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	N087059	A. BUILDING: _____ B. WING _____	03/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD OF CRESTVIEW	600 N 127TH STREET EAST WICHITA, KS 67206

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S 000	INITIAL COMMENTS The following represents the findings of a resurvey with attached complaints #194043, #190751, #190622, #188798, #188113, #185378, #184221, and #178721 at the above named assisted living conducted on 03/18/25, 03/19/25, and 03/24/25.	S 000		
S3026 SS=J	26-41-101 (f) (1) Staff Treatment of Residents ANE (f)The administrator or operator shall ensure that all of the following requirements are met: (1) No resident shall be subjected to any of the following: (A) Verbal, mental, sexual, or physical abuse, including corporal punishment and involuntary seclusion; (B) neglect; or (C) exploitation. This REQUIREMENT is not met as evidenced by: KAR 26-41-101(f)(1)(A) The facility reported a census of 12 memory care unit residents and 29 assisted living residents for a total of 41 residents. Three residents were included in the sample with 9 focused record reviews. Based on interview and record review the administrator failed to protect Resident (R)3 from physical abuse when she suffered a left eye injury of unknown origin. This placed R3 in immediate jeopardy on 03/08/25 at approximately 05:25 AM. The administrator further failed to protect R9 from verbal abuse by a direct care member on 01/22/24.	S3026		

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

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S3026	Continued From page 1 Findings included: - Record review for R3 revealed an admission date of 08/12/22 with diagnoses of dementia and weakness. The 06/21/24 (before the incident) "Functional Capacity Screen" (FCS) identified R3 required physical assistance with bathing, dressing, toileting, transfers, walking/mobility, and management of medications and treatments. R3 was frequently incontinent of bladder, had short-term and long-term memory, memory/recall, and decision-making cognitive difficulties; was usually understood and usually understood others during communication; and was marked for falls, impaired decision-making, and wandering. Inappropriate behavior was not marked on the "FCS." The 06/21/24 (before the incident) "Negotiated Service Agreement/Healthcare Service Plan" (NSA/HSP) identified facility staff and an outside provider provided R3 assistance with bathing. Facility staff provided assistance with dressing, toileting, and transfers. Facility staff provided reminders to R3 to use her wheelchair for mobility and management of medications and treatments. R3 wore incontinence briefs for bladder incontinence. Facility staff provided routine monitoring for cognitive difficulties. Facility staff provided reminders to seek staff assistance when getting off of bed and assistance to pick things up so R3 wouldn't slip or trip on them to prevent falls. R3 had a Durable Power of Attorney (DPOA) to assist with impaired	S3026		

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decision-making. The 06/21/24 "NSA" failed to describe services provided R3 for wandering and did not instruct staff to seek assistance from another staff if R3 exhibited resistance to cares.

The 03/08/25 (after the incident) "FCS" identified R3 required the same as the 06/21/25 "FCS" with the following changes: R3 required physical assistance with eating, was always incontinent of bladder, sometimes understood others during communication, was not marked for wandering, and was marked for inappropriate behaviors.

The 03/08/25 (after the incident) "NSA/HSP" identified the same as the 06/21/24 "NSA/HSP" with the following changes: two staff provided R3 assistance with transfers using a mechanical lift and propelled her wheelchair for mobility. Facility staff provided assistance with eating and checked R3 every two hours for bladder incontinence and changed soiled briefs as needed. Facility staff provided removal from situations when R3 exhibited increased agitation, reported increased agitation or un-directable behaviors to the nurse, maintained a calm/soothing environment, and offered diversional activities or interactions. Facility staff provided assistance with cares by two staff due to cognitive and physical limitations. Facility staff reported any physical and verbal aggression to the nurse and executive director immediately. R3 had a conjunctival hematoma to her left eye.

The 03/08/25 "Late Entry Nurses Note" created by Administrative Nurse C on 03/10/25 at 01:00 PM documented that on 03/08/25 facility staff notified Administrative Staff A that R3 had an

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unexplained injury to her left eye. An unidentified nurse completed an assessment and noted swelling and bruising to R3's left eye with no other visible injuries. R3 lived in the memory care unit of the facility, was dependent on facility staff for all activities of daily living (ADL) needs and was unable to explain what happened to cause injury to her left eye.

Review of nursing progress notes from 01/01/25 to 03/17/25 revealed no evidence of documentation R3 exhibited behaviors. The nursing progress notes further revealed the first documentation of R3's left eye injury was dated 03/10/25 which was two days after facility direct care staff reported the injury to a licensed nurse and/or administrative staff.

