STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046051	A. BUILDING: _____ B. WING _____	08/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PRESERVE AT TOWN CENTER	11909 LAMAR AVENUE OVERLAND PARK, KS 66209

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S 000	INITIAL COMMENTS The following citations represent the findings of the licensure resurvey with attached complaint numbers 196696, 196697, 196632, 196561, 196528, 196388, 196248, 196113, 196086, 195861, 195843, 195463, 194920, 194766, 194697, 194649, 194025, 192516, 192299, 192112, 192034, 191950, 191816, 191665, 191673, 191419, 191311, 191301, 191243, 191249, and 191252, for the above named facility conducted on 07/29/25, 07/30/25, 07/31/25, 08/04/25 and 08/05/25.	S 000		
S 110 SS=E	26-39-103 (c) NOTICE OF RIGHTS AND SERVICES (c) Notice of rights and services. (1) Before admission, the administrator or operator shall ensure that each resident or the resident's legal representative is informed, both orally and in writing, of the following in a language the resident or the resident ' s legal representative understands: (A) The rights of the resident; (B) the rules governing resident conduct and responsibility; (C) the current rate for the level of care and services to be provided; and (D) if applicable, any additional fees that will be charged for optional services. (2) The administrator or operator shall ensure that each resident or the resident ' s legal representative is notified in writing of any changes in charges or services that occur after admission and at least 30 days before the effective date of the change. The changes shall not take place until notice is given, unless the change is due to a change in level of care.	S 110		

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

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S 110	Continued From page 1 This STANDARD is not met as evidenced by: K.A.R. 26-39-103 (c)(1)(C) The facility reported a census of 75 residents. The sample included six sampled residents, six focused record reviews, and 5 closed record reviews. Based interview and record review the administrator failed to inform, prior to admission, in writing, the rate for services for R4 and R14. Findings included: - Record review for R4 revealed an admission date of 02/05/24 with diagnoses including hypertension, Parkinson's, multiple sclerosis, and hypothyroidism. The 03/05/25 FCS identified R4 required physical assistance with bathing; supervision with dressing, mobility, and eating; was unable to perform management of medications and treatments; and had short-term memory and memory/recall difficulties. The 03/05/25 NSA/HSP for R4 identified facility staff provided minimal assistance with bathing twice a week, administered medications as well as obtaining prescriptions and refills, kept routine constant to assist with cognition difficulties, and listed Administrative Nurse P as the licensed nurse responsible for implementing and supervising the HSP. Review of "Attachment E Services and Rates/Negotiated Service Agreement" of R4's admission agreement dated 02/26/24 in section "C. Basic Services" under "1.)" failed to include	S 110		

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S 110	Continued From page 2 an amount for the basic services rate. - Record review for R14 revealed an admission date of 02/15/23 with diagnoses of cerebral infarction, chronic kidney disease, hypothyroidism, glaucoma, muscle weakness, and unsteadiness on feet. The 06/30/24 FCS identified R14 required physical assistance with dressing, toileting, and management of medications; was unable to perform bathing; was occasionally incontinent of bladder; had short-term memory, long-term memory, memory/recall, and decision-making difficulties; was usually understood and usually understandable during communication; and had impaired vision, impaired hearing, impaired decision-making, and wandering problems. The 06/30/24 NSA/HSP identified R14 received total assistance with bathing and moderate assistance with dressing and toileting from caregiver. She needed directions and reminding for cognition and total assistance for with medications from caregiver. The NSA/HSP failed to provide services for impaired vision, hearing, decision-making, and wandering. Review of page two of R4's "Assisted LIving Facility Admission Agreement" dated 02/14/23 under "Base Rate and Services" failed to include an amount for the basic services. On 08/04/25 at 01:15 PM Administrative Staff E confirmed the admission agreements for R4 and R14 failed to provide a basic services rate. The administrator failed to inform, prior to	S 110		

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S 110	Continued From page 3 admission, in writing, the rate for services for R4 and R14.	S 110		
S 190 SS=E	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 4 This REQUIREMENT is not met as evidenced by: K.A.R. 26-39-102 (e)(2)(A) The facility reported a census of 75 residents. The sample included 12 Residents and 5 closed record reviews. Based on record review and interview the Administrator failed to ensure the resident's physician substantiated the reason for the discharge by documenting the rational for the discharge in the resident clinical record if the discharge was necessary for the resident's welfare, and the resident's needs could not be met by the adult care home prior to the 30-day involuntary discharge letter being provided to R1 and R13. Findings included: - Record review for R1 revealed an admission date of 01/08/19 with diagnoses of hemi plegia, hypertension, and type two diabetes mellitus. Review of R1's "Functional Capacity Screen" (FCS) dated 11/07/24 revealed R1 was unable to perform any part of the task of bathing, toileting, and transferring. R1 required physical assistance with dressing and management of medical treatments. R1 was independent with mobility and management of her medications. R1 was continent, her cognition was intact, and she was able to make herself understood and she understood others. R1 was identified at risk for falls, socially inappropriate disruptive behavior, and impaired decision making. R1 had a brace and used a wheelchair mobility device.	S 190		

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S 190	Continued From page 5 Review of R1's unsigned "Negotiated Service Agreement" (NSA) dated 11/07/24 instructed facility staff to speak slowly and cordially when speaking with resident. Staff to notify nurse if R1 presented with behaviors. R1 would resist cares often and staff instructed to provide protection and supervision due to R1 making unsafe or inappropriate decisions. Staff instructed to provide "Total" assistance with transfers. Under the section titled "Medication" It was documented that R1 was independent and did not require assistance with medication administration. Facility staff were to provide extensive hands-on assistance with bathing, dressing and toileting. "Time spent on morning routine 16 to 30 minutes" and "Resident is very specific with her routine". Review of R1's "Service Plan" Report revealed the following; On 06/10/25 R1's Durable Power of Attorney would be administering R1's medications. Review of R1's electronic "Medical Record" under the evaluations tab revealed a "Self-Administration of Medication Assessment" dated 06/06/25 that revealed the following; R1 was capable of recognizing each medication she was taking. R1 required assistance with stating what the medication was used for. R1 required assistance with stating the side effects of each medication she was taking. R1 was capable of stating the number of tablets she should take of each medication. R1 required assistance with stating the	S 190		

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S 190	Continued From page 6	S 190		

frequency of each medication.
R1 was identified as not capable to self-administer her own mediations.
The "Evaluation" sections identified the facility staff would administer "none" of R1's medications.

Review of a letter provided by R1 dated 11/14/25 revealed it was a written notice that R1 was to be discharged from the facility on 08/14/25 for the reason as R1's needs could not be met related to "the provision and control of medications", and signed by Administrative staff A.

Review of the facility provided electronic mail dated 06/07/25 from R1's Durable Power of Attorney (DPOA) revealed she would assume full responsibility for the management and administration of R1's medications until R1 successfully completed her self-medication assessment.

Review of a letter addressed to R1, provided by Administrative staff E dated 07/14/25 and signed by Administrative Staff A revealed it was a written notification that R1 was to be discharged from the facility. The discharge was necessary for R1's welfare and the welfare of the residents, due to "his" mental condition and recent behaviors that have resulted in both violations of law and regulations and filing of police reports for inappropriate behavior that were state reportable incidents being investigated. "Therefore, it has been determined that the resident's needs cannot be met. And the resident is being discharged with an effective date of 08/14/25.

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Interview on 07/31/25 at 01:15 PM with Administrative Staff E confirmed the letter provided to R1 and the letter provided by Administrative Staff E do not match in reasons for the discharge.

Interview on 07/31/25 at approximately 01:30 PM with Administrative Nurse D confirmed that she did perform a new Self administration assessment on R1 as instructed to by the "Corporate Nurse". She stated there was not a change in R1's "Ability". Administrative Nurse D state that she, the prior Director of Nursing P, and the R1's DPOA were present for the assessment. Administrative Nurse D continued to state that R1 had expired medications and medications that were not in the correct containers in her room, and Prior DON P removed the medications, made a list, gave the medications to R1's DPOA and had her sign the list. Administrative Nurse D continued that she was unsure if the option of a medication planner was discussed at this time.

Record review of a facility provided piece of blank paper dated 06/06/25 and signed by R1's DPOA and Prior DON P revealed a list of eleven medications were provided to R1's DPOA. The document lacked noting if the medications were expired or not in the appropriate containers.
- Record review for R13 revealed an admission date of 10/11/24 with diagnoses of depression, hypertension, and chronic obstructive pulmonary disease.

The 04/11/25 FCS identified R13 required supervision with bathing, dressing, and eating; was unable to perform management of

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medications and treatments; and had memory/recall difficulty.

The 04/11/25 NSA/HSP identified R13 was supervised and cued with bathing and dressing and was encouraged to drink with eating. It did not state the provider. Facility staff administered medications and obtained prescriptions and refills for R13.

Review of R13's record revealed a letter dated 07/11/25 sent to R13's responsible parties as a 30-day notice of discharge from the facility due to R13's mental condition and recent behaviors. The letter documented the resident's needs cannot be met and the resident was to be discharged by 08/11/25.

Review of "Health Status Note" dated 06/16/25 at 10:47 PM read R13 was sent to local hospital emergency room.

Review of R13's "Psychiatric Periodic Evaluation" note dated 06/18/25 revealed R13 was seen at the hospital but he was transported to a facility without a psychiatric unit so he was discharged back to the facility within a few hours.

Review of "Discharge/Transfer out of Facility" note dated 07/11/25 at 10:35 PM reavealed R13 requested to call an ambulance for itching. He was taken to the same local emergency room as on 06/16/25.

Review of "Health Status Note" dated 07/12/25 at 03:42 AM documented R13 was returned to the facility and then requested to be returned back to the hospital due to dehydration. The ambulance

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S 190	Continued From page 9 was notified for transportation. Review of "Health Status Note" note dated 07/12/25 at 11:45 AM reavealed R13 was being discharged back to the facility and the facility refused to take him due to recent behaviors. R13's record failed to include documentation of rationale by R13's physicain for transfer or discharge due to R13's needs not met by the facility. On 08/04/25 at 03:45 PM Administrative Nurse B confirmed R13's record did not include a physicain note including rationale for discharge. The facility's undated "Senior Living Resident Involuntary Discharge Policy" details the discharge "justification must be documented in the resident record by the resident's physician." The facility's "Resident Discharge" policy dated 04/20 read a discharge is conducted in a dignified manner to ensure the resident's needs are met. For R1 and R13, the Administrator failed to ensure the resident's physician substantiated the reason for the discharge by documenting the rational for the discharge in the resident clinical record if the discharge was necessary for the resident's welfare, and the resident's needs could not be met by the adult care home prior to the 30-day involuntary discharge letter being provided.	S 190		
S3026 SS=J	26-41-101 (f) (1) Staff Treatment of Residents ANE	S3026		

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S3026	Continued From page 10 (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: KAR 26-41-101(f)(1)(A)(B) The facility reported a census of 75 residents. The sample included 12 "Residents" (R)'s, and 5 closed record reviews. Based on observation, interview, and record review, the Administrator failed to protect R2 from neglect when R2 left the facility in her wheelchair through an unlocked door to an unsecured gated courtyard, she then left the facility property without staff knowledge. This placed R2 in immediate jeopardy for approximately 75 minutes, when local law enforcement returned R2 to the facility. The administrator furthermore failed to protect R8 from neglect of care when sustaining a fall, lying on the floor for hours without care, and sustaining a broken hip; R13 from abuse when staff took him to the ground, and he sustained injury and R16 and R17 from verbal and emotional abuse. Findings included - Review of the facility provided document titled "Resident Roster" revealed the facility had	S3026		

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S3026	Continued From page 11 identified four residents as "Wanderers". Record review for R2 revealed an admission date of 11/24/23 with diagnoses of chronic obstructive pulmonary disease, atherosclerotic heart disease, depression, chronic kidney disease stage three, acute kidney failure, repeated falls, type two diabetes mellitus, anxiety, insomnia, and mild cognitive impairment of uncertain or unknown etiology. Review of R2's unsigned combined "Functional Capacity Screen" (FCS)/ "Negotiated Service Agreement" (NSA)/"Health Service Plan" (HSP) dated 07/04/25 revealed R2 required physical assistance with bathing ,dressing and toileting. Facility staff instructed to provide extensive assistance with bathing twice weekly, dressing and undressing, and assistance with toileting. R2 required physical assistance with transferring, and facility staff were instructed to provide minimal assistance with transferring. R2 was marked as unable to perform any part of the task of walking/mobility. R2 was identified to have been frequently incontinent and facility staff were instructed to assist R2 with incontinent products R2 was usually able to make herself understood and she usually understood others. R2 was marked at risk for falls and used a walker and wheelchair mobility device. R2 was identified having impaired short-term memory, long-term memory, memory recall and impaired decision making, and facility staff were instructed to administer R2's medications as ordered and to keep R2's routine consistent and try to provide consistent care givers as much as possible to decrease R2's confusion.	S3026		

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S3026	Continued From page 12 The combined FCS/NSA/HSP lacked instructions for facility staff in the section titled "Walking, Mobility". The document continued to lack instructions to facility staff on communication and falls. Review of R2's unsigned "Service Plan Report " dated 04/28/25 instructed facility staff to "Be sure the resident's call device is withing reach and encourage the resident to use it for assistance as needed". Under the section titled "Mobility" it noted "Resident self-propels in her wheelchair. Resident will ask staff for help if needed". Under the section titled "Transferring" staff were instructed to provide "minimal assistance with transfers", and that R2 was independent with smoking. Review of R2's unsigned "Service Plan Report" updated 07/29/25, revealed the following updated interventions for R2; 30-minute checks, all team members to be aware of resident's elopement risk and smoking routine, staff will visually check on resident while the resident was outside smoking. Review of R2's electronic "Medical Record" under the "Progress Notes" tab revealed the following entries; On 06/29/25 at 03:49 AM an "Incident Note" revealed that R2 was found on the floor in the commons area, and she had no shoes or socks on. "Resident seemed to be hallucinating". R2 reported to staff that she was trying to get away from her brother who had been in the building all day. R2 reported to staff that her brother knocked	S3026		

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on her door and that it startled her, and she was trying to get to the elevator, and she landed on her buttocks.

