service Plan" dated 05/02/25 instructed facility staff R3 was independent with toileting with the assistance of an over the toilet commode to assist R3 in getting off and on the toilet. R3 was independent with ambulation with the assistance of a four wheeled walker. Review of R3's electronic "Medical Record" under the "Miscellaneous" tab revealed a document titled "Bed Rail Use Assessment Form" dated 07/07/25 revealed that R3 demonstrated proper use of the "quarter length rail" and it posed no risk for entrapment. R3 used the device	S3171		

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S3171	Continued From page 8 for mobility and transferring. Under the section titled "Benefits to Using the Bedrail" It was documented that the bedrail was securely attached to the bed. Observation on 10/02/25 at approximately 03:00 PM R3's head of the bed sat against the west wall. The north side of the bed had an inverted "U" shaped device that slid under the matters and had legs that extended to the floor, that measured 17.5 inches in width and 37 inches from the top of the device to the floor. The device freely pulled away from the bed. The 17.5 inch opening was covered to pose no risk for entrapment. Interview on 10/02/25 at approximately 04:00 PM with Operator A and Licensed Nurse B by phone confirmed the NSA for R3 lacked documentation of a description of the device, the purpose of the device, and special instructions for use and monitoring of the device. Operator A further confirmed the bed assist device pulled freely away from the bed. 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.	S3171		

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S3171	Continued From page 9 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 Operator failed to ensure to provide healthcare services for R3 in accordance with professional standards of practice when the operator failed to perform an assessment to confirm the device posed no risk for entrapment, and document a description of the device, the purpose of the device, and special instructions for use and monitoring of the device in R2's "Negotiated Service Agreement/Health Service Plan"(NSA/HSP).	S3171		
S3186 SS=D	26-41-205 (b) Administration of Selected Medications (b) Administration of select medications. Any resident who self-administers medication may select some medications to be administered by a	S3186		

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S3186	Continued From page 10 licensed nurse or medication aide. The negotiated service agreement shall reflect this service and identify who is responsible for the administration and management of selected medications. This REQUIREMENT is not met as evidenced by: K.A.R. 26-41-205 (b) The facility reported a census of 31 residents. Based on record review and interview the Operator failed to ensure the "Negotiated Service Agreement" (NSA) for R3 identified who was responsible for which medications, when R3 self-administered her own insulin. Findings included: - Record review for R3 revealed an admission date of 05/15/24 with diagnoses of type one diabetes mellitus, hypertension, muscle weakness, need for assistance with personal car and atrial fibrillation. Review of R3's "Functional Capacity Screen" (FCS) dated 05/02/25 revealed R3 required physical assistance with bathing. R3 was incontinent and lacked the ability to manage her own medications and medical treatments. R3 was cognitively intact and used a walker mobility device.	S3186		

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S3186	Continued From page 11 Review of R3's NSA dated 05/02/25 identified qualified facility staff would administer R3's medications and perform R3's medical treatments per physician's orders. Facility staff would change the continues blood glucose device every 10 days. R3's NSA lacked documentation of who was responsible for the administration of the insulin. Review of R3's "Health Service Plan" dated 05/02/25 instructed facility staff to administer R3's medications and perform R3's medical treatments per physician's orders. Facility staff would change the continues blood glucose device every 10 days. Review of R3's electronic "Medical Record" under the "Forms" tab revealed a document titled "Medication Self -Administration Safety Screen" dated 07/07/25. Under the section titled "A.1" it was documented that "Qualified staff" would dial the insulin pen to the correct dosage and R4 would verify the dose and administer the medication. Review of R3's signed orders revealed the following orders; Lispro Insulin give 9 units at breakfast, give 6 units at lunch and give 9 units at dinner. Tresiba Insulin Pen 100 units/milliliter give 10 units if blood sugar less than 160. If blood sugar 160 or above give 20 units. Interview on 10/02/25 at approximately 04:00 PM	S3186		

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S3186	Continued From page 12 with Operator A and Licensed Nurse B by phone confirmed the NSA for R3 did not identify who was responsible for the administration of R3's insulin. The Operator failed to ensure the "Negotiated Service Agreement" (NSA) for R3 identified who was responsible for which medications, when R3 self-administered her own insulin.	S3186		
S3200 SS=D	26-41-205 (d) (1-2) Facility Administration of Medications (d) Facility administration of resident ' s medications. If a facility is responsible for the administration of a resident ' s medications, the administrator or operator shall ensure that all medications and biologicals are administered to that resident in accordance with a medical care provider ' s written order, professional standards of practice, and each manufacturer ' s recommendations. The administrator or operator shall ensure that all of the following are met: (1) Only licensed nurses and medication aides shall administer and manage medications for which the facility has responsibility. (2) Medication aides shall not administer medication through the parenteral route. This REQUIREMENT is not met as evidenced by: K.A.R. 26-41-205 (d) The facility reported a census of 31 residents.	S3200		