The 03/14/25 facility's "Investigation" to the department documented the following:

1) On 03/08/25 facility staff notified Administrative Staff A that R3 had an unexplained injury to her left eye. A nurse completed an assessment and noted swelling and bruising to R3's left eye with no other visible injuries. R3 lived in the memory care unit of the facility, was dependent on facility staff for all activities of daily living (ADL) needs and was unable to explain what happened to cause injury to her left eye.

2) R3 went to the hospital for further evaluation. Facility administrative staff immediately initiated an investigation. They interviewed direct care staff who worked the previous 24 hours and reviewed video/audio footage.

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S3026	Continued From page 4 3) On undated day at 06:30 PM and 10:00 PM Certified Medication Aide (CMA) G observed R3 had no visible eye injury. 4) Administrative Staff A reviewed recorded video footage from the camera located outside of R3's room from 03/07/25 at 10:00 PM to an unidentified time. The video did not record into R3's room but staff entry and exit was recorded as well as audio heard from within R3's room. The following was recorded on 03/08/25: a) 01:11 AM CMA G entered R3's room and exited at 01:12 PM b) 04:06 AM Certified Nurse Aide (CNA) F entered R3's room and exited at 04:07 AM c) 05:24 AM CNA F entered R3's room alone. Sounds from audio revealed CNA F "aggressively" talked to R3 with periodic intervals of "distinctive loud striking or clapping sounds" followed by R3 "yelling out and/or crying." d) 05:42 AM (18 minutes later after CNA F entered R3's room) CNA F said "your eye is bleeding" and exited the room soon after. e) 05:44 AM CNA F used her cell phone to report to the on-call nurse R3's eye was bleeding. 5) On-coming day shift staff reported CMA F informed them R3 had an issue with her eye. The facility's 05/2019 "Dementia and Behavior Management for Staff" self-directed learning module covered symptoms, causes, stages, and suggestions to implement at each stage. The training included resisting care and agitation with a list of suggestions to try including "have someone else approach them." The "Dementia and Behavior Management for Staff" training did	S3026		

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not suggest assistance of more than one staff for cares. This training was provided to and signed by CNA F on 05/16/24 and reviewed and signed by Administrative Staff A.

6) CNA F informed facility administrative staff she would arrive at the facility on 03/13/25 at 01:00 PM to provide a notarized witness statement and discuss employment status. CNA F failed to arrive at the scheduled time.

The 03/08/25 letter from the facility to CNA F informed her multiple attempts were made to contact her and she was terminated from employment on 03/11/25 per the disciplinary record.

The facility's 05/2019 "Dementia and Behavior Management for Staff" self-directed learning module covered symptoms, causes, stages, and suggestions to implement at each stage. The training included resisting care and agitation with a list of suggestions to try including "have someone else approach them." The "Dementia and Behavior Management for Staff" training did not include guidance regarding assistance of more than one staff for cares.

Observation on 03/19/25 at 02:24 PM revealed R3 laid in bed covered with a blanket. The bed was in low position with a wheelchair and mechanical lift nearby. R3's eyes opened, she nodded and smiled but was unable to respond to questions appropriately. R3's eyes appeared to have no bruising, redness, or signs of injury.

On 03/19/25 at 11:53 AM Advanced Practice Nurse Practitioner (ARNP) stated facility staff

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notified her on 03/08/25 R3 had an unexplained injury to her left eye. She instructed staff to send R3 to the hospital for evaluation. R3 returned to the facility with negative findings of for any kind of fracture.

On 03/19/25 at 02:58 PM Administrative Nurse B stated she heard what sounded like slapping when she watched the recorded video footage from early morning on 03/08/25. The slapping happened approximately 10 times and R3 cried after each slapping sound most of the time but not every time. Sometimes she was already crying. Direct care staff reported R3's eye was swollen to Licensed Nurse E with text messages. Administrative Nurse B arrived at the facility and conducted an assessment of R3 and notified the hospice nurse. The hospice nurse completed an assessment for R3 by video. Administrative Staff suspended CNA F pending investigation and she had not worked any more shifts. Facility staff attempted to contact CNA F multiple times with no response. Facility staff reported the incident to the police and there was an on-going investigation.

On 03/19/25 at 03:23 PM Licensed Nurse E stated she was on call when CNA F notified her early in the morning on 03/08/25 that "something happened" and texted a photo of R3's eye. CNA F reported she did not know what happened to R3's eye but it appeared bruised. Facility administrative staff informed Licensed Nurse E to avoid all contact with CNA F because they were filing abuse charges, so she deleted all her text messages with CNA F.

