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	N008009	A. BUILDING: _____ B. WING _____	07/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD OF EL DORADO	1650 E 12TH AVENUE EL DORADO, KS 67042

(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
S 000	INITIAL COMMENTS The following citations represent the findings of the licensure resurvey with attached complaint numbers 195670, 195699, 195676, 192286, 191708, and 191049, for the above named facility conducted on 07/21/25, 07/22/25, 07/23/25 and 07/24/25.	S 000		
S 100 SS=D	26-39-103 (a) RESIDENT RIGHTS a) Protection and promotion of resident rights. Each administrator or operator shall ensure the protection and promotion of the rights of each resident as set forth in this regulation. Each resident shall have a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the adult care home. This STANDARD is not met as evidenced by: K.A.R. 26-39-103 (a) The facility reported a census of 39 residents. The sample included 3 "Residents'" (R)'s, and 4 closed record reviews. Based on record review and interview the Operator failed to ensure the protection and promotion of the rights for each resident by ensuring each resident was provided the right to have a dignified existence inside the adult care home. Findings included: - Record Review for R6 revealed an admission date of 06/12/24 with diagnoses of atrial	S 100		

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

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fibrillation and flutter, shortness of breath, mild cognitive impairment, combined systolic congestive and diastolic heart failure, need for assistance with personal care, chronic obstructive pulmonary disease, and Parkinson's disease.

Review of R6's "Functional Capacity Screen" (FCS)/ "Negotiated Service Agreement" (NSA) dated 06/12/24 revealed R6 required physical assistance with bathing, dressing, and management of medications. R6 required supervision with toileting, transferring, and mobility. R6 was frequently incontinent and had impaired memory recall. R6 was able to make himself understood and he understood others. R6 was marked at risk for falls and had impaired vision.

Review of R6's combined NSA/"Health Service Plan" (HSP) instructed facility staff to provide bathing assistance two times a week, bathroom assistance as needed, supervision with transfers, and assistance with dressing in the morning and evenings.

Record review for "Certified Nurse Aide" (CNA) K revealed a hire date of 02/29/24 and a termination date of 10/18/24.

Review of the facility provided document titled "Employee Handbook Acknowledgement" dated 02/28/24 and signed by CNA K.

Review of the facility provided document titled "Employee Disciplinary Action Record" dated 10/18/24 revealed CNA K was terminated for "utilizing a personal cell phone capturing picture

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S 100	Continued From page 2	S 100		

of resident".

Record review for CNA L revealed a hire date of 08/13/24 and a termination date of 10/21/24.

Review of the facility provided document titled "Employee Disciplinary Action Record" dated 10/21/24 revealed CNA L was terminated for "utilizing a personal cell phone capturing picture of resident".

Review of the undated and unsigned facility document titled "Witness Statement" with CNA L's name handwritten at the top of the document revealed that on 10/04/24 she did have her personal phone out "responding to a message and sent a photo of myself to a family member". She continued to write it was simply her face and the side of the wall.

Review of the undated and unsigned facility document titled "Witness Statement" revealed the unidentified author of the statement revealed the following handwritten statement; R6 "had a rash on his very lower stomach and his penis happened to be in it". The author wrote she showed the other "aide" who was helping her and she meant to show it to the Certified Mediation Aide, "but we just started getting calls like crazy".

Review of the facility provided self-report to the department dated 10/14/24 revealed the following;
Administrative Nurse C received a call on 10/04/24 at 09:52 PM from a family member of R6 stating that the family member reviewed camera footage from the family placed camera in

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S 100	Continued From page 3 R6's room showing CNA L taking pictures of R6 while she was to be providing cares. Administrative Nurse C immediately opened an investigation. The facility investigation revealed that staff reported to Prior Operator M an incident where facility staff reported CNA K had taken photos of R6's "groin" area and "shared the image with others, while making disparaging remarks" of R6's "anatomy related to advanced disease processes and failing to protect his modesty or dignity. Review of the facility provided document titled "staff Meeting" dated 06/20/24 revealed the following; "3. Cell phone usage should be kept to a minimum. Do not use it in a resident's room while doing cares." Review of the facility provided documents dated 12/15/22 and confirmed to be pages 33 and 34 of 50 by Administrative Staff B as a page from the employee handbook revealed the following statement; Taking photographs or video or audio recordings (including but not limited to videos and photographs previously taken and/or live streaming media) of a resident and/or the resident's private space is strictly prohibited unless the resident or the resident's designated representative provides written consent of such. The Operator failed to ensure the protection and promotion of the rights for each resident by ensuring each resident was provided the right to have a dignified existence inside the adult care	S 100		