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S3200	Continued From page 13 Based on record review and interview the Operator failed to ensure the "Licensed Nurse" (LN) administered R2's medications were administered in accordance with a medial care providers written order. Findings included: - Record review for R2 revealed an admission date of 09/16/24 with diagnoses of type two diabetes mellitus, mild cognitive impairment, morbid obesity, and chronic kidney disease stage four. Review of R2's "Functional Capacity Screen" (FCS) dated 01/23/25 revealed R2 required supervision with bathing and dressing. She lacked the ability to manage her own medications and medical treatments. R2 was able to make herself understood and she understood others. R2 was cognitively intact and used a walker mobility device. Review of R2's "Negotiated Service Agreement" (NSA) dated 01/23/25 identified the facility staff would manage R2's medications and perform her medical treatments. Review of R2's "Health Service Plan" instructed the facility staff to administer medications and medical treatments per the physicians' orders. Review of R2's electronic "Medical Records" under the progress notes tab revealed the following entry; On 04/29/25 at 02:04 PM a "Nurse Note"	S3200		

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S3200	Continued From page 14 revealed that R2 was "very impacted of stool" ..."Assisted resident by digitally removing some stool. Able to insert saline enema and resident able to pass the rest. New order for Miralax 17 grams daily in 8 ounces of water." The record lacked documentation of the provider being notified and the record further lacked the order for the enema. Interview on 10/02/25 at approximately 04:00 PM by phone with Licensed Nurse B and Operator A confirmed the record for R2 lacked an order for the saline enema. License Nurse B confirmed she had a verbal conversation with the provider that she did not document in the resident record. The Operator failed to ensure the "Licensed Nurse" (LN) administered R2's medications were administered in accordance with a medial care providers written order.	S3200		
S3216 SS=D	26-41-205 (i) Disposition of Medication (i) Accountability and disposition of medications. Licensed nurses and medication aides shall maintain records of the receipt and disposition of all medications managed by the facility in sufficient detail for an accurate reconciliation. (1) Records shall be maintained documenting the destruction of any deteriorated, outdated, or discontinued controlled medications and biologicals according to acceptable standards of practice by one of the following combinations: (A) Two licensed nurses; or (B) a licensed nurse and a licensed pharmacist. (2) Records shall be maintained documenting the destruction of any deteriorated, outdated, or	S3216		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N096011	A. BUILDING: _____ B. WING _____	10/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARIA COURT	633 E MAIN STREET MULVANE, KS 67110

(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
S3216	Continued From page 15 discontinued non-controlled medications and biologicals according to acceptable standards of practice by any of the following combinations: (A) Two licensed nurses; (B) a licensed nurse and a medication aide; (C) a licensed nurse and a licensed pharmacist; or (D) a medication aide and a licensed pharmacist. This REQUIREMENT is not met as evidenced by: K.A.R. 26-41-205 (i)(1)(A) (B) The facility reported a census of 31 residents. Based on observation, interview and record review the Operator failed to ensure the destruction of controlled medications was performed according to acceptable standards of practice by one of the following two combinations: Two licensed nurses or a licensed nurse and a licensed pharmacist. Findings included: - Observation on 10/01/25 at approximately 01:00 PM, "Certified Medication Aide" (CMA) C unlocked the facility medication cart located in the facility medication room. Observation of a controlled Tramadol 50 milligram card for R5 compared to the "Controlled Medication Administration Record" revealed on 09/12/25, four tablets were "Wasted" and signed by CMA C and Licensed Nurse B.	S3216		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S3216	Continued From page 16 Interview on 10/01/25 at approximately 01:00 PM with CMA C, she stated when the card was received from the pharmacy there was "tape" on the backs of four of the tablets. CMA C continued that she and Licensed Nurse B wasted the tablets. Interview by phone on 10/02/25 at approximately 04:00 PM with Licensed Nurse B and Operator A, confirmed Licensed Nurse B and CMA C wasted the four controlled medication tablets for R5 together. The Operator failed to ensure the destruction of controlled medications was performed according to acceptable standards of practice by one of the following two combinations: Two licensed nurses or a licensed nurse and a licensed pharmacist.	S3216		