| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | N087090 | A. BUILDING: _____ B. WING _____ | 03/05/2026 |

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| CEDARHURST OF WICHITA | 11820 W 29TH N WICHITA, KS 67205 |

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| S 000 | INITIAL COMMENTS<br><br>The following citations represent the findings of the licensure resurvey with attached complaint numbers 198023, 198208, 198135, 198047, 197996, 197746, 197793, 197662, 197607, 197270, 197059, 197001, 196990, 196742, and 195646, for the above named facility conducted on 03/03/26, 03/04/26, and, 03/05/26. | S 000 | | |
| S3026 SS=J | 26-41-101 (f) (1) Staff Treatment of Residents ANE<br><br>(f)The administrator or operator shall ensure that all of the following requirements are met:<br>(1) No resident shall be subjected to any of the following:<br>(A) Verbal, mental, sexual, or physical abuse, including corporal punishment and involuntary seclusion;<br>(B) neglect; or<br>(C) exploitation.<br><br>This REQUIREMENT is not met as evidenced by:<br>K.A.R. 26-41-101 (f) (1) (B)<br><br>The facility reported a census of 87 residents. The sample included 6 Resident's (R) and 9 focused reviews. There were 28 residents that resided in the secured specialty unit. Based on observation, interview and record review, the Administrator failed to ensure staff responded to a door alarm that led to the exterior of the facility on 03/03/26 at approximately 06:48 PM when cognitively impaired R14 exited the secure unit. A local homeowner observed R14 sitting on the porch of their home and called local law | S3026 | | |

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

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| S3026 | Continued From page 1 | S3026 | | |

enforcement. R14 returned to the facility at approximately 08:00 PM with Licensed Nurse C. The neglect of staff to respond to the door alarm placed R14 in immediate jeopardy for 72 minutes when she left the secured specialty unit without staff knowledge.

Findings included:

- Record review for R14 revealed an admission date of 05/17/25 with diagnoses of Alzheimer's disease, effusion of unspecified joint, essential hypertension, iron deficiency anemia, and unspecified dementia, severe, with mood disturbance.

Review of R14's "Functional Capacity Screen" (FCS) dated 12/30/25 revealed R14 required physical assistance with bathing, dressing, and toileting. R14 was independent with walking, mobility, transferring, and eating. R14 lacked the ability to manage her own medications and medical treatments. R14 was occasionally incontinent and had impaired short-term memory, long-term memory, memory/recall and decision making. R14 was usually able to make herself understood and she usually understood others. R14 was identified to be at risk for falls, wandering, socially inappropriate disruptive behavior, and impaired decision making. R14 used no mobility device.

Review of R14's "Negotiated Service Agreement" (NSA) dated 12/31/25 revealed, in the section titled 'Redirection/Safety Checks" facility staff were instructed to provide redirection for R14 when they observed her "at an exit door or

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| S3026 | Continued From page 2 | S3026 | | |

wandering". Staff were instructed to provide safety checks at "01:00 AM, 03:00 AM, 05:00 AM, 07:00 AM 09:00 AM, 11:00 AM, 01:00 PM, 03:00 PM, 05:00 PM, 07:00 PM, 09:00 PM, 11:00 PM" and as needed.

Review of a screen shot from the facility video camera revealed the month and day could not be read. The words "Spa Exit" were covering the month and date. The year displayed was 2026. The image showed there were no staff in the area, and the resident walked out of the exit at 06:48 PM. A second screen shot at 07:01 PM showed two facility staff members at the exit. Twelve minutes after the door alarmed.

According to wunderground.com the temperature on 03/30/26 at 6:48 PM it was 47 degrees Fahrenheit.

Observation on 03/05/26 revealed the door R14 exited was by the facility parking lot. R14's path would have been across an uneven surface to the sidewalk located on the northwest side of the block that ran parallel to a two-lane street, with a 40 miles per hour speed limit. R14 was found in a residential area on a private citizen's porch. The home was on the same side of the street as the facility.

Interview on 03/05/26 at approximately 05:00 PM with Administrator A and Maintence Director D confirmed the screen shots should be dated 03/03/26, that R14 was the resident who exited, and staff responded to the door alarm at 07:01 PM, approximately 12 minutes after R14 had set the door alarm off.