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S 100	Continued From page 4 home	S 100		
S 190 SS=D	26-39-102 (e) Admission, Transfer, Discharge (e) Before a resident is transferred or discharged involuntarily, the administrator or operator, or the designee, shall perform the following: (1) Notify the resident, the resident ' s legal representative, and if known, a designated family member of the transfer or discharge and the reasons; and (2) record the reason for the transfer or discharge under any of the circumstances specified in paragraphs (d) (1) through (4) in the resident ' s clinical record, which shall be substantiated as follows: (A) The resident's physician shall document the rationale for transfer or discharge in the resident ' s clinical record if the transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met by the adult care home; (B) the resident's physician shall document the rationale for transfer or discharge in the resident ' s clinical record if the transfer or discharge is appropriate because the resident's health has improved sufficiently so that the resident no longer needs the services provided by the adult care home; and (C) a physician shall document the rationale for transfer or discharge in the resident ' s clinical record if the transfer or discharge is necessary because the health or safety of other individuals in the adult care home is endangered.	S 190		

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S 190	Continued From page 5 This REQUIREMENT is not met as evidenced by: K.A.R. 26-39-102 (e)(1) The facility reported a census of 39 residents. The sample included 3 "Residents'" (R)'s, and 4 closed record reviews. Based on record review and interview the Operator failed to ensure the documentation of R5's legal representative being notified when R5 was transferred to a local hospital and a "Notice of Discharge letter was issued". Findings included: - Record review for R5 revealed an admission date of 04/26/25 with diagnoses of unspecified psychosis not due to a substance or known physiological condition, insomnia, unspecified dementia, moderate with other behavioral disturbances, altered mental status, need for assistance with personal care and emphysema. Review of R5's combined "Functional Capacity Screen" (FCS)/"Negotiated Service Agreement" (NSA) dated 04/26/25 revealed R5 required supervision with bathing and dressing. Facility staff were instructed to provide assistance with bathing and dressing. R5 was independent with toileting, transferring, walking, and eating. R5 lacked the ability to manage his own medications and was frequently incontinent. Facility staff were instructed to manage R5's medications. R5 had impaired short-term memory, memory recall, and impaired decision making. Facility staff were instructed to be given in a timely manner. R5 was able to make him self understood and R5	S 190		

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understood others. R5 was scored at risk for falls, impaired vision and impaired decision making. Under the section titled "2. Behaviors 1. Does the resident have behaviors?" The question was answered "No".

Review of R5's "Health Service Plan" (HSP) dated 04/26/25 in the column titled "Interventions" documented the following "All treatments and medications and routine monitoring tasks will be given/completed in a timely manner per physician's orders." R5 had impaired judgement, was forgetful, disorientated and had altered perception, and R5 had difficulty sleeping.

R5's NSA/HSP lacked instructions to facility staff on services to be provided for his impaired judgement, forgetfulness, orientation, altered perception and difficulty sleeping.

Record review of R5's electronic "Medical Record" under the "Progress Notes" tab revealed the following entries;

On 04/30/25 at 11:41 AM a "Nurses Note" revealed facility staff were reporting R5 was experiencing "issues with sundowners". Staff redirected with some success. "Advanced Practice Registered Nurse" (APRN) notified.

On 05/13/25 at 10:45 AM a "Nurses Note" revealed R5 was seen by the APRN for exhibiting symptoms of "sundowning, becoming notably agitated and anxious in the late afternoons". The documentation continued to state the facility managed R5 anxiety with significant redirection and R5 suffered form disturbed sleep patterns.

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The "Medication Administration Record" was updated to reflect the changes made.

On 05/16/25 at 11:37 AM "Nurses Note" revealed APRN notified of R5's increased agitation and aggression and a medication change was made.

On 05/20/25 at 11:26 AM "Behavior Note" revealed staff reported R5 making comments wanting to die. The nurse assessed the resident and did not make any comments about wanting to die to the nurse. Staff instructed to redirect R5 from "those conversations" and report any other incidents to the nurse.

On 05/25/25 at 10:02 PM an "Occurrence" note revealed that R5 was observed pacing the facility hallways, walking into other resident's doors, and going in and out of his apartment frequently. Staff were attempting to redirect R5 throughout the evening and were unsuccessful. At 08:53 PM R5 opens the door to the resident room and the other resident struck R5 across the face and closed the door. The APRN was notified.

On 05/27/25 at 11:13 AM a "Nurses Note" revealed R5 was sent to a local hospital for a behavioral evaluation after he pulled the facility fire alarm, shouted profanities at another resident, and made motions to hit another resident. R5 was able to be redirected.

