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	N087071	A. BUILDING: _____ B. WING _____	05/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHISHOLM PLACE	1859 N. WEBB ROAD 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
S 000	INITIAL COMMENTS The following citations represent the findings of an abbreviated survey for complaints #194824, 194600, 194578, 194477, 194341, 192720, 192511 and 192267 of the above named facility conducted on 05/06/25, 05/07/25 and 05/08/25.	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)(B) The facility reported a census of 64 residents. The sample included 10 residents with one closed record review. The facility identified 15 residents who wandered and were at risk for elopement. Based on observation, interview, and record review the administrator failed to ensure all exit doors had the alarm system activated. This resulted in immediate jeopardy when the newly admitted and cognitively impaired R3, who had displayed exit seeking behaviors on 01/03/25, exited the facility on 01/04/25 through an exit door that did not have the alarm	S3026		

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

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S3026	Continued From page 1	S3026		

activated, and without staff knowledge. R3 remained outside and unaccounted for by staff for approximately 10 minutes in 32-degree Fahrenheit (F) weather with a wintery mix precipitation and was found shivering after staff heard him knocking on the door.

Findings included:

- R3's medical record revealed he moved into the memory care facility on 01/03/25 with a diagnosis of frontotemporal dementia.

R3's "Functional Capacity Screen" (FCS) dated 01/10/25 revealed he was independent with transfers and mobility without the use of a walker. R3 had a cognitive score of four indicating he had severely impaired cognition with long-term memory, short-term memory, memory/recall and decision-making impairments. The FCS identified R3 as at risk for wandering.

R3's "Negotiated Service Agreement/Health Service Plan" (NSA/HSP) dated 12/05/24 identified R3 was independent with transfers and ambulation, wandered, and staff monitored him closely as he tried to escape from the community whenever he had the chance.

Review of R3's medical record revealed the following:

The 01/03/25 at 07:48 PM "Progress Note" by Licensed Nurse (LN) K documented R3 was active with exit-seeking and R3 pressed against all egress doors and set off the door alarms. Staff were unable to redirect R3 with activities, toileting, eating, and companionship.

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S3026	Continued From page 2 The 01/04/24 at 06:34 PM "Progress Note" by LN L documented R3 continued to exit seek throughout the shift. R3 knew how long to hold the handle on the doors to get out. R3 was found knocking on the door at the end of the 200 Hall from the outside. R3 had exited the door, and it shut behind him locking him out of the building. Review of a facility door report which indicated what egress doors were opened on 01/04/25 did not indicate the 200-Hall door had been opened. An incident report submitted to the state agency documented the following: On Saturday, 01/04/25 at around 06:00 PM, Certified Medication Aide (CMA) E heard a loud noise coming from the north hall. CMA E heard someone knocking on the exit door. CMA E opened the door to find R3 outside dressed in a long-sleeved shirt, a sweater, jeans and shoes. R3 appeared to be shivering, and it was sleeting but neither his hair nor his clothing was damp. R3 was in a gated area and was not able to leave the property. No staff had witnessed R3 going outside but CMA O last saw R3 between 05:45 PM and 05:50 PM and Certified Nurse Aide (CNA) P reported last seeing R3 at 05:45 PM. Staff checked all gates and doors to make sure they were locked, and alarms were reset properly. Staff were reminded on how to check and cancel the door alarms. An observation on 05/06/25 at 03:06 PM revealed the 200 Hall emergency egress door had a red STOP sign posted on it. The door alarm was activated as indicated by the solid red	S3026		

