| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | N001006 | A. BUILDING: _____ B. WING _____ | 10/08/2025 |

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| GRAYSTONE RESIDENTIAL CARE | 2620 N KENTUCKY STREET IOLA, KS 66749 |

| (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 |
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| S 000 | INITIAL COMMENTS<br><br>The following citations represent the findings of the licensure resurvey with attached complaint numbers 196869, 196627, 195794, 195722, and 192066 for the above named facility conducted on 10/06/25, 10/07/25 and 10/08/25. | S 000 | | |
| S3171 SS=D | 26-41-204 (i) Health Care Services Standards of Practice<br><br>(i) All health care services shall be provided to residents by qualified staff in accordance with acceptable standards of practice.<br><br>This REQUIREMENT is not met as evidenced by:<br>K.A.R. 26-41-204 (i)<br><br>The facility reported a census of 21 residents. The sample included 3 "Residents'" (R)'s and 1 closed record review. Based on observation, record review, and interview the Operator failed to ensure health care services were provided within professional standards of practice when Operator A failed to ensure an annual re-assessment was performed for R1 showing R1's bed assist device posed no risk for entrapment, confirmed the device was not a restraint, R1's ability to safely use the bed assist device, and provide a description of the device, the purpose of the device and special instructions on use and monitoring in R1's "Negotiated Service Agreement" (NSA). Operator A further failed to ensure the documentation in the facility's "Controlled Drug Administration Record" was performed within professional | S3171 | | |

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

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| S3171 | Continued From page 1 | S3171 | | |

standards of practice when facility "Certified Medication Aides (CMA)s used white out on the "Controlled Drug Administration Records" for R1.

Findings included:

- Record review for R1 revealed an admission date of 02/28/19 with diagnoses of Parkinson's disease, Neuropathy, hypertension, chronic pain, depression, chronic obstructive pulmonary disease, anemia, heart failure, anxiety, and fibromyalgia.

Review of R1's "Functional Capacity Screen" (FCS) dated 06/11/25 revealed R1 required physical assistance with bathing, and dressing. R1 required supervision with toileting and eating. R1 was independent with walking/mobility and transferring. R1 required physical assistance with the management of her medications/medical treatments. R1 was occasionally incontinent and had impaired short-term memory. R1 was able to make herself understood and R1 understood others. R1 had impaired vision and impaired hearing. R1 used a walker and wheelchair mobility device.

R1's FCS lacked documentation in the comments section of a bed assist device.

Review of R1's combined NSA/"Health Service Plan" (HSP) dated 02/26/24 under the section titled "Transfers" identified R1 was "Independent" and "Has grab bar on bed to assist".

R1's NSA lacked a description of the device and special instructions on use and monitoring of the device.

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| S3171 | Continued From page 2<br><br>Review of R1's medical record revealed a document titled "Supportive Device/Bed Entrapment Assessment" dated 02/26/23 revealed the handwritten description of the device was a "bed cane".<br><br>R1's medical record lacked documentation of an annual re-assessment of the bed assist device.<br><br>Observation on 10/08/25 at approximately 05:15 PM of R1's bed revealed the head of the bed sat against the northeast corner of the room with one side of the bed against the east wall and one side of the bed open to the west side of the room. An inverted "U" shaped bed assist device was slid under the mattress and the device was securely attached to the bed. The device had a cloth covering over the open "U" shape of the device. The device measured approximately 20.5 inches wide and 19 inches from the top of the device to the bottom side of the mattress where it slid under the mattress.<br><br>Interview on 10/08/25 at approximately 05:00 PM with Operator A and "Licensed Nurse" (LN) LN B confirmed the medical record for R1 lacked an annual re-assessment of R1's bed assist device, its purpose and R1's ability to safely use the device.<br><br>The FDA (food and drug administration) "Bedrails in Assisted Living, Residential Health Care and Home Plus Facilities" recommended the following:<br><br>Complete an assessment of the resident to | S3171 | | |