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| S3026 | Continued From page 3 | S3026 | | |

Review of the facility provided investigation revealed that facility staff last saw R14 at approximately 06:30 PM.

Observation on 03/03/26 at approximately 11:27 AM during the facility tour with Administrator A and "Licensed Nurse"(LN) B revealed an exterior door in the southeast corner of the secured specialty unit. The door had an egress bar (a horizontal metal bar installed on emergency exit doors, allowing for quick, single motion unlatching by pushing to exit), that when held down for 15 seconds activated the door alarm and allowed the door to open freely. Facility staff E responded at 11:28.AM she checked the door and used her key to reset the alarm on the door.

Review of the facility provided un-notarized document titled "Signed Witness Statement" dated 03/03/26 and signed by "Certified Nurse Aide" (CNA) F revealed she "saw the alarm had been going for about 10 minutes". CNA F then wrote that she went and checked the back door and found it unlocked , "we did a head count" and it was discovered at this time that R14 was not counted. CNA F wrote that they notified "Licensed Nurse" C at 07:13 PM that they were unable to find R14.

Administrator A was notified on 03/06/26 at approximately 05:15 PM of the Immediate Jeopardy for the elopement of R14 on 03/03/25. At 6:48 PM when staff failed to respond to the door alarm for 12 minutes and R14 left the secured unit without staff knowledge. R14 was wearing sweatpants, a fleece jacket, a blouse and tennis shoes. She was returned to the facility approximately 72 minutes later at

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| S3026 | Continued From page 4<br>approximately 08:02 PM by LN C.<br><br>The facility removal plan included:<br><br>On 03/03/26 upon R14's return to the facility she was placed on every 30-minute visual checks.<br><br>On 03/03/26 an elopement drill was completed and education was provided to onsite facility staff.<br><br>The Maintenance Director will continue to complete a Memory Care entry/exit door function weekly.<br><br>On 03/03/26 staff education began around 08:00 PM to include responding to door alarms, the enunciator chime at the nursing station for the exit door, the elopement policy and pager wearing.<br><br>Elopement drills would be completed on 03/04/26, and two drills on 03/05/26. Additional drills will be completed daily for four weeks, with at least two drills on each shift weekly.<br><br>Monthly in-service training on missing resident/elopements for the next three months.<br><br>On 03/06/26 Audible doorbell will be moved to ceiling for better acoustics.<br><br>On 03/06/26 a magnetic alarm will be added to the emergency exit as a backup alarm. | S3026 | | |
| S3028 SS=E | 26-41-101 (f) (3) Staff Treatment of Residents Reporting | S3028 | | |

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| S3028 | Continued From page 5<br>(f) (3) Each allegation of abuse, neglect, or exploitation shall be reported to the administrator or operator of the facility as soon as staff is aware of the allegation and to the department within 24 hours. The administrator or operator shall ensure that all of the following requirements are met:<br>(A) An investigation shall be started when the administrator or operator, or the designee, receives notification of an alleged violation.<br>(B) Immediate measures shall be taken to prevent further potential abuse, neglect, or exploitation while the investigation is in progress.<br>(C) Each alleged violation shall be thoroughly investigated within five working days of the initial report. Results of the investigation shall be reported to the administrator or operator.<br>(D) Appropriate corrective action shall be taken if the alleged violation is verified.<br>(E) The department ' s complaint investigation report shall be completed and submitted to the department within five working days of the initial report.<br>(F) A written record shall be maintained of each investigation of reported abuse, neglect, or exploitation.<br><br>This REQUIREMENT is not met as evidenced by:<br>K.A.R. 26-41- 101 (f)(3)(E)<br><br>The facility reported a census of 87 residents. The sample included 6 "Residents'" (R)'s and 9 focused reviews. Based on record review and | S3028 | | |

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| S3028 | Continued From page 6 | S3028 | | |

interview the Administrator failed to ensure that all allegations of neglect were reported to the department within 24 hours, when the facility investigation of a medication error involving insulin revealed the "Licensed Nurse" (LN) neglected to put an end date on a one-time insulin order. The Administrator continued to fail to report to the department an insulin medication error when the "Certified Medication Aide" neglected to follow the rights of medication administration when she handed the resident the wrong insulin pen to self-administer. The Administrator failed to notify the department of the allegation of neglect for the "Licensed Nurse" who failed to provide services which were reasonably necessary to ensure the safety and wellbeing of the residents and was terminated after the facility substantiated the allegation. The Administrator failed to ensure the department's complaint investigation report was completed and submitted within 5 working days of the initial report.