05/27/25 at 09:37 PM an "Occurrence" Note revealed staff reported to the nurse R5 was exhibiting exit seeking and aggressive behaviors. R5 was wandering into other residents' rooms and knocking and shaking door handles aggressively. R5 entered his apartment and

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"flipped over his recliner", knocked his television over, and flipped over his television stand. At 10:00 PM R5 was sent by emergency medical services to a local hospital and returned at approximately 11:00 PM with no new orders.

05/28/25 at 05:47 PM a "Behavior Note" "Late entry" revealed at 07:10 AM the staff reported to the nurse R5 was experiencing increased wandering, agitation, and aggression. Staff reported R5 was using a ceramic coffee mug to try and hit the staff member and then R5 hit the maintence man in the chest with the coffee mug. R5 picked up a fork and was swinging it at staff and approaching other residents. Facility staff instructed to call 911 for assistance from emergency personnel and to attempt to keep the other residents away from R5. Local Police arrived tried to get R5 to put down the fork. R5 was taken to the ground by the officers after not complying with officer's request to put the fork down. R5 was placed in handcuffs. R5's glasses were broken and the police officers "radioed for emergency medical services" (EMS) to come assist with transport of R5 to a local hospital for evaluation and treatment. At approximately 09:09 AM the local hospital Registered Nurse contacted the facility requesting contact information from the Durable Power of Attorney for information so R5 could be transferred to a local hospital for behavioral health.

R5's progress notes lacked documentation of R5's legal representative of R5's discharge from the facility when a "Notice of Discharge" letter was issued.

Review of the facility provided document titled

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S 190	Continued From page 9 "Order Form" signed by the provider on 05/28/25 revealed the following; "Note to provider; due to reported and documented actions related to escalating behaviors and repeated physical aggression" R5 required immediate discharge from the Assisted Living and required a higher level of care. The assisted living environment could not meet R5's needs as he posed a risk to himself and others at the time. Review of the facility provided undated document titled "Notice of Discharge" revealed the facility intended to discharge R5 immediately as the facility could not provide the care that R5 required based on his medical and behavioral needs. Interview on 07/24/25 with Administrative Staff A, B, and C confirmed R5's resident record lacked documentation of R5's legal representative being notified of his transfer to a local hospital. The Operator failed to ensure the documentation of R5's legal representative being notified when R5 was transferred to a local hospital and a "Notice of Discharge letter was issued".	S 190		
S 200 SS=D	26-39-102 (g) Written Discharge Notice Requirements (g) Each written transfer or discharge notice shall include the following: (1) The reason for the transfer or discharge; (2) the effective date of the transfer or discharge; (3) the address and telephone number of the complaint program of the Kansas department on aging where a complaint related to involuntary transfer or discharge can be registered;	S 200		

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S 200	Continued From page 10 (4) the address and telephone number of the state long-term care ombudsman; and (5) for residents who have developmental disabilities or who are mentally ill, the address and telephone number of the Kansas advocacy and protection organization. This REQUIREMENT is not met as evidenced by: K.A.R. 26-39-102 (g)(2) The facility reported a census of 39 residents. The sample included 3 "Residents'" (R)'s, and 4 closed record reviews. Based on record review and interview the Operator failed to ensure the undated "Notice of Discharge" letter contained the effective date. Findings included: - Record review for R5 revealed an admission date of 04/26/25 with diagnoses of unspecified psychosis not due to a substance or known physiological condition, insomnia, unspecified dementia, moderate with other behavioral disturbances, altered mental status, need for assistance with personal care and emphysema. Review of R5's combined "Functional Capacity Screen" (FCS)/"Negotiated Service Agreement" (NSA) dated 04/26/25 revealed R5 required supervision with bathing and dressing. Facility staff were instructed to provide assistance with bathing and dressing. R5 was independent with	S 200		

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S 200	Continued From page 11	S 200		

toileting, transferring, walking, and eating. R5 lacked the ability to manage his own medications and was frequently incontinent. Facility staff were instructed to manage R5's medications. R5 had impaired short-term memory, memory recall, and impaired decision making. Facility staff were instructed to be given in a timely manner. R5 was able to make him self understood and R5 understood others. R5 was scored at risk for falls, impaired vision and impaired decision making. Under the section titled "2. Behaviors 1. Does the resident have behaviors?" The question was answered "No".