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S3026	Continued From page 3 light located on the push bar. An observation on 05/07/25 at 10:30 AM revealed the facility was in a mixed residential/commercial neighborhood with an office park with businesses located around the memory care facility to the north and east and residential housing located nearby to the south and to the west. The street on which the facility was located was paved and the north side of the street had a sidewalk. The facility was located approximately 695 feet to the east of a busy, four-lane undivided road with a posted speed limit of 40 miles per hour (mph). South of the facility was a tree line with a graveled bike trail that ran east/west and intersected with numerous other busy streets. Weather conditions at the time of the elopement as verified on https://www.wunderground.com/ revealed the sun had already set, the temperature was approximately 32 degrees Fahrenheit, sleet falling and east-northeast winds at 14 mph. An observation on 05/07/25 at approximately 07:20 PM revealed Administrator A led the resident from the front door of the secured specialty unit while a visitor waited for a staff member to enter the code in the secured door so the visitor could exit the unit. CNA H entered the code and let the visitor out. R3 approached the door at a rapid pace and moved CNA H out of the way and pushed on the closed door in an attempt to exit the secured unit. The visitor then pushed from the outside of the door and met resistance from R3 trying to push it open from the other side. The visitor was finally able to	S3026		

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S3026	Continued From page 4	S3026		

push the door until the door closed and the lock engaged on the door while CNA H redirected R3.

On 05/06/25 at 01:55 PM CMA E stated that if someone went out the egress door without it being disarmed, it would set off the alarm. CMA E stated the day R3 exited the building without staff knowledge she was helping in the laundry room. CMA E stated she did not hear an alarm go off but when she went out of the laundry room to deliver tablecloths to the dining room, she came across a resident who needed assistance to his room on the 200-Hall. It was then that CMA E heard a loud noise but did not know where it was coming from, so she went to check on each resident room on the 200-Hall to try and find where the noise was coming from. CMA E realized the loud pounding noise came from outside of the egress door and when she opened it, she found R3 outside in the gated area.

On 05/06/25 at 02:07 PM CMA F stated the exit doors at the end of the halls were egress doors that sounded with a loud beep when the push bar was pushed and released. CMA F stated when the doors opened a steady alarm would sound and the red light on the push bar would flash until staff reset the alarm properly.

On 05/07/25 at 03:05 PM CMA F stated it was possible for staff to turn off the alarm on an egress door and leave the alarm deactivated. CMA F stated staff needed to make sure they heard the door "click" and the flashing red light turned solid red indicating the door alarm was activated.

On 05/07/25 at 03:12 PM CMA E clarified the

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S3026	Continued From page 5 200-Hall egress door was not alarming when she went to it to check to see where the loud pounding noise came from. CMA E stated she was able to push on the door bar to open the door and this did not set off the alarm at that time. On 05/07/25 at 03:20 PM LN D stated the 200-Hall egress door was not reset properly from a previous time the door was opened and this allowed R3 to go out the door without staff knowledge. On 05/07/25 at 04:55 PM Administrative Staff A and Administrative Staff B were informed of the findings which resulted in immediate jeopardy regarding a newly admitted and cognitively impaired resident exiting the facility unsupervised, and the failure to ensure staff properly reset the door alarm which allowed R3 to exit the facility without staff knowledge, for 10 minutes in a wintery mix, and was found shivering. Administrative Staff A provided corrective actions taken by the facility which included the following: 1. R3 was brought inside and given hot chocolate. 2. R3 was added to hourly rounding. 3. Family came to community to provide one-on-one care until R3 fell asleep. 4. On 01/05/25 a new order for lorazepam was obtained to help with R3's anxiety. 5. Staff education was provided verbally on 01/04/25 and again on 01/07/25. Protocols already in place/previously in place: 1. Weekly door checks completed by	S3026		

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S3026	Continued From page 6 maintenance staff. 2. Daily door checks completed by clinical staff. The facility implemented corrections on 01/04/25 and completed them on 01/07/25.	S3026		
S3080 SS=D	26-41-201 (a) (b) Functional Capacity Screen on Admission a) On or before each individual ' s admission to an assisted living facility or residential health care facility, a licensed nurse, a licensed social worker, or the administrator or operator shall conduct a screening to determine the individual ' s functional capacity and shall record all findings on a screening form specified by the department. The administrator or operator may integrate the department ' s screening form into a form developed by the facility, which shall include each element and definition specified by the department. (b) A licensed nurse shall assess any resident whose functional capacity screening indicates the need for health care services. This REQUIREMENT is not met as evidenced by: 3080 KAR 26-41-201(a) The facility reported a census of 64 residents. The sample included 10 residents with one closed record review. Based on interview, and record review the administrator failed to ensure the "Functional Capacity Screen" (FCS) was completed on or before admission for Resident (R)3.	S3080		