Findings included:

- Personnel record review for "Licensed Nurse" (LN) C revealed a document titled "Counseling Documentation Form" dated 01/09/26. In the "Detail and Documentation of the Violation" it was documented that LN C put a medication order in for a resident for "Insulin Lispro 15 units one time now". The order was set to begin on 01/07/26 and to end on 01/14/26. The medication order was wrong in the "lectronic Medication Administration Record" eMar and on the next day the "Certified Medication Aide" (CMA) instructed resident to self-administer the

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| S3028 | Continued From page 7<br>wrong insulin.<br><br>Review of the facility provided document titled "General Information" dated 01/08/26 revealed that a family member had called the nurse and asked if the residents insulin order had changed. The family member reported that the CMA had instructed the resident to administer 15 units of Lantus insulin "along with receiving Lispro as ordered". The nurse documented that she checked the residents eMAR and the order for the Insulin Lispro was on the eMAR to give 15 units one time. The nurse documented that the one-time order lacked an end date. The nurse continued to document that the CMA "admitted" that she inadvertently gave the Lantus insulin instead of the Lispro".<br><br>Review of the facility provided document titled "Counseling Documentation Form" dated 06/30/25 revealed LN H was investigated for the neglect to provide services which were reasonably necessary to ensure the safety and wellbeing of the residents. LN H was investigated for "instructing medication aides on duty to provide and administer medication to residents ...using an incomplete MAR (Medication Administration Record"". "It was validated through investigation that medication aides on duty were instructed to contact" LN H "prior to administering medication to the resident that was not listed on the current MAR. The document continued to reveal LN H had received a "written warning" for not meeting performance standards related to the "Timeliness of care plans and assessments of residents". The documentation revealed a resident moved into the community on 06/21/25 and LN H neglected to provide a care | S3028 | | |

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| S3028 | Continued From page 8 | S3028 | | |

plan for 24 hours after their arrival to the community. "There have been in addition three residents" who had "vacated the community, specifically notating lack of care for their loved ones being the cause for ending their residency".

Interview on 03/05/26 at approximately 05:00PM with Administrator A and Licensed Nurse B confirmed that the medication error was not reported to the department within 24 hours, and the full investigation ruling out neglect was not submitted within 5 days. Licensed Nurse B continued to confirm she spoke with her "Regional Manager" and it was confirmed the allegation of neglect of services for LN H was not reported to the department within 24 hours, and the full investigation ruling out or substantiating neglect was not submitted to the department within 5 days.

The Administrator failed to ensure that all allegations of neglect were reported to the department within 24 hours, when the facility investigation of a medication error involving insulin revealed the LN neglected to put an end date on a one-time insulin order. The Administrator continued to fail to report to the department an insulin medication error when the CMA neglected to follow the rights of medication administration when she handed the resident the wrong insulin pen to self-administer. The Administrator failed to notify the department of the allegation of neglect for the LN H who failed to provide services which were reasonably necessary to ensure the safety and wellbeing of the residents and was terminated after the facility substantiated the allegation. The Administrator failed to ensure the department's complaint

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| S3028 | Continued From page 9<br>investigation report was completed and submitted within 5 working days of the initial report. | S3028 | | |
| S3085 SS=D | 26-41-202 (a) Negotiated Service Agreement<br>(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:<br>(1) A description of the services the resident will receive;<br>(2) identification of the provider of each service; and<br>(3) identification of each party responsible for payment if outside resources provide a service.<br><br>This REQUIREMENT is not met as evidenced by:<br>K.A.R. 26-41-202 (a) (1) (2)<br><br>The facility reported a census of 87 residents. The sample included 6 "Residents'" (R)'s and 9 focused reviews. Based on observation, record review and interview the Administrator failed to ensure the "Negotiated Service Agreement" (NSA) contained a description of services the resident would receive and identification of the | S3085 | | |

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| S3085 | Continued From page 10 | S3085 | | |

provider of services the resident would receive for R5 when a local home health agency was contacted to manage R5's wound.

Findings included:

- Record Review for R5 revealed an admission date of 12/17/25 with diagnoses of dementia, coronary artery disease, hearing loss, skin cancer of scalp and left ear.

