STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087089	A. BUILDING: _____ B. WING _____	12/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE RUSHWOOD SENIOR COMMUNITY	2121 N 143RD STREET E WICHITA, KS 67230

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S 000	INITIAL COMMENTS The following citations represent the findings of a Re-Licensure survey with complaint investigations 192772, 192770, 193248, 193819, 196606, 196712, 197218, 197371 for the above named Assisted Living facility conducted on 12/03/25, 12/04/25, and 12/08/25.	S 000		
S3026 SS=E	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)(B) The facility reported a census of 59 residents (R), with 15 of those residents residing in the memory care secured area. The sample included three residents and six focused record reviews. Based on interview, and record review, the executive director failed to protect R4, R6, and R7 who lived on the memory care unit and failed to protect R8 from direct care staff calling residents names and using menacing/threatening tone when providing care for R4, R6, R7, and R8.	S3026		

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

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S3026	Continued From page 1 Findings included: - Review of R4's record revealed she moved into the facility with a diagnosis of dementia. Interview on 12/03/25 at 2:50 PM Administrative Nurse B reported they used a screening tool that included the "Functional Capacity Screen" and the "Negotiated Service Agreement" all in one document, titled the "CBA: Comprehensive Resident Evaluation" (CBA). R4's CBA identified she needed physical assistance with bathing and dressing and was unable to participate in toileting. She also had impaired cognition and impaired communication. The CBA directed staff to assist with toileting including peri-care and to assist with dressing and bathing. R4's care plan dated 07/25/25 directed staff to speak softly and provide reassurance and offer redirection and identified the resident would live in an environment without fear or abuse. Review of Dietary witness statement dated 07/30/25 Dietary staff C walked to the memory care to provide dinner and heard Certified Nurse Aide (CNA) G yelling saying "What are you doing ... Stop that ... You [expletive]". Dietary staff went directly to Administrative staff I and explained the situation. Review of witness statement dated 07/31/25 Administrative staff I and Administrative staff L went to the memory care unit to discuss situation with CNA G, and she became defensive, wrote derogatory messages on the facility group chat	S3026		

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and walked out of the wellness station cussing and slammed the door in front of residents in the dining room. When asked to provide a statement of what happened she started yelling, cursing and walked out of the facility.

According to the report dated 07/30/25, CNA G was immediately asked to leave the facility, put on suspension and then terminated from employment.

Interview on 12/04/25 at 11:45 AM Administrative staff A reported this incident occurred before he was at the facility but confirmed the way CNA G spoke to R4 is not appropriate and not to be tolerated.

The executive director failed to protect R4 when CNA G yelled and called R4 [expletive] yelling at the resident using a threatening tone.

- Review of R6's record revealed she moved into the facility on 06/13/25 with a diagnosis of dementia.

Interview on 12/03/25 at 2:50 PM Administrative Nurse B reported they used a screening tool that included the "Functional Capacity Screen" and the "Negotiated Service Agreement" all in one document, titled the "CBA: Comprehensive Resident Evaluation" (CBA).

R6's CBA dated 06/13/25 identified she was unable to participate in toileting, had occasional bladder incontinence, and had significant impaired cognition. It identified staff were to provide her complete toileting and continence assistance. It also identified R6 could be

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aggressive at times and staff needed to speak to her softly and provide reassurance and offer redirection as needed.

Review of Certified Nurse Aide (CNA) M's witness statement dated 10/15/25 revealed at an unknown time Certified Medication Aide (CMA CMA) H had escorted R6 back to her room and CNA M stepped into the room when CMA H appeared to push R6 toward the bed and force her back to bed. The resident appeared very distressed and held onto CNA M stating there was a man trying to harm her and kill her. R6 refused to go to bed until approximately 04:00 AM.

Review of the facility report dated 10/15/25 revealed CNA M reported what she saw to Administrative Staff N at approximately 08:30 AM who then reported it to Administrative Staff A. CMA H was immediately suspended pending investigation and has since been terminated from employment.

Interview on 12/04/25 at 11:45 AM Administrative staff A confirmed CMA H was terminated for how she treated R6.

The executive director failed to protect R when CMA H pushed her toward her bed forcing her to get into bed causing distress to the resident thinking a man was in the room trying to hurt her.

- Review of R7's record revealed she moved into the facility on 09/02/25 with diagnosis of moderate dementia.

Interview on 12/03/25 at 02:50 PM Administrative

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S3026	Continued From page 4 Nurse B reported they used a screening tool that included the "Functional Capacity Screen" and the "Negotiated Service Agreement" all in one document, titled the "CBA: Comprehensive Resident Evaluation" (CBA) R7s CBA identified she needed physical assistance with bathing and was unable to participate in dressing or toileting and had impaired cognition. It identified staff would provide assistance with activities of daily living and provide repeated verbal prompts and reminders throughout the day as need. Review of Certified Nurse Aide (CNA) M's witness statement dated 10/15/25 revealed at approximately 06:00 am during rounds she overheard Certified Medication Aide (CMA) H speaking to R7 in a raised and aggressive tone and heard her say "this is why I hate you', "I hate you" and then called R7 a "bitch". Review of the facility report dated 10/15/25 revealed CNA M reported what she had overheard to Administrative Staff N at approximately 08:30 AM who then reported it to Administrative Staff A. CMA H was immediately suspended pending investigation and has since been terminated from employment. Interview on 12/04/25 at 11:45 AM Administrative staff A confirmed CMA H was terminated for how she spoke and acted toward R7. The executive director failed to protect R7 when CNA H raised her voice in an aggressive tone and said she hated R7 and called her a "bitch".	S3026		

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- R8's medical record revealed she moved into the facility on 03/21/25 with diagnosis of diabetes mellitus type II.