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| S3171 | Continued From page 3<br>confirm that the device is not a restraint.<br><br>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.<br><br>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.<br><br>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.<br><br>Include a description of the device, its purpose and special instructions on use and monitoring in the resident's NSA.<br><br>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.<br><br>- Review of the facility provided "Controlled Drug Administration Records" for R1 revealed white out was used on the documents on the following days:<br><br>On 07/23/25 - 07/25/25 and signed by CMA C<br>On 07/24/25 and signed by CMA F<br>On 07/25/25 and signed by CMA G<br>On 07/26/25 and signed by CMA C<br>On 07/30/25 and signed by CMA G | S3171 | | |

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| S3171 | Continued From page 4<br>On 08/05/25 and signed by CMA C<br>On 08/04/25 and signed by CMA G<br>On 008/06/25 and signed by CMA C<br><br>Interview on 10/08/25 at approximately 01:15 PM with LN B and CMA C confirmed that the CMA C used white out on the "Controlled Drug Administration Records".<br><br>Interview on 10/08/25 at approximately 05:00 PM with Operator A and LN B confirmed they have removed the white out bottles from the medication carts and there is a CMA who continues to purchase the bottles of white out.<br><br>Review of the "Kansas Certified Medication Aide Curriculum" dated 05/10/13 on page 176 revealed the following instructions when an error was made on the documentation of the CMA;<br><br>" ...do not erase it. Place one line through the error, and initial and date above the line then continue writing the rest of your charting. NEVER erase or use whit-out or obliterate by repeated marking over. Make sure the error is still readable after you correct it".<br><br>Operator A failed to ensure the documentation in the facility's "Controlled Drug Administration Record" was performed within professional standards of practice when facility "Certified Medication Aides (CMA)s used white out on the "Controlled Drug Administration Records" for R1. | S3171 | | |
| S3175 SS=E | 26-41-205 (a) (1) Self Administration of Medication<br><br>(a) Self-administration of medication. Any | S3175 | | |

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| S3175 | Continued From page 5<br>resident may self-administer and manage medications independently or by using a medication container or syringe prefilled by a licensed nurse or pharmacist or by a family member or friend providing this service gratuitously, if a licensed nurse has performed an assessment and determined that the resident can perform this function safely and accurately without staff assistance.<br>(1) An assessment shall be completed before the resident initially begins self-administration of medication, if the resident experiences a significant change of condition, and annually.<br><br>This REQUIREMENT is not met as evidenced by:<br>K.A.R. 26-41-205 (a) (1)<br><br>The facility reported a census of 21 residents. The sample included 3 "Residents'" (R)'s and 1 closed record review. Based on record review and interview the Operator failed to ensure the "Licensed Nurse" (LN) performed an annual re-assessment for R1 that determined she could safely, accurately and without staff assistance self-administer her own medications. The Operator further failed to ensure the LN performed an assessment for R3 that determined that R3 could safely, accurately and without staff assistance self-administer her insulin.<br><br>Findings included: | S3175 | | |

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| S3175 | Continued From page 6 | S3175 | | |

- Record review for R1 revealed an admission date of 02/28/19 with diagnoses of Parkinson's disease, Neuropathy, hypertension, chronic pain, depression, chronic obstructive pulmonary disease, anemia, heart failure, anxiety, and fibromyalgia.

Review of R1's "Functional Capacity Screen" (FCS) dated 06/11/25 revealed R1 required physical assistance with bathing, and dressing. R1 required supervision with toileting and eating. R1 was independent with walking/mobility and transferring. R1 required physical assistance with the management of her medications/medical treatments. R1 was occasionally incontinent and had impaired short-term memory. R1 was able to make herself understood and R1 understood others. R1 had impaired vision and impaired hearing. R1 used a walker and wheelchair mobility device.

Review of R1's combined NSA/"Health Service Plan" (HSP) dated 02/26/24 under the section titled "Medication Management" identified the facility staff would provide physician ordered medications, and "Over-the-counter" (OTC) medications were at "chair side" , "Melatonin-May leave 1 tab at bedside, Ventolin also". It was documented that the "Registered Nurse determined" that it was safe for R1 to self-administer her own medications.

Review of R1's medical record revealed a document titled "Negotiated Service Agreement Updates" dated 06/11/25 revealed the NSA was reviewed with no revisions made.