Review of R5's Functional Capacity Screen (FCS) revealed R5 required physical assistance with bathing. R5 required supervision with dressing and toileting. R5 was independent with transferring, walking, mobility, and eating. R5 lacked the ability to manage his own medications and medical treatments. R5 was occasionally incontinent, and had impaired short-term memory, long-term memory, memory recall, and decision making. R5 was able to make himself understood and he understood others. R5 was marked at risk for impaired hearing, wandering, and impaired decision making. R5 used a walker mobility device.

Review of R5's NSA dated 12/17/25 instructed facility staff to provide assistance with all aspects of bathing and dressing. Facility staff were instructed to remind R5 to go to the bathroom at 10:00 AM, 02:00 PM, 07:00 PM, and as needed. Facility staff were instructed to manage and administer R5's medications.

Review of R5's electronic "Medical Record" under the "Observation" tab was the following entry:

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| S3085 | Continued From page 11<br><br>On 01/06/26 at 03:15 PM Licensed Nurse B entered, R5 had a scab on the top of his head due to skin cancer. The scab had been dislodged, and the area was open. Provider was notified and a local home health agency was contacted to manage the wound.<br><br>Interview on 03/05/26 at approximately 05:00 PM with Administrator A and Licensed Nurse B confirmed R5 received wound care services from an outside provider.<br><br>The Administrator failed to ensure the NSA contained a description of services the resident would receive and identification of the provider of services the resident would receive for R5 when a local home health agency was contacted to manage R5's wound. | S3085 | | |
| S3165 SS=F | 26-41-204 (d) Health Care Services<br><br>(d) The negotiated service agreement shall contain a description of the health care services to be provided and the name of the licensed nurse responsible for the implementation and supervision of the plan.<br><br>This REQUIREMENT is not met as evidenced by:<br>K.A.R. 26-41-204 (d)<br><br>The facility reported a census of 87 residents. The sample included 6 "Residents'" (R)'s and 9 focused reviews. Based on observation, record review and interview the Administrator failed to ensure the "Negotiated Service Agreement" | S3165 | | |

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(NSA) contained the name of the nurse responsible for the supervision and implementation of the "Health Service Plan" (HSP) for R1, R2, R3, R4, R5, R6, and R14.

Findings included:

- Record review for R1 revealed an admission date of 08/15/25 with diagnoses of Alzheimer's disease, atherosclerotic heart disease, hypertension and type two diabetes mellitus.

Review of R1's "Functional Capacity Screen" (FCS) dated 02/26/26 revealed R1 required physical assistance with bathing and dressing. R1 was independent with toileting, transferring, walking, mobility, and eating. 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 decision making. R1 was able to make himself understood and he usually understood others. R1 was marked at risk for falls and impaired decision making. R1 used no walking mobility device.

Review of R1's "Negotiated Service Agreement" (NSA) dated 02/26/26 instructed facility staff to provide standby assistance with bathing and dressing. Under the section titled "Fall Risk" facility staff were instructed to monitor R1 to ensure that he had his "Cane" when ambulating in the hallways and provide redirection if R1 seemed confused. Under the section titled "Safety Check" facility staff were instructed to check on R1 at the following times: 3:00 PM, 7:00 PM, 10:00 PM, 10:00 AM, 12:00 PM, 2:00

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PM, 6:00 PM, 9:00 PM, and as needed. Nursing staff will administer all medications. Nursing will dial the insulin pen and hand to R1 to self-inject.

R1's NSA lacked documentation of the nurse responsible for the supervision and implementation of the HSP.

- Record review for R2 revealed an admission date of 08/15/25 with diagnoses of anxiety, erosive arthritis, and Parkinson's disease.

Review of R2's FCS dated 08/25/25 revealed R2 was independent with bathing, dressing, toileting, transferring, walking, mobility, and eating. R2 managed her own medications, was frequently incontinent, and her cognition was intact. R2 was able to make herself understood and she understood others. R2 used a walker mobility device.

Review of R2's NSA dated 02/26/26 instructed facility staff to provide weekly housekeeping, wash and change her linens, and monitor her for falls.

R2's NSA lacked documentation of the nurse responsible for the supervision and implementation of the HSP.