On 07/01/25 at 12:08 PM a "Health Status" note revealed R2 had been complaining of "chest pain for several days." R2 insisted on going to the local emergency room for evaluation and treatments.

On 07/01/25 at 04:47 PM a "Health Status" note revealed the nurse from the facility called the hospital for an update on R2 and was told R2 was admitted to the hospital, and they are running cardiac tests, and that R2 was "stable".

On 07/04/25 at 01:50 AM an "Orders Note" revealed R2 had returned from the hospital stay with a diagnosis of pneumonia. R2 was "Alert and oriented X2."

On 07/17/25 at 00:00 an "Encounter" note signed by R2's medical provider revealed R2 underwent vein mapping for possible dialysis treatment. R2 was now wheelchair bound and was a poor historian secondary to advanced dementia. R2 was unable to make her own decisions due to cognitive impairment. The provider continued to document the dementia was progressing and R2 had very minimal short-term memory and R2 had no exit seeking behaviors.

On 07/22/25 at 08:33 AM a "Health Status" Note revealed that at 06:00 AM the nurse on duty spoke to R2 and R2 stated her son was trying to "pin everyone against her and he was beating her up". The nurse on duty reassured R2 that R2 was safe and that her family was not present in

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the building at the that time. R2 told the nurse she was hungry and was waiting for the "breakfast doors to open". The nurse documented that she left R2 in the dining room for breakfast alongside another resident. At approximately 07:15 AM local law enforcement came into the facility and showed a picture of R2's "ID" (identification) and asked if R2 lived at the facility. The nurse on duty confirmed R2 lived at the facility. Local law enforcement stated R2 was found at another facility that sat behind this facility after a resident of the other facility called local law enforcement reporting that the resident was outside. R2 stated "at the time of the elopement she left the facility because her son kicked her out".

Review of R2's electronic "Medical Record" under the "Evaluations" tab revealed a "Brief Interview for Mental Status" (BIMS) that scored R2 within a score of 7 which was listed as "Severe Impairment".

Review of the facility provided document titled "Witness Statement" signed by "Licensed Nurse" (LN) O dated and notarized on 08/04/25 revealed on 07/22/25 at approximately 06:00 AM she observed R2 going in and out of the back patio door to smoke "like she had been doing all night". When R2 came back inside R2 told her that her son was "trying to pin everyone against her and that her son tried to beat her up". LN O reassured R2 that her son was not in the building, and she left R2 sitting next to another resident in the dining room. LN O continued to write that at 07:15 AM local law enforcement brought in a picture of R2 asking if she lived at the facility. Local law enforcement stated that the

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resident was found at the neighboring facility where she reported to law enforcement that her son had kicked her out of the house.

Observation on 07/29/25 at approximately 11:30 AM during the facility tour with Maintenance Staff F revealed the north patio exit door had a keypad device to exit the door that was not active, and the door freely opened when pushed on to exit the door from the building onto the patio. The southeast exit door to the patio was not alarmed. The gated courtyard had two exit gates. The exit gate on the southeast side of the courtyard had a lock on the gate. The exit gate on the north side of the patio in the courtyard did not have a lock on the gate. The north and southeast gate doors exited to a private street that separated the two unrelated assisted living facilities. It was approximately 60 steps and across a private two-way street, from the north exit gate of the courtyard where R2 left to the awning of the neighboring facility. From the neighboring assisted living facility to the northeast corner of the neighboring property at the end of the street was approximately 100 steps. From the corner of the neighboring property to the front of the neighboring assisted living facility where R2 was found, was approximately 100 steps.

Interview on 07/29/25 at approximately 11:30 AM with Maintenance Staff F confirmed the lock on the north gate had been removed on 07/29/25 in the morning. He continued to state that prior to the elopement the courtyard gates were not locked, and the locks were added after the elopement. He further confirmed the keypad on the exit door on the north side of the patio was not active and that all you had to do was freely

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open the door. He confirmed that the facility was not a locked building and there were no active alarms going to the exit doors of the facility. He confirmed R2 self-propelled her wheelchair out onto the private street. He continued to state that the street between the buildings was a private area and only those associated with the two facilities used the street.

Interview on 08/04/25 at approximately 01:30 PM with Administrative Nurse D confirmed on that on 06 /29/25 R2's brother had not been in the building, and R2 was having hallucinations, Administrative Nurse D further confirmed R2 was returned to the facility by local law enforcement on 07/22/25 after they found her outside of the facility.

On 07/31/25 at approximately 09:23 AM Administrative Nurse B and Administrative Staff E were notified that R2 who had been experiencing hallucinations the same morning she left the facility out of an unalarmed door to the unsecured courtyard and left the facility without staff knowledge, was in immediate jeopardy until local law enforcement returned her to the facility approximately 75 minutes after the nurse last reported seeing and speaking to the resident.

The facility implemented the following actions prior to the surveyor's arrival and submitted the following removal plan on 07/31/25.

On 07/22/25 all staff were educated on the Elopement Policy.
On 07/22/25 - 07/24/24 R2 was placed one-on-one.
On 07/24/25 R2 was placed on 30-minute

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observation checks.

FCS and Service Plan/Agreement will be reviewed and updated by 07/31/25.
Door Alarms were added to exit doors to alert staff to the door opening 07/31/25.

Director of Nursing and Assistant Director of Nursing educated on completing a new FCS/Service Plan/NSA upon resident with a change of condition.

All staff educated on the process of responding to the door alarms and appropriate actions to take before resetting the door alarms prior to their next shift.

- Record review for R8 revealed an admission date of 10/04/24 with diagnoses of dysphagia, cognitive communication deficit, gait and mobility abnormalities, hypertension, and depression.

The 11/27/24 Functional Capacity Screen (FCS) identified R8 was independent with dressing, toileting, transfers, and mobility. She had memory/recall difficulty and was at risk for falls with impaired vision and impaired hearing.

The 12/04/24 Negotiated Service Agreement (NSA) documented R8 as independent with toileting, transfers, and mobility. The NSA failed to list services and provider of service to prevent R8 from falling.

The 12/21/24 at 09:15 AM Nursing note documented R8 was found on the floor by a Certified Nurse Aide when going to take breakfast order. R8 stated at the time that she

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had fallen around midnight and had been calling for help (vocally) with her call light pendant out of reach. She was transported by EMS to local hospital.

Investigation of the incident was requested which the facility failed to provide.

The administrator failed to protect R8 from neglect of care when sustaining a fall and injury.

- Record review for R13 revealed an admission date of 10/11/24 with diagnoses of depression, hypertension, and chronic obstructive pulmonary disease.

The 04/11/25 FCS identified R13 required supervision with bathing, dressing, and eating; was unable to perform management of medications and treatments; and had memory/recall difficulty.

The 04/24/25 NSA/HSP identified R13 was supervised and cued with bathing and dressing and was encouraged to drink with eating without stating the provider. Facility staff administered medications and obtained prescriptions and refills for R13. The NSA/HSP failed to address his needs and preferences related to behaviors.

The facility's "Incident Information" signed 06/23/25 documented on the evening of 06/16/25 R13 attempted to flee the facility after staff notified him of transfer to a local hospital due to his behaviors. He was assisted to the ground and sustained abrasions. R13's statement to Administrative Nurse D detailed three staff physically grabbed him and forced him to the

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ground causing injury. Certified Medication Aide (CMA) L, Licensed Nurse (LN) O, and Certified Nurse Aid Z were suspended.

Administrative Nurse P's statement detailed R13 showing each move of the incident including his elopement from the facility, hiding from staff, and then how the staff "beat him up." R13 told Administrative Nurse P the nurse that found him grabbed his hand and forearm and got him to the entrance and the CMA held on to the other arm. R13 agreed he was kicking and punching.

CMA L's statement read she held onto R13's hand while LN O held onto his other side.

CNA Z's statement documented the nurse had one of R13's arms and CMA L had the other. R13 was still attempting to get away from them.

The local provider's note from 05/23/25 documented R13's post-traumatic stress disorder (PTSD) gets triggered, he resorts to fight or flight, preferring fight. He may flail his arms to scare off his "attacker." It further explains "He can calm himself and will be aided in this endeavor by approaching him with a calm, understanding, soothing and non-judgmental attitude." "Under no circumstances should he be touched without his permission during a PTSD episode. This will only exacerbate his panic and fear."

The local provider's note from 06/18/25 documented R13 said he was still upset the staff took "it as far as they did."

The administrator failed to protect R13 from

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abuse when he attempted to leave the facility and get away from staff which resulted in three staff members assisting him to the ground and he sustained abrasions.

- Record review for R16 revealed an admission date of 11/09/22 with diagnoses of unspecified hydrocephalus, unspecified exotropia, anxiety disorder, major depressive disorder, developmental disorder of scholastic skills, Parkinson's disease, and unspecified tremors.

Review of R16's unsigned, combined FCS/NSA/HSP dated 05/09/25 revealed R16 required physical assistance with bathing and staff were instructed to provide minimal assistance with bathing. R16 required physical assistance with dressing and staff were instructed to provide extensive or total assistance with dressing. R16 was cognitively intact, and he was able to make himself understood and he understood others. R16 used a wheelchair mobility device.

R16's combined FCS/NSA/HSP lacked documentation of R16 having the current risk or problem of Socially Inappropriate Disruptive Behavior or Impaired Decision Making..

Review of the facility provided document titled "Witness Statement" notarized on 08/04/25 and signed by Administrative "Licensed Nurse" (LN) C, revealed R16 reported to her an incident of CNA R "got in his face in the lunchroom". R16 continued to report to Administrative LN C that R16 stated "she scared the crap out of me and almost made me cry".

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S3026	Continued From page 21 Interview on 08/04/25 at approximately 02:15 PM with Administrative Nurses C and D confirmed at the time of the incident no action was taken to protect R16. Administrative Nurse C confirmed the incident happened while she was working in the facility as an agency nurse, and she filled out the witness statement and put it on the office door of Prior DON P. Administrative Nurse D confirmed she saw the written witness statement from Administrative Nurse C and Prior DON P took it out of her hand and told her he would start the investigation. Review of the facility provided document titled "Witness Statement" notarized on 08/04/25 and signed by CNA R wrote the following; She did "admit" she spoke "from a place of built up frustration" and her "tone did not reflect the respect and compassion" that she held for the residents in her care. "In that moment" CNA R allowed her "frustration to guide" her "tone." Review of the facility provided document titled "Witness Statement" signed by CNA Y and notarized on 08/04/25 wrote that she and CNA R had a conversation after the incident and CNA R stated "she may have been a little hard" on R16. - Record review for R17 revealed an admission date of 09/03/24 with a diagnosis of seizures. The 04/07/25 FCS identified R17 was unable to perform bathing, dressing, toileting, and management of medications and treatments; required physical assistance with transfers; required supervision with mobility and eating; had short-term memory, long-term memory, memory/recall, and decision-making difficulties;	S3026		

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and usually understood and was usually understandable during communication.

The 04/07/25 NSA/HSP for R17 documented staff provided extensive assist with bathing and dressing, minimal assistance with transfers, administration and getting refills for medication management, and assistance with toileting. The NSA/HSP documented for cognition to break tasks into small sub tasks without listing a provider. The NSA/HSP failed to provide services or the provider of the service for mobility, eating, and communication.

CNA V's notarized witness statement read she noticed "some left over poop" on R17 and she asked CNA W if she was going to finish cleaning in which CNA W responded, "no it's fine." CNA V returned with Administrative Nurse D to finish R17's cares.

Administrative Nurse D's notarized witness statement documented R17 still had fecal matter on him. She assisted CNA V to clean him up.

The facility's 03/2025 "Abuse, Prevention and prohibition Policy" documented the facility prohibits mistreatment, neglect, or abuse of residents which includes deprivation of services that are necessary to maintain physical, mental and psychosocial well-being. Resident behaviors were monitored for changes which may trigger abusive behaviors. Intervention strategies based on resident screening were implemented to prevent occurrences of abuse. The administrator would complete a thorough investigation of alleged violations and document appropriate action.