Review of R5's "Health Service Plan" (HSP) dated 04/26/25 in the column titled "Interventions" was documented the following "All treatments and medications and routine monitoring tasks will be given/completed in a timely manner per physician's orders." R5 had impaired judgement, was forgetful, disorientated and had altered perception, and R5 had difficulty sleeping.

R5's NSA/HSP lacked instructions to facility staff on services to be provided for his impaired judgement, forgetfulness, orientation, altered perception and difficulty sleeping.

Record review of R5's electronic "Medical Record" under the "Progress Notes" tab revealed the following entries;

On 04/30/25 at 11:41 AM a "Nurses Note" revealed facility staff were reporting R5 was experiencing "issues with sundowners". Staff redirected with some success. "Advanced Practice Registered Nurse" (APRN) notified.

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S 200	Continued From page 12 On 05/13/25 at 10:45 AM a "Nurses Note" revealed R5 was seen by the APRN for exhibiting symptoms of "sundowning, becoming notably agitated and anxious in the late afternoons". The documentation continued to state the facility managed R5 anxiety with significant redirection and R5 suffered form disturbed sleep patterns. The "Medication Administration Record" was updated to reflect the changes made. On 05/16/25 at 11:37 AM "Nurses Note" revealed APRN notified of R5's increased agitation and aggression and a medication change was made. On 05/20/25 at 11:26 AM "Behavior Note" revealed staff reported R5 making comments wanting to die. The nurse assessed the resident and did not make any comments about wanting to die to the nurse. Staff instructed to redirect R5 from "those conversations" and report any other incidents to the nurse. On 05/25/25 at 10:02 PM "Occurrence" note revealed that R5 was observed pacing the facility hallways, walking into other resident's doors, and going in and out of his apartment frequently. Staff were attempting to redirect R5 throughout the evening and were unsuccessful. At 08:53 PM R5 opens the door to the resident room and the other resident struck R5 across the face and closed the door. The APRN was notified. On 05/27/25 at 11:13 AM "Nurses Note" revealed R5 was sent to a local hospital for a behavioral evaluation after he pulled the facility fire alarm, shouted profanities at another resident, and made motions to hit another resident. R5 was able to be redirected.	S 200		

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S 200	Continued From page 13 05/27/25 at 09:37 PM "Occurrence" Note revealed staff reported to the nurse R5 was exhibiting exit seeking and aggressive behaviors. R5 was wandering into other residents' rooms and knocking and shaking door handles aggressively. R5 entered his apartment and "flipped over his recliner", knocked his television over, and flipped over his television stand. At 10:00 PM R5 was sent by emergency medical services to a local hospital and returned at approximately 11:00 PM with no new orders. 05/28/25 at 05:47 PM "Behavior Note" "Late entry" revealed at 07:10 AM the staff reported to the nurse R5 was experiencing increased wandering, agitation, and aggression. Staff reported R5 was using a ceramic coffee mug to try and hit the staff member and then R5 hit the maintence man in the chest with the coffee mug. R5 picked up a fork and was swinging it at staff and approaching other residents. Facility staff instructed to call 911 for assistance from emergency personnel and to attempt to keep the other residents away from R5. Local Police arrived tried to get R5 to put down the fork. R5 was taken to the ground by the officers after not complying with officer's request to put the fork down. R5 was placed in handcuffs. R5's glasses were broken and the police officers "radioed for emergency medical services" (EMS) to come assist with transport of R5 to a local hospital for evaluation and treatment. At approximately 09:09 AM the local hospital Registered Nurse contacted the facility requesting contact information from the Durable Power of Attorney for information so R5 could be transferred to a local hospital for behavioral health.	S 200		

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	N008009	A. BUILDING: _____ B. WING _____	07/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD OF EL DORADO	1650 E 12TH AVENUE EL DORADO, KS 67042

(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
S 200	Continued From page 14 R5's progress notes lacked documentation of R5's legal representative of R5's discharge from the facility when a "Notice of Discharge" letter was issued. Review of the facility provided document titled "Order Form" signed by the provider on 05/28/25 revealed the following; "Note to provider; due to reported and documented actions related to escalating behaviors and repeated physical aggression" R5 required immediate discharge from the Assisted Living and required a higher level of care. The assisted living environment could not meet R5's needs as he posed a risk to himself and others at the time. Review of the facility provided undated document titled "Notice of Discharge" revealed the facility intended to discharge R5 immediately as the facility could not provide the care that R5 required based on his medical and behavioral needs. The "Notice of Discharge" letter lacked a date. Interview on 07/24/25 with Administrative Staff A, B, and C confirmed the "Notice of Discharge" letter lacked a date. The Operator failed to ensure the undated "Notice of Discharge" letter contained the effective date.	S 200		
S3081 SS=D	26-41-201 (c) Functional Capacity Screen Reassessment (c) Designated facility staff shall conduct a	S3081		

