STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087071	A. BUILDING: _____ B. WING _____	08/21/2025

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 the licensure resurvey with attached complaint numbers 196784, 196654, 196588, 196586, and 194499, for the above named facility conducted on 08/18/25, 08/19/25, 08/20/25, and 08/21/25.	S 000		
S3026 SS=L	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: K.A.R. 26-41-101 (f)(1) (B) The facility reported a census of 61 residents. The sample included 6 "Residents" (R)'s and 2 closed record reviews. Based on observation, interview, and record review the Administrator failed to protect R1 from neglect when R1 left the facility through the unlocked activities room interior door and exited through the malfunctioning exterior to the secured gated activities courtyard without staff knowledge. This placed R1 in immediate jeopardy for approximately three hours until facility staff found him in the secured back gated area. The	S3026		

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

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Administrator further failed to protect R2 from neglect when a "Certified Nurse Aide" (CNA) left R2 in bed all day and neglected to provide care to R2; R3 from neglect when staff watched her try to self-transfer and failed to assist R3 resulting in R3 falling and receiving a bruise to the left side of her back; and R4 from neglect when staff failed to redirect her from the facility kitchen and R4 walked out the exit door to the gated and secured parking lot without staff knowledge.

Findings included:

- Record review for R1 revealed an admission date of 02/11/25 with diagnoses of unspecified dementia, atrial fibrillation, congestive heart failure, anemia, type two diabetes, heart failure, anxiety, and psychophysiologic insomnia.

Review of R1's "Functional Capacity Screen" (FCS) dated 02/13/25 revealed R1 required supervision with bathing, dressing, walking, and transferring. R1 was independent with toileting. R1 lacked the ability to manage his own medications and medical treatments. R1 was continent and had impaired short-term memory, long-term memory, memory/recall, and impaired decision making. R1 was able to make himself understood and he understood others. R1 was identified at risk for wandering and used no mobility device.

Review of R1's combined "Negotiated Service Agreement" (NSA)/"Health Service Plan" (HSP) identified the facility staff would offer reminders and assistance to events and meals, ensure R1

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was dressed in proper fitting clothing, supervision with showering, and assist R1 in reminding him to take his room key with him when leaving his room. R1 was able to self-transfer. R1 was known to become "unsteady" when he had not slept "for a while" as he had insomnia. R1 was able to ambulate independently and would become "unsteady" if he was not sleeping at night and would become a high fall risk. R1 did wander around the front commons area, and he did "not exit seek" and was "easily redirected".

Review of the facility provided document titled "Elopement Risk" revealed R1 scored 13 points. "A score of 10 or higher = At Risk". The document revealed three different occasions while at home R1 had gotten lost and had a silver alert sent out for police to "Help find him". The document identified the following elopement protocols for R1: Place on elopement risk list, apply appropriate system to prevent elopement, and "Resident agrees not to leave facility without staff or family member."

Record review of R1's electronic "Medical Record" under the section titled "Progress Notes" revealed the following nursing entries:
On 02/12/25 at 02:38 PM R1 was experiencing some anxiety and restlessness. R1 was observed pacing the halls with a bag of personal items and R1 was "easily redirected".

On 02/13/25 at 07:01 AM R1 had been awake "most of the night" and was restless, anxious and pacing the hallway.

On 02/13/25 at 02:52 PM R1 was redirected and

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"put belongings away" every shift. R1 was upset that his brother was not there and R1 had not "slept much".

On 02/14/25 at 02:45 AM R1 remained awake, stripped the linens off of his bed, and was difficult to redirect. An order for Lorazepam 0.5 milligrams was administered for increased anxiety.

On 02/14/25 at 01:41 PM resident seen via Telehealth by the "Advanced Practice Registered Nurse" (APRN) with new orders for Lorazepam scheduled, PRN Lorazepam, and in increase to R1's Seroquel at night.

On 02/14/25 at 04:02 PM R1 believed he was in a hotel and asked repeatedly where he could check out so he could leave. R1 was "visibly exhausted". R1 wandered the halls "all day".

On 02/16/24 at 03:13 AM R1 had increased exit seeking, pacing and agitation noted. R1 was looking for his car key, elevator, and jacket.