Interview on 12/03/25 at 2:50 PM Administrative Nurse B reported they used a screening tool that included the "Functional Capacity Screen" and the "Negotiated Service Agreement" all in one document, titled the "CBA: Comprehensive Resident Evaluation" (CBA).

R8's CBA revealed she was unable to participate in her Activities of daily living, used a wheelchair for mobility and was at risk for falls. It also identified R8 had no cognitive impairment The CBA directed staff to provide complete assistance to R8 with her activities of daily living.

Observation/Interview on 12/8/25 at 1:13 PM R8 invited surveyor into her room. She sat in her wheelchair, had splint on left hand, braces on both feet. She reported staff treat her with respect and dignity, but in he past there were two staff who were very argumentative and mean to me. R8 said it was all caught on my camera. (Resident has electronic monitoring in her room by her/family request). R8 reported administrative staff A suspended them right away and took care of it.

Interview on 12/08/25 at 01:45 PM Certified Nurse Aide (CNA) O reported staff have to help her a lot with everything. She has one arm that she cannot use at all and basically that whole left side she can't use, and both of her feet do not work well and wears braces. She is a two-person transfer, sometimes she can help with some cares but other times we must do

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S3026	Continued From page 6 everything, it just depends on her day. Surveyor had requested a list of all employees terminated related to abuse and neglect and a list of allegations of resident abuse, (physical, verbal, exploitation) including staff being rude/mean to residents. On 12/03/25 Administrative staff A provided a list of employes with their hire date and termination date related to abuse. Review of the video provided by family included the following: On 11/01/25 at 06:01 PM as CNA P and CNA Q were assisting R8 CNA P raised her voice, pointing at the R8 and saying that she is going to start refusing to take care of her and said the resident is doing a lot of lying and she is sick of it. As CNA P pushed resident into the bathroom via wheelchair, she continued to talk down to the resident saying she is playing games and need to stop. During care CNA P said she was going to quit coming in her room to care for her because she was done, and R8 said maybe that is for the best. CNA Q then proceeded to help R8 sit on the toilet. Both staff left the room at 06:06 PM and returned at 06:39, 33 minutes later, and R8 mentioned she did not think the staff were very timely getting her taken care off. Both CNA P and CNA q proceeded to let R8 know that she is not the only resident in the facility and there are people who have been waiting 30 and 40 minutes for them to answer their lights. The conversation got a little more aggressive when R8 said she felt like the staff cater to some of the other residents and maybe they are getting paid to take better care of them.	S3026		

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S3026	Continued From page 7 Both CNA P and CNA Q told R8 that is not happening and told R8 if she didn't like her care, she needed to talk to someone else about it. This argumentative and condescending talk continued while CNA P tried to take off R8's pants because they were wet, however R8 didn't want her boots (shoes with braces) taken off because she couldn't stand without them on. CNA P tried to explain she needed to take off the boots to get her pants of and R8 kept saying she couldn't stand without them and then CNA P proceeded to tell R8 to just stop it, she has had it up to here (raised her hand to her head) and she is going to get someone else, again telling R8 she has to stop it that this was her last warning and told R8 to hush. As CNA P and R8 continued to argue CNA P ended up putting R8's boot back on and left her sitting in the wheelchair with wet pants on stating she was going to walk away because she had that right, and left the room. On 12/04/25 at approximately 10:50 AM Administrative staff A reported R8's family brought in a video on 11/02/25 that showed how Certified Nurse Aides (CNA) P and CNA Q talked to and treated R8 and were very upset. Administrative Staff A reported he knew nothing of the events until family brought in the video and both staff were immediately terminated. He confirmed the way CNA P and CNA Q treated R8 is not appropriate and would not be tolerated. The executive failed to protect R8 from CNA P and CNA Q when they began to argue with her, made accusatory statements, belittling her, pointing fingers at her, telling her to hush, and telling her they were going to refuse to care for her and not come into her room anymore.	S3026		

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S3080 SS=F	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: K.A.R.26-41-201(a) The facility reported a census of 59 residents (R). The sample included three residents and 6 focused record reviews. Based on record review and interview for 3 (R5, R8, R9) of 3 sampled residents, and all other residents in the facility, the operator failed to ensure each resident's Functional Capacity Screen included each element and definition specified by the department. Findings included: - Interview on 12/03/25 at 2:50 PM Administrative Nurse B reported they use a	S3080		