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S3026	Continued From page 23 For R2, R8, R13, R16 and R17 the Administrator failed to protect the residents from abuse and neglect.	S3026		
S3028 SS=E	26-41-101 (f) (3) Staff Treatment of Residents Reporting (f) (3) Each allegation of abuse, neglect, or exploitation shall be reported to the administrator or operator of the facility as soon as staff is aware of the allegation and to the department within 24 hours. The administrator or operator shall ensure that all of the following requirements are met: (A) An investigation shall be started when the administrator or operator, or the designee, receives notification of an alleged violation. (B) Immediate measures shall be taken to prevent further potential abuse, neglect, or exploitation while the investigation is in progress. (C) Each alleged violation shall be thoroughly investigated within five working days of the initial report. Results of the investigation shall be reported to the administrator or operator. (D) Appropriate corrective action shall be taken if the alleged violation is verified. (E) The department ' s complaint investigation report shall be completed and submitted to the department within five working days of the initial report. (F) A written record shall be maintained of each investigation of reported abuse, neglect, or exploitation.	S3028		

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S3028	Continued From page 24 This REQUIREMENT is not met as evidenced by: KAR 26-41-101(f)(3) The facility reported a census of 75 residents with six residents included in the sample, six focused record reviews, and five closed record reviews. Based on interview and record review the administrator failed to report an allegation of neglect to the department within 24 hours when Resident (R) 8 sustained a fall and was on the floor without assistance for an unknown amount of time and sustained a broken bone, R13 left the building and sustained abrasions after staff assisted him to the ground, R14 sustained an injury fall, R16 sustained verbal abuse, and R17 was verbal abused and neglected by staff. Findings included: - Record review for R8 revealed an admission date of 10/04/24 with diagnoses of dysphagia, cognitive communication deficit, gait and mobility abnormalities, hypertension, and depression. The 03/30/25 Functional Capacity Screen (FCS) identified R8 required physical assistance with bathing and toileting; supervision with dressing, transferring, mobility, and eating; was unable to perform management of medications and treatments; was occasionally incontinent of bladder; had short-term memory, long-term memory, memory/recall, and decision-making difficulties; and had impaired decision making. The facilities "Service Plan Report" is the combined Negotiated Service Agreement and	S3028		

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S3028	Continued From page 25 Healthcare Service Plan (NSA/HSP). The 03/30/25 NSA/HSP for R8 identified facility staff supervised and provided cues for dressing, transfers, and eating; administered medications as well as obtaining prescriptions and refills, provided extensive assist with toileting, provided assist twice a week with bathing. The NSA/HSP failed to provide services for impaired decision making or cognition difficulties. The "Intake Information" received 12/23/24 documented R8 fell on 12/21/24 around midnight and remained on the floor until "morning." After admission to the hospital, it was determined she had a fracture to her hip that required surgery. The 12/21/24 at 09:15 AM Nursing note documented R8 was found on the floor by a Certified Nurse Aide when going to take breakfast order. R8 stated at the time that she had fallen around midnight and had been calling for help with her call light pendant out of reach. She was transported by EMS to local hospital. Documentation the incident was reported to the department within 24 hours was requested which the facility failed to provide. - Record review for R13 revealed an admission date of 10/11/24 with diagnoses of depression, hypertension, and chronic obstructive pulmonary disease. The 04/11/25 FCS identified R13 required supervision with bathing, dressing, and eating; was unable to perform management of medications and treatments; and had memory/recall difficulty.	S3028		

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S3028	Continued From page 26 The 04/25/25 NSA/HSP identified R13 was supervised and cued with bathing and dressing and was encouraged to drink with eating without stating the provider. Facility staff administered medications and obtained prescriptions and refills for R13. The "Incident Information" provided to the department included resident statement to Administrative Nurse D. R13 stated three staff physically grabbed him and forced him to the ground causing injury. On 08/05/25 at 01:50 PM Administrative Nurse B confirmed R13's incident from 06/16/25 was not reported to the department within 24 hours. - Record review for R14 revealed an admission date of 02/15/23 with diagnoses of cerebral infarction, chronic kidney disease, hypothyroidism, glaucoma, muscle weakness, and unsteadiness on feet. The 06/30/24 FCS identified R14 required physical assistance with dressing, toileting, and management of medications; was unable to perform bathing; was occasionally incontinent of bladder; had short-term memory, long-term memory, memory/recall, and decision-making difficulties; was usually understood and usually understandable during communication; and had impaired vision, impaired hearing, impaired decision-making, and wandering problems. The 06/30/24 NSA/HSP identified R14 received total assistance with bathing and moderate assistance with dressing and toileting from	S3028		

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caregiver. She needed directions and reminding for cognition and total assistance for with medications from caregiver. The NSA/HSP failed to provide services for impaired vision, hearing, decision-making, and wandering.

Review of Nursing Note on 11/02/24 at 04:56 AM staff completed a check on R14 at 04:00 AM and found her lying on her back in the bathroom with blood covering most of her face, her clothing, the floor and her right forearm. She sustained lacerations to her right forearm and her forehead.

Documentation the incident was reported to the department within 24 hours was requested which the facility failed to provide.

- Record review for R16 revealed an admission date of 11/09/22 with diagnoses of unspecified hydrocephalus, unspecified exotropia, anxiety disorder, major depressive disorder, developmental disorder of scholastic skills, Parkinson's disease, and unspecified tremors.

Review of R16's unsigned, combined FCS/NSA/HSP dated 05/09/25 revealed R16 required physical assistance with bathing and staff were instructed to provide minimal assistance with bathing. R16 required physical assistance with dressing and staff were instructed to provide extensive or total assistance with dressing. R16 was continent and he required physical assistance with toileting, and staff were instructed to provide minimal assistance with toileting. R16 required supervision with transferring and staff were to provide minimal assistance with transferring. R16 required supervision with walking/mobility, and

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S3028	Continued From page 28	S3028		

staff were instructed to provide supervision when R16 was walking.

R16's combined FCS/NSA/HSP lacked documentation of R16 having the current risk or problem of Socially Inappropriate Disruptive Behavior or Impaired Decision Making.

Review of the facility provided self-report to the department an allegation of abuse dated 08/04/25 revealed that Administrative Nurse B found a handwritten note referencing a potential allegation of verbal abuse that was reported to the prior Director of Nursing (DON) P on 06/12/25, and that during her investigation the allegation was not investigated by prior DON P.

- Record review for R17 revealed an admission date of 09/03/24 with a diagnosis of seizures.

The 04/07/25 FCS identified R17 was unable to perform bathing, dressing, toileting, and management of medications and treatments; required physical assistance with transfers; required supervision with mobility and eating; had short-term memory, long-term memory, memory/recall, and decision-making difficulties; and usually understood and was usually understandable during communication.

The 04/07/25 NSA/HSP for R17 documented staff provided extensive assist with bathing and dressing, minimal assistance with transfers, administration and getting refills for medication management, and assistance with toileting. The NSA/HSP documented for cognition to break tasks into small sub tasks without listing a provider. The NSA/HSP failed to provide

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S3028	Continued From page 29 services or the provider of the service for mobility, eating, and communication. The "Intake Information" submitted by Administrative Nurse B on 07/30/25 read Certified Nurse Aide (CNA) V reported abuse and neglect of R17 by CNA W on 04/03/25 to Administrative Nurse D. Documentation the incident was reported to the department within 24 hours was requested which the facility failed to provide. The facility's 03/2025 "Abuse, Prevention and prohibition Policy" documented the administrator, employee, or agent aware of any allegation of abuse or neglect should report to the state agency per reporting criteria. The administrator failed to report an allegation of neglect to the department within 24 hours when R8 sustained a fall and was on the floor without assistance for an unknown amount of time which resulted in a broken bone, R13 left the building and sustained abrasions after staff assisted him to the ground, R14 sustained an injury fall, R16 sustained verbal abuse, and R17 was verbally abused and neglected by staff.	S3028		
S3030 SS=F	26-41-101 (g) Availability of Policies and Procedures (g) Availability of policies and procedures. Each administrator or operator shall ensure that policies and procedures related to resident services are available to staff at all times and are available to each resident, legal representatives of residents, case managers, and families during	S3030		

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S3030	Continued From page 30 normal business hours. A notice of availability shall be posted in a place readily accessible to residents. This REQUIREMENT is not met as evidenced by: KAR 26-41-101(g) The facility reported a census of 75 residents. Based on observation and interview the administrator failed to ensure a notice of the availability of the facility's policies and procedures was posted in a place accessible to all residents. Findings included: - Observation on 07/29/25 at 10:52 AM during the initial tour revealed a notice that the facility's policies and procedures were available was not posted. On 07/29/25 at 10:52 AM Unlicensed Staff N confirmed a notice of the facility's policies and procedures available was not posted. On 08/04/25 at 05:28 PM Administrative Staff E confirmed a notice of the facility's policies and procedures available was still not posted. The administrator failed to ensure a notice of the availability of the facility's policies and procedures was posted in a place accessible to all residents.	S3030		
S3055 SS=F	26-41-101 (l) Survey Report (l) Survey report and plan of correction. Each	S3055		

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S3055	Continued From page 31 administrator or operator shall ensure that a copy of the most recent survey report and plan of correction is available in a public area to residents and any other individuals wishing to examine survey results. This REQUIREMENT is not met as evidenced by: KAR 26-41-101(l) The facility reported a census of 75 residents. Based on observation and interview the administrator failed to ensure the most recent survey results were available in a common area. Findings included: - Observation on 07/29/25 at 10:52 AM during the initial tour revealed the most recent survey results were not available to examine in a common area. On 07/29/25 at 10:52 AM Unlicensed Staff N confirmed the survey results were not in a common area. The administrator failed to ensure the most recent survey results were available in a common area.	S3055		
S3081 SS=E	26-41-201 (c) Functional Capacity Screen Reassessment (c) Designated facility staff shall conduct a screening to determine each resident ' s functional capacity according to the following requirements: (1) At least once every 365 days;	S3081		

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S3081	Continued From page 32 (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 75 residents. The sample included 12 Residents (Rs) and 5 closed record reviews. Based on record review and interview the administrator failed to ensure a screening determining the residents functional capacity following any significant change of condition for R's 1, 2, and 4. Findings included: - Record review for R1 revealed an admission date of 01/08/19 with diagnoses of hemiplegia, hypertension, and type two diabetes mellitus. Review of R1's "Functional Capacity Screen" (FCS) dated 11/07/24 revealed R1 was unable to perform any part of the task of bathing, toileting, and transferring. R1 required physical assistance with dressing and management of medical treatments. R1 was independent with mobility and management of her medications. R1 was continent, her cognition was intact, and she was able to make herself understood and she understood others. R1 was identified at risk for falls, socially inappropriate disruptive behavior, and impaired decision making. R1 had a brace and used a wheelchair mobility device.	S3081		

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S3081	Continued From page 33 Review of R1's unsigned "Negotiated Service Agreement" (NSA) dated 11/07/24 instructed facility staff to speak slowly and cordially when speaking with resident. Staff to notify nurse if R1 presented with behaviors. R1 would resist cares often and staff instructed to provide protection and supervision due to R1 making unsafe or inappropriate decisions. Staff instructed to provide "Total" assistance with transfers. Under the section titled "Medication" It was documented that R1 was independent and did not require assistance with medication administration. Facility staff were to provide extensive hands-on assistance with bathing, dressing and toileting. "Time spent on morning routine 16 to 30 minutes" and "Resident is very specific with her routine". Review of R1's "Service Plan" Report revealed the following; On 06/10/25 R1's Durable Power of Attorney would be administering R1's medications. Review of R1's electronic "Medical Record" under the evaluations tab revealed a "Self-Administration of Medication Assessment" dated 06/06/25 that revealed the following; R1 was capable of recognizing each medication she was taking. R1 required assistance with stating what the medication was used for. R1 required assistance with stating the side effects of each medication she was taking. R1 was capable of stating the number of tablets she should take of each medication.	S3081		

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S3081	Continued From page 34 R1 required assistance with stating the frequency of each medication. R1 was identified as not capable to self-administer her own mediations. The "Evaluation" sections identified the facility staff would administer "none" of R1's medications. Review of the facility provided electronic mail dated 06/07/25 from R1's Durable Power of Attorney (DPOA) revealed she would assume full responsibility for the management and administration of R1's medications until R1 successfully completed her self-medication assessment. Interview on 07/31/25 at approximately 01:30 PM with Administrative Nurse D confirmed that she did perform a new Self administration assessment on R1 as instructed to by the "Corporate Nurse". She stated there was not a change in R1's "Ability" and she further confirmed she did not perform a new screening determining if R1 had experienced a change of condition. Administrative Nurse D state that she, the prior Director of Nursing P, and the R1's DPOA were present for the assessment. Administrative Nurse D continued to state that R1 had expired medications and medications that were not in the correct containers in her room, and Prior DON P removed the medications, made a list, gave the medications to R1's DPOA and had her sign the list. Administrative Nurse D confirmed that FCS was not performed and she further confirmed R1's record lacked documentation of the medications taken out of her room being expired or not stored properly.	S3081		

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S3081	Continued From page 35 - Record review for R2 revealed an admission date of 11/24/23 with diagnoses of chronic obstructive pulmonary disease, atherosclerotic heart disease, depression, chronic kidney disease stage three, acute kidney failure, repeated falls, type two diabetes mellitus, anxiety, insomnia, and mild cognitive impairment of uncertain or unknown etiology . Review of R2's unsigned combined "Functional Capacity Screen" (FCS)/ "Negotiated Service Agreement" (NSA)/"Health Service Plan" (HSP) dated 07/04/25 revealed R2 required physical assistance with bathing ,dressing and toileting. Facility staff instructed to provide extensive assistance with bathing twice weekly, dressing and undressing, and assistance with toileting. R2 required physical assistance with transferring, and facility staff were instructed to provide minimal assistance with transferring. R2 was marked as unable to perform any part of the task of walking/mobility. R2 was identified to have been frequently incontinent and facility staff were instructed to assist R2 with incontinent products R2 was usually able to make herself understood and she usually understood others. R2 was marked at risk for falls and used a walker and wheelchair mobility device. R2 was identified having impaired short-term memory, long-term memory, memory recall and impaired decision making, and facility staff were instructed to administer R2's medications as ordered and to keep R2's routine consistent and try to provide consistent care givers as much as possible to decrease R2's confusion.	S3081		

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S3081	Continued From page 36 The combined FCS/NSA/HSP lacked instructions for facility staff in the section titled "Walking, Mobility". The document continued to lack instructions to facility staff on communication and falls. Review of R2's unsigned "Service Plan Report " dated 04/28/25 instructed facility staff to "Be sure the resident's call device is withing reach and encourage the resident to use it for assistance as needed". Under the section titled "Mobility" it noted "Resident self-propels in her wheelchair. Resident will ask staff for help if needed". Under the section titled "Transferring" staff were instructed to provide "minimal assistance with transfers", and that R2 was independent with smoking. Review of R2's electronic "Medical Record" under the "Progress Notes" tab revealed the following entries; On 06/29/25 at 03:49 AM an "Incident Note" revealed that R2 was found on the floor in the commons area, and she had no shoes or socks on. "Resident seemed to be hallucinating". R2 reported to staff that she was trying to get away from her brother who had been in the building all day. R2 reported to staff that her brother knocked on her door and that it startled her, and she was trying to get to the elevator, and she landed on her buttocks. On 07/17/25 at 00:00 an "Encounter" note signed by R2's medical provider revealed R2 underwent vein mapping for possible dialysis treatment. R2 was now wheelchair bound and was a poor historian secondary to advanced dementia. R2	S3081		

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was unable to make her own decisions due to cognitive impairment. The provider continued to document the dementia was progressing and R2 had very minimal short-term memory and R2 had no exit seeking behaviors.