On 02/19/25 at 04:57 AM "02:30 AM R1 had increased anxiety, he was exit seeking, pacing halls, looking for keys and a trying to find a way home. R1 was awake and had not slept. He broke glass out of two 5inch x 7 inch picture frames, and he would yell out periodically. Lorazepam 0.5 milligrams was administered. R2 "relief" as evidenced by decreased anxiety.

On 02/19/25 at 01:12 PM R1 was seen by the APRN.

On 03/14/25 at 05:09 PM R1was documented as

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S3026	Continued From page 4 having hallucinations of a "woman in the corner". Staff reported that R1 was yelling at an "empty wall". On 03/31/25 at 03:38 AM the nurse documented that at 11:00 PM the resident had an incident of an "Elopement". At approximately 10:40 PM the CNA asked the nurse if R1 was out of the facility with family as the CNA reported that she last saw R1 at approximately 03:45 PM. The nurse checked R1's record and the record lacked a note of the family taking R1 out of the facility, and the nurse has staff start looking for R1. The nurse continued to document that the CNA unlocked the back activity room "French doors" and opened the "exit door without alarm or light flashing", R1 was located within the gated area. R1 was wearing a long-sleeved shirt, long pants and shoes. R1's body temperature was documented at 96.1. The documentation lacked Fahrenheit or Celsius . Review of the facility provided investigation revealed the weather was "54 degrees and clear", R1 was cool to the touch and was offered a blanket "as he was cold".The CNA stated the exit door did not alarm when she went out the door to let R1 in the facility. "Upon further investigation the alarm was noted to not be working". Review of the facility provided signed and unnotarized document titled "Witness Statement" revealed CNA C arrived on shift at approximately 07:30 PM and she did not see R1 in the television room or the dining room at that time.	S3026		

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S3026	Continued From page 5 Review of the facility provided signed and unnotarized document titled "Witness Statement" revealed Facility Staff D observed R1 by one of the emergency exits at approximately 08:00 PM, and did not "notice him after that time". Observation on 08/08/25 at approximately 09:45 AM of the activities room exit door to the secured gated area revealed the door was alarmed and the gate to the courtyard area was secured. Interview on 08/19/25 with Maintence Staff E revealed when the elopement happened on 03/30/25 he came into fix the exterior door that led to the gated courtyard area outside of the activities room. He continued to state when he was finished fixing the door it showed it was alarmed. He stated that they called a professional company to come out and look at the door, the company referred the facility to a third company who on 05/25/25 replaced the circuit board on the activity room exit door push bar. Maintence Staff E provided documentation dated prior to the 03/30/25 date of elopement, of weekly door checks on the door showing the door was alarmed. Review of the facility provided document "Discharged Residents" revealed R1 passed away at the facility on 08/16/25. On 08/19/25 at approximately 04:15 Administrator B was notified that R1 who had been experiencing an increase in wandering and exit seeking behavior exited the facility's activity room exterior door without staff knowledge in 54-degree (Fahrenheit) weather and had not been observed by staff for approximately 3	S3026		

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S3026	Continued From page 6 hours. The facility implemented the following actions prior to the surveyor's arrival and submitted their removal plan on 08/19/25. On 03/30/25 R1 was added to hourly rounding and daily charting. On 03/30/25 Maintence came into fix the activities room exterior door. On 05/25/25 a professional door company came in and replaced the circuit board on the activity room exit door push bar. Facility staff initiated a door check to ensure the interior activities room door was locked prior to leaving their shift. Lock to the interior activity room door was changed so only management and activities staff had keys to the door. May 2025 weekly elopement drills conducted four times on all shifts in May 2025. Daily door checks added to maintenance rounds . - Record review for R2 revealed an admission date of 03/11/20 with diagnoses of cognitive communication deficit, acute kidney failure, anemia, hypertension, difficulty in walking, unspecified symptoms and signs involving cognitive functions and awareness, need for assistance with personal care, history of falling, unspecified dementia, and other cardiac arrhythmias.	S3026		