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S3081	Continued From page 15 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: K.A.R. 26-41-201 (c)(2) The facility reported a census of 39 residents. The sample included 3 "Residents'" (R)'s, and 4 closed record reviews. Based on record review and interview the Operator failed to ensure a screening determining R5's functional capacity was performed following a significant change in condition. Findings included: - Record review for R5 revealed an admission date of 04/26/25 with diagnoses of unspecified psychosis not due to a substance or known physiological condition, insomnia, unspecified dementia, moderate with other behavioral disturbances, altered mental status, need for assistance with personal care and emphysema. Review of R5's combined "Functional Capacity Screen" (FCS)/"Negotiated Service Agreement" (NSA) dated 04/26/25 revealed R5 required supervision with bathing and dressing. Facility	S3081		

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S3081	Continued From page 16	S3081		

staff were instructed to provide assistance with bathing and dressing. R5 was independent with toileting, transferring, walking, and eating. R5 lacked the ability to manage his own medications and was frequently incontinent. Facility staff were instructed to manage R5's medications. R5 had impaired short-term memory, memory recall, and impaired decision making. Facility staff were instructed to be given in a timely manner. R5 was able to make him self understood and R5 understood others. R5 was scored at risk for falls, impaired vision and impaired decision making. Under the section titled "2. Behaviors 1. Does the resident have behaviors?" The question was answered "No".

Review of R5's "Health Service Plan" (HSP) dated 04/26/25 in the column titled "Interventions" documented the following "All treatments and medications and routine monitoring tasks will be given/completed in a timely manner per physician's orders." R5 had impaired judgement, was forgetful, disorientated and had altered perception, and R5 had difficulty sleeping.

R5's NSA/HSP lacked instructions to facility staff on services to be provided for his impaired judgement, forgetfulness, orientation, altered perception and difficulty sleeping.

Record review of R5's electronic "Medical Record" under the "Progress Notes" tab revealed the following entries;

On 04/30/25 at 11:41 AM "Nurses Note" revealed facility staff were reporting R5 was experiencing "issues with sundowners". Staff

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S3081	Continued From page 17	S3081		

redirected with some success. "Advanced Practice Registered Nurse" (APRN) notified.

On 05/13/25 at 10:45 AM "Nurses Note" revealed R5 was seen by the APRN for exhibiting symptoms of "sundowning, becoming notably agitated and anxious in the late afternoons". The documentation continued to state the facility managed R5 anxiety with significant redirection and R5 suffered form disturbed sleep patterns. The "Medication Administration Record" was updated to reflect the changes made.

On 05/16/25 at 11:37 AM "Nurses Note" revealed APRN notified of R5's increased agitation and aggression and a medication change was made.

On 05/20/25 at 11:26 AM "Behavior Note" revealed staff reported R5 making comments wanting to die. The nurse assessed the resident and did not make any comments about wanting to die to the nurse. Staff instructed to redirect R5 from "those conversations" and report any other incidents to the nurse.

On 05/25/25 at 22:02 PM "Occurrence" note revealed that R5 was observed pacing the facility hallways, walking into other resident's doors, and going in and out of his apartment frequently. Staff were attempting to redirect R5 throughout the evening and were unsuccessful. At 08:53 PM R5 opens the door to the resident room and the other resident struck R5 across the face and closed the door. The APRN was notified.

On 05/27/25 at 11:13 AM "Nurses Note" revealed R5 was sent to a local hospital for a behavioral evaluation after he pulled the facility

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S3081	Continued From page 18	S3081		

fire alarm, shouted profanities at another resident, and made motions to hit another resident. R5 was able to be redirected.

05/27/25 at 09:37 PM "Occurrence" Note revealed staff reported to the nurse R5 was exhibiting exit seeking and aggressive behaviors. R5 was wandering into other residents' rooms and knocking and shaking door handles aggressively. R5 entered his apartment and "flipped over his recliner", knocked his television over, and flipped over his television stand. At 10:00 PM R5 was sent by emergency medical services to a local hospital and returned at approximately 11:00 PM with no new orders.