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S3080	Continued From page 7 Findings included: - R3's medical record revealed he moved into the facility on 01/03/25 with a diagnosis of frontotemporal dementia. Review of R3's medical record revealed a FCS was not completed upon admission to the facility but instead was completed one week later. On 05/08/25 at 01:40 PM Administrative Staff A stated the admitting FCS was not completed for R3 until 01/10/25 and acknowledged this should have been completed prior to or the day of admission. The administrator failed to ensure R3's FCS was completed on or before the day of admission to the facility.	S3080		
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: K.A.R. 26-41-204 (i) The facility reported a census of 64 residents. The sample included 10 Residents (R) and one closed record review. Based on record review	S3171		

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S3171	Continued From page 8	S3171		

and interview the Administrator failed to ensure all health care services were provided by qualified staff in accordance with acceptable standards of practice when the Licensed Nurse (LN) was alerted by the facility Certified Nurse Aide (CNA) that R6 had experienced a change of condition and was not responding within her normal limits. The LN failed to do an immediate assessment for R6 when staff reported the change of condition, and R6 died approximately2 hours and 19 minutes after staff notified the LN of R6's change of condition.

Findings included:

- Record review for R6 revealed an admission date of 06/18/21 with diagnoses of Type I Diabetes Mellitus, hypertension, anxiety with depression, history of trans ischemic attack, cognitive impairment, dementia, coronary artery disease, and memory loss.

Review of R6's "Functional Capacity Screen" (FCS) dated 11/06/24 revealed R6 required physical assistance with dressing and mobility. R6 lacked the ability to manage her own medications/medical treatments. R6 was incontinent, and had impaired short-term memory, impaired long-term memory, impaired memory/recall, and impaired decision making. R6 could sometimes make herself understood and she sometimes understood others. R6 used a wheelchair mobility device and a mechanical lift. Under the section titled "Comments" was typed the following: R6 was a full assist of 2 staff to transfer and ambulation cares. R6 went out to all meals. R6 was alert and orientated to self. R6 required assistance with all cares as well as

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S3171	Continued From page 9 making sure food was cut up and sometimes needed to be fed. Review of R6's unsigned, combined "Negotiated Service Agreement" (NSA)/ "Health Service Plan" (HSP) dated 11/14/24 revealed the following health services to be provided to R6. Under the section titled "Communication" facility staff instructed to be aware of R6's body language to assist in communication. Under the section titled "Expression" facility staff were instructed to "be aware" of R6's body language and ask questions and provide time for R6 to comprehend and respond. Under the section titled "Medication" facility "Certified Medication Aide" (CMA) or LN would administer treatments per provider orders. Review of R6's facility provided printed electronic "Medication Administration Record" (MAR) revealed the following orders: Humalog Kwik Injection (fast acting insulin) 100 units/milliliter (ml) - inject per sliding scale three times daily with each meal as follows: blood glucose of 151-200 mg/dl = 4 units, blood glucose of 201-250 mg/dl = 5 units, blood glucose of 251-300 mg/dl = 6 units, blood glucose of 301-350 mg/dl = 7 units, blood glucose of greater than 350 mg/dl = 8 units. Staff were instructed to hold the medication until after the resident ate their meal and only give if more than 50% of meal was consumed. Staff were further directed to call the resident's provider if their blood glucose was greater than 350. Toujeo Solo Injection (long-acting insulin) 300 units/ml, staff were to inject 12 units subcutaneously every morning.	S3171		