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S3026	Continued From page 7 Review of R2's FCS dated 07/01/25 revealed R2 required physical assistance with bathing, dressing, toileting, transferring, walking, and eating. R2 lacked the ability to manage her own medications and medical treatments. R2 was incontinent and had impaired short-term memory, long-term memory, memory/recall and impaired decision making. R2 could rarely make herself understood and she sometimes understood others. R2 was identified to be at risk for impaired vision and impaired decision making. R2 used a walker and wheelchair mobility device. Review of R2's combined NSA/HSP instructed facility staff to provide a one-person physical assistance for R2 with showering, dressing, transferring, and physical assistance with meals. Facility staff were to provide one-person physical assistance with toileting every two hours and assist with incontinence care and products. Review of R2's electronic "Medical Record" under the section titled "Progress Notes" revealed the notes lacked documentation of facility staff reporting to the nurse an occasion where R2 refused cares and was left in bed the full day. Review of the facility provided outside provider notes from an outside provider for hospice services revealed an entry on 08/03/25 and signed by the "Skilled Nurse" which read that R2 had been left in bed all day and was "soaked" in urine when the nurse arrived. The Skilled Nurse wrote that she assisted the "Aide" in "cleaning her up" and she spoke to facility "Director of	S3026		

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Nursing" A. The outside provider note lacked a time of the entry.

Interview with Administrator B on 08/19/25 at approximately 11:18 AM confirmed the hospice nurse and the facility CNA assisted in getting R2 "cleaned up". Administrator A confirmed she interviewed CNA F who was assigned to R2 on the day of the allegation and that CNA F confirmed R2 refused all cares during her shift and CNA F continued to confirm CNA F did not report R2's refusal of cares to the nurse on shift. Administrator A further confirmed that CNA F gave her notice of termination to the facility and she did not work after her interview with Administrator A , CNA F's official termination date was 08/14/25.

Interview with R2 on 08/19/25 at approximately 02:08 PM in the common room revealed she was awake and answered simple yes and no questions sometimes appropriately. CNA G confirmed that R2 had been out of bed since 10:00 AM that morning.

The Administrator failed to protect R2 from neglect when staff left her in bed all day not providing care and failed to report to the shift nurse of R2's refusals of care.

- Record review for R3 revealed an admission date of 03/23/23 with diagnoses of unspecified dementia, mild cognitive impairment of uncertain or unknown etiology, hypertension, other symptoms and signs involving cognitive functions and awareness, and pain.

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S3026	Continued From page 9 Review of R3's FCS dated 07/20/25 revealed R3 required physical assistance with bathing, dressing, toileting, and transferring. R3 required supervision with walking/mobility and eating. R3 lacked the ability to manage her own medications and medical treatments. R3 was incontinent and had impaired short-term memory, long-term memory, memory/recall and impaired decision making. R3 could sometimes make herself understood and she sometimes understood others. R3 was identified to have poor vision and used a wheelchair mobility device. R3's FCS lacked documentation of R3 being identified at risk for falls. Review of R3's combined NSA/HSP instructed facility staff to provide one person assist with bathing, dressing and toileting. Staff were instructed to provide one to two staff members for transferring. Under the section titled "Falls/Unsteadiness" Staff were to provide one to two person transfer assistance with all transfers and to educate R3 to utilize the call light system when in need of assistance of transferring. Review of R3's electronic "Medical Record" in the section titled "Progress Notes" revealed the following entries; On 06/15/25 at 08:35 PM an "Incident" note revealed R3 had an unwitnessed fall with bruising to her left back. On 06/17/25 at 01:30 AM revealed R3 continued to be monitored post fall. R3 continued to "be in need of" one staff assist and wheelchair for mobility.	S3026		

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S3026	Continued From page 10 On 07/20/25 at 01:36 PM R3's "Durable Power of Attorney" (DPOA) was contacted regarding changes in R3's needs and level of cares. On 07/27/25 at 11:22 PM a late entry revealed R3's current cares and fall interventions were reviewed with R3's DPOA and there were no concerns. On 08/14/25 at 10:44 PM the note revealed that at 08:55 PM a CNA reported that the CNA was sitting in the television room observing everyone when R3 tried to go from wheelchair to recliner, "thinking nothing of it" the CNA reported she let R3 continue to try and self-transfer. The CNA reported she turned to another resident for "30 seconds" and she turned back and R3 was "on the floor lying on her right hip". The note continued that the nurse responded to R3's fall and R3 was having left hip pain. The nurse called 911 and R3 was assessed by the responding emergency crew and assisted to the recliner. Interview on 08/19/25 at approximately 02:55 PM with Administrator A confirmed R3's FCS did not identify her at risk for falls, and she further confirmed the documentation in R3's nurse notes showed the facility staff failed to assist R3 when she was observed trying to transfer herself from the wheelchair to the recliner. The Administrator failed to protect R3 from neglect when the facility staff failed to follow R3's NSA and provide a one person assist for transfers. The facility staff reported they observed R3 trying to self-transfer, resulting in	S3026		