05/28/25 at 05:47 PM "Behavior Note" "Late entry" revealed at 07:10 AM the staff reported to the nurse R5 was experiencing increased wandering, agitation, and aggression. Staff reported R5 was using a ceramic coffee mug to try and hit the staff member and then R5 hit the maintence man in the chest with the coffee mug. R5 picked up a fork and was swinging it at staff and approaching other residents. Facility staff instructed to call 911 for assistance from emergency personnel and to attempt to keep the other residents away from R5. Local Police arrived tried to get R5 to put down the fork. R5 was taken to the ground by the officers after not complying with officer's request to put the fork down. R5 was placed in handcuffs. R5's glasses were broken and the police officers "radioed for emergency medical services" (EMS) to come assist with transport of R5 to a local hospital for evaluation and treatment. At approximately 09:09 AM the local hospital Registered Nurse contacted the facility requesting contact

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S3081	Continued From page 19 information from the Durable Power of Attorney for information so R5 could be transferred to a local hospital for behavioral health. Review of the facility provided document titled "Order Form" signed by the provider on 05/28/25 revealed the following; "Note to provider; due to reported and documented actions related to escalating behaviors and repeated physical aggression" R5 required immediate discharge from the Assisted Living and required a higher level of care. The assisted living environment could not meet R5's needs as he posed a risk to himself and others at the time. Interview on 07/24/25 with Administrative Staff A, B, and C confirmed a screening determining R5's functional capacity was not performed when he experienced a significant change of condition with his aggressive behaviors. The Operator failed to ensure a screening determining R5's functional capacity was performed following a significant change in condition.	S3081		
S3085 SS=D	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	S3085		

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S3085	Continued From page 20	S3085		

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:
K.A.R. 26-41-202 (a)(1)

The facility reported a census of 39 residents. The sample included 3 "Residents'" (R)'s, and 4 closed record reviews. Based on record review and interview the Operator failed to ensure at the time of admission a description of health services for R5 for his identified diagnoses of cognitive impairment, altered mental status, and unspecified psychosis.

Findings included:

- Record review for R5 revealed an admission date of 04/26/25 with diagnoses of unspecified psychosis not due to a substance or known physiological condition, insomnia, unspecified dementia, moderate with other behavioral disturbances, altered mental status, need for assistance with personal care and emphysema.

Review of R5's combined "Functional Capacity Screen" (FCS)/"Negotiated Service Agreement" (NSA) dated 04/26/25 revealed R5 required

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S3085	Continued From page 21	S3085		

supervision with bathing and dressing. Facility staff were instructed to provide assistance with bathing and dressing. R5 was independent with toileting, transferring, walking, and eating. R5 lacked the ability to manage his own medications and was frequently incontinent. Facility staff were instructed to manage R5's medications. R5 had impaired short-term memory, memory recall, and impaired decision making. Facility staff were instructed to be given in a timely manner. R5 was able to make him self understood and R5 understood others. R5 was scored at risk for falls, impaired vision and impaired decision making. Under the section titled "2. Behaviors 1. Does the resident have behaviors?" The question was answered "No".

Review of R5's "Health Service Plan" (HSP) dated 04/26/25 in the column titled "Interventions" documented the following "All treatments and medications and routine monitoring tasks will be given/completed in a timely manner per physician's orders." R5 had impaired judgement, was forgetful, disorientated and had altered perception, and R5 had difficulty sleeping.

R5's NSA/HSP lacked instructions to facility staff on services to be provided for his impaired judgement, forgetfulness, orientation, altered perception and difficulty sleeping.

Record review of R5's electronic "Medical Record" under the "Progress Notes" tab revealed the following entries;

On 04/30/25 at 11:41 AM "Nurses Note" revealed facility staff were reporting R5 was

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S3085	Continued From page 22	S3085		

experiencing "issues with sundowners". Staff redirected with some success. "Advanced Practice Registered Nurse" (APRN) notified.

On 05/13/25 at 10:45 AM "Nurses Note" revealed R5 was seen by the APRN for exhibiting symptoms of "sundowning, becoming notably agitated and anxious in the late afternoons". The documentation continued to state the facility managed R5 anxiety with significant redirection and R5 suffered form disturbed sleep patterns. The "Medication Administration Record" was updated to reflect the changes made.
On 05/16/25 at 11:37 AM "Nurses Note" revealed APRN notified of R5's increased agitation and aggression and a medication change was made.

On 05/20/25 at 11:26 AM "Behavior Note" revealed staff reported R5 making comments wanting to die. The nurse assessed the resident and did not make any comments about wanting to die to the nurse. Staff instructed to redirect R5 from "those conversations" and report any other incidents to the nurse.

On 05/25/25 at 10:02 PM "Occurrence" note revealed that R5 was observed pacing the facility hallways, walking into other resident's doors, and going in and out of his apartment frequently. Staff were attempting to redirect R5 throughout the evening and were unsuccessful. At 08:53 PM R5 opens the door to the resident room and the other resident struck R5 across the face and closed the door. The APRN was notified.