On 07/22/25 at 08:33 AM a "Health Status" Note revealed that at 06:00 AM the nurse on duty spoke to R2 and R2 stated her son was trying to "pin everyone against her and he was beating her up". The nurse on duty reassured R2 that R2 was safe and that her family was not present in the building at the that time. R2 told the nurse she was hungry and was waiting for the "breakfast doors to open". The nurse documented that she left R2 in the dining room for breakfast alongside another resident. At approximately 07:15 AM local law enforcement came into the facility and showed a picture of R2's "ID" (identification) and asked if R2 lived at the facility. The nurse on duty confirmed R2 lived at the facility. Local law enforcement stated R2 was found at another facility that sat behind this facility after a resident of the other facility called local law enforcement reporting that the resident was outside. R2 stated "at the time of the elopement she left the facility because her son kicked her out".

Interview on 08/04/25 at approximately 01:30 PM with Administrative Nurse D confirmed on that on 06 /29/25 R2's brother had not been in the building, and she was having hallucinations, she further confirmed the record lacked an updated FCS after the resident experienced a change of cognitive condition.
- Record review for R4 revealed an admission date of 02/05/24 with diagnoses including

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hypertension, Parkinson's, multiple sclerosis, and hypothyroidism.

The 03/05/25 FCS identified R4 required physical assistance with bathing; supervision with dressing, mobility, and eating; was independent with toileting and transferring; was unable to perform management of medications and treatments; and had short-term memory and memory/recall difficulties.

The 03/05/25 NSA/HSP for R4 identified facility staff provided minimal assistance with bathing twice a week, administered medications as well as obtaining prescriptions and refills, kept routine constant to assist with cognition difficulties, and listed Administrative Nurse P as the licensed nurse responsible for implementing and supervising the HSP.

Review of "Health Status Note" dated 07/14/25 at 06:23 PM revealed R4 was admitted to hospice due to functional decline and needed more assitance and encouragement with meals.

Review of "Health Status Note" dated 07/17/25 at 04:57 PM documented R4 had a change of condition.

Review of facility's "Incidents" report for fall incidents revealed R4 had falls on 06/16/25, 06/18/25, 06/21/25, 07/03/25, 07/04/25, and 07/27/25. The 06/21/25 predisposing physiological factor was a recent change in condition.

Interview on 07/31/25 at 01:33 PM of Certified Medication Aide (CMA) J stated R4 needed

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S3081	Continued From page 39 assistance from staff to toilet and transfer. He confirmed R4 has had multiple falls. On 07/29/25 the most recent FCS and NSA were requested with 03/05/25 being the most recent documentation provided. On 08/05/25 at 09:54 AM Administrative Nurse B stated the facility does not have a policy regarding FCS. The administrator failed to ensure a screening determining the residents functional capacity following any significant change of condition for R's 1, 2, and 4.	S3081		
S3082 SS=E	26-41-201 (d) Functional Capacity Screen Accurate d) Designated facility staff shall ensure that each resident ' s functional capacity at the time of screening is accurately reflected on that resident ' s screening form. This REQUIREMENT is not met as evidenced by: K.A.R. 26-41-201 (d) The facility reported a census of 75 residents. The sample included 12 "Residents'" (R)'s and 5 closed record reviews. Based on observation, record review and interview the Administrator failed to ensure that each residents functional capacity screen was accurately reflected on that resident's screening form for R's 1, 2, and 3. Findings included:	S3082		

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S3082	Continued From page 40 - Record review for R1 revealed an admission date of 01/08/19 with diagnoses of hemi plegia, hypertension, and type two diabetes mellitus. Review of R1's "Functional Capacity Screen" (FCS) dated 11/07/24 revealed R1 was unable to perform any part of the task of bathing, toileting, and transferring. R1 required physical assistance with dressing and management of medical treatments. R1 was independent with mobility and management of her medications. R1 was continent, her cognition was intact, and she was able to make herself understood and she understood others. R1 was identified at risk for falls, socially inappropriate disruptive behavior, and impaired decision making. R1 had a brace and used a wheelchair mobility device. Review of R1's unsigned "Negotiated Service Agreement" (NSA) dated 11/07/24 instructed facility staff to speak slowly and cordially when speaking with resident. Staff to notify nurse if R1 presented with behaviors. R1 would resist cares often and staff instructed to provide protection and supervision due to R1 making unsafe or inappropriate decisions. Staff instructed to provide "Total" assistance with transfers. Under the section titled "Medication" It was documented that R1 was independent and did not require assistance with medication administration. Facility staff were to provide extensive hands-on assistance with bathing, dressing and toileting. "Time spent on morning routine 16 to 30 minutes" and "Resident is very specific with her routine". Review of R1's "Service Plan" Report revealed	S3082		

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S3082	Continued From page 41 the following; On 06/10/25 R1's Durable Power of Attorney would be administering R1's medications. Review of R1's electronic "Medical Record" under the evaluations tab revealed a "Self-Administration of Medication Assessment" dated 06/06/25 that revealed the following; R1 was capable of recognizing each medication she was taking. R1 required assistance with stating what the medication was used for. R1 required assistance with stating the side effects of each medication she was taking. R1 was capable of stating the number of tablets she should take of each medication. R1 required assistance with stating the frequency of each medication. R1 was identified as not capable to self-administer her own mediations. The "Evaluation" sections identified the facility staff would administer "none" of R1's medications. Review of the facility provided electronic mail dated 06/07/25 from R1's Durable Power of Attorney (DPOA) revealed she would assume full responsibility for the management and administration of R1's medications until R1 successfully completed her self-medication assessment. Observation on 07/31/25 of R1 at approximately 11:20 AM certified facility staff Q came into to R1's apartment with certified staff R and provided a one person physical assistance with the	S3082		

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placement of R1's left lower leg brace and shoe. Certified facility staff with the assistance of a gait belt assisted R1 from a sitting to a standing position, and R1 turned and pivoted into the wheelchair that had been placed on her right side.

R1 participated in the transfer with a one person assist.

Interview on 07/31/25 at approximately 01:30 PM with Administrative Nurse D confirmed that she did perform a new Self administration assessment on R1 as instructed to by the "Corporate Nurse". She stated there was not a change in R1's "Ability" and she further confirmed she did not perform a new screening determining if R1 had experienced a change of condition. Administrative Nurse D state that she, the prior Director of Nursing P, and the R1's DPOA were present for the assessment. Administrative Nurse D continued to state that R1 had expired medications and medications that were not in the correct containers in her room, and Prior DON P removed the medications, made a list, gave the medications to R1's DPOA and had her sign the list. Administrative Nurse D confirmed that FCS was not performed and she further confirmed R1's record lacked documentation of the medications taken out of her room being expired or not stored properly.

- Record review for R2 revealed an admission date of 11/24/23 with diagnoses of chronic obstructive pulmonary disease, atherosclerotic heart disease, depression, chronic kidney disease stage three, acute kidney failure,

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S3082	Continued From page 43 repeated falls, type two diabetes mellitus, anxiety, insomnia, and mild cognitive impairment of uncertain or unknown etiology . Review of R2's unsigned combined "Functional Capacity Screen" (FCS)/ "Negotiated Service Agreement" (NSA)/"Health Service Plan" (HSP) dated 07/04/25 revealed R2 required physical assistance with bathing ,dressing and toileting. Facility staff instructed to provide extensive assistance with bathing twice weekly, dressing and undressing, and assistance with toileting. R2 required physical assistance with transferring, and facility staff were instructed to provide minimal assistance with transferring. R2 was marked as unable to perform any part of the task of walking/mobility. R2 was identified to have been frequently incontinent and facility staff were instructed to assist R2 with incontinent products. R2 was usually able to make herself understood and she usually understood others. R2 was marked at risk for falls and used a walker and wheelchair mobility device. R2 was identified having impaired short-term memory, long-term memory, memory recall and impaired decision making, and facility staff were instructed to administer R2's medications as ordered and to keep R2's routine consistent and try to provide consistent care givers as much as possible to decrease R2's confusion. The combined FCS/NSA/HSP lacked instructions for facility staff in the section titled "Walking, Mobility". The document continued to lack instructions to facility staff on communication and falls.	S3082		

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S3082	Continued From page 44 Review of R2's unsigned "Service Plan Report " dated 04/28/25 instructed facility staff to "Be sure the resident's call device is withing reach and encourage the resident to use it for assistance as needed". Under the section titled "Mobility" it noted "Resident self-propels in her wheelchair. Resident will ask staff for help if needed". Under the section titled "Transferring" staff were instructed to provide "minimal assistance with transfers", and that R2 was independent with smoking. Review of R2's electronic "Medical Record" under the "Progress Notes" tab revealed the following entries; On 06/29/25 at 03:49 AM an "Incident Note" revealed that R2 was found on the floor in the commons area, and she had no shoes or socks on. "Resident seemed to be hallucinating". R2 reported to staff that she was trying to get away from her brother who had been in the building all day. R2 reported to staff that her brother knocked on her door and that it startled her, and she was trying to get to the elevator, and she landed on her buttocks. On 07/17/25 at 00:00 an "Encounter" note signed by R2's medical provider revealed R2 underwent vein mapping for possible dialysis treatment. R2 was now wheelchair bound and was a poor historian secondary to advanced dementia. R2 was unable to make her own decisions due to cognitive impairment. The provider continued to document the dementia was progressing and R2 had very minimal short-term memory and R2 had no exit seeking behaviors.	S3082		

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S3082	Continued From page 45 Interview on 08/04/25 at approximately 01:30 PM with Administrative Nurse D confirmed on that on 06 /29/25 R2's brother had not been in the building, and she was having hallucinations, she further confirmed the record lacked an updated FCS after the resident experienced a change of cognitive condition. Observation on 07/31/25 at approximately 11:26 AM of R2 in her room revealed she required assistance with propelling her wheelchair to the bathroom, where she locked the wheelchair, stood without assistance, and turned and sat on the toilet, voided the bladder and performed hygiene. - Record review for R3 revealed an admission date of 10/12/22 with diagnoses of chronic obstructive pulmonary disease, anxiety, other seizures, asthma, opioid dependence, unsteadiness on feet, major depressive disorder, bipolar disorder, unspecified pain, and hypertension. Review of R3's unsigned combined FCS/ NSP/ HSP dated 05/07/25 revealed R3 was unable to perform any part of the task for bathing and facility staff were instructed to check R3's skin and provide 2 showers/baths per week. R3 was identified as unable to perform and tasks related to ambulation and facility staff were instructed that R3 used an unidentified mobility device. R3 needed a caregiver to administer her medications. R3 required physical assistance for dressing and staff were instructed to provide extensive or total assistance for dressing. R3 required physical assistance with toileting and facility staff were instructed that R3 uses	S3082		

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incontinence products, and she required extensive assistance with toileting. R3 required supervision with transferring and facility staff were instructed to provide minimal assistance with transferring. R3 required supervision with eating and facility staff were instructed to encourage fluids and food consumption. R3 was frequently incontinent and facility staff instructed to provide extensive assistance with toileting. R3 had impaired short-term memory and impaired memory recall facility staff instructed to administer R3's medications on time and to assist R3 in making decisions in new situations. R3 was marked at risk for falls and used a wheelchair mobility device.

The combined FCS/NSA/HSP lacked services for R3 usually being able to make herself understood and usually understanding others and for falls.

Review of the departments "Functional Capacity Screen Manual" dated 02/97 and updated on 07/11/08 revealed under the section titled "Walking/Mobility" "Unable to perform" was used to score the resident was unable to perform any tasks related to ambulation. "Use this code for residents who are bedfast and do not use a wheelchair or other mobility device.

Review of R3's unsigned "Service Plan" updated on 04/17/25 under the section titled falls instructed facility staff to "be sure the resident's call device is withing reach and encourage the resident to use the device". Under the section titled "Mobility" it informed facility staff that R3 used a power wheelchair assistive device. Staff were instructed to provide extensive assistance

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with bathing, toileting, and dressing. Staff were instructed to provide minimal assistance with transferring.

Review of R3's electronic "Medical Record" under the "Progress Notes" tab revealed the following entries:

On 04/22/25 at 02:43 PM a "Late Entry Fall Note" revealed that R3 had called the nurse line and reported that she had fallen and gotten herself up.

On 05/28/25 at 08:00 PM staff notified the nurse that R3 was on the floor and was unable to recall the fall.

On 05/30/25 at 04:05 PM a "Health Status Note" revealed that at approximately 03:00 PM staff reported that R3 had slid out of her chair and was sitting on the floor.

On 06/01/25 at 06:53 an "Incident Note: revealed R3's hospice nurse received a call from R3 reporting that R3 was on the floor. R3 was found seated on her bottom sitting upright next to her toilet.

On 06/11/25 at 06:59 a "Health Status Note" revealed R3 was found sitting on the floor next to her bed trying to stand back up.

On 06/26/25 at 05:10 PM a "Health Status Note" revealed that R3's family received a call from R3 stating that R3 took a "Hand full of Tylenol for pain relief". R3's family contacted the hospice agency. R3's hospice nurse contacted the facility nurse.