Review of R1's medical record revealed a

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| S3175 | Continued From page 7<br>document titled "Resident Qualification for Self-Medication" was dated 02/26/23.<br><br>Interview on 10/08/25 at approximately 05:00 PM with Operator A and LN B confirmed the medical record for R1 lacked an annual re-assessment that determined that R1 could safely, accurately and without staff assistance self-administer her medications.<br><br>- Record review for R3 revealed an admission date of 08/20/25 with diagnoses of anxiety, mild episode of recurrent major depressive disorder, type two diabetes mellitus, and coronary artery disease.<br><br>Review of R3's FCS dated 08/20/25 revealed R3 required supervision with bathing and physical assistance with dressing. R3 was independent with toileting, transferring, walking/mobility, and eating. R3 lacked the ability to manage her own medications/medical treatments and was incontinent. R3 had impaired decision making and was able to make herself understood and she understood others. R3 was documented at risk for falls, impaired vision, and impaired hearing. R3 used a walker mobility device.<br><br>Review of R3's combined NSA/HSP dated 08/20/25 under the section titled "Medication Management" identified facility staff would provide physician ordered medications.<br><br>The NSA lacked identification of who was responsible for R3's administration of her insulin.<br><br>Review of R3's "Medication Administration | S3175 | | |

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| S3175 | Continued From page 8 | S3175 | | |

Record" (MAR) dated 10/25 revealed the following orders:

Lantus Solostar inject 6 units subcutaneous daily in the evening.

Novolog Flex Pen Inject 3 units subcutaneous 3 times a day with meals.

Ozempic injection 2 milligrams/1 milliliter inject 0.5 milligrams subcutaneous once weekly on Thursday.

Interview on 09/08/25 at approximately 05:00 PM with Operator A and LN B confirmed the staff "Certified Mediation Aides" (CMA)'s dial the insulin pen and then hand the insulin pen to R3 for the self-administration of the insulin. Operator A and LN B continued to confirm the medical record lacked the documentation of an assessment of R3 that determined R3 could safely, accurately and without staff assistance self-administer her insulin. NSA for R3 lacked identification of who was responsible for the administration of R3's insulin.

The Operator failed to ensure the "Licensed Nurse" (LN) performed an assessment for R3 that determined that R3 could safely, accurately and without staff assistance self-administer her insulin.

The Operator failed to ensure the LN performed an annual re-assessment for R1 that determined she could safely, accurately and without staff assistance self-administer her own medications. The Operator further failed to ensure the LN performed an assessment for R3 that determined

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| S3175 | Continued From page 9<br>that R3 could safely, accurately and without staff assistance self-administer her insulin. | S3175 | | |
| S3186 SS=D | 26-41-205 (b) Administration of Selected Medications<br><br>(b) Administration of select medications. Any resident who self-administers medication may select some medications to be administered by a 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.<br><br>This REQUIREMENT is not met as evidenced by:<br>K.A.R. 26-41-205 (b)<br><br>The facility reported a census of 21 residents. The sample included 3 "Residents'" (R)'s and 1 closed record review. Based on record review and interview the Operator failed to ensure the "Negotiated Service Agreement" (NSA) for R3 identified who was responsible for the administration of R3's insulin.<br><br>Findings included:<br><br>- Record review for R3 revealed an admission date of 08/20/25 with diagnoses of anxiety, mild episode of recurrent major depressive disorder, | S3186 | | |

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| S3186 | Continued From page 10 | S3186 | | |

type two diabetes mellitus, and coronary artery disease.

Review of R3's "Functional Capacity Screen" (FCS) dated 08/20/25 revealed R3 required supervision with bathing and physical assistance with dressing. R3 was independent with toileting, transferring, walking/mobility, and eating. R3 lacked the ability to manage her own medications/medical treatments and was incontinent. R3 had impaired decision making and was able to make herself understood and she understood others. R3 was documented at risk for falls, impaired vision, and impaired hearing. R3 used a walker mobility device.

Review of R3's combined NSA/"Health Service Plan" (HSP) dated 08/20/25 under the section titled "Medication Management" identified facility staff would provide physician ordered medications.

The NSA lacked identification of who was responsible for R3's administration of her insulin.

Review of R3's "Medication Administration Record" (MAR) dated 10/25 revealed the following orders:

Lantus Solostar inject 6 units subcutaneous daily in the evening.