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S3171	Continued From page 10 Glucagon Kit 1 mg staff would inject 1 mg s needed for hypoglycemia. The order lacked parameters for hypoglycemia. Glutose 15 Gel 40% (Glucose) staff would administer 15 mg by mouth as directed for hypoglycemia. The order lacked parameters for hypoglycemia. The resident's physician orders lacked the treatment of hypoglycemia (low blood sugar) with the use of orange juice or honey. Review of the facility provided printed electronic "Progress Notes" revealed the following entries: On 03/10/25 at 01:45 AM entered by LN J revealed staff placed R6's Dexcom blood glucose monitoring system sensor to the resident's left upper arm. On 03/27/25 at 06:29 PM LN I noted she held R6's medications due to R6 being over sedated and not getting up for breakfast, lunch, or dinner. R6's blood sugar dropped to 63 mg/dl (70 -100 mg/dl) and glucagon gel (medication used to raise blood sugar) and "Honey" was administered orally. R6 woke up and took approximately five bites of food then fell back asleep. Staff rechecked the resident's blood sugar and it measured 207 mg/dl. The note lacked documentation R6's medical provider and/or the resident's Durable Power of Attorney (DPOA) was notified of resident's low blood sugar or change in status on 03/27/25. On 04/06/25 at 07:34 PM LN K noted it was	S3171		

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reported R6's blood glucose measured 54 mg/dl and was declining. The writer instructed staff to give resident juice, and the resident was unable to drink due to increased lethargy. The nurse utilized glucose in R6's cheeks and bottom lip, R6's blood sugar went up to 127 mg/dl, and she consumed all of her dinner.

On 04/11/25 at 02:48 AM LN J documented R6's Dexcom blood glucose monitoring system sensor was replaced to the left upper arm.

On 04/15/25 at 04:31 PM a "Late Entry" for 04/13/25 at 07:00 PM entered by LN I revealed R6's blood sugar reading in the morning read "HI" and she called the resident's medical provider. Advanced Practice Registered Nurse (APRN) M gave a verbal telephone order for the LN to administer 10 units of Humalog insulin (rapid acting insulin to help manage blood glucose levels), recheck the blood glucose results on R6 in one hour, and to call the results to APRN M. After an hour the resident's blood glucose continued to read "HI" and a second verbal telephone order to administer another 10 units of Humalog insulin was given by APRN M. Staff were directed to recheck R6's blood glucose in one hour and call APRN M back with those results. LN I called APRN M and reported the resident had a blood glucose level of 329 mg/dl. APRN M gave a verbal telephone order to continue with the resident's regular insulin and sliding scale(adjusting insulin doses based on the blood sugar levels before meals). R6's blood glucose reading at lunch was 249 mg/dl, R6 consumed 100% of the meal served, and she received 6 units of Humalog insulin per the sliding scale order. R6 watched some television

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S3171	Continued From page 12 in the common area and then was laid down in her room to rest. R6 was gotten out of bed with the assistance of a mechanical lift at 05:00 PM. R6 noting she was tired and did not want to get up. Staff checked R6's blood glucose, which measured 45mg/dl. LN I noted she got R6 up and sat with her in the television room where she administered honey to the resident. The note included R6 was alert and able to respond with no issues at the time. LN I then rechecked R6's blood glucose manually and the result was 110 mg/dl. R6 was then transferred to the dining room for dinner. LN I stated she administered another med (medication) cup of "Honey" and R6 ate a couple of bites of food. LN I documented R6 was still able to swallow. A local hospice nurse arrived to see other residents the facility had called about, and noticed R6 was pale and did not arouse to a sternal rub (medical technique used to assess a resident's level of consciousness by applying stimulus to the sternum). R6's vitals were obtained, and her blood pressure measured 95/40 Millimeters of mercury (mm Hg), pulse rate of 52 beats per minute, and a room oxygen saturation level of 40% (normal range 92-100%. The staff and hospice nurse transferred R6 to her room and she began to turn "blue". R6 was transferred from her wheelchair to her bed and she expired at 05:55 PM. The note lacked documentation of the time in which R6 began having signs/symptoms of illness, what time the facility took action to help R6, and specific follow up related to actions taken when R6 had a change in condition. On 04/14/25 at 12:13 AM LN L documented R6 exited the community with a local funeral home at	S3171		