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S3082	Continued From page 48 On 07/10/25 at 04:53 AM a "Health Status Note" revealed that R3 called the nurse and reported that she had fallen due to her "toilet moved". R3 continued to report that she had gotten herself up. R3's FCS/NSA/HSP did not accurately reflect that R3 used a mobility device and was not bedfast. On 08/05/25 at 09:54 AM Administrative Nurse B stated the facility does not have a policy regarding FCS.	S3082		
S3085 SS=E	26-41-202 (a) Negotiated Service Agreement (a) The administrator or operator of each assisted living facility or residential health care facility shall ensure the development of a written negotiated service agreement for each resident, based on the resident ' s functional capacity screening, service needs, and preferences, in collaboration with the resident or the resident ' s legal representative, the case manager, and, if agreed to by the resident or the resident ' s legal representative, the resident ' s family. The negotiated service agreement shall provide the following information: (1) A description of the services the resident will receive; (2) identification of the provider of each service; and (3) identification of each party responsible for payment if outside resources provide a service.	S3085		

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S3085	Continued From page 49 This REQUIREMENT is not met as evidenced by: K.A.R. 26-41-202 (a) (1) The facility reported a census of 75 residents. The sample included 12 "Residents'" (R)'s and 5 closed record reviews. Based on record review and interview the Administrator failed to ensure the "Negotiated Service Agreement" (NSA) for each resident contained a description of services the residents would receive for R1, R2, R5, R7, and R9. Findings included: - Record review for R1 revealed an admission date of 01/08/19 with diagnoses of hemi plegia, hypertension, and type two diabetes mellitus. Review of R1's "Functional Capacity Screen" (FCS) dated 11/07/24 revealed R1 was unable to perform any part of the task of bathing, toileting, and transferring. R1 required physical assistance with dressing and management of medical treatments. R1 was independent with mobility and management of her medications. R1 was continent, her cognition was intact, and she was able to make herself understood and she understood others. R1 was identified at risk for falls, socially inappropriate disruptive behavior, and impaired decision making. R1 had a brace and used a wheelchair mobility device. Review of R1's unsigned "Negotiated Service Agreement" (NSA) dated 11/07/24 instructed facility staff to speak slowly and cordially when speaking with resident. Staff to notify nurse if R1 presented with behaviors. R1 would resist cares	S3085		

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often and staff instructed to provide protection and supervision due to R1 making unsafe or inappropriate decisions. Staff instructed to provide "Total" assistance with transfers. Under the section titled "Medication" It was documented that R1 was independent and did not require assistance with medication administration. Facility staff were to provide extensive hands-on assistance with bathing, dressing and toileting. "Time spent on morning routine 16 to 30 minutes" and "Resident is very specific with her routine".

R1's NSA lacked a description of services for her morning routine.

On 04/05/25 at 03:30 PM a "Behavior Note" revealed R1 required assistance with toileting. Two staff members arrived to assist R1 and she asked if they were "Trained". The staff indicated they were trained and R1 allowed the to assist her with toileting. The writer documented that R1 was "snippy with staff and when R1 stated they were standing on the wrong side to assist her the writer wrote "the staff member moved to the other side to try and oblige" R1. R1 stated the staff are not "trained right" and R1 dismissed one staff member. The second staff member told R1 "We have to have two people her to assist you".

On 04/10/25 at 02:23 AM a "Behavior Note" revealed R1 had an increase in behaviors and refused her shower due to R1 not trusting the training the "Certified Nurse Aide" received. R1 put her call light on and "92 seconds" later she called the nurse's phone. The writer of the note revealed that R1 did not want a stranger taking care of her because "They aren't trained".

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S3085	Continued From page 51 - Review of the facility provided document titled "Resident Roster" revealed the facility had identified four residents as "Wanderers". Record review for R2 revealed an admission date of 11/24/23 with diagnoses of chronic obstructive pulmonary disease, atherosclerotic heart disease, depression, chronic kidney disease stage three, acute kidney failure, repeated falls, type two diabetes mellitus, anxiety, insomnia, and mild cognitive impairment of uncertain or unknown etiology . Review of R2's unsigned combined "Functional Capacity Screen" (FCS)/ "Negotiated Service Agreement" (NSA)/"Health Service Plan" (HSP) dated 07/04/25 revealed R2 required physical assistance with bathing ,dressing and toileting. Facility staff instructed to provide extensive assistance with bathing twice weekly, dressing and undressing, and assistance with toileting. R2 required physical assistance with transferring, and facility staff were instructed to provide minimal assistance with transferring. R2 was marked as unable to perform any part of the task of walking/mobility. R2 was identified to have been frequently incontinent and facility staff were instructed to assist R2 with incontinent products R2 was usually able to make herself understood and she usually understood others. R2 was marked at risk for falls and used a walker and wheelchair mobility device. R2 was identified having impaired short-term memory, long-term memory, memory recall and impaired decision making, and facility staff were instructed to administer R2's medications as	S3085		

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ordered and to keep R2's routine consistent and try to provide consistent care givers as much as possible to decrease R2's confusion.

The combined FCS/NSA/HSP lacked instructions for facility staff in the section titled "Walking, Mobility". The document continued to lack instructions to facility staff on communication and falls.

Review of R2's unsigned "Service Plan Report " dated 04/28/25 instructed facility staff to "Be sure the resident's call device is withing reach and encourage the resident to use it for assistance as needed". Under the section titled "Mobility" it noted "Resident self-propels in her wheelchair. Resident will ask staff for help if needed". Under the section titled "Transferring" staff were instructed to provide "minimal assistance with transfers", and that R2 was independent with smoking.

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

On 06/29/25 at 03:49 AM an "Incident Note" revealed that R2 was found on the floor in the commons area, and she had no shoes or socks on. "Resident seemed to be hallucinating". R2 reported to staff that she was trying to get away from her brother who had been in the building all day. R2 reported to staff that her brother knocked on her door and that it startled her, and she was trying to get to the elevator, and she landed on her buttocks.

R2's combined FCS/NSA/HSP lacked services

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for R2 when she was having hallucinations.

- Record review for R7 revealed an admission date of 12/17/24 with diagnoses of depression, ataxic gait, and adverse effect of other agents primarily affecting the cardiovascular system.

Review of R7's FCS dated 12/20/24 revealed R7 required supervision with bathing, walking, and management of her medications and medical treatments. R7 was identified at risk for falls, impaired vision and used a walker mobility device. R7 was able to make herself understood and she understood others. R7 was cognitively intact.

Review of R7's unsigned NSA dated 12/20/24 instructed facility staff that R7 would require minimal prompts or cues for safety. The NSA lacked any services for falls, and occasional assistance for medication assistance.

Interview on 08/05/24 at approximately 08:30 AM with R7 confirmed while she was in the hospital prior Director of Nursing P removed her medications from her room and she no longer self-administers her own medications.
- Record review for R5 revealed an admission date of 12/14/20 with diagnoses including obesity, diabetes mellitus, and hypothyroidism.

The 05/07/25 FCS identified R5 required physical assistance with bathing; supervision with dressing, toileting, mobility, and eating; was unable to perform management of medications and treatments; was occasionally incontinent of bladder; and had memory/recall difficulties.

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S3085	Continued From page 54 The 05/07/25 "Service Plan Report" which is the facility's combined NSA/HSP for R5 identified facility staff administered medications as well as obtaining prescriptions and refills, assisted with oxygen, and provided minimal assist with toileting. The NSA/HSP detailed R5 received supervision and cues with dressing and assistance with mobility without a provider of the service and further failed to provide service and provider of service for eating and bladder incontinence. - Record review for R9 revealed an admission date of 10/19/20 with diagnoses of diabetes mellitus type two, depression, hypertension, and psoriasis. The 04/19/25 FCS identified R9 was independent with bathing, dressing, toileting, transfers, mobility, and eating; was unable to perform management of medications and treatments; was understandable and understood others with communication; and had no cognition difficulties. The 03/30/25 NSA/HSP for R9 identified facility staff administered medications as well as obtaining prescriptions and refills. The NSA/HSP failed to instruct staff on how to communicate effectively with R9 based on his needs and preferences. On 08/05/25 at 10:33 AM R9 was watching a favorite television show and did not want to be interrupted. He needed time to process having an interview and put his thoughts together before talking.	S3085		

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S3085	Continued From page 55 On 08/05/25 at 11:30 AM R9 stated staff say "have a good day" and he feels it is "dismissing" him. R9 stated he would like to see improvement in communication with staff by giving him enough time to respond, slowing down for his need to absorb the question, and not rushing by asking the same question multiple times. On 08/05/25 at 09:54 AM Administrative Nurse B stated the facility does not have a policy regarding NSAs. The administrator failed to ensure the NSA for each resident contained a description of services and the provider of the service the residents would receive for R1, R2, R5, R7, and R9.	S3085		
S3101 SS=F	26-41-202 (h) NSA Signatures (h) Each individual involved in the development of the negotiated service agreement shall sign the agreement. The administrator or operator shall ensure that a copy of the initial agreement and any subsequent revisions are provided to the resident or the resident's legal representative. This REQUIREMENT is not met as evidenced by: KAR 26-41-202(h) The facility reported a census of 75 residents with six residents included in the sample, six focused record reviews, and five closed record reviews. Based on interview and record review the administrator failed to ensure that each	S3101		

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S3101	Continued From page 56 individual involved in the development of the Negotiated Service Agreement (NSA) signed the agreement for all residents. Findings included: - Record review for R1 revealed an admission date of 01/08/19 with diagnoses of hemi plegia, hypertension, and type two diabetes mellitus. Review of R1's "Functional Capacity Screen" (FCS) dated 11/07/24 revealed R1 was unable to perform any part of the task of bathing, toileting, and transferring. R1 required physical assistance with dressing and management of medical treatments. Review of R1's unsigned "Negotiated Service Agreement" (NSA) dated 11/07/24 instructed staff to provide "Total" assistance with transfers. Under the section titled "Medication" It was documented that R1 was independent and did not require assistance with medication administration. Facility staff were to provide extensive hands-on assistance with bathing, dressing and toileting. Review of R1's unsigned "Service Plan" Report revealed the following revision; On 06/10/25 R1's Durable Power of Attorney would be administering R1's medications. R1's combined FCS/NSA/HSP and "Service Plan" lacked signatures of all who participated in the plan. - Record review for R2 revealed an admission	S3101		

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S3101	Continued From page 57 date of 11/24/23 with diagnoses of chronic obstructive pulmonary disease, atherosclerotic heart disease, depression, chronic kidney disease stage three, acute kidney failure, repeated falls, type two diabetes mellitus, anxiety, insomnia, and mild cognitive impairment of uncertain or unknown etiology . Review of R2's unsigned combined "Functional Capacity Screen" (FCS)/ "Negotiated Service Agreement" (NSA)/"Health Service Plan" (HSP) dated 07/04/25 revealed R2 required physical assistance with bathing ,dressing and toileting. Review of R2's unsigned "Service Plan Report " dated 04/28/25 instructed facility staff to "Be sure the resident's call device is withing reach and encourage the resident to use it for assistance as needed". Review of R2's unsigned "Service Plan Report" Updated 07/29/25 revealed the following updated interventions for R2; 30-minute checks, all team members to be aware of resident's elopement risk and smoking routine, staff will visually check on resident while the resident was outside smoking. R2's combined FCS/NSA/HSP and "Service Plan" lacked signatures of all who participated in the plan. - Record review for R3 revealed an admission date of 10/12/22 with diagnoses of chronic obstructive pulmonary disease, anxiety, other seizures, asthma, opioid dependence, unsteadiness on feet, major depressive disorder, bipolar disorder, unspecified pain, and	S3101		

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S3101	Continued From page 58 hypertension. Review of R3's unsigned combined FCS/ NSP/ HSP dated 05/07/25 revealed R3 was unable to perform any part of the task for bathing and facility staff were instructed to check R3's skin and provide 2 showers/baths per week. Review of R3's unsigned "Service Plan" updated on 04/17/25 under the section titled falls instructed facility staff to "be sure the resident's call device is withing reach and encourage the resident to use the device". R3's combined FCS/NSA/HSP and "Service Plan" lacked signatures of all who participated in the plan. - Record review for R7 revealed an admission date of 12/17/24 with diagnoses of depression, ataxic gait, and adverse effect of other agents primarily affecting the cardiovascular system. Review of R7's FCS dated 12/20/24 revealed R7 required supervision with bathing, walking, and management of her medications and medical treatments. R7 was identified at risk for falls, impaired vision and used a walker mobility device. R7 was able to make herself understood and she understood others. R7 was cognitively intact. Review of R7's unsigned NSA dated 12/20/24 instructed facility staff that R7 would require minimal prompts or cues for safety. The NSA lacked any services for falls, and occasional assistance for medication assistance.	S3101		

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S3101	Continued From page 59 R7's combined FCS/NSA/HSP and "Service Plan" lacked signatures of all who participated in the plan. - Upon further review of all resident records listed in the sample, the NSAs failed to include signatures by the residents and/or the residents' legal representatives. On 07/31/25 at 09:36 AM Administrative Nurse B confirmed all residents' current NSAs lacked signatures by residents and/or their legal representatives. On 08/05/25 at 09:54 AM Administrative Nurse B stated the facility does not have a policy regarding NSAs. The administrator failed to ensure that each individual involved in the development of the NSA signed the agreement for all residents.	S3101		
S3102 SS=E	26-41-202 (i) Negotiated Service Agreement Service Received (i) Each administrator or operator shall ensure that each resident receives services according to the provisions of that resident ' s negotiated service agreement This REQUIREMENT is not met as evidenced by: K.A.R. 26-41-202 (i) The facility reported a census of 75 residents. The sample included 12 "Residents'" (Rs) and 5 closed record reviews. Based on observation, record review, and interview the administrator	S3102		

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S3102	Continued From page 60	S3102		

failed to ensure that R1 and R4 received services according to their Negotiated Service Agreements.