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S3080	Continued From page 9 screening tool that included the "Functional Capacity Screen" and the "Negotiated Service Agreement" all in one document, the "CBA: Comprehensive Resident Evaluation" (CBA). - Review of R5's medical record revealed she moved into the facility on 12/06/24 with a diagnosis of dementia. Review of R5's CBA dated 01/31/25 included a section H titled "Resident Functional Capacity Screen". This section failed to include the "Medication" section as specified by the department, which includes all medication the resident is taking at the time of the screening. - Review of R8's medical record revealed she moved intot he facility on 03/21/25 with diagnosis of diabetes type II. Review of R8's CBA dated 01/31/25 included a section H titled "Resident Functional Capacity Screen". This section failed to include the "Medication" section as specified by the department, which includes all medication the resident is taking at the time of the screening - Review of R9's medical record revealed he moved into the facility with diagnoses of diabetes mellitus type II and heart failure. Review of R9's CBA dated 01/31/25 included a section H titled "Resident Functional Capacity Screen". This section failed to include the "Medication" section as specified by the department, which includes all medication the resident is taking at the time of the screening.	S3080		

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S3080	Continued From page 10 Interview on 10/04/25 at 09:40 AM Administrative Nurse B reviewed the CBA and section H titled "Resident Functional Capacity Screen" and confirmed it did not include a section for "Medications". She also confirmed the same CBA assessment tool is used for all residents int he facility. Review of the Functional Capacity Screen manual included under section VI - "Medications" to include all medications the resident is taking at the time of the screen. The executive director failed to ensure each residents "Functional Capacity Screen" section of the CBA contained the designated element and definition for medications according to the department.	S3080		
S3085 SS=E	26-41-202 (a) Negotiated Service Agreement (a) The administrator or operator of each assisted living facility or residential health care facility shall ensure the development of a written negotiated service agreement for each resident, based on the resident ' s functional capacity screening, service needs, and preferences, in collaboration with the resident or the resident ' s legal representative, the case manager, and, if agreed to by the resident or the resident ' s legal representative, the resident ' s family. The negotiated service agreement shall provide the following information: (1) A description of the services the resident will receive; (2) identification of the provider of each service; and (3) identification of each party responsible for	S3085		

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S3085	Continued From page 11 payment if outside resources provide a service. This REQUIREMENT is not met as evidenced by: KAR 26-41-202 (a)(1)(2)(3) The facility reported a census of 59 residents (R). The sample included threes residents and six focused record reviews. Based on record review and interview the executive director failed to ensure designated staff completed the "Negotiated Service Agreement" for three (R5, R8, R9) of three sampled residents based on the resident's "Functional Capacity Screen" and service needs, which included a description of the services the resident received, the provider of each service, and payment source if the service was provided by an outside resource. Findings included: - Review of R5s medical record revealed she moved into the facility on 12/06/24 with a diagnosis of Alzheimer's disease. Interview on 12/03/25 at 2:50 PM Administrative Nurse B reported they used a screening tool that included the "Functional Capacity Screen" and the "Negotiated Service Agreement" all in one document, titled the "CBA: Comprehensive Resident Evaluation" (CBA). R5's CBA identified she was independent with activities of daily living, was at risk for falls and had impaired cognition and decision-making ability. It failed to identify she received services	S3085		

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S3085	Continued From page 12 from a local company for podiatry. Review of R5's medical record included notes from a local company that provided in house podiatry services. Interview on 12/8/25 at 10:19 AM Administrative Nurse B confirmed the podiatry service was an outside resource that provided services in the facility. Administrative Nurse B reviewed R5's CBA and confirmed it did not include that she received podiatry services, who provided it and who paid for it. The executive director failed to ensure R5's NSA included a description of services related to podiatry, who provided the service and who was responsible for payment of the service. - R8's medical record revealed she moved into the facility on 03/21/25 with diagnosis of diabetes mellitus type II. Interview on 12/03/25 at 02:50 PM Administrative Nurse B reported they used a screening tool that included the "Functional Capacity Screen" and the "Negotiated Service Agreement" all in one document, titled the "CBA: Comprehensive Resident Evaluation" (CBA). R8's CBA revealed she was unable to participate in her Activities of daily living, used a wheelchair for mobility and was at risk for falls. It failed to identify R8 received services from a local company for podiatry and another company for physical therapy. R8's record include notes from a local podiatry	S3085		

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company for her podiatry visits.

Interview on 12/08/25 at 02:46 PM with local Home Health company revealed R8 started physical therapy on 10/10/25 and continues on services.

Interview on 12/08/25 at 03:04 PM Administrative Nurse B reviewed R8's CBA and confirmed it did not include services related to podiatry or her physical therapy.

The executive director failed to ensure R8's CBA included a description of services related to podiatry and physical therapy, who provided the service and who was responsible for payment of the service.

- Review of R9's record revealed he moved into the facility on 12/02/24 with a diagnosis of diabetes mellitus type II.

Interview on 12/03/25 at 02:50 PM Administrative Nurse B reported they used a screening tool that included the "Functional Capacity Screen" and the "Negotiated Service Agreement" all in one document, titled the "CBA: Comprehensive Resident Evaluation" (CBA).

R9's CBA identified he was independent with activities of daily living and was at risk for falls. It failed to identify he received services from a local podiatry company.

R9s record included notes from a local podiatry company for podiatry services.