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S3171	Continued From page 13 08:00 PM. On 04/25/25 at 04:21 PM an "Incident Note" entered by the facility Director of Nursing (DON)/LNB revealed CNA R stated at 03:40 PM she reported to LN I R6 had a "low" blood glucose reading when she attempted to assist R6 to get out of bed and she was unable to arouse resident. CNA R then walked down to the nursing office and informed LN I that R6 was not responding when spoken to and R6 "appeared to be sweating". At this time CNA R included R6's phone was alerting and showing "low" in her Dexcom Application. LN I instructed CNA R to get R6 up and bring her to the commons area. CNA R and CNA Q assisted R6 out of bed and to the commons area as instructed by LN I. Approximately 45 minutes later CNA R went to check on R6 and she was unresponsive, CNA R asked LN I if she had assessed R6 and LN I showed her the medication cup of honey. LN I then asked CNA R to assist with administering the honey into R6's mouth. At approximately 05:00 PM a local hospice nurse arrived to see other patients in the facility. The hospice nurse confirmed R6 was one of her clients, obtained a room oxygen saturation level of 31%, and had facility staff assist in taking R6 to her room. the hospice nurse informed LN I that R6 was "actively passing" and confirmed the official time of death of R6 at 05:59 PM. Review of R6's facility provided printed electronic "Medication Administration Record" (MAR) revealed the following entries on 04/13/25: Humalog Kwik Injection 100units/ml revealed LN	S3171		

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S3171	Continued From page 14 I documented she administered 20 units for the "Morning", with a blood glucose reading of "Hi". Toujeo Solo Injection 300units/ml revealed LN I documented she administered 12 units for the 08:00 AM dose. Humalog Kwik Injection 100units/ml revealed LN I documented she administered 6 units for the "Mid-Day", with a blood glucose reading of 269 mg/dl. Record Review of the facility provided report titled "Medication Delivery" for R6 dated 04/13/25 revealed the following: The resident's Humalog Kwik Injection was noted as given late for the "Morning Dose" at 03:59 PM by LN I. The resident's Humalog Kwik Injection was noted as given late for the "Mid-Day" dose at 04:21 PM by LN I. The resident's 08:00AM Toujeo Solo Injection was noted as given late at 03:59 PM by LN I. Record review of the facility provided document titled "Encounter Summary Progress Note" dated 11/08/24, 01/17/25, 02/12/25, 02/14/25, and 03/05/25 revealed "staff were to have Glucagon on site for low blood sugars as needed and instructed not to hold the resident's long-acting insulin. .Review of the facility provided document titled "Witness Statement" dated and notarized on 05/01/25 and signed by "Certified Medication Aide" (CMA) S wrote that about 04:30 PM she heard CNA R call over the facility walkie talkies stating R6 was unresponsive, and about 10 minutes later she called again over the walkie	S3171		

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talkie stating R6's blood sugar was reading "Extremely" low. The statement indicated the nurse never responded, and when CNA R wheeled R6 out she was grey and unresponsive. The nurse began giving her honey, but R6 could not swallow. CMA S continued that a Hospice nurse came for another resident, began taking R6's vitals, and informed LN I that R6 was actively dying.

Review of the facility provided document titled "Witness Statement" dated and notarized on 05/02/25 and signed by local hospice LN V, revealed she observed a resident sitting at the dining room table who was unresponsive, pale and had a "Tracheal Rattle ", a specific phenomenon which occurs due to the accumulation of fluids in the throat and upper airways, which can happen when a person loses the ability to swallow. It is commonly seen in terminally ill patients and can be a predictor of imminent death. After confirming the resident was on hospice with the same hospice company Hospice LN V assessed R6's vitals and confirmed R6's room air oxygen saturation was 31%. She asked the facility staff present to assist her with getting R6 to her room and R6 began having apnea up to 90 seconds. Staff placed R6 on her bed with mechanical lift assist and the time of death called by the hospice nurse was 05:59 PM.