Findings included:

- Record review for R1 revealed an admission date of 01/08/19 with diagnoses of hemiplegia, hypertension, and type two diabetes mellitus.

Review of R1's "Functional Capacity Screen" (FCS) dated 11/07/24 revealed R1 was unable to perform any part of the task of bathing, toileting, and transferring. R1 required physical assistance with dressing and management of medical treatments. R1 was independent with mobility and management of her medications. R1 was continent, her cognition was intact, and she was able to make herself understood and she understood others. R1 was identified at risk for falls, socially inappropriate disruptive behavior, and impaired decision making. R1 had a brace and used a wheelchair mobility device.

Review of R1's unsigned "Negotiated Service Agreement" (NSA) dated 11/07/24 instructed facility staff to speak slowly and cordially when speaking with resident. Staff to notify nurse if R1 presented with behaviors. R1 would resist cares often and staff instructed to provide protection and supervision due to R1 making unsafe or inappropriate decisions. Staff instructed to provide "Total" assistance with transfers. Under the section titled "Medication" It was documented that R1 was independent and did not require assistance with medication administration. Facility staff were to provide extensive hands-on assistance with bathing twice weekly, and

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S3102	Continued From page 61	S3102		

assistance with dressing and toileting. "Time spent on morning routine 16 to 30 minutes" and "Resident is very specific with her routine".

Review of R1's "Service Plan" Report lacked instructions to facility staff on R1's routine for bathing.

Review of the facility provided documents titled "Skin Monitoring": Comprehensive "Certified Nurse Aide" (CNA) Shower Review revealed R1 received a shower on the following dates:

05/28/25, 06/21/25, 06/25/25, 07/09/25, 07/16/25, 07/25/25, 07/30/25

On 07/23/25 Handwritten on the shower sheet was the following: "checked in room at 08:30 PM and 09:20 PM both times was asleep didn't want to wake her up", and signed by CNA S.

Interview with R1 on 07/31/25 at approximately 11:20 AM revealed confirmed she does not always get her showers twice weekly.
- Record review for R4 revealed an admission date of 02/05/24 with diagnoses including hypertension, Parkinson's, multiple sclerosis, and hypothyroidism.

The 03/05/25 FCS identified R4 required physical assistance with bathing; supervision with dressing, mobility, and eating; was unable to perform management of medications and treatments; and had short-term memory and memory/recall difficulties.

The 03/05/25 NSA/HSP for R4 identified facility staff provided minimal assistance with bathing

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S3102	Continued From page 62 twice a week, administered medications as well as obtaining prescriptions and refills, kept routine constant to assist with cognition difficulties, and listed Administrative Nurse P as the licensed nurse responsible for implementing and supervising the HSP. Review of the facility provided documents titled "Skin Monitoring: Comprehensive CNA Shower Review" revealed R4 received a shower on 06/26/25, 06/30/25, 07/07/25, 07/19/25, 07/28/25, and 07/30/25. Interview with R4 on 07/31/25 at 11:16 AM revealed she does not always remember but does not agree that she gets showers twice weekly. On 08/05/25 at 09:54 AM Administrative Nurse B stated the facility does not have a policy regarding NSA. The administrator failed to ensure R1 and R4 received shower services according to their Negotiated Service Agreements.	S3102		
S3155 SS=E	26-41-204 (a) Health Care Services . (a) The administrator or operator in each assisted living facility or residential health care facility shall ensure that a licensed nurse provides or coordinates the provision of necessary health care services that meet the needs of each resident and are in accordance with the functional capacity screening and the negotiated service agreement.	S3155		

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S3155	Continued From page 63	S3155		

This REQUIREMENT is not met as evidenced by:
KAR 26-41-204(a)

The facility reported a census of 75 residents with six included in the sample, six focused record reviews, and five closed record reviews. Based on observation, interview, and record review the administrator failed to ensure a licensed nurse provided the necessary health care services that met the needs for Resident (R) 4 and R5 by the failure to include bed assist devices on their Negotiated Service Agreements (NSAs) and properly assessing the devices used.

Findings included:

- Record review for R4 revealed an admission date of 02/05/24 with diagnoses including hypertension, Parkinson's, multiple sclerosis, and hypothyroidism.

The 03/05/25 Functional Capacity Screen (FCS) identified R4 required physical assistance with bathing; supervision with dressing, mobility, and eating; was unable to perform management of medications and treatments; and had short-term memory and memory/recall difficulties.

The 03/05/25 "Service Plan Report," the facilities combined Negotiated Service Agreement and Healthcare Service Plan (NSA/HSP), for R4 identified facility staff provided minimal assistance with bathing twice a week,

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S3155	Continued From page 64	S3155		

administered medications as well as obtaining prescriptions and refills, and kept routine constant to assist with cognition difficulties. The NSA/HSP failed to list a bed assist device used while transferring to and from bed.

On 07/30/25 at 10:35 AM bed assistance device assessment was requested by email sent to Administrative Nurse B.

Review of "Bed Assist Device Evaluation" dated 07/30/25 was entered into electronic medical record at 12:32 PM. The evaluation failed to assess R4's cognitive level regarding the device, what the device was used for, and assessment of the device itself including sizes of zones of entrapment.

Observation on 07/31/25 at approximately 11:30 AM revealed a bed assist device was attached to the left side of R4's bed. The bed cane attached had a zone of entrapment greater than 4.75 inches.

On 08/04/25 at 05:17 PM Administrative Nurse B confirmed R4's bed cane zone of entrapment was larger than 4.75 inches. She states the expected space between bars per facility policy is 4.75 inches or less.

- Record review for R8 revealed an admission date of 10/04/24 with diagnoses of dysphagia, cognitive communication deficit, gait and mobility abnormalities, hypertension, and depression.

The 03/30/25 FCS identified R8 required physical assistance with bathing and toileting; supervision with dressing, transferring, mobility,

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S3155	Continued From page 65 and eating; was unable to perform management of medications and treatments; was occasionally incontinent of bladder; had short-term memory, long-term memory, memory/recall, and decision-making difficulties; and had impaired decision making. The 03/30/25 NSA/HSP for R8 identified facility staff supervised and provided cues for dressing, transfers, and eating; administered medications as well as obtaining prescriptions and refills, provided extensive assist with toileting, provided assist twice a week with bathing. The NSA/HSP failed to provide services for impaired decision making or cognition difficulties and to list a bed assist device used while transferring to and from bed. Review of "Resident Roster" provided by facility on 07/29/25 revealed R8 was not identified as a resident with a bed assistive device. Record review revealed lack of documentation R8 had a bed assistive device assessment completed. Observation on 08/05/25 at 10:16 AM revealed a bed assist device was attached to the left side of R8's bed. The bed cane attached had a zone of entrapment greater than 4.75 inches. On 08/05/25 at 11:54 AM Administrative Nurse B confirmed R8's bed cane zone of entrapment was larger than 4.75 inches. On 08/05/25 at approximately 10:20 AM R8 stated she used the bed assist to transfer in and out of bed.	S3155		

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S3155	Continued From page 66 On 02/29/24 at approximately 10:54 AM Administrative Nurse B confirmed R8's NSA lacked evidence of documentation a bed assist device was used while transferring to and from bed. The facility's "Bed Mobility Enabler Management" policy dated 01/2023 read prior to installation the resident will be assessed for the use of a device including the risk of entrapment, the resident's ability to safely use the device, and a description of the device's purpose. The administrator failed to ensure a licensed nurse provided the necessary health care services that met the needs for R4 and R5 by the failure to include bed assist devices on their Negotiated Service Agreements (NSAs) and properly assessing the devices used.	S3155		
S3165 SS=E	26-41-204 (d) Health Care Services (d) The negotiated service agreement shall contain a description of the health care services to be provided and the name of the licensed nurse responsible for the implementation and supervision of the plan. This REQUIREMENT is not met as evidenced by: - KAR 26-41-204(d) The facility reported a census of 75 residents with six residents included in the sample, six	S3165		

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focused record reviews, and five closed record reviews. Based on record review and interview the administrator failed to ensure the Negotiated Service Agreement (NSA) for Residents (R)1, R3, R4, R5, R7, R8, and R9 named the licensed nurse responsible for implementing and supervising their Healthcare Service Plans (HSP).

Findings included:

Record review for R1 revealed an admission date of 01/08/19 with diagnoses of hemi plegia, hypertension, and type two diabetes mellitus.

Review of R1's "Functional Capacity Screen" (FCS) dated 11/07/24 revealed R1 was unable to perform any part of the task of bathing, toileting, and transferring. R1 required physical assistance with dressing and management of medical treatments.

Review of R1's unsigned "Negotiated Service Agreement" (NSA) dated 11/07/24 instructed facility staff to provide "Total" assistance with transfers. Under the section titled "Medication" It was documented that R1 was independent and did not require assistance with medication administration. Facility staff were to provide extensive hands-on assistance with bathing, dressing and toileting. R1's NSA listed the nurse responsible for the implementation and supervision pf the nursing plan was prior Licensed Practical Nurse (LPN) P.

Revive of R1's electronic "Medical Record" under the "Service Plan" tab revealed that on 07/29/25 the document was revised and the nurse

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S3165	Continued From page 68	S3165		

responsible was identified as Administrative Nurse C. The NSA lacked an addendum/notification of family for the new nurse responsible.

- Record review for R3 revealed an admission date of 10/12/22 with diagnoses of chronic obstructive pulmonary disease, anxiety, other seizures, asthma, opioid dependence, unsteadiness on feet, major depressive disorder, bipolar disorder, unspecified pain, and hypertension.

R3's unsigned combined FCS/ NSP/ HSP dated 05/07/25 revealed R3 was unable to perform any part of the task for bathing and facility staff were instructed to check R3's skin and provide 2 showers/baths per week. R3 was identified as unable to perform and tasks related to ambulation.

R3's electronic "Medical Record" under the "Service Plan" tab revealed that on 07/29/25 the document was revised ad the nurse responsible was identified as Administrative Nurse C. The NSA lacked an addendum/notification of family for the new nurse responsible..

- Record review for R4 revealed an admission date of 02/05/24 with diagnoses including hypertension, Parkinson's, multiple sclerosis, and hypothyroidism.

The 03/05/25 FCS identified R4 required physical assistance with bathing; supervision with dressing, mobility, and eating; was unable to perform management of medications and treatments; and had short-term memory and

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S3165	Continued From page 69 memory/recall difficulties. The 03/05/25 NSA/HSP for R4 identified facility staff provided minimal assistance with bathing twice a week, administered medications as well as obtaining prescriptions and refills, kept routine constant to assist with cognition difficulties, and listed Administrative Nurse P as the licensed nurse responsible for implementing and supervising the HSP. The NSA/HSP failed to list a current licensed nurse responsible. - Record review for R5 revealed an admission date of 12/14/20 with diagnoses including obesity, diabetes mellitus, and hypothyroidism. The 05/07/25 FCS identified R5 required physical assistance with bathing; supervision with dressing, toileting, mobility, and eating; was unable to perform management of medications and treatments; was occasionally incontinent of bladder; and had memory/recall difficulties. The FCS failed to document R5 at risk of falls. The 05/07/25 NSA/HSP for R5 identified facility staff administered medications as well as obtaining prescriptions and refills, assisted with oxygen, provided minimal assist with toileting, and listed Administrative Nurse P as the licensed nurse responsible for implementing and supervising the HSP. The NSA/HSP failed to list a current licensed nurse responsible. - Record review for R7 revealed an admission date of 12/17/24 with diagnoses of depression, ataxic gait, and adverse effect of other agents primarily affecting the cardiovascular system.	S3165		

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S3165	Continued From page 70	S3165		

Review of R7's FCS dated 12/20/24 revealed R7 required supervision with bathing, walking, and management of her medications and medical treatments. R7 was identified at risk for falls, impaired vision and used a walker mobility device. R7 was able to make herself understood and she understood others. R7 was cognitively intact.

Review of R7's unsigned NSA dated 12/20/24 instructed facility staff that R7 would require minimal prompts or cues for safety. The NSA lacked any services for falls, and occasional assistance for medication assistance.

R7's NSA lacked the name of the nurse responsible for the implementation and supervision of health services.

- Record review for R8 revealed an admission date of 10/04/24 with diagnoses of dysphagia, cognitive communication deficit, gait and mobility abnormalities, hypertension, and depression.

The 03/30/25 FCS identified R8 required physical assistance with bathing and toileting; supervision with dressing, transferring, mobility, and eating; was unable to perform management of medications and treatments.