Interview on 12/08/25 at 04:59 PM Administrative

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	N087089	A. BUILDING: _____ B. WING _____	12/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE RUSHWOOD SENIOR COMMUNITY	2121 N 143RD STREET E WICHITA, KS 67230

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S3085	Continued From page 14 Nurse B confirmed R9's CBA did not include the appropriate information regarding podiatry services. The executive director failed to ensure R9's CBA included a description of services related to podiatry, who provided the service and who was responsible for payment of the service.	S3085		
S3211 SS=E	26-41-205 (g) (3) OVER THE COUNTER DRUGS (3) A licensed nurse or medication aide may accept over-the-counter medication only in its original, unbroken manufacturer ' s package. A licensed pharmacist or licensed nurse shall place the full name of the resident on the package. If the original manufacturer ' s package of an over-the-counter medication contains a medication in a container, bottle, or tube that can be removed from the original package, the licensed pharmacist or a licensed nurse shall place the full name of the resident on both the original manufacturer ' s medication package and the medication container. This REQUIREMENT is not met as evidenced by: KAR 26-41-205 (g)(3) The facility reported a census of 59 residents(R). Based on observation and interview, the executive director failed to ensure a licensed nurse or pharmacist wrote the residents full name on all over-the-counter medications, including the original manufacturer's medication	S3211		

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S3211	Continued From page 15 package and the medication container/tube. Findings included: - Observation on 12/04/25 at 03:32 PM Administrative Nurse B unlocked medication cart (101-103) for inspection which revealed the following: a bottle of eye drops without a name, bottle of Vitamin D3, bottle of One-A-Day multivitamin, bottle of Vitamin B-12, and a bottle of Allergy Relief that either had no name or just the first name of a resident. Interview on 12/04/25 at 03:33 PM Administrative Nurse B did not realize the bottles needed to have a resident's "full" name on them. The executive director failed to ensure a licensed nurse or pharmacist wrote the residents full name on all over-the-counter medications, including the medication package and container.	S3211		
S3214 SS=D	26-41-205 (g) (4) Sample & Indigent Medication Program Meds (g) (4) Licensed nurses and medication aides may administer sample medications and medications from indigent medication programs if the administrator or operator ensures the development of policies and implementation of procedures for receiving and identifying sample medications and medications from indigent medication programs that include all of the following conditions: (A) The medication is not a controlled medication. (B) A medical care provider ' s written order accompanies the medication, stating the resident	S3214		

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S3214	Continued From page 16 ' s name; the medication name, strength, dosage, route, and frequency of administration; and any cautionary instructions regarding administration. (C) A licensed nurse or medication aide receives the medication in its original, unbroken manufacturer ' s package. (D) A licensed nurse documents receipt of the medication by entering the resident ' s name and the medication name, strength, and quantity into a log. (E) A licensed nurse places identification information on the medication or package containing the medication that includes the medical care provider ' s name; the resident ' s name; the medication name, strength, dosage, route, and frequency of administration; and any cautionary instructions as documented on the medical care provider ' s order. Facility staff consisting of either two licensed nurses or a licensed nurse and a medication aide shall verify that the information on the medication matches the information on the medical care provider ' s order. (F) A licensed nurse informs the resident or the resident ' s legal representative that the medication did not go through the usual process of labeling and initial review by a licensed pharmacist pursuant to K.S.A. 65-1642 and amendments thereto, which requires the identification of both adverse drug interactions or reactions and potential allergies. The resident ' s clinical record shall contain documentation that the resident or the resident ' s legal representative has received the information and accepted the risk of potential adverse consequences.	S3214		

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S3214	Continued From page 17 This REQUIREMENT is not met as evidenced by: KAR 26-41-205(g)(4)(D)(E)(F) The facility reported a census of 59 residents (R). The sample included three residents and 6 focused record reviews including one (R11) who received sample medications. Based on observation, interview and record review the operator failed to ensure 1 (R11) of 1 resident that received sample medications included the following: 1. License Nurse document receipt of medication with appropriate information into a log; 2. Licensed Nurse failed to included required information on each box and indicate verification of such information.; 3. A licensed nurse failed to inform the resident/family, medications were not received through a pharmacy and were not reviewed by a pharmacist. Findings included: - Interview on 12/03/25 at 02:50 PM Administrative Nurse B reported they use a screening tool that included the "Functional Capacity Screen" and the "Negotiated Service Agreement" all in one document, titled the "CBA: Comprehensive Resident Evaluation" (CBA). Review of R11's medical record revealed she moved into the facility on 04/11/25 with diagnoses of overactive bladder. R11's CBA dated 12/05/25 identified she was unable to manage her medications and had no cognitive impairment. It also identified staff managed her medication and administration of medications.	S3214		

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S3214	Continued From page 18 R11's record included a physicians order dated 10/06/25 for Gemtesa 75 milligrams daily. The record also indicated that family provided the medication on 11/17/25 for staff to administer. Observation on 12/03/25 at 03:08 PM Administrative Staff B unlocked medication cart (124-139) for inspection which included a sample bottle of Gemtesa (for overactive bladder) that was opened and an unopened box with a bottle in it. Neither the box or bottle had a resident name on it, physician name, directions for how to take it or cautionary instructions regarding administration. On 12/03/25 at 03:20 PM Certified Medication Aide (CMA) J confirmed the medications were samples that family brought in for her. CMA J reported she did not know if there was a list or log of when family brought in the medications. Interview on 03:32 PM Administrative Nurse B thought the family had just brought the medications in today. She confirmed staff had not completed a log with the appropriate information, and did not include orders on the medication package, or informed the resident/family the medication did not go through a pharmacy to identify potential interactions with other medications. The executive director failed to ensure the appropriate information regarding the administration of sample medications for R11 was written and explained to the resident or his/her legal representative, failed to include appropriate information on the medication box,	S3214		