- Record review for R3 revealed an admission date of 09/30/24 with diagnoses of atherosclerosis of the coronary artery bypass grafts, basal cell carcinoma of the skin, hypertension, impaired fasting glucose, malignant neoplasm of the prostate, and type two diabetes mellites.

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| S3165 | Continued From page 14<br><br>Review of R3's FCS dated 10/01/25 revealed R3 required supervision with bathing and dressing. He was independent with toileting, transferring, walking, mobility, and eating. R3 lacked the ability to manage his own medications and medical treatments, was occasionally incontinent, and had impaired short-term memory. R3 was able to make himself understood and he understood others. R3 was marked at risk for impaired decision making and used no mobility device.<br><br>Review of R3's NSA dated 09/02/25 instructed facility staff to provide stand by assistance for bathing, dressing, safety checks "with all cares", dialing the insulin pen for R3 to self-administer, and manage all other ordered medications.<br><br>R3's NSA lacked documentation of the nurse responsible for the supervision and implementation of the HSP.<br><br>- Record review for R4 revealed an admission date of 09/20/24 with diagnoses of dementia, anemia, heart failure, central retinal artery occlusion of the right eye, chronic kidney disease stage three, major depressive disorder, Parkinson's disease, peripheral vascular disease, and atrial fibrillation.<br><br>Record review of R4's FCS dated 09/09/25 revealed R4 required physical assistance with bathing, dressing, toileting, transferring, walking, mobility, and supervision with eating. R4 lacked the ability to manage his own medications and medical treatments. R4 was frequently incontinent and had impaired short-term memory, | S3165 | | |

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long-term memory, memory/recall, and decision making. R4 was able to make himself understood and he understood others. R4 was marked at risk for falls, impaired vision, and impaired decision making. R4 used a walker and wheelchair mobility device.

Review of R4's NSA dated 01/01/25 revealed R4 was on hospice service with a local hospice provider. Facility staff were instructed to assist the hospice provider with bathing twice weekly. Facility staff were instructed to assist R4 in dressing daily, assist in setting up R4's meals, escort R4 to meals, provide hands on assistance for transferring, check on R4 evert two hours, assist with toileting and providing hygiene care, and administer medications.

R4's NSA lacked documentation of the nurse responsible for the supervision and implementation of the HSP.

- Record Review for R5 revealed an admission date of 12/17/25 with diagnoses of dementia, coronary artery disease, hearing loss, skin cancer of scalp and left ear.

Review of R5's FCS revealed R5 required physical assistance with bathing. R5 required supervision with dressing and toileting. R5 was independent with transferring, walking, mobility, and eating. R5 lacked the ability to manage his own medications and medical treatments. R5 was occasionally incontinent, and had impaired short-term memory, long-term memory, memory recall, and decision making. R5 was able to make himself understood and he understood others. R5 was marked at risk for impaired

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hearing, wandering, and impaired decision making. R5 used a walker mobility device.

Review of R5's NSA dated 12/17/25 instructed facility staff to provide assistance with all aspects of bathing and dressing. Facility staff were instructed to remind R5 to go to the bathroom at 10:00 AM, 02:00 PM, 07:00 PM, and as needed. Facility staff were instructed to manage and administer R5's medications.

Review of R5's electronic "Medical Record" under the "Observation" tab was the following entry:

On 01/06/26 at 03:15 PM Licensed Nurse B entered R5 had a scab on the top of his head due to skin cancer. The scab had been dislodged, and the area was open. Provider was notified and a local home health agency was contacted to manage the wound.

R5's NSA lacked documentation of the nurse responsible for the supervision and implementation of the HSP.

- Record review for R6 revealed an admission date of 12/01/25 with diagnoses of Alzheimer's disease and age-related osteoporosis.

Review of R6's FCS dated 02/02/26 revealed R6 required supervision with bathing and walking and mobility. R6 was independent with dressing, toileting, transferring, and eating. R6 lacked the ability to manage her own medications, she was continent, and R6 had impaired short-term memory, long-term memory, memory/recall, and decision making. R6 was able to make herself

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understood and she understood others. R6 was at risk for wandering and impaired decision making. R6 required no mobility device.

Review of R6's NSA dated 01/17/26 instructed facility staff to provide stand by assistance with bathing, monitor for cleanliness of clothing, escort to and from meals, provide visual check every two hours for safety, and administer medications.