On 03/19/25 at 03:57 PM Administrative Staff A

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S3026	Continued From page 7 stated the following: 1) Licensed Nurse E notified her on 03/08/25 at 10:18 AM R3 had an unexplained left eye injury. Administrative Staff A arrived to the facility at approximately 11:30 AM and completed a head-to-toe assessment. The only injury was R3's left eye was swollen and bruised but not bleeding. Administrative Staff A was also a licensed nurse. 2) Administrative Staff A listened to the video/audio footage recorded by the camera located outside of R3's room from the early morning of 03/08/25. Administrative Staff A heard things that were not appropriate. It was enough she reported her findings to the police and let them take the investigation from there. The facility provided the video/audio footage to the police. 3) Upon listening to the audio in the video footage, Administrative Staff A heard "banging" sounds and R3 yelled out or cried multiple times. One time, R3 said "that hurts." Administrative Staff A heard CNA F say "(R3's name) let go of me. 4) Facility administrative staff emailed an initial intake report to the Kansas Department for Aging and Disability Services (KDADS) and an investigation report. The times mentioned in the intake and investigation reports when CMA G observed R3 had no visible eye injury at 06:30 PM and 10:00 PM were on 03/07/25. 5) The hospital reported R3 suffered a sub-conjunctival hematoma with no fractures to	S3026		

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surrounding bone tissue.

On 03/20/25 at approximately 10:36 AM Administrative Nurse C stated staff knew if a resident exhibited behavior, they were to have another staff member present with them.

On 03/20/25 at approximately 10:36 AM Administrative Nurse B stated it was part of the facility's dementia training to ask another staff for assistance if a resident resisted cares which CNA F failed to do on 03/08/25.

The administrator failed to protect R3 from physical abuse when she suffered a left eye injury of unknown origin which placed her in immediate jeopardy on 03/08/25 at approximately 05:25 AM.

Immediate jeopardy was removed when the facility implemented mandatory re-education to all staff regarding abuse, neglect, and exploitation on 03/13/25 and 03/14/25 as documented in the 03/20/25 "Abatement Plan" which was accepted by the department on 03/20/25 at 02:58 PM.

- Record review for R3 revealed an admission date of 05/17/23 with a diagnosis of dementia.

The 01/19/24 "FCS" identified R9 required physical assistance with dressing and toileting, had short-term and long-term memory, memory/recall, and decision-making cognitive difficulties.

The 01/19/24 "NSA/HSP" identified facility staff provided assistance with dressing and toileting.

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S3026	Continued From page 9 The "NSA/HSP" failed to describe services provided R9 for cognitive difficulties. The 01/26/24 "Investigation" to the department documented on 01/22/24 a staff member reported to her that CMA I reported R9 hit her multiple times and tried to take his pants off in the common area of the memory care unit. Administrative Staff A reviewed video footage and observed R9 sat in a recliner in the common area of the memory care unit. He pulled his pants down and tried to take them off. Administrative Staff A observed via video CMA I approached R9 and said in a loud voice "we are not doing this. . . we are not stripping in the damn living room. . . what the hell is your problem. . . this is not your house, you cannot do this. . ." At one point R9 said "get the hell out of here" and pushed CMA I's hand away. CMA I said "if you hit me again. . .I don't give a rat's behind. . . you are not in control of this house. . . if you don't put your pants on, I will call someone and we will put your pants on." CMA I and R9 were the only people in the common area of the memory care unit at the time of the incident. CMA I was immediately suspended pending investigation and terminated on 01/25/24. All current staff completed re-education on abuse, neglect, exploitation, and resident rights on 01/29/24. The administrator failed to protect R9 from verbal abuse by a direct care staff member on 01/22/24. On 03/24/25 at approximately 02:38 PM Administrative Nurse C stated the "FCS/NSA" was the "Negotiated Service Agreement." The "Service Plan" were combined with the "FCS/NSA" and signed by all parties involved in	S3026		

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S3026	Continued From page 10 its development. The facility's 01/22/24 "Abuse, Neglect, and Exploitation" policy documented "The resident has the right to be free from verbal . . . abuse, corporal punishment. . . and injuries of unknown origin. . ." Verbal abuse included disparaging and derogatory language, threats of harm, and/or making statements to frighten a resident. Physical abuse included hitting, slapping, pinching, kicking. The administrator failed to protect R3 from physical abuse when she suffered a left eye injury of unknown origin on 03/08/25 at approximately 05:25 AM. The administrator further failed to protect R9 from verbal abuse by a direct care member on 01/22/24.	S3026		
S3171 SS=J	26-41-204 (i) Health Care Services Standards of Practice (i) All health care services shall be provided to residents by qualified staff in accordance with acceptable standards of practice. This REQUIREMENT is not met as evidenced by: KAR 26-41-204 (i) The facility reported a census of 41 residents with three included in the sample and nine focused record reviews. Based on observation, interviews, and record review, the operator failed to keep one resident safe from potential injury or death, when staff failed to complete an accurate	S3171		

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headcount per standards of practice for elopements, after resident (R)12 exited from the facility and triggered door alarms. This left R12 unaccounted for 57 minutes and placed R12 in immediate jeopardy on 09/14/24 at 06:36 PM.