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S3214	Continued From page 19 and failed to have the appropriate information regarding the acceptance of the medication in the facility.	S3214		
S3215 SS=D	26-41-205 (h) Medication Storage (h) Storage. Licensed nurses and medication aides shall ensure that all medications and biologicals are securely and properly stored in accordance with each manufacturer ' s recommendations or those of the pharmacy provider and with federal and state laws and regulations. (1) Licensed nurses or medication aides shall store non-controlled medications and biologicals managed by the facility in a locked medication room, cabinet, or medication cart. Licensed nurses and medication aides shall store controlled medications managed by the facility in separately locked compartments within a locked medication room, cabinet, or medication cart. Only licensed nurses and medication aides shall have access to the stored medications and biologicals. (2) Each resident managing and self-administering medication shall store medications in a place that is accessible only to the resident, licensed nurses, and medication aides. (3) Any resident who self-administers medication and is unable to provide proper storage as recommended by the manufacturer or pharmacy provider may request that the medication be stored by the facility. (4) A licensed nurse or medication aide shall not administer medication beyond the manufacturer ' s or pharmacy provider ' s recommended date of expiration.	S3215		

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S3215	Continued From page 20 This REQUIREMENT is not met as evidenced by: KAR 26-41-205(h)(1)(4) The facility reported a census of 59 residents. Based on observation and interview, the executive director failed to ensure staff stored insulin pens according to manufacturer's recommendations to ensure staff did not administer the medication beyond the manufacturer's recommended date of expiration. Findings included: - Observation on 12/03/25 at 03:23 PM Licensed Nurse C unlocked the Memory Care medication cart for inspection. The medication cart contained Soliqua Insulin Pen, that was approximately half empty, that did not include the date it was initiated into use. Interview on 12/03/25 at 03:23 PM Licensed Nurse C confirmed all insulin pens were supposed to have the date opened on them. Review of the manufacturer's recommendations directed for the pen to be discarded 28 days after it's first used. The executive director failed to ensure designated staff dated Soliqua insulin pen, so staff knew when to discard it according to manufacturers recommended date of expiration.	S3215		

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S3227	Continued From page 21	S3227		
S3227 SS=E	26-41-205 (l) (2) Medication Regimen Review Variance Report (l) (2) The licensed pharmacist or licensed nurse shall notify the medical care provider upon discovery of any variance identified in the medication regimen review that requires immediate action by the medical care provider. The licensed pharmacist shall notify a licensed nurse within 48 hours of any variance identified in the resident ' s regimen review that does not require immediate action by the medical care provider and specify a time within which the licensed nurse must notify the resident ' s medical care provider. The licensed nurse shall seek a response from the medical care provider within five working days of the medical care provider ' s notification of a variance. This REQUIREMENT is not met as evidenced by: KAR 26-41-205 (l)(2) The facility reported a census of 59 residents. The sample included three residents and six focused record reviews. Based on interview for all residents, and record review for two (R5 and R8) of three sampled residents the operator failed to ensure the licensed nurse attempted to get a response from the medical provider for pharmacy recommendations. Findings included: - Review of R5s medical record revealed she moved into the facility on 12/06/24 with a	S3227		

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S3227	Continued From page 22 diagnosis of Alzheimer's disease. Interview on 12/03/25 at 2:50 PM Administrative Nurse B reported they used a screening tool that included the "Functional Capacity Screen" and the "Negotiated Service Agreement" all in one document, titled the "CBA: Comprehensive Resident Evaluation" (CBA). R5's CBA identified she could not manage her medications, had impaired cognition and impaired decision-making ability. Review of R5's "progress notes" included consultant pharmacist documentation that read "MRR completed. please see report for recommendations". The pharmacist documented this for 12/23/24, 03/11/25, 06/29/25 and 09/16/25 to identify recommendations were made. Review of R5's medical record lacked evidence that a nurse attempted to seek a response from the medical provider related to what the pharmacist had recommended. - R8's medical record revealed she moved into the facility on 03/21/25 with diagnosis of diabetes mellitus type II. Interview on 12/03/25 at 02:50 PM Administrative Nurse B reported they used a screening tool that included the "Functional Capacity Screen" and the "Negotiated Service Agreement" all in one document, titled the "CBA: Comprehensive Resident Evaluation" (CBA). R8's CBA revealed she was unable to manage	S3227		

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S3227	Continued From page 23 her medications, and they would be administered by facility staff. Review of R8's progress notes included consultant pharmacist documentation for 06/29/25 "MRR completed, please see report for recommendations" and on 09/16/25 resident on medical leave. Review of R8's medical record lacked evidence the nurse attempted to seek a response from the medical provider related to what the pharmacist had recommended. - Review of the pharmacy reports provided by Administrative Staff A on 12/05/25 at 08:35 AM revealed the following: Review for 06/20/25- This visit included 17 recommendations were forwarded to the following disciplines: eight written to medical doctor and nine written to Nursing. All eight provider recommendations included the discontinuation of medications the resident had not used in the last 60 days. Surveyor checked three of the residents who had recommendations, and the records lacked evidence the licensed nurse attempted to get a response from the medical provider for the pharmacist recommendations. Interview on 12/08/25 at 03:50 PM Administrative Nurse K reported the best practice for pharmacy reviews would be for the pharmacist to email it to the Executive Director and the Wellness Director and then it is printed and sent to the physician or addressed as appropriate. After the	S3227		