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S3026	Continued From page 11 R3 falling and required emergency medical personnel to perform an assessment. - Record review for R4 revealed an admission date of 09/06/23 with diagnoses of Alzheimer's disease, hypertension, type two diabetes mellitus, history of falling, glaucoma, and depression. Review of R4's FCS dated 11/26/24 revealed R4 required physical assistance with bathing and toileting. R4 required supervision with dressing, and she was independent with transferring, walking/mobility, and she was continent. R4 lacked the ability to manage her own medications/medical treatments, and had impaired short-term memory, long-term memory, memory/recall and impaired decision making. Review of R4's most recent combined NSA/HSP dated 09/26/23 revealed R4 required one-person physical assistance with bathing and toileting. R4's record lacked an NSA being reviewed and if necessary, revised every 365 days, or with significant change of condition. 07/24/25 "Progress Note" by the nurse revealed "It was reported to this nurse that resident attempted to elope on 07/22/25. Resident reportedly followed beautician into kitchen and wandered out the back door of the kitchen. Staff has been instructed to keep kitchen door closed at all times. Review of the facility provided signed and unnotarized document titled "Witness Statement"	S3026		

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S3026	Continued From page 12 revealed Dietary Director H at approximately 05:30 PM on 07/22/25 observed the beautician come into the kitchen with R4 following her. Dietary Director H wrote that he went into the walk-in refrigerator and retrieved something and when he exited the refrigerator, he did not see R4, but saw the beautician in the dining room. Dietary Director H continued to write that a few minutes later Dietary Staff I went out the back door of the kitchen and noticed R4 was outside. Dietary Director H and Dietary Staff I assisted R4 back into the facility. Review of the facility provided signed and unnotarized document titled "Witness Statement" revealed Beautician J wrote that she went into the facility kitchen between 04:45 PM and 05:15 PM to sign in for a meal. Beautician J wrote that R4 followed her into the kitchen and two "aides" asked R4 to leave, and Beautician J thought R4 left the kitchen with the "aides". Record review of the facility provided documents for 2025 titled "In-Service Agenda" revealed on 03/24/(the year was not indicated) there was to be a facility wide carnival. At the bottom of the page was handwritten "no residents in kitchen". The Administrator failed to protect R4 from neglect when she was observed in the kitchen area of the facility and the facility staff failed to ensure her safe return to the facility dining room prior to her exiting out the back door.	S3026		
S3082 SS=D	26-41-201 (d) Functional Capacity Screen Accurate d) Designated facility staff shall ensure that each	S3082		

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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 61 residents. The sample included 6 "Residents'" (R)'s and 2 closed record reviews. Based on record review and interview the Administrator failed to ensure R3's functional capacity at the time of the screening was accurately reflected on R3's screening form.

Findings included:

- Record review for R3 revealed an admission date of 03/23/23 with diagnoses of unspecified dementia, mild cognitive impairment of uncertain or unknown etiology, hypertension, other symptoms and signs involving cognitive functions and awareness, and pain.

Review of R3's FCS dated 07/20/25 revealed R3 required physical assistance with bathing, dressing, toileting, and transferring. R3 required supervision with walking/mobility and eating. R3 lacked the ability to manage her own medications and medical treatments. R3 was incontinent and had impaired short-term memory, long-term memory, memory/recall and impaired decision making. R3 could sometimes make herself understood and she sometimes understood others. R3 was identified to have poor vision and

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	N087071	A. BUILDING: _____ B. WING _____	08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHISHOLM PLACE	1859 N. WEBB ROAD WICHITA, KS 67206

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S3082	Continued From page 14 used a wheelchair mobility device. R3's FCS lacked documentation of R3 being identified at risk for falls. Review of R3's combined NSA/HSP dated 08/13/25 instructed facility staff to provide one person assist with bathing, dressing and toileting. Staff were instructed to provide one to two staff members for transferring. Under the section titled "Falls/Unsteadiness" Staff were to provide one to two person transfer assistance with all transfers and to educate R3 to utilize the call light system when in need of assistance of transferring. Review of R3's electronic "Medical Record" in the section titled "Progress Notes" revealed the following entries; On 06/15/25 at 08:35 PM an "Incident" note revealed R3 had an unwitnessed fall with bruising to her left back. On 06/17/25 at 01:30 AM a Nurse note revealed R3 continued to be monitored post fall. R3 continued to "be in need of" one staff assist and wheelchair for mobility. On 07/20/25 at 01:36 PM R3's "Durable Power of Attorney" (DPOA) was contacted regarding changes in R3's needs and level of cares. Interview on 08/19/25 at approximately 02:55 PM R3's FCS lacked documentation of her being at risk for falls.	S3082		