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S3085	Continued From page 23	S3085		

fire alarm, shouted profanities at another resident, and made motions to hit another resident. R5 was able to be redirected.

05/27/25 at 09:37 PM "Occurrence" Note revealed staff reported to the nurse R5 was exhibiting exit seeking and aggressive behaviors. R5 was wandering into other residents' rooms and knocking and shaking door handles aggressively. R5 entered his apartment and "flipped over his recliner", knocked his television over, and flipped over his television stand. At 10:00 PM R5 was sent by emergency medical services to a local hospital and returned at approximately 11:00 PM with no new orders.

05/28/25 at 05:47 PM "Behavior Note" "Late entry" revealed at 07:10 AM the staff reported to the nurse R5 was experiencing increased wandering, agitation, and aggression. Staff reported R5 was using a ceramic coffee mug to try and hit the staff member and then R5 hit the maintence man in the chest with the coffee mug. R5 picked up a fork and was swinging it at staff and approaching other residents. Facility staff instructed to call 911 for assistance from emergency personnel and to attempt to keep the other residents away from R5. Local Police arrived tried to get R5 to put down the fork. R5 was taken to the ground by the officers after not complying with officer's request to put the fork down. R5 was placed in handcuffs. R5's glasses were broken and the police officers "radioed for emergency medical services" (EMS) to come assist with transport of R5 to a local hospital for evaluation and treatment. At approximately 09:09 AM the local hospital Registered Nurse contacted the facility requesting contact

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S3085	Continued From page 24 information from the Durable Power of Attorney for information so R5 could be transferred to a local hospital for behavioral health. Review of the facility provided document titled "Order Form" signed by the provider on 05/28/25 revealed the following; "Note to provider; due to reported and documented actions related to escalating behaviors and repeated physical aggression" R5 required immediate discharge from the Assisted Living and required a higher level of care. The assisted living environment could not meet R5's needs as he posed a risk to himself and others at the time. Interview on 07/24/25 with Administrative Staff A, B, and C confirmed R5's NSA lacked health services for his diagnoses of cognitive impairment, altered mental status, and unspecified psychosis. The Operator failed to ensure at the time of admission a description of health services for R5 for his identified diagnoses of cognitive impairment, altered mental status, and unspecified psychosis.	S3085		
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,	S3298		

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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:
KAR 26-41-206(d)

The facility reported a census of 39 residents. The facility had a main kitchen where food was stored, prepared, and transported to residents in the memory care unit. Based on interview and record review, the Operator failed to ensure dietary staff served food at an appropriate temperature after it was transported to memory care residents.

Findings included:

- Observation on 07/21/25 at approximately 03:04 PM of the memory care kitchen revealed the lack of a food temperature log for food that is delivered from the main kitchen to residents in the memory care unit.

Interview on 07/21/25 at approximately 03:35 PM Dietary Staff I confirmed that staff had not been logging food temperatures after food had been transported to the memory care unit from the

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S3298	Continued From page 26 main kitchen. On 07/28/25 at approximately 11:43 AM a food service policy was provided upon request. This policy, dated 01/22/25, documents "Staff should be educated on food safety, infection control policies and practices and special diets." Dietary guidelines for Americans 2005 recommends using a clean thermometer that measures the internal temperature of cooked food to make sure food is cooked to and held at proper temperatures and to keep food out of the "danger zone" (40 degrees Fahrenheit to 140 degrees Fahrenheit) where bacteria can multiply rapidly. The Operator failed to ensure dietary staff dietary staff served food at an appropriate temperature after it was transported to memory care residents.	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. (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: KAR 26-41-206(e)	S3299		

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The facility reported a census of 39 residents. The facility had a main kitchen where dietary staff stored and served food for all residents and a small memory care kitchen where dietary staff stored and served food for eight residents. Based on observation and interview the Operator failed to ensure designated staff stored food items under safe conditions.

Findings included:

- Observation on 07/21/25 at approximately 03:00 PM of the memory care kitchen revealed a refrigerator/freezer unit which contained the following items:

One opened gallon of Hiland two percent milk, undated.

The memory care kitchen cupboards revealed the following food items:

One plastic container of breakfast cereal, unlabeled and undated.
One 35-ounce bag of Hospitality corn flakes unsealed and undated.

- Observation of the main kitchen on 07/21/25 at approximately 03:28 PM revealed a refrigerator/freezer unit containing one opened gallon of Hiland two percent milk, undated.