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S3227	Continued From page 24 recommendations are addressed by the physician or nurse they are either filed in the paper chart or uploaded in the electronic record. The executive director failed to ensure a licensed nurse attempted to get a response from the medical care provider related to pharmacy recommendations.	S3227		
S3228 SS=E	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: KAR 26-41-205(l)(3) The facility reported a census of 59 residents. The sample included three residents and six focused record reviews. Based on interview for all residents, and record review for two (R5, R8) of three sampled residents, the administrator failed to ensure designated staff kept the medication regimen reviews in each resident's clinical record. Findings included: - Review of R5s medical record revealed she moved into the facility on 12/06/24 with a diagnosis of Alzheimer's disease.	S3228		

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S3228	Continued From page 25 Interview on 12/03/25 at 02:50 PM Administrative Nurse B reported they used a screening tool that included the "Functional Capacity Screen" and the "Negotiated Service Agreement" all in one document, titled the "CBA: Comprehensive Resident Evaluation" (CBA). R5's CBA identified she could not manage her medications, had impaired cognition and impaired decision-making ability. Review of R5's "progress notes" included consultant pharmacist documentation that read "MRR completed. please see report for recommendations". The pharmacist documented this for 12/23/24, 03/11/25, 06/29/25 and 09/16/25 to identify recommendations were made. Review of R5's medical record lacked evidence of what the pharmacist had recommended for either the physician or the nurse. - R8's medical record revealed she moved into the facility on 03/21/25 with diagnosis of diabetes mellitus type II. Interview on 12/03/25 at 02:50 PM Administrative Nurse B reported they used a screening tool that included the "Functional Capacity Screen" and the "Negotiated Service Agreement" all in one document, titled the "CBA: Comprehensive Resident Evaluation" (CBA). R8's CBA revealed she was unable to manage her medications and they would be administered by facility staff.	S3228		

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S3228	Continued From page 26 Review of R8's progress notes included consultant pharmacist documentation for 6/29/25 "MRR completed, please see report for recommendations" and on 09/16/25 resident on medical leave. Review of R8's medical record lacked evidence of what the pharmacist had recommended for either the physician or the nurse. Interview on 12/04/25 at 04:36 PM pharmacist reported they do have a pharmacist who comes to the facility and thought the pharmacist left a copy with the nurse at the facility or might have emailed them the report later. He reported he could send the past reports to the regional nurse to make sure they had them all. Interview on 12/04/25 at 04:15 PM Administrative Nurse B did not know where the pharmacy reviews were kept and had not seen any since she was hired. Interview on 12/04/25 at 04:36 PM pharmacist reported they do have a pharmacist who comes to the facility and thought the pharmacist left a copy with the nurse at the facility or might have emailed them the report later. He reported he could send the past reports to the regional nurse to make sure they had them all. Interview on 12/08/25 at 03:50 PM Administrative Nurse K reported the best practice for pharmacy reviews would be for the pharmacist to email it to the Executive Director and the Wellness Director and then it is printed and sent to the physician or addressed as appropriate. After the recommendations are addressed by the	S3228		

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S3228	Continued From page 27 physician or nurse they are either filed in the paper chart or uploaded in the electronic record. The executive director failed to ensure the medication regimen reviews were kept in each resident's clinical record.	S3228		
S3248 SS=F	26-41-102 (d) Staff Qualifications Employee Records (d) The employee records and agency staff records shall contain the following documentation: (1) Evidence of licensure, registration, certification, or a certificate of successful completion of a training course for each employee performing a function that requires specialized education or training; (2) supporting documentation for criminal background checks of facility staff and contract staff, excluding any staff licensed or registered by a state agency, pursuant to K.S.A. 39-970 and amendments thereto; (3) supporting documentation from the Kansas nurse aide registry that the individual does not have a finding of having abused, neglected, or exploited a resident in an adult care home; and (4) supporting documentation that the individual does not have a finding of having abused, neglected, or exploited any resident in an adult care home, from the nurse aide registry in each state in which the individual has been known to have worked as a certified nurse aide.	S3248		

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S3248	Continued From page 28 This REQUIREMENT is not met as evidenced by: KAR 26-41-102(d)(2) The facility reported a census of 59 residents. Based on interview and record review of five newly hired employees, the operator failed to have evidence the facility completed a criminal background check by the required state agency, pursuant to K.S.A.39-970 and amendments thereto for four of five newly hired staff. The findings included: - Review of the employee records revealed the following: Certified Nurse Aide (CNA) F hired on 08/07/25 lacked receipt for a criminal background check through "Kansas Department for Aging and Disabilities" (KDADS) or printed results of completing the background check. Dietary staff D hired on 05/08/25 lacked receipt for a criminal background check through "Kansas Department for Aging and Disabilities" (KDADS) or printed results of completing the background check. CNA G hired on 05/22/25 lacked receipt for a criminal background check through "Kansas Department for Aging and Disabilities" (KDADS) or printed results of completing the background check. Certified Medication Aide (CMA) H lacked receipt for a criminal background check through "Kansas Department for Aging and Disabilities" (KDADS)	S3248		

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THE RUSHWOOD SENIOR COMMUNITY	2121 N 143RD STREET E WICHITA, KS 67230