Findings included:

Record review for R12 revealed an admission date of 08/01/24 with the following diagnoses: unspecified dementia (unspecified severity), without behavioral disturbance, psychotic depression (unspecified), type two diabetes mellitus.

The "Functional Capacity Screen" (FCS) dated 08/01/24, identified R12 required supervision with walking, mobility and transfers and had been marked for impaired vision, hearing, short-term and long-term memory loss, memory/recall, and decision-making impairments.

The 08/01/24 "Negotiated Service Agreement/Healthcare Service Plan" (NSA/HSP) identified facility staff provided supervision for transfers and reminders to use a walker for walking/mobility. Facility staff removed R12 when she exhibited increased agitation and contacted nurse if she refused care. Facility staff faced R12 when speaking to her for impaired hearing. The "NSA/HSP" failed to describe services provided for impaired vision.

R12's record lacked evidence of an elopement risk assessment before the incident.

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Nursing notes dated 08/05/24 documented facility staff notified nurse that R12 attempted to breach memory care doors by pushing on them.

Nursing notes dated 08/08/24 documented facility staff notified nurse that R12 had set off door alarms and had opened windows in another resident's room.

The 09/17/24 "Intake Report" (IR) to the department revealed that a video surveillance review and timeline indicated R12 exited the facility at 06:36 PM and was returned by law enforcement personnel after nearby citizens notified them. R12 was returned to the facility at 07:33 PM, 57 minutes after she exited the facility.

The "IR" revealed that the on-call nurse reported that staff witness statements were obtained. "Staff were performing scheduled evening showers and care needs in residents' rooms causing staff to be unable to hear the initial alarm sounding. Alarm notification transferred to pager/phone notifying staff of alarm on the Memory Care unit. 2 staff responded to alarm, resetting the system. R12's usual routine is to go to bed at approximately 7pm every evening, Certified Medication Aide M had seen R12 go to her room prior to initiating another resident's shower and had included this visualization in her head count for all residents, not realizing resident had changed her normal routine and had left room, pushed on door, activating alarm and exiting from community onto the grounds."

On 03/24/25 at approximately 10:45 AM, a review of the facility's "Elopement Prevention and Wandering Behavior Self Directed Learning

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Module," also referred to as "Resident Elopement Drill," failed to outline a required headcount to identify if a resident was missing.

Nursing notes dated 09/14/24 documented facility staff notified on-call nurse that R12 had exited the facility and returned with local law enforcement.

Observation on 03/18/25 at approximately 04:24 PM revealed alarms on all memory care doors. Observed that R12's room was approximately 25 paces from the door she exited from. At approximately 04:45 PM, an observation of the general area outside the facility revealed a nearby golf course which included water hazards and revealed a busy four lane highway nearby. The temperature was between 85 and 90-degrees Fahrenheit at that time-of-day according to Wunderground.com.

Observation on 03/19/25 at approximately 02:15 PM revealed R12 was in her room in bed and refused to interview with state surveyor.

On 03/20/25 at approximately 10:36 AM Administrative Nurse C stated staff saw R12 go to her room and assumed she was in facility and failed to include her in a head count and that was the facility's policy to complete a headcount and open doors if they were closed.

On 03/20/25 at approximately 10:36 AM Administrative Staff A stated a couple in the neighborhood saw R12 lying on the ground and called law enforcement.