On 07/21/25 PM at approximately 03:11 PM Administrative Nurse A verified foods in memory care refrigerator and cupboards were unlabeled, undated, and/or unsealed.

On 07/21/25 PM at approximately 03:37 PM

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	N008009	A. BUILDING: _____ B. WING _____	07/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD OF EL DORADO	1650 E 12TH AVENUE EL DORADO, KS 67042

(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
S3299	Continued From page 28 Dietary Staff I verified undated opened gallon of milk. The facility's food storage policy, dated 04/06/20, documented "Label all food items. The label must include the name of the food and the date it was opened or prepared, or the date it should be sold, consumed or discarded." The Operator failed to ensure designated staff stored food items under safe conditions.	S3299		
S3305 SS=F	26-41-207 (a) (b) Infection Control (a) The administrator or operator of each assisted living facility or residential health care facility shall ensure the provision of a safe, sanitary, and comfortable environment for residents. (b) Each administrator or operator shall ensure the development of policies and implementation of procedures to prevent the spread of infections. These policies and procedures shall include the following requirements: (1) Using universal precautions to prevent the spread of blood-borne pathogens; (2) techniques to ensure that hand hygiene meets professional health care standards; (3) techniques to ensure that the laundering and handling of soiled and clean linens meet professional health care standards; (4) providing sanitary conditions for food service; (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;	S3305		

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S3305	Continued From page 29 (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 (7) transferring a resident with an infectious disease to an appropriate health care facility if the administrator or operator is unable to provide the isolation precautions necessary to protect the health of other residents. This REQUIREMENT is not met as evidenced by: K.A.R. 26-41-207 (a) The facility reported a census of 39 residents. The facility had a main kitchen where dietary staff stored, prepared, and served food for all residents. Based on observation and interview, the Operator failed to ensure sanitary conditions for food service by not ensuring dishwasher chemical strengths were tested and documented at least daily. Findings included: - Observation on 07/21/25 at approximately 03:56 PM revealed the lack of daily chemical strength testing results for the facility's low-temperature dishwasher. Interview on 07/21/25 with dietary staff I confirmed she did not log the daily chemical strength test results.	S3305		

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S3305	Continued From page 30 Interview on 07/21/25 at approximately 04:06 PM with Licensed Nurse A confirmed the lack of daily documentation of chemical sanitation strength and confirmed the dietary staff should be completing the chemical strength test daily to ensure the chemical strengths were appropriate. On 07/21/25 at approximately 04:02 PM a dishwasher policy was provided upon request. The policy, dated 04/27/20, documented, "Document water temperatures and/or sanitizer concentration on appropriate logs." The Operator failed to ensure sanitary conditions for food service by not ensuring chemical strengths were tested and documented at least daily.	S3305		
S3310 SS=F	26-41-207 (b) (5-6) (c) Infection Control Policies (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; (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 (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		

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S3310	Continued From page 31 This REQUIREMENT is not met as evidenced by: KAR 26-41-207(c) The facility reported a census of 39 residents. The sample included 3 "Residents'" (R)'s 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 for adult care homes adopted by reference in K.A.R. 226-39-105 for "Certified Nurse Aide" (CNA) K and L, and for R2. Findings included: - Record review for R2 revealed an admission date of 06/05/25 with a diagnosis of type two diabetes mellitus and dementia. R2's record revealed a TB skin test administration date of 06/06/25 with a negative result recorded but lacked evidence of documentation of a first step read date and administration of a second step TB test. Review of CNA K's employee record revealed a hire date of 08/13/24. Her record lacked evidence of documentation she completed a two-step TB skin test within seven days of hire. Review of CNA L's employee record revealed a hire date of 02/29/24. Her record revealed a first step administered on 02/19/24 and read 02/26/24, outside the required 72-hour limit. Her	S3310		

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S3310	Continued From page 32 record lacked evidence of documentation of the second step of a two-step TB skin test. On 07/24/25 at approximately 09:37 AM Administrative Nurse A confirmed CNA K's employee record lacked documentation of a completed TB skin test within seven days of hire, CNA L's employee record indicated a first step had not been read within the required 72 hour limit and lacked evidence of a completed second step, and that R2's resident record lacked a first step read date and lacked evidence of a completed second step. On 07/28/25, at 11:43 AM, a response to a request for the facility's TB policy was "We don't have a specific TB Policy as we follow the KDADS (Kansas Department of Aging and Disability Services) TB guidelines," from Administrative Nurse A. The Operator failed to ensure the facility remained in compliance with the department's tuberculosis guidelines for adult care homes adopted by reference in KAR 26-39-105.	S3310		