R6's NSA lacked documentation of the nurse responsible for the supervision and implementation of the HSP.

- Record review for R7 revealed an admission date of 12/01/25 with diagnoses of Alzheimer's disease and heart failure, and type two diabetes mellitus.

Review of R7's FCS dated 11/13/25 revealed R7 required supervision with bathing, dressing, and walking and mobility. He was independent with toileting, transferring and eating. He lacked the ability to manage his own medications, and had impaired short-term memory, long-term memory, memory/recall and decision making. R7 was able to make himself understood and he understood others. R7 was marked at risk for falls and impaired decision making. R7 used no mobility device.

Review of R7's NSA dated 12/22/25 instructed facility staff to provide stand by assistance for bathing, dressing, and management of his medications. Under the section titled "Impaired Decision Making" facility staff were instructed to provide hourly checks for R1's safety and

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appropriateness daily.

R7's NSA lacked documentation of the nurse responsible for the supervision and implementation of the HSP.

- Record review for R14 revealed an admission date of 05/17/25 with diagnoses of Alzheimer's disease, effusion of unspecified joint, essential hypertension, iron deficiency anemia, and unspecified dementia, severe, with mood disturbance.

Review of R14's "Functional Capacity Screen" (FCS) dated 12/30/25 revealed R14 required physical assistance with bathing, dressing, and toileting. R14 was independent with walking, mobility, transferring, and eating. R14 lacked the ability to manage her own medications and medical treatments. R14 was occasionally incontinent and had impaired short-term memory, long-term memory, memory/recall and decision making. R14 was usually able to make herself understood and she usually understood others. R14 was identified to be at risk for falls, wandering, socially inappropriate disruptive behavior, and impaired decision making. R14 used no mobility device.

Review of R14's "Negotiated Service Agreement" dated 12/31/25 instructed facility staff to provide assistance in all aspects of bathing, dressing, provide an escort to meals and activities, provide reminders to go to the toilet and assist in hygiene, and administer and manage medications. In the section titled 'Redirection/Safety Checks" facility staff were instructed to provide redirection for R14 when

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| S3165 | Continued From page 19<br>they observed her "at an exit door or wandering". Staff were instructed to provide safety checks at "01:00 AM, 03:00 AM, 05:00 AM, 07:00 AM 09:00 AM, 11:00 AM, 01:00 PM, 03:00 PM, 05:00 PM, 07:00 PM, 09:00 PM, 11:00 PM" and as needed.<br><br>R14's NSA lacked documentation of the nurse responsible for the supervision and implementation of the HSP.<br><br>Interview on 03/05/26 at approximately 05:00 PM with Administrator A and Licensed Nurse B confirmed the NSA's for R's 1, 2, 3, 4, 5, 6, 7, and 14, lacked documentation of the nurse responsible for the supervision and implementation of the HSP.<br><br>The Administrator failed to ensure the NSA contained the name of the nurse responsible for the supervision and implementation of the HSP for R1, R2, R3, R4, R5, R6, R7 and R14. | S3165 | | |
| S3171 SS=E | 26-41-204 (i) Health Care Services Standards of Practice<br><br>(i) All health care services shall be provided to residents by qualified staff in accordance with acceptable standards of practice.<br><br>This REQUIREMENT is not met as evidenced by:<br>K.A.R. 26-41-204 (i)<br><br>The facility reported a census of 87 residents. The sample included 6 "Residents'" (R)'s and 9 focused reviews. Based on observation, record | S3171 | | |

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review and interview the Administrator failed to ensure health care services were provided within professional standards of practice when Administrator A failed to ensure an assessment was performed for R1, R2, and R7 showing their bed assist devices posed no risk for entrapment, confirmed the device were not a restraint, and R's 1, 2, and 7's ability to safely use the bed assist devices.

Findings included:

- Record review for R1 revealed an admission date of 08/15/25 with diagnoses of Alzheimer's disease, atherosclerotic heart disease, hypertension and type two diabetes mellitus.

Review of R1's "Functional Capacity Screen" (FCS) dated 02/26/26 revealed R1 required physical assistance with bathing and dressing. R1 was independent with toileting, transferring, walking, mobility, and eating. 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 decision making. R1 was able to make himself understood and he usually understood others. R1 was marked at risk for falls and impaired decision making. R1 used no walking mobility device.