Novolog Flex Pen Inject 3 units subcutaneous 3 times a day with meals.

Ozempic injection 2 milligrams/1 milliliter inject 0.5 milligrams subcutaneous once weekly on Thursday.

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| S3186 | Continued From page 11<br><br>Interview on 09/08/25 at approximately 05:00 PM with Operator A and LN B confirmed the staff "Certified Mediation Aides" (CMA)'s dial the insulin pen and then hand the insulin pen to R3 for the self-administration of the insulin. Operator A and LN B continued to confirm the NSA for R3 lacked identification of who was responsible for the administration of R3's insulin.<br><br>The Operator failed to ensure the NSA for R3 identified who was responsible for the administration of R3's insulin. | S3186 | | |
| S3216 SS=D | 26-41-205 (i) Disposition of Medication<br><br>(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.<br>(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:<br>(A) Two licensed nurses; or<br>(B) a licensed nurse and a licensed pharmacist.<br>(2) Records shall be maintained documenting the destruction of any deteriorated, outdated, or discontinued non-controlled medications and biologicals according to acceptable standards of practice by any of the following combinations:<br>(A) Two licensed nurses;<br>(B) a licensed nurse and a medication aide;<br>(C) a licensed nurse and a licensed pharmacist; or<br>(D) a medication aide and a licensed pharmacist. | S3216 | | |

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| S3216 | Continued From page 12 | S3216 | | |

This REQUIREMENT is not met as evidenced by:
K.A.R. 26-41-205 (i)

The facility reported a census of 21 residents. The sample included 3 "Residents'" (R)'s and 1 closed record review. Based on record review and interview the Operator failed to ensure the "Licensed Nurse" (LN) maintained documentation of the destruction of any deteriorated, outdated, or discontinued controlled medications by one of the two following combinations; two licensed nurses or a licensed nurse and a licensed pharmacist.

Findings included:

- Record review for R1 revealed an admission date of 02/28/19 with diagnoses of Parkinson's disease, Neuropathy, hypertension, chronic pain, depression, chronic obstructive pulmonary disease, anemia, heart failure, anxiety, and fibromyalgia.

Review of R1's "Functional Capacity Screen" (FCS) dated 06/11/25 revealed R1 required physical assistance with bathing, and dressing. R1 required supervision with toileting and eating. R1 was independent with walking/mobility and transferring. R1 required physical assistance with the management of her medications/medical treatments. R1 was occasionally incontinent and had impaired short-term memory. R1 was able to

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| S3216 | Continued From page 13 | S3216 | | |

make herself understood and R1 understood others. R1 had impaired vision and impaired hearing. R1 used a walker and wheelchair mobility device.

Review of R1's combined NSA/"Health Service Plan" (HSP) dated 02/26/24 under the section titled "Medication Management" identified the facility staff would provide physician ordered medications, and "Over-the-counter" (OTC) medications were at "chair side", "Melatonin-May leave 1 tab at bedside, Ventolin also". It was documented that the "Registered Nurse determined" that it was safe for R1 to self-administer her own medications.

Review of R1's medical record revealed a document titled "Negotiated Service Agreement Updates" dated 06/11/25 revealed the NSA was reviewed with no revisions made.

Review of R1's medical record revealed a document titled "Resident Qualification for Self-Medication" was dated 02/26/23.

Review of the facility provided documents titled "Controlled Drug Administration Record" for Oxycodone/ Acetaminophen 7.5milligrams-325milligrams every 6 hours, revealed CMA C wrote the medication had been dropped on the following dates; 07/23/25, 07/26/25, 08/10/25.

Review of the facility provided documents titled "Controlled Drug Administration Record" for Gabapentin 100 milligrams one by mouth three times daily, revealed CMA C wrote the medication was dropped on the following dates;