Review of the facility provided document titled "Witness Statement" dated and notarized on 05/02/25 and signed by CNA Q revealed at around 04:00 PM on 04/13/25 she heard CNA R call for assistance with R6 and responded to the request to assist. While assisting CNA R to get

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S3171	Continued From page 16 R6 out of bed when CNA Q noticed that R6 was not acting like her usual self and, she was not responsive which was very unusual for R6. CNA R and CNA Q checked the blood sugar monitor and saw that it was reading "Low", took her to the nurse's station, and informed LN I. At 06:00 PM CNA Q was informed of R6's death. Review of the facility provided document titled "Witness Statement" dated and notarized on 05/02/25 and signed by CNA R revealed she entered R6's room at 03:40 PM and noticed R6 was not opening her eyes and responding within her normal limits. CNA R observed R6 was really sweaty, and her clothes were wet with sweat and R6 was "cold and clammy" to the touch. CNA R continued to write that she checked R6's Dexom meter, a continuous glucose monitoring device, showed that R6's blood glucose had started dropping around 12:30 PM. CNA R "radioed" the nurse with no response and then walked to the nurse's station to report the low blood sugars and the change of condition of R6 being non-responsive. CNA R wrote that LN I instructed her to get R6 out of bed and bring her to the commons area. CNA R wrote after taking R6 to the commons area she continued with her job duties and came back approximately 30 to 45 minutes later and R6 was in the same area she left her. CNA R went to LN I and asked if she had assessed R6 and instructed CNA R to administer honey using a syringe into R6's mouth. CNA R wrote that R6 was unresponsive at this time. Review of the facility provided document titled "Witness Statement", which was undated/unnotarized and signed by CNA W revealed at approximately 05:45 PM on 04/13/25	S3171		

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she observed R6 sitting across from her at the dining room table where LN I was trying to orally administer honey to R6 with a syringe. CNA W wrote that she told LN I R6 was turning grey. CNA W stated R6 started gasping hard and "almost as if she was choking". The local hospice nurse arrived and started taking her vitals and told staff R6 was "actively dying".

Review of the facility provided document titled "Witness Statement", which was undated/unnotarized and signed by CNA P revealed at approximately 04:30 PM she heard CNA R call for help over the walkie talkies stating that R6's blood sugar was reading "Low". CNA P wrote that when CNA R brought R6 to the commons area, she noticed R6 was pale, "blue" in the face, and cold to the touch. CNA P wrote that LN I started giving R6 honey and R6 "began to aspirate".

Review of the facility provided handwritten statement dated 04/13/25, and signed by LN I revealed the following:

LN I wrote the off going nurse reported that R6 had a critically high blood glucose reading and she called APRN M, who gave a telephone order for 10 units of Humalog and directed her to recheck the resident's blood glucose in one hour and call the results to APRN M in one hour (at approximately 07:50 AM). LN I called APRN M back an hour later with the blood glucose results of "high" and was given another order for 10 units of Humalog to be administered and call APRN M back in one hour with the results. The results after one hour were 329 mg/dl and the resident ate between 80 and 90 percent of her

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S3171	Continued From page 18 breakfast. APRN M was notified of the 329 mg/dl result and ordered to continue regular insulin sliding scale if blood glucose was within normal range. At 11:30 AM the resident's blood sugar reading result of 249 mg/dl was and R6 ate 100 % of her lunch, and she was alert. The r laid down in bed to rest after the noon meal. When staff attempted to get the resident up for supper they came to nurse's station and asked if the resident could stay in bed as the patient did not look like she felt well. LN I stated she replied no due to the resident needing to be observed during meals R6 was transported to the television room and blood sugar obtained read "Low". LN I stated staff administered honey with a syringe. LN I wrote that she rechecked the blood sugar and with a result of 110mg/dl, and stated the resident was able to swallow and open her mouth on command. LN I continued to write that R6 was alert and making eye contact when she took R6 to the dining room where she administered a second medication cup of honey. The local hospice nurse arrived and attempted to arouse R6 who appeared pale. R6 was declining in cognition at this point and LN I assisted in transferring R6 to her room where she appeared cyanotic (bluish discoloration) and was short of air. Review of the facility provided document titled "Witness Statement" dated and notarized on 05/05/25 and signed by CMA O revealed she walked into the small facility dining room and observed LN I administer a "honey like substance" with a syringe into R6's mouth. R6 was not responding. On 05/07/25 at approximately 04:00 PM	S3171		