The 03/30/25 NSA/HSP for R8 identified facility staff supervised and provided cues for dressing, transfers, and eating; administered medications as well as obtaining prescriptions and refills, provided extensive assist with toileting, provided assist twice a week with bathing, and listed Administrative Nurse P as the licensed nurse responsible for implementing and supervising the

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S3165	Continued From page 71 HSP. The NSA/HSP failed to provide services for impaired decision making or cognition difficulties. The NSA/HSP failed to list a current licensed nurse responsible. - Record review for R9 revealed an admission date of 10/19/20 with diagnoses of diabetes mellitus type two, depression, hypertension, and psoriasis. The 04/19/25 FCS identified R9 was independent with bathing, dressing, toileting, transfers, mobility, eating, and was unable to perform management of medications and treatments. The 03/30/25 NSA/HSP for R9 identified facility staff administered medications as well as obtaining prescriptions and refills and listed Administrative Nurse P as the licensed nurse responsible for implementing and supervising the HSP. The NSA/HSP failed to list a current licensed nurse responsible. On 07/29/25 at 10:32 AM Administrative Nurse B confirmed not all NSAs prior to Administrative Nurse C's hire had been updated with nurse responsible. On 09/17/24 at 12:16 PM Administrative Staff A confirmed that Administrative Nurse C was hired 06/29/25 into the DON position. The administrator failed to ensure R1, R3, R4, R5, R7, R8, and R9's NSAs named the licensed nurse responsible for implementing and supervising their HSPs.	S3165		

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S3215	Continued From page 72	S3215		
S3215 SS=F	26-41-205 (h) Medication Storage (h) Storage. Licensed nurses and medication aides shall ensure that all medications and biologicals are securely and properly stored in accordance with each manufacturer ' s recommendations or those of the pharmacy provider and with federal and state laws and regulations. (1) Licensed nurses or medication aides shall store non-controlled medications and biologicals managed by the facility in a locked medication room, cabinet, or medication cart. Licensed nurses and medication aides shall store controlled medications managed by the facility in separately locked compartments within a locked medication room, cabinet, or medication cart. Only licensed nurses and medication aides shall have access to the stored medications and biologicals. (2) Each resident managing and self-administering medication shall store medications in a place that is accessible only to the resident, licensed nurses, and medication aides. (3) Any resident who self-administers medication and is unable to provide proper storage as recommended by the manufacturer or pharmacy provider may request that the medication be stored by the facility. (4) A licensed nurse or medication aide shall not administer medication beyond the manufacturer ' s or pharmacy provider ' s recommended date of expiration. This REQUIREMENT is not met as evidenced	S3215		

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S3215	Continued From page 73 by: KAR 26-41-205(h) The facility reported a census of 75 residents. Based on observation and interview, the administrator failed to ensure medications were stored in accordance with each manufacturer's recommendations or those of federal and state laws and regulations. Findings included: - Observation on 07/31/25 at 11:08 AM of the nurse office revealed four unsecured containers of carded medications sitting on the floor, three bottles of medications and nine cards of medications on the nurse's desk, and an unlocked refrigerator holding insulins with the door open and no staff member in the room. On 07/31/25 at 11:18 AM an unidentified resident entered the room and sat down in a chair with no staff in the room. On 07/31/25 at 12:17 PM Administrative Staff E confirmed the medications were not secured. - Observation on 07/31/25 at approximately 11:35 AM of the medication cart located on the second floor, CMA L unlocked the medication cart and then unlocked the secured controlled medication storage box. In the controlled medication storage box was a bottle of Lorazepam 2miligrams/1milliliter that had a sticker on the bottle that read "Store In Fridge" and the sticker for date opened lacked a date of when the bottle was opened. The label stated to discard after 90 days.	S3215		

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S3215	Continued From page 74 Interview on 07/31/25 at approximately 11:35 AM with CMA A confirmed the nurses administer the Lorazepam and that it should have been stored in the refrigerator. The facility's undated "Medication Administration Policy for Senior Living" policy stated medications were stored in a secure and locked area where only authorized personnel have access. Proper storage was ensured for each medication like insulin and controlled substances were double locked. The administrator failed to ensure medications were stored in accordance with each manufacturer's recommendations or those of federal and state laws and regulations.	S3215		
S3248 SS=F	26-41-102 (d) Staff Qualifications Employee Records (d) The employee records and agency staff records shall contain the following documentation: (1) Evidence of licensure, registration, certification, or a certificate of successful completion of a training course for each employee performing a function that requires specialized education or training; (2) supporting documentation for criminal background checks of facility staff and contract staff, excluding any staff licensed or registered by a state agency, pursuant to K.S.A. 39-970 and amendments thereto; (3) supporting documentation from the Kansas nurse aide registry that the individual does not have a finding of having abused, neglected, or	S3248		

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S3248	Continued From page 75 exploited a resident in an adult care home; and (4) supporting documentation that the individual does not have a finding of having abused, neglected, or exploited any resident in an adult care home, from the nurse aide registry in each state in which the individual has been known to have worked as a certified nurse aide. This REQUIREMENT is not met as evidenced by: KAR 26-41-102(d)(1)(4) The facility reported a census of 75 residents. Based on interview and record review the administrator failed to ensure evidence of certification for one staff was obtained upon hire. Findings included: - Record review of Unlicensed Staff G's employee record revealed a hire date of 04/01/25. The record lacked evidence of documentation her certification was verified upon hire. On 07/29/25 at 04:24 PM Administrative Staff A confirmed Unlicensed Staff G's employee records lacked evidence of documentation certification was verified upon hire stating the employee has not applied for certification in this state. The administrator failed to ensure evidence of certification was obtained upon hire.	S3248		

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S3261 SS=E	26-41-105 (f) (11) Resident Record Documentation of Incidents (f) (11) documentation of all incidents, symptoms, and other indications of illness or injury including the date, time of occurrence, action taken, and results of the action This REQUIREMENT is not met as evidenced by: K.A.R. 26-41-105 (f) (11) The facility reported a census of 75 residents. The sample included 12 "Residents'" (R)'s and 5 closed record reviews. Based on record review and interview the Administrator failed to ensure the documentation of all incidents, symptoms, and other indications of illness or injury including the date, time of occurrence, action taken and results of the actions for R1, R4, R5, and R13. Findings included: - Record review for R1 revealed an admission date of 01/08/19 with diagnoses of hemi plegia, hypertension, and type two diabetes mellitus. Review of R1's "Functional Capacity Screen" (FCS) dated 11/07/24 revealed R1 was unable to perform any part of the task of bathing, toileting, and transferring. R1 required physical assistance with dressing and management of medical treatments. R1 was independent with mobility and management of her medications. R1 was continent, her cognition was intact, and she was able to make herself understood and she	S3261		

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understood others. R1 was identified at risk for falls, socially inappropriate disruptive behavior, and impaired decision making. R1 had a brace and used a wheelchair mobility device.

Review of R1's unsigned "Negotiated Service Agreement" (NSA) dated 11/07/24 instructed facility staff to speak slowly and cordially when speaking with resident. Staff to notify nurse if R1 presented with behaviors. R1 would resist cares often and staff instructed to provide protection and supervision due to R1 making unsafe or inappropriate decisions. Staff instructed to provide "Total" assistance with transfers. Under the section titled "Medication" It was documented that R1 was independent and did not require assistance with medication administration. Facility staff were to provide extensive hands-on assistance with bathing, dressing and toileting. "Time spent on morning routine 16 to 30 minutes" and "Resident is very specific with her routine".

Review of R1's "Service Plan" Report revealed the following revision;

On 06/10/25 R1's Durable Power of Attorney would be administering R1's medications.

Review of R1's electronic "Medical Record" under the evaluations tab revealed a "Self-Administration of Medication Assessment" dated 06/06/25 that revealed the following;

R1 was capable of recognizing each medication she was taking.
R1 required assistance with stating what the medication was used for.

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S3261	Continued From page 78 R1 required assistance with stating the side effects of each medication she was taking. R1 was capable of stating the number of tablets she should take of each medication. R1 required assistance with stating the frequency of each medication. R1 was identified as not capable to self-administer her own mediations. The "Evaluation" sections identified the facility staff would administer "none" of R1's medications. Review of the facility provided electronic mail dated 06/07/25 from R1's Durable Power of Attorney (DPOA) revealed she would assume full responsibility for the management and administration of R1's medications until R1 successfully completed her self-medication assessment. Review of R1's electronic "Medical Record" under the "Progress Note" tab revealed the following entries: On 04/05/25 at 03:30 PM a "Behavior Note" revealed R1 required assistance with toileting. Two staff members arrived to assist R1 and she asked if they were "Trained". The staff indicated they were trained and R1 allowed the to assist her with toileting. The writer documented that R1 was "snippy with staff and when R1 stated they were standing on the wrong side to assist her the writer wrote "the staff member moved to the other side to try and oblige" R1. R1 stated the staff are not "trained right" and R1 dismissed one staff member. The second staff member told R1 "We have to have two people her to assist you".	S3261		

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R1's progress notes lacked documentation of actions taken and results of actions taken when two staff members started assisting her and the note further lacked actions taken to address her concerns related to staff training.

On 04/10/25 at 02:23 AM a "Behavior Note" revealed R1 had an increase in behaviors and refused her shower due to R1 not trusting the training the "Certified Nurse Aide" received. R1 put her call light on and "92 seconds" later she called the nurse's phone. The writer of the note revealed that R1 did not want a stranger taking care of her because "They aren't trained".

R1's progress notes lacked actions taken and results of those actions for R1 refusing her shower due to having concerns about staff not being trained.

On 07/08/25 at 03:00 PM a late entry "Health status note" revealed that R1 called the police "this date" regarding her not being able to self-administer her own medications. A meeting had taken place on 06/06/25 with prior "Director of Nursing" (DON) P, Administrative Nurse D, R1 and R1's "Durable Power of Attorney". R1's DPOA agreed to manage R1's mediations and refused to have a meeting with administrative facility staff.

R1's progress notes lack documentation of R1 not being able to self-administer her own medications. R1's progress notes further lack documentation of the results of actions for the administration of R1's medications.

Interview on 07/31/25 at approximately 01:30 PM

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with Administrative Nurse D confirmed that she did perform a new Self administration assessment on R1 as instructed to by the "Corporate Nurse". She stated there was not a change in R1's "Ability" and she further confirmed she did not perform a new screening determining if R1 had experienced a change of condition. Administrative Nurse D state that she, the prior Director of Nursing P, and the R1's DPOA were present for the assessment. Administrative Nurse D continued to state that R1 had expired medications and medications that were not in the correct containers in her room, and Prior DON P removed the medications, made a list, gave the medications to R1's DPOA and had her sign the list. Administrative Nurse D confirmed that FCS was not performed, and she further confirmed R1's record lacked documentation of the medications taken out of her room being expired or not stored properly, she continued to confirm that R1 called the police on the same day the medications were removed from her room after her daughter had left the building.

Interview on 07/31/25 at approximately 02:15 PM with Administrative Staff E revealed the facility call light system cannot print a report and the system does not record call light response times.

- Record review for R4 revealed an admission date of 02/05/24 with diagnoses including hypertension, Parkinson's, multiple sclerosis, and hypothyroidism.

The 03/05/25 FCS identified R4 required physical assistance with bathing; supervision

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S3261	Continued From page 81 with dressing, mobility, and eating; was unable to perform management of medications and treatments; and had short-term memory and memory/recall difficulties. The 03/05/25 NSA/HSP for R4 identified facility staff provided minimal assistance with bathing twice a week, administered medications as well as obtaining prescriptions and refills, and kept routine constant to assist with cognition difficulties. Review of facility's "Incidents" report for fall incidents revealed R4 had falls on 06/16/25, 06/18/25, 06/21/25, 07/03/25, 07/04/25, and 07/27/25. The 06/21/25 incident resulted in R4 being transferred to the local emergency room. Review of "Progress Notes" for R4 revealed a lack of documentation of falls for 06/18/25, 06/21/25, 07/03/25, and 07/27/25. Review of "Progress Notes" revealed a lack of documentation R4 was transferred to the hospital on 06/21/25 or the date and time in which she returned. Observation on 07/31/25 at 11:04 AM revealed R4's room number written on the whiteboard in the nurse's office under "Falls" with dates in parentheses of "7/28-7/31." The administrator failed to ensure the documentation of all incidents, symptoms, and other indications of illness or injury including the date, time of occurrence, action taken and results of the actions for R4.	S3261		

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S3261	Continued From page 82 - Record review for R5 revealed an admission date of 12/14/20 with diagnoses including obesity, diabetes mellitus, and hypothyroidism. The 05/07/25 FCS identified R5 required physical assistance with bathing; supervision with dressing, toileting, mobility, and eating; was unable to perform management of medications and treatments; was occasionally incontinent of bladder; and had memory/recall difficulties. The FCS failed to document R5 at risk of falls. The 05/07/25 NSA/HSP for R5 identified facility staff administered medications as well as obtaining prescriptions and refills, assisted with oxygen, and provided minimal assist with toileting. Review of "Health Status Note" dated 05/02/25 at 09:05 PM revealed the resident requested to lay down. The next "Health Status Note" was dated 05/06/25 at 06:41 PM and documented the resident arrived back to the facility with medical transport. The notes lacked documentation of all incidents, symptoms, and other indications of illness or injury including the date, time of occurrence, action taken and results of the actions for R5. Review of "Health Status Note" dated 05/08/25 at 09:29 AM revealed R5 was transported to the hospital due to not feeling good, shakiness, sweatiness, and stomach pain. The next three notes were dated 05/23/25 and were "Physician's Order Notes" including	S3261		

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S3261	Continued From page 83 medication changes. The "Progess Notes" lacked documentation when R5 was returned to the facility from the hospital. The facility's "Senior Living Fall Policy" dated 04/2025 failed to instruct staff on what to do when a resident falls including documentation required and the development of interventions to prevent future falls and injury. The administrator failed to ensure the documentation of all incidents, symptoms, and other indications of illness or injury including the date, time of occurrence, action taken and results of the actions for R5.	S3261		
S3280 SS=F	26-41-104 (d) Disaster and Emergency Preparedness (d) Each administrator or operator shall ensure disaster and emergency preparedness by ensuring the performance of the following: (1) Orientation of new employees at the time of employment to the facility ' s emergency management plan; (2) education of each resident upon admission to the facility regarding emergency procedures; (3) quarterly review of the facility ' s emergency management plan with employees and residents; and (4) an emergency drill, which shall be conducted at least annually with staff and residents. This drill shall include evacuation of the residents to a secure location.	S3280		