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | N001006 | A. BUILDING: _____ B. WING _____ | 10/08/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GRAYSTONE RESIDENTIAL CARE | 2620 N KENTUCKY STREET IOLA, KS 66749 |

| (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 14<br>07/26/25, 08/01/25.<br><br>Interview on 10/08/25 at approximately 01:15 PM with LN B and CMA C confirmed CMA C did not notify LN B when the controlled medications were dropped. CMA C stated she flushed the controlled medications down the toilet. CMA C and LN B confirmed the record lacked the documentation that the dropped controlled medication were destroyed by two licensed nurses or a licensed nurse and a licensed pharmacist.<br><br>The Operator failed to ensure the LN maintained documentation of the destruction of any deteriorated, outdated, or discontinued controlled medications by one of the two following combinations; two licensed nurses or a licensed nurse and a licensed pharmacist. | S3216 | | |
| S3310 SS=F | 26-41-207 (b) (5-6) (c) Infection Control Policies<br><br>(b) (5) prohibiting any employee with a communicable disease or any infected skin lesions from coming in direct contact with any resident, any resident ' s food, or resident care equipment until the condition is no longer infectious;<br>(6) providing orientation to new employees and employee in-service education at least annually on the control of infections in a health care setting; and<br>(c) Each administrator or operator shall ensure the facility ' s compliance with the department ' s tuberculosis guidelines for adult care homes adopted by reference in K.A.R. 26-39-105 | S3310 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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|---|---|---|---|---|
| S3310 | Continued From page 15 | S3310 | | |

This REQUIREMENT is not met as evidenced by:
K.A.R. 26-41-207 (c)

The facility reported a census of 21 residents. The sample included 3 "Residents'" (R)'s, 1 closed record review, and 5 newly hired employees. Based on record review and interview the Operator failed to ensure the facility's compliance with the department's "Tuberculosis" (TB) guidelines adopted by reference in K.A.R. 26-39-105 for R3, "Licensed Nurse" (LN) B, and Dietary Staff E.

Findings included:

- Record review for R3 revealed an admission date of 08/20/25 with diagnoses of anxiety, mild episode of recurrent major depressive disorder, type two diabetes mellitus, and coronary artery disease.

Review of R3's medical record revealed a document titled "Resident TB Skin Test" dated 08/20/25 that revealed the first step of the required two step TB skin test was administered on 08/20/25. The document lacked a date of the skin test being read in 48 to 72 hours after the administration of the test. The document further lacked the documentation of the required second step of the TB skin test being administered.

Review of LN B's personnel record revealed she began her employment on 05/11/25. LN B's personnel record lacked documentation of the

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|---|---|---|---|---|
| S3310 | Continued From page 16<br>required two step TB skin test being administered within 7 days of employment.<br><br>Review of Dietary Staff E's personnel record revealed he began his employment on 04/29/25. Dietary Staff E's personnel record lacked documentation of the required two step TB skin test being administered within 7 days of employment.<br><br>Interview on 10/08/25 at approximately 05:00 PM with Operator A and LN B confirmed R3's medical record lacked documentation of the first step of her TB skin test being read and Operator A and LN B further confirmed R3's medical record lacked documentation of the second step of the required two step TB skin test being administered. Operator A and LN B continued to confirm the personnel records for LN B and Dietary Staff E lacked the documentation of the required two step TB skin test being administered within 7 days of employment.<br><br>The Operator failed to ensure the facility's compliance with the department's TB guidelines adopted by reference in K.A.R. 26-39-105 for R3, LN B, and Dietary Staff E. | S3310 | | |
| S9999 | Final Observations<br><br>K.S.A. 39-928<br><br>Upon receipt of an application for license, the licensing agency with the approval of the state fire marshal shall issue a license if the applicant is fit and qualified and if the adult care home facilities meet the requirements established | S9999 | | |

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|---|---|---|---|---|
| S9999 | Continued From page 17<br>under this law. A license, unless sooner suspended or revoked, shall remain in effect upon filing by the licensee, and approval by the licensing agency and the state fire marshal or their duly authorized agents, of an annual report upon such uniform dates and containing such information in such form as the licensing agency prescribes and payment of an annual fee.<br><br>S/S level F<br><br>Findings included:<br><br>Department records revealed the facility failed to file and pay the 2024 annual renewal licensing fees.<br><br>Interview on 10/09/25 at approximately 05:00 PM with Operator A confirmed the facility had been working with the department on the facility's failure to provide the required requested information to the department, and the further failure to pay the renewal fee to the department for 2024.<br><br>The facility failed to file and pay the 2024 annual renewal licensing fee to the department as required by KSA 39- 928. | S9999 | | |