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S3171	Continued From page 19 Administrator A, DON/LN B, Regional Clinical Director C, and LN D were informed of R6 being placed in immediate jeopardy on 04/13/25, when LN I failed to respond to CNA R's request for an assessment on R6 when the blood glucose device read "Low", and R6 experienced a change of condition. LN I administered honey, when the current orders read to administer oral Glucose gel or Glucose 1 mg. Interview on 05/07/25 at approximately 06:15 PM with Administrator A, DON/LN B, Reginal Clinical Services Director C, and LN D confirmed R6's medical record lacked clarification of the Toujeo Solo Injection 300 units/ml order that was identified on the R6's MAR for 12 units one time a day, and the provider notes instructed to continue Toujeo Solo Injection 300 units/ml 8 units in the morning and 8 units at hour of sleep and they further confirmed the glucose that was ordered for R6 was available at the time of the incident on 04/13/25. They continued to confirmed CNA R did not report the incident/concerns about the follow up of care for R6's change of condition that happened on 04/13/25 until two days later on 04/15/25. The Administrator failed to ensure all health care services were provided by qualified staff in accordance with acceptable standards of practice when LN I was alerted by facility CNA R, that R6 had experienced a change of condition and was not responding within her normal limits. The LN failed to do an immediate assessment for R6 when staff reported the change of condition, and R6 died approximately 2 hours and 19 minutes after staff notified the LN of R6's change	S3171		

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S3171	Continued From page 20 of condition, based on times provided in the signed witness statements. The facility provided an abatement plan on (DATE) at (TIME), which included: On 04/15/25, the facility immediately suspended LN I when administration was made aware of the concern from staff on 04/15/25. On 04/17/24 the facility terminated of LN I, based on the facility investigation. The facility put the following protocols in place: If residents had blood glucose readings of "low" or if resident is not alert enough to swallow staff were instructed to call 911. If a resident had a Glucagon order staff were instructed to administer Glucagon. The facility provided re-education for staff regarding immediate reporting of suspicions of abuse or neglect. Staff were to call 911 if a resident's blood glucose measured less than 50 mg/dl or greater than 450 mg/dl.	S3171		
S3200 SS=D	26-41-205 (d) (1-2) Facility Administration of Medications (d) Facility administration of resident ' s medications. If a facility is responsible for the administration of a resident ' s medications, the administrator or operator shall ensure that all medications and biologicals are administered to	S3200		

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S3200	Continued From page 21 that resident in accordance with a medical care provider ' s written order, professional standards of practice, and each manufacturer ' s recommendations. The administrator or operator shall ensure that all of the following are met: (1) Only licensed nurses and medication aides shall administer and manage medications for which the facility has responsibility. (2) Medication aides shall not administer medication through the parenteral route. This REQUIREMENT is not met as evidenced by: K.A.R. 26-41-205 (d) The facility reported a census of 64 residents. The sample included 10 "Residents'" (R)'s and 1 closed record review. Based on interview and record review the Administrator failed to ensure the medications managed by the facility were managed for each resident according to professional standards of practice and manufacturer's recommendations for R5 when a medication to treat Schizophrenia and depression were suddenly stopped. Findings included: - Record review for R5 revealed an admission date of 02/27/25 with diagnoses of major neuro cognitive disorder, Schizophrenia, and hypertension.	S3200		

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S3200	Continued From page 22 Record review of R5's "Functional Capacity Screen" (FCS) dated 03/05/25 revealed R5 required supervision with bathing, dressing, toileting, and eating. He was independent with transferring and mobility. R5 lacked the ability to manage his own medications and he was continent. R5 had impaired short-term memory, impaired long-term memory, impaired memory/recall, and impaired decision making. R5 was sometimes able to make himself understood and he usually understood others. R5 was identified as have socially inappropriate behaviors. Record review of R5's unsigned combined "Negotiated Service Agreement (NSA)/ "Health Service Plan (HSP)" instructed facility "Certified Medication Aide" (CMA) or "Licensed Nurse" to administer all medications and to mange and perform all task related to related to ordered treatments. Review of the facility provided electronic "Progress Notes" for R5 revealed the following entries: On 04/02/25 at 09:59 AM R5 was involved in a resident to resident altercation, where R5 pushed another resident because the other resident was walking too close to R5 while he was eating. On 04/02/24 at 05:25 PM R5 was being monitored hourly for inappropriate behaviors. On 04/03/24 (no time indicated) R5 was noted to have been increasingly agitated and difficult to redirect.	S3200		