On 03/24/25 at approximately 02:38 PM

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	N087059	A. BUILDING: _____ B. WING _____	03/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD OF CRESTVIEW	600 N 127TH STREET EAST WICHITA, KS 67206

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S3171	Continued From page 14 Administrative Nurse C stated "FCS/NSA" was the "Negotiated Service Agreement." The service plan was combined with the "FCS/NSA" and signed by all parties involved in its development. The administrator failed to protect R12 from neglect by the failure to ensure staff completed an accurate headcount after resident left the facility, unsupervised. This failure placed R12 in Immediate Jeopardy, when she exited the facility through a memory care unit door and staff did not perform an accurate head count to determine who was missing. Immediate jeopardy was abated when the following actions were taken by the facility and completed on 03/03/25. 1. Mandatory all staff in-service on elopement procedure and alarm handling and response process was completed on 09-16-. 2. Elopement drill completed on 09/30/24 3. Installation of iron privacy fence around the memory care unit grounds on 10-18-24. 4. Mandatory all staff in-service on emergency procedure review, elopement prevention and reporting and communication was completed on 01/13/25. 5. Elopement drill completed on 01/27/25. 6. New iPhone system installed with Viking Call System for the community memory care unit on 03-03-25.	S3171		
S3240 SS=F	26-41-103 (c) Staff Development on Dementia (c) If the facility admits residents with dementia, the administrator or operator shall ensure the	S3240		

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S3240	Continued From page 15	S3240		

provision of staff orientation and in-service education on the treatment and appropriate response to persons who exhibit behaviors associated with dementia.

This REQUIREMENT is not met as evidenced by:
KAR 26-41-103(c)
The facility reported a census of 41 residents. Based on interview and record review the administrator failed to provide dementia training to direct care staff upon hire for five out of five sampled staff.

Findings included:

- Record review for Certified Medication Aide (CMA) L revealed a hire date of 12/27/23. The record lacked evidence of documentation dementia training was completed upon hire.

Record review for Certified Nurse Aide F revealed a hire date of 05/02/24. The record lacked evidence of documentation dementia training was completed upon hire.

Record review for Licensed Nurse K revealed a hire date of 11/13/24. The record lacked evidence of documentation dementia training was completed upon hire.

Record review for Licensed Nurse E revealed a hire date of 12/23/24. The record lacked evidence of documentation dementia training was completed upon hire.

Record review for Licensed Nurse J hired on

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S3240	Continued From page 16 unknown date lacked evidence of documentation dementia training was completed upon hire. Resident roster identified 18 residents as having cognitive impairment, with 12 of the residents residing in the dementia/memory care unit. On 03/24/25 at 11:13 AM Administrative Staff A confirmed dementia training for staff had not been completed upon hire. On 03/24/25 at approximately 02:38 PM Administrative Nurse C stated the facility did not have a dementia training policy. The administrator failed to provide dementia training to direct care staff upon hire for five out of five sampled staff.	S3240		
S3305 SS=F	26-41-207 (a) (b) Infection Control (a) The administrator or operator of each assisted living facility or residential health care facility shall ensure the provision of a safe, sanitary, and comfortable environment for residents. (b) Each administrator or operator shall ensure the development of policies and implementation of procedures to prevent the spread of infections. These policies and procedures shall include the following requirements: (1) Using universal precautions to prevent the spread of blood-borne pathogens; (2) techniques to ensure that hand hygiene meets professional health care standards; (3) techniques to ensure that the laundering and handling of soiled and clean linens meet professional health care standards;	S3305		

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S3305	Continued From page 17 (4) providing sanitary conditions for food service; (5) prohibiting any employee with a communicable disease or any infected skin lesions from coming in direct contact with any resident, any resident ' s food, or resident care equipment until the condition is no longer infectious; (6) providing orientation to new employees and employee in-service education at least annually on the control of infections in a health care setting; and (7) transferring a resident with an infectious disease to an appropriate health care facility if the administrator or operator is unable to provide the isolation precautions necessary to protect the health of other residents. This REQUIREMENT is not met as evidenced by: KAR 26-41-207(a) The facility reported a census of 41 residents. Based on observation and interview the operator failed to ensure facility staff kept food items safe and sanitary during delivery to residents' rooms. Findings included: - Observation on 03/18/25 at 05:30 PM revealed a cart in the hallway near resident room 201. The cart was unattended with no facility staff nearby. The cart had three shelves containing eight disposable cups of what appeared to be ice water and 12 individual-sized	S3305		

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S3305	Continued From page 18 bowls of what appeared to be red colored gelatin dessert with whipped topping. Approximately two minutes later a staff member came out of a resident room and approached the cart. On 03/18/25 at approximately 05:32 PM an unidentified facility staff member confirmed she left the food items on the cart for the residents unattended and uncovered. She could not ensure the food items were safe from direct contact (if someone touched them) or from airborne contaminants. On 03/24/25 at approximately 02:38 PM Administrative Staff A stated she expected food items to be covered during delivery to residents' rooms. On 03/24/25 at approximately 02:38 PM Administrative Nurse C stated the facility did not have a policy regarding safe and sanitary delivery of food items to residents' rooms. The operator failed to ensure facility staff kept food items safe and sanitary during delivery to residents' rooms.	S3305		