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S3280	Continued From page 84 This REQUIREMENT is not met as evidenced by: KAR 26-41-104(d)(3)(4) The facility reported a census of 75 residents. Based on interview and record review the administrator failed to ensure disaster and emergency preparedness by ensuring the performance of an emergency drill annually with staff and residents to include an evacuation of the residents to a secure location and provide evidence of documentation quarterly reviews of the facility's emergency management plan were completed with all residents and staff. Findings included: - Review of the facility's emergency plan records lacked evidence of documentation quarterly reviews were completed with residents or staff since the last survey or an annual evacuation had been completed. On 07/31/25 at 09:30 AM Administrative Nurse B confirmed the facility's records lacked documentation reviews of the emergency management plan were completed quarterly with staff and residents, furthermore, no evacuations were completed. The 08/05/25 at 09:52 AM an Emergency Management Plan quarterly review and evacuation policy was requested which the facility failed to provide. The administrator failed to ensure disaster and emergency preparedness by the failure to ensure	S3280		

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S3280	Continued From page 85 the performance of an emergency drill annually with staff and residents to include an evacuation of the residents to a secure location and to provide evidence of documentation quarterly reviews of the facility's emergency management plan were completed with all residents and staff.	S3280		
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 This REQUIREMENT is not met as evidenced by: KAR 26-41-207(c) The facility reported a census of 75 residents with six residents included in the sample, six focused record reviews, and five closed record reviews. Based on interview and record review the administrator failed to ensure the facility remained in compliance with the department's tuberculosis (TB) guidelines for adult care homes	S3310		

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S3310	Continued From page 86 adopted by reference in KAR 26-39-105 for four residents and four of five sampled staff. Findings included: - Record review for R1 revealed an admission date of 01/08/19 with diagnoses of hemi plegia, hypertension, and type two diabetes mellitus. Review of R1's electronic "Medical Record" on 07/30/25 under the "Immunizations" tab revealed a TB 2 step Mantoux Skin Test was administered on 07/25/25 and the status was pending. Review of R1's electronic "Medical Record" under the "Evaluations" tab lacked an annual TB screening. - Record review for R2 revealed an admission date of 11/24/23 with diagnoses of chronic obstructive pulmonary disease, atherosclerotic heart disease, depression, chronic kidney disease stage three, acute kidney failure, repeated falls, type two diabetes mellitus, anxiety, insomnia, and mild cognitive impairment of uncertain or unknown etiology . Review of R2's electronic "Medical Record" under the "Evaluations" tab lacked an annual TB screening. - Record review for R6 revealed an admission date of 06/07/25. The first step of the TB two-step skin test (TST) for R6 was administered 06/06/25 with no read date. The record failed to include a second step.	S3310		

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S3310	Continued From page 87 R6's record lacked evidence of documentation a TB skin test was completed. On 07/29/25 at 05:07 PM Administrative Nurse B confirmed R6's record failed to include a completed TB TST. - Record review for R7 revealed an admission date of 12/17/24 with diagnoses of depression, ataxic gait, and adverse effect of other agents primarily affecting the cardiovascular system. Review of R7's electronic "Medical Record" under the "Immunizations" tab revealed the first step TB 2 Step Mantoux was administered on 06/03/25 and read negative. The second step TB Mantoux skin test lacked a date of administration, and the status was "Pending". Review of R7's electronic "Medical Record" under the "Evaluations" tab lacked an annual TB screening. - Review of Unlicensed Staff G's employee record revealed a hire date of 04/01/25. The first step of the TST was administered 05/29/25 (59 days after employment began) and read on 05/31/25 with a negative result. The facility failed to ensure administration of the TST within seven days of employment. - Review of Certified Medication Aide (CMA) L's employee record revealed a hire date of 02/11/25. The first step of the TST was administered	S3310		

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S3310	Continued From page 88 02/24/25 (13 days after employment began) and read on 02/26/25 with a negative result. The facility failed to ensure administration of the TST within seven days of employment. - Review of CMA K's employee record revealed a hire date of 02/13/25. The first step of the TST was administered 04/28/25 (74 days after employment began) and read on 05/02/25 with a negative result. The facility failed to ensure administration of the TST within seven days of employment. - Review of Certified Nurse Aide (CNA) M's employee record revealed a hire date of 03/07/25. CNA M's record lacked evidence of documentation a TB TST was administered. On 07/29/25 at 05:07 PM Administrative Nurse B confirmed the four employee records failed to include completed TB TST which were started within seven days of employment. The June 2013 department's "Tuberculosis (TB) Guidelines for Adult Care Homes" documented each new employee and each new resident shall receive a two-step TB skin test and symptom screen questionnaire within seven days of employment or admission. On 08/05/25 at 09:54 AM Administrative Nurse B confirmed the facility does not have a policy regarding tuberculosis stating, "we just follow the regs."	S3310		

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S3310	Continued From page 89 The administrator 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		
S3320 SS=F	28-39-254 CONSTRUCTION (a) The assisted living facility or residential health care facility shall be designed, constructed, equipped and maintained to protect the health and safety of residents, personnel and the public. (b) All new construction, renovation, remodeling and changes in building use in existing buildings shall comply with building and fire codes, ordinances and regulations enforced by city, county, and state jurisdictions, including the state fire marshal. (c) New construction, modifications and equipment shall conform to the following codes and standards: (1) Title III of the Americans with disabilities act, 42 U.S.C. 12181, effective as of January 26, 1992; and (2) "Food Service Sanitation Manual," health, education, and welfare (HEW) publication no. FDA 78-2081, as in effect on July 1, 1981. This REQUIREMENT is not met as evidenced by: KAR 28-39-254(a) The facility reported a census of 75 residents.	S3320		

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Based on observation and interview the administrator failed to ensure the facility was maintained to protect the health and safety of the residents and visitors by ensuring no fall hazards or potential for injury locations were located within the facility and chemicals were stored within locked areas.

Findings included:

- Observation during initial tour on 07/29/25 at 11:20 AM of the activity room revealed a cabinet door under the sink with only one working hinge letting the door hang open when not being held up by another door. Inside were three containers of chemicals.

On 07/29/25 at 11:20 AM Unlicensed Staff N confirmed the cabinet door was broken and was used to store chemicals.

- Observation on 07/29/25 at 11:22 AM of the water boiler room revealed water pooled in back of room with white debris.

On 07/29/25 at 11: AM Unlicensed Staff N confirmed the water boiler room has had water in it since the last large rain and it had not been evacuated.

- Observation on 07/29/25 at 11:43 AM of the west hall stairwell revealed loose and rippled carpet causing a fall hazard.

On 07/29/25 at 11:43 AM Unlicensed Staff N confirmed the carpet was loose.

- Observation on 08/05/25 at 10:29 AM of the

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third-floor hallway revealed approximately one square foot of wallpaper peeled away from the wall which does not allow for the surface to be cleaned properly.

- Observation on 08/05/25 at 10:30 AM of a south hall stairwell revealed a loose rubber stair cover causing a fall hazard.

- Observation on 07/29/25 at approximately 11:16 AM during the facility tour in the third-floor common kitchen in the unlocked cabinet under the sink was a one-gallon container of ZEP cleaner and one can of Lysol spray. On the third floor down the southwest hallway and on the southeast hallway there were sections of wallpaper hanging off of the wall, and in the 3rd floor common bathroom the faucet lifted freely away from the sink. The third-floor stairwell landing contained a clear bag of garbage.

- Observation on 07/31/25 at approximately 11:30 AM in a resident room there was a toilet seat riser in place and there was a black film in the toilet bowel at the bottom edge of the toilet seat riser.

- Observation on 07/31/25 at approximately 11:40 AM in a resident room there was a commode with collection bucket removed placed over the toilet that already had a toilet seat riser attached, and the toilet freely wobbled from side to side.

- Observation on 08/05/25 at approximately 11:20 AM on the first floor on the southeast hall was a cleaning cart that was unlocked with a roll top cover standing open that contained 3 spray

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S3320	Continued From page 92 bottles of cleaners and 1 aerosol can of cleaner. Printed on a laminated sign at the end of the cart by the push handle was a notice that stated "Must Be Locked" with a picture of the cleaning cart above the statement. The administrator failed to ensure the facility was maintained to protect the health and safety of the residents and visitors by ensuring a cleanly facility with no fall hazards or potential for injury locations were located within the facility and chemicals were stored within locked areas.	S3320		
S3420 SS=F	28-39-256 MECHANICAL REQUIREMENTS (c) Mechanical requirements. (1) Heating, air conditioning, and ventilating systems. (A) The system shall be designed to maintain a year-round indoor temperature range of 70oF or 21oC to 85oF or 26oC. (B) Each apartment or individual living unit shall allow the resident to control the temperature. (2) Plumbing and piping systems. (A) Backflow prevention devices or vacuum breakers shall be installed on fixtures to which hoses or tubing can be attached. (B) Water distribution systems shall be arranged to provide hot water at outlets at all times. The temperature of hot water shall range between 98oF and 120oF at bathing facilities,	S3420		

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S3420	Continued From page 93 sinks, and lavatories in resident use areas. (3) Electrical requirements. (A) All spaces occupied by persons or machinery and equipment within the buildings, approaches to buildings, and parking lots shall have adequate lighting. (B) Minimum lighting intensity levels shall be as required in Table 1. (C) Each corridor and stairway shall remain lighted at all times. (D) Each light in resident use areas shall be equipped with shades, globes, grids, or glass panels. This REQUIREMENT is not met as evidenced by: KAR 28-39-256(c)(2)(B) The facility reported a census of 75 residents. The sample included six residents, six focused record reviews, and five closed record reviews. Based on observation and interview the administrator failed to ensure the facility water distribution system maintained a safe hot water temperature between 98- and 120-degrees Fahrenheit (F) at the sinks in resident use areas. Findings included: - During the initial tour on 07/29/25 at 11:13 AM the water temperatures in the women's public restroom sink on first floor was 126.5 degrees F	S3420		

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S3420	Continued From page 94 with department thermometer. On 07/29/25 at 12:43 PM Maintenance Staff F provided documentation one boiler was set to 131 degrees F. - On 08/05/25 at approximately 10:20 AM R8's kitchenette sink water temperature was 127.8 degrees F. R8 stated, "it is hot." Recheck of the water temperature in the first-floor women's public bathroom on 08/05/25 at 11:16 AM revealed the water temperature was 129.0 degrees F. Observations on 07/29/25 revealed all residents in the facility were able to access the public restrooms. On 08/05/25 water temperature logs were requested which the facility failed to provide. The administrator failed to ensure the facility water distribution system maintained a safe hot water temperature between 98- and 120-degrees F in resident use areas.	S3420		
S9999	Final Observations Kansas Statute 39-981. Authorized electronic monitoring; reasonable accommodations; notice; consent; use as evidence; prohibitions. (d) A resident, or such resident's guardian or legal representative, who wishes to conduct authorized electronic monitoring shall notify the adult care home on a form prescribed by the	S9999		

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secretary for aging and disability services.
(i) Each adult care home shall post a conspicuous notice at the entrance to the adult care home and each resident's room stating that the rooms of some residents may be monitored electronically by or on behalf of the room's resident or residents.

This Requirement is not met as evidenced by:

Scope and Severity of E.

This requirement is not met as evidenced by:

The facility reported a census of 75 residents. The sample included 12 residents and 5 closed record reviews. Based on observation and interviews for all residents, the facility failed to post a conspicuous notice at the entrance to the adult care home and each resident's room stating that the rooms of some residents may be monitored electronically by or on behalf of the room's resident or residents.

Findings included:

- Record review for R10 revealed an admission date of 02/20/24 with diagnoses of chronic kidney disease, vitamin D deficiency, orthostatic hypotension, anxiety, depression, and occlusion and stenosis of bilateral coronary artery.

Review of R10's "Functional Capacity Screen" (FCS) dated 05/07/25 revealed R10 required supervision with bathing and walking. R10 was independent with toileting and transferring. R10

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was continent and had impaired short-term memory and impaired decision making. R10 was usually able to make herself understood and she usually understood others.

Review of R10's combined "Negotiated Service Agreement" (NSA)/"Health Service Plan" (HSP) dated 05/07/25 instructed facility staff to provide supervision with bathing, dressing and medication management and administration.

Observation on 08/05/25 at approximately 10:25 AM of R10's room revealed the kitchenette in the northwest corner of the apartment sitting on top of the miniature refrigerator a small square device with a red light.

Interview on 08/05/25 at approximately 10:25 AM with R10 revealed there was a language barrier, and the communication was very limited.

Observation on 08/05/24 at approximately 10:45 AM revealed the following:

The front entrance to the facility lacked a conspicuous posting at the adult care home entrance that stated, "The rooms of some residents may be monitored electronically by or on behalf of the room's resident or residents."

36 rooms had postings in the window next to the front door of their apartments that stated, "The rooms of some residents may be monitored electronically by or on behalf of the room's resident or residents."

58 rooms lacked a posting in the window next to the front door of the apartments that stated, "The

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rooms of some residents may be monitored electronically by or on behalf of the room's resident or residents."

A room on the third floor had a small square sticker next to the posting that stated a "Ring" device was in the room posted next to the required posting that stated, "The rooms of some residents may be monitored electronically by or on behalf of the room's resident or residents."

A room on the third floor had a laminated rectangular piece of paper with black lettering that stated, "Video Monitoring in Progress" posted above the required posting that stated, "The rooms of some residents may be monitored electronically by or on behalf of the room's resident or residents."

Interview on 07/28/25 at approximately 10:00 AM with Administrative Staff A confirmed there were some cameras in resident rooms.

Interview on 08/05/25 at approximately 10:40 AM with Administrative Staff E confirmed not all rooms had a posting that, "The rooms of some residents may be monitored electronically by or on behalf of the room's resident or residents. He further confirmed the entrance of the front entrance of the adult care home lacked a conspicuous notice stating, "The rooms of some residents may be monitored electronically by or on behalf of the room's resident or residents."

The facility failed to post a conspicuous notice at the entrance to the adult care home and each resident's room stating that the rooms of some residents may be monitored electronically by or

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S9999	Continued From page 98 on behalf of the room's resident or residents.	S9999		