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S3228	Continued From page 15	S3228		
S3228 SS=F	26-41-205 (l) (3) Medication Regimen Review Record (l) (3) The administrator or operator, or the designee, shall ensure that the medication regimen review is kept in each resident ' s clinical record. This REQUIREMENT is not met as evidenced by: K.A.R. 26-41-205 (l) (3) The facility reported a census of 61 residents. The sample included 6 "Residents'" (R)'s and 2 closed record reviews. Based on record review and interview the Administrator failed to ensure the quarterly medication regimen review performed by a pharmacist was kept in each resident's clinical record for all residents. Findings included: - Record review of the facility provided resident roster revealed the facility managed the medications for all residents. On 08/19/25 at approximately 04:30 the request was made to Administrator B and "Director of Nursing" (DON) A for the quarterly pharmacy reviews for R1, R2, R3, R4, R5, and R6. Interview on 08/21/25 at approximately 02:15 PM with Administrator B confirmed that the facility had a change in the DON Position. The prior DON terminated on 05/23/25 and the new DON	S3228		

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S3228	Continued From page 16 started on 05/23/25. Administrator B stated that the Prior DON "wiped his computer". She stated after talking to the pharmacy provider, they confirmed all quarterly pharmacy reviews were sent by electronic mail to the prior DON. Administrator B continued to confirm they could not provide the requested pharmacy reviews at the time of the survey. The Administrator failed to ensure the quarterly medication regimen review performed by a pharmacist was kept in each resident's clinical record for all residents.	S3228		
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. This REQUIREMENT is not met as evidenced	S3280		

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S3280	Continued From page 17 by: K.A.R. 26-41-104 (d) (3) The facility reported a census of 61 residents. The sample included 6 "Residents'" (R)'s and 2 closed record reviews. Based on record review and interview the Administrator failed to ensure the quarterly review of the facility's emergency management plan with all residents. Findings included: - Record review of the facility provided "Resident Council" meeting notes dated 09/24 to 07/25 revealed the notes lacked documentation of the review of the facility's emergency management plan with all residents. Interview on 08/21/25 at approximately 02:15 PM with Administrator B confirmed the resident quarterly emergency preparedness training was to take place during the resident council meetings. Administrator A further confirmed that activities staff was newly hired and they were unaware this training had to be performed at least quarterly with all residents. The Administrator failed to ensure the quarterly review of the facility's emergency management plan with all residents.	S3280		
S3299 SS=F	26-41-206 (e) (1) Facility Food Storage (e) Food storage. Facility staff shall store all food under safe and sanitary conditions. (1) Containers of poisonous compounds and cleaning supplies shall not be stored in the areas used for food storage, preparation, or serving.	S3299		

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S3299	Continued From page 18	S3299		

This REQUIREMENT is not met as evidenced by:
K.A.R. 26-41-206 (e) (1)

The facility reported a census of 61 residents. Based on observation and interview the Administrator failed to ensure the facility staff stored all food under safe and sanitary conditions and all cleaning supplies shall not be stored in the areas used for food storage.

Findings included:

- Observation on 08/19/25 at approximately 10:05 AM of the kitchens dry food storage area revealed two dead black bugs and a large sticky spot on the floor under the cart in the northeast corner of the storage area, and small pieces of trash on the floor center of the floor. Hanging on the southwest cart that held nonperishable food items next to the door of the storage area hung a white spray bottle that contained a green liquid. On the bottle it was handwritten "Kitchen", the bottle lacked identification of the liquid contents of the bottle.

Interview on 08/18/24 at approximately 10:15 AM with Administrator B confirmed there should be no chemicals in the dry food storage area.

The Administrator failed to ensure the facility staff stored all food under safe and sanitary conditions and all cleaning supplies shall not be

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S3299	Continued From page 19 stored in the areas used for food storage.	S3299		