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S3248	Continued From page 29 or printed results of completing the background check. Surveyor checked the Kansas Nurse Aide Registry on 12/04/25 for CNA F, CNA G and CMA H and all three lacked "The Rushwood Senior Community" name on the registry as a facility that completed a criminal background check. Interview on 12/04/25 at approximately 12:30 PM Administrative staff I reviewed employee records provided to surveyor and confirmed she did not see where a criminal background check was run through KDADS as required. The executive director failed to ensure designated staff completed the criminal background checks through KDADS as directed by the department.	S3248		
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	S3280		

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S3280	Continued From page 30 drill shall include evacuation of the residents to a secure location. This REQUIREMENT is not met as evidenced by: KAR 26-41-104(d)(3) The facility reported a census of 59 residents. Based on record review and interview for all facility residents and all facility staff, the executive director failed to ensure disaster and emergency preparedness by ensuring performance of quarterly reviews of the facility's emergency management plan with all residents and facility staff. Findings include: - After entering the facility on 12/03/25 at 11:18 AM surveyor sent Executive Director an email with a list of records to provide. This list included provision of quarterly reviews of the emergency management plan with residents and staff and resident council minutes for review. Review of Resident council minutes lacked any information related to reviewing the emergency management plan with residents. Interview on 12/04/25 at 11:56 AM Administrative staff A reported maintenance staff did not have record of completing quarterly reviews of the emergency management plan with residents and/or staff. Administrative staff A stated they have had a couple of in-services since he started	S3280		

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S3280	Continued From page 31 in September 2025, but had nothing to show that the emergency management plan was reviewed. The executive director failed to ensure disaster and emergency preparedness by ensuring performance of quarterly reviews of the required possible emergencies with all residents and facility staff.	S3280		
S3296 SS=E	26-41-206 (c) (1) Dietary Services Weekly Menu (c) (1) Menu plans shall be available to each resident on at least a weekly basis. This REQUIREMENT is not met as evidenced by: KAR 26-41-206(c)(1) The facility reported a census of 59 residents. Based on observation and interview the executive director failed to ensure the menu plans were available to each resident on at least a weekly basis in the assisted living. Findings included: - During initial tour on 12/03/25 at 11:30 AM surveyor did not observe a weekly menu available to residents. There was nothing posed in the Bistro, main kitchen or by their mailboxes. Interview on 12/03/25 at 03:45 PM Dietary staff D reported the menus are on the tables every day and dietary staff change the daily special each day. He confirmed at this time he did not know how the residents were informed of the menu on	S3296		

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S3296	Continued From page 32 a weekly basis. Interview on 12/04/25 at 10:14 AM Dietary staff D reported families and residents could get an app on their phones which has different areas they can go to including the menu. The menu section will allow them to see the menu for multiple days in the future. Interview on 12/04/25 at 10:25 AM Administrative staff E confirmed they did have an app that residents and families could put on their phones but not very many residents are able to use it. Interview on 12/04/25 at 11:45 AM Administrative Staff A confirmed many residents would not be able to use the app to know what is available on the menu by the week and currently did not have another way of informing residents of the upcoming menu. Review of the undated Planning of Menu policy identified menus shall be posted or easily available to residents. The executive director failed to ensure the menu was available the residents in assisted living on at least a weekly basis.	S3296		
S3298 SS=F	26-41-206 (d) Food Preparation (d) Food preparation. Food shall be prepared using safe methods that conserve the nutritive value, flavor, and appearance and shall be served at the proper temperature. (1) Food used by facility staff to serve to the residents, including donated food, shall meet all applicable federal, state, and local laws and	S3298		

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S3298	Continued From page 33 regulations. (2) Food in cans that have significant defects, including swelling, leakage, punctures, holes, fractures, pitted rust, or denting severe enough to prevent normal stacking or opening with a manual, wheel-type can opener, shall not be used. (3) Food provided by a resident ' s family or friends for individual residents shall not be required to meet federal, state, and local laws and regulations. This REQUIREMENT is not met as evidenced by: KAR 26-41-206(d) The facility reported a census of 59 residents. Based on interview, and record review the executive director failed to ensure dietary staff monitored food temperatures to ensure it was prepared and served at the proper temperature. Findings included: - During initial tour on 12/03/25 at 12:30 PM review of the food temperature log book in Memory Care included temperatures started on 09/12/25. From 09/12/25 to 09/30/25 staff failed to temp food 25 meal times in memory care. For the month of October staff failed to temp foods for 30 meals. For the month of November staff failed to temp foods for 39 meals, and as of 12/03/25, staff failed to temp two meals. Review of the food temperature log in the main kitchen for the month of November did not have	S3298		

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S3298	Continued From page 34 logs for 15 days and failed to have food temps for 6 different meals. It also lacked food temperature sheets for 12/01/25 and 12/02/25. Interview on 12/04/25 at 10:16 Dietary staff C reported when he came in September, they did not have any food temperature logs and he has been working on getting staff to remember to temp foods and fill out the log. Dietary staff C confirmed dietary staff are supposed to document the temperature in the log to help ensure they cook and served foods to the proper temperature. Interviews on 12/05/25 with thirteen alert and oriented residents revealed six of those residents said the food does not come to the table hot and they either eat it cold or send it back for staff to reheat it. Four of the thirteen residents said most of the time it comes out hot and three residents said staff served it hot enough for them. Review of the "Culinary Temperature Audit" policy directed that food temperatures were checked by dietary staff prior to serving and documented on the food temperature log. The executive director failed to ensure dietary staff monitored food temperatures to ensure they were prepared and served at the proper temperatures.	S3298		
S3310 SS=F	26-41-207 (b) (5-6) (c) Infection Control Policies (b) (5) prohibiting any employee with a communicable disease or any infected skin lesions from coming in direct contact with any resident, any resident ' s food, or resident care	S3310		