The comments section of the FCS lacked documentation of R1 having a bed assist device.

Review of R1's "Negotiated Service Agreement" (NSA) dated 02/26/26 instructed facility staff to provide standby assistance with bathing and

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dressing. Under the section titled "Fall Risk" facility staff were instructed to monitor R1 to ensure that he had his "Cane" when ambulating in the hallways.

R1's NSA lacked documentation of a description of the bed assist device, its purpose and special instructions on use of the bed assist device, and monitoring of R1's ability to use the device.

Review of R1's electronic "Medical Record" lacked documentation of an assessment for R1 showing that the bed assist device posed no risk for entrapment, confirmed the device was not a restraint, and R1's ability to safely use the bed assist device.

Observation on 03/05/26 at approximately 01:15 PM of R1's bed revealed the head of the bed sat against the middle of the west wall of the room. On the south side of the bed was an inverted square bed assist device that measured 17 inches in width and 14 inches in height. There were no large openings in the inverted square space. The device slid under the mattress and was securely attached to the north side of the bed with a black nylon strap.

- Record review for R2 revealed an admission date of 08/15/25 with diagnoses of anxiety, erosive arthritis, and Parkinson's disease. Review of R2's FCS dated 08/25/25 revealed R2 was independent with bathing, dressing, toileting, transferring, walking, mobility, and eating. R2 managed her own medications, was frequently incontinent, and her cognition was intact. R2 was able to make herself understood and she understood others. R2 used a walker

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| S3171 | Continued From page 22<br>mobility device.<br><br>The comments section of the FCS lacked documentation of R2 having a bed assist device.<br><br>Review of R2's NSA dated 02/26/26 instructed facility staff to provide weekly housekeeping, wash and change her linens, and monitor her for falls.<br><br>R2's NSA lacked documentation of a description of the bed assist device, its purpose and special instructions on use of the bed assist device, and monitoring of R2's ability to use the device.<br><br>Review of R2's electronic "Medical Record" lacked documentation of an assessment for R2 showing that the bed assist device posed no risk for entrapment, confirmed the device was not a restraint, and R2's ability to safely use the bed assist device.<br><br>Observation on 03/05/26 at approximately 01:15 PM of R2's bed revealed the head of the bed sat against the middle of the west wall of the room. On the north side of the bed was an inverted "U" bed assist device that measured approximately 19.5 inches in width and approximately 31 inches in height. The space between the legs of the inverted "U" shaped measured approximately 18 inches. The device slid under the mattress and was securely attached to the north side of the bed with a black nylon strap.<br><br>- Record review for R7 revealed an admission date of 12/01/25 with diagnoses of Alzheimer's disease and heart failure, and type two diabetes mellitus. | S3171 | | |

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| S3171 | Continued From page 23<br><br>Review of R7's FCS dated 11/13/25 revealed R7 required supervision with bathing, dressing, and walking and mobility. He was independent with toileting, transferring and eating. He lacked the ability to manage his own medications, and had impaired short-term memory, long-term memory, memory/recall and decision making. R7 was able to make himself understood and he understood others. R7 was marked at risk for falls and impaired decision making. R7 used no mobility device.<br><br>The comments section of the FCS lacked documentation of R7 having a bed assist device.<br><br>Review of R7's NSA dated 12/22/25 instructed facility staff to provide stand by assistance for bathing, dressing, and management of his medications.<br><br>R7's NSA lacked documentation of a description of the bed assist device, its purpose and special instructions on use of the bed assist device, and monitoring of R7's ability to use the device.<br><br>Review of R7's electronic "Medical Record" lacked documentation of an assessment for R7 showing that the bed assist device posed no risk for entrapment, confirmed the device was not a restraint, and R7's ability to safely use the bed assist device.<br>Observation on 03/05/26 at approximately 02:30 PM of R7's bed revealed the head of his bed sat against the middle of the east wall of the room. On the north and south side of the bed were rectangular shaped bed assist devices that measured approximately 55.5 inches in length | S3171 | | |

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and approximately 12 inches in height. There were no large openings in the devices. The devices were securely attached to the bed frame and were in the down position during the observation.

Interview on 03/05/26 at approximately 05:00 PM with Administrator A and Licensed Nurse B confirmed the electronic "Medical Records" for R1, R2, and R7 lacked an assessment for R1, R2, and R7 