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S3200	Continued From page 23 On 04/03/25 at 02:35 PM R5 was noted to continue to have inappropriate behaviors of yelling at the other residents and not able to calm the resident down. At 01:30 PM resident went into the facility common area and became aggressive. An ambulance was called and R5 went to the local hospital for evaluation and treatment. On 04/18/24 at 02:37 PM R5 readmitted to the facility after a fifteen day stay in a behavioral health unit. Record review of the facility provided printed electronic "Medication Administration Record" dated 03/2025 for R5 revealed the following medications were administered: Aripiprazole (antipsychotic) 20 mg on 03/19/2025 to 03/26/25 Aripiprazole 5 mg on 03/19/2025 to 03/26/25 Sertraline (antidepressaant) 50 mg last dose on 03/27/27 Review of the facility provided report titled "Resident Medications" for R5 revealed the following; Aripiprazole Tab 20 "milligrams" 1 daily started on 03/19/25 and stopped on 03/27/24. Aripiprazole Tab 5mg 1 daily started on 03/19/24 and stopped on 03/27/24. Sertraline tab 50 mg 1 tab started on 03/01/25 and stopped on 03/28/25. Review of R5's medical record revealed the following document titled "New Prescription Summary" Dated 02/26/25 for Sertraline 50mg. 1 tablet by	S3200		

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S3200	Continued From page 24 mouth daily for 4 weeks. Review of R5's medical record revealed the following document titled "New Prescription Summary" Dated 02/26/25 for Aripiprazole 20 mg. 1 tablet by mouth daily for 4 weeks. Take with 5mg for total of 25mg. Review of R5's medical record revealed the following document titled "New Prescription Summary" Dated 02/26/25 for Aripiprazole 5 mg. 1 tablet by mouth daily for 4 weeks. Record review of R5's medical record revealed a document titled "Encounter Summary - Progress Note" dated 03/19/25 and was signed by APRN S; she documented R5 was reported to be adjusting well to the facility and maintaining a good sleep routine. Under the section titled "Assessment and Plan" she documented to continue Aripiprazole 25 mg as ordered and Zoloft (Sertraline) 50 mg daily as ordered. Interview 05/07/25 with Regional Clinical Services Director C confirmed the Sertraline 50 mg and Aripiprazole 25 milligrams were discontinued and the facility Licensed nurses did not call for clarification for the order at the time of admission to stop the two medications in 4 weeks. Review of the manufacturers recommendation for Antidepressant Sertraline revealed the following: This drug is used to treat depression, obsessive compulsive disorder, social anxiety disorder and mood swings. If Sertraline is suddenly stopped	S3200		

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S3200	Continued From page 25 the patient could experience mood changes, frenzied or abnormally excited mood, irritability, or confusion. (medlineplus.gov) Review of the manufacturers recommendation for Aripiprazole a medication used to treat Schizophrenia. If Aripiprazole is suddenly stopped it can cause anxiety, restlessness, mood swings, irritability, aggressive behavior, and agitation. (drugs.com) Interview on 05/07/25 at approximately 06:13 PM with Administrator A, Director of Nursing B, Regional Clinical Director C, and Licensed Nurse D confirmed the facility nurses failed to follow up for clarification of R5's orders for Aripiprazole a medication to treat Schizophrenia, and Sertraline an anti-depressant, upon admission when the orders read for 4 only weeks. The Administrator failed to ensure the medications managed by the facility were managed for each resident according to professional standards of practice and manufacturer's recommendations for R5 when a medication to treat Schizophrenia and depression were suddenly stopped.	S3200		