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S3310	Continued From page 35 equipment until the condition is no longer infectious; (6) providing orientation to new employees and employee in-service education at least annually on the control of infections in a health care setting; and (c) Each administrator or operator shall ensure the facility ' s compliance with the department ' s tuberculosis guidelines for adult care homes adopted by reference in K.A.R. 26-39-105 This REQUIREMENT is not met as evidenced by: KAR 26-41-207(c) The facility reported a census of 59 residents (R). The sample included three residents and review of five newly hired employees' record. Based on interview and record review the executive director failed to ensure the facility remained in compliance with the department's tuberculosis (TB) guidelines for adult care homes adopted by reference in KAR 26-39-105 for two (R5 and R9) of three residents and one of five newly hired employees. Findings included: - Review of R5's record revealed she moved into the facility on 12/06/24 with a diagnosis of Alzheimer's disease. R3's record include an initial TB symptom screen completed on 02/06/25 and a two-step TB skin test administered on 02/08/25 and read on	S3310		

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S3310	Continued From page 36 03/05/25. The TB symptom screen and two-step skin test were not initiated within seven days of moving into the facility. Interview on 12/08/25 at 10:17 AM Administrative Nurse B reported the TB screen, and first skin test are to be completed on day of admission and the second TB skin test done 10 days after the first one given. She confirmed staff failed to complete R5's TB screen and skin tests according to guidelines. - Review of R9's record revealed he moved into the facility on 12/02/24 with diagnosis of diabetes mellitus type II. R9's record included an initial TB symptom screen conducted on 11/18/24 but he did not receive TB skin testing until 02/06/25 and 03/05/25. The TB two-step skin test was not administered by the nurse within seven days of moving into the facility. Interview on 12/08/25 at 10:17 AM Administrative Nurse B reported the TB screen and first skin test are to be completed on day of admission and the second TB skin test done 10 days after the first one given. She confirmed staff failed to complete R5's TB screen and skin tests according to guidelines. Review of the "Tuberculosis (TB) Guidelines for Adult Care Homes" June 2013, revealed each new resident shall have an initial TB symptom screen questionnaire within seven days of residency. Each new resident shall receive a two-step TB skin test within seven days of residency.	S3310		

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S3310	Continued From page 37 The executive director failed to ensure R5 and R9 received TB symptom screen and TB skin testing according to the departments guidelines. - Review of one newly hired staff employee file revealed the following TB information: Certified Nurse Aide G hired on 05/22/25 and termed on 07/29 had record of a TB symptom screen completed on 05/05/25 but did not have a two-step TB skin test completed. Review of the "TB Tracking: Employee" policy dated 06/10/25 revealed when a candidate receives a job offer the nurse will administer the first step of a two-step TB screen and return in 48 to 72 hours to have it read. All employees must have the first of the two-step process completed and read prior to working in the community. Review of the "Tuberculosis (TB) Guidelines for Adult Care Homes" June 2013, revealed each new employee shall have an initial TB symptom screen questionnaire within seven days of employment and shall receive a two-step TB skin test within seven days of employment. The executive director failed to ensure the facility remained in compliance with the department's tuberculosis guidelines for adult care homes adopted by reference in KAR 26-39-105.	S3310		
S9999	Final Observations Kansas Statute 39-981.	S9999		

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S9999	Continued From page 38 Authorized electronic monitoring; reasonable accommodations; notice; consent; use as evidence; prohibitions. (d) A resident, or such resident's guardian or legal representative, who wishes to conduct authorized electronic monitoring shall notify the adult care home on a form prescribed by the secretary for aging and disability services. This Requirement is not met as evidenced by: Scope and Severity of D. The facility reported a census of 59 residents(R). The sample included three residents and six focused record reviews. Based on record review, and interview, the executive director failed to ensure R8'slegal representative completed the required paperwork as prescribed by the secretary for aging and disability services for Authorized Electronic Monitoring R8's room. Findings included: - During initial tour on 12/03/25 from 11:30 Am to 02:00 PM observations revealed each resident door in assisted living and memory care had a notice posted that said "Electronic monitoring in progress" or "Rooms of some residents may be monitored electronically by or on behalf of the room's resident or residents. During the initial entrance conference on 12/03/25 at 02:53 PM Administrative staff A reported there was one resident who had authorized electronic monitoring in her room, R8.	S9999		

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S9999	Continued From page 39 An observation on 12/08/25 at 01:13 PM while interviewing R8 surveyor observed the monitoring device on top of R8's cabinet by the entry door. Interview on 12/08/25 at 03:12 PM Administrative staff A reported they had forms but did not have anything to show that R8 or her family had completed them. The Executive Director failed to ensure all required forms related to Authorized Electronic Monitoring were completed by the resident/family and in the resident's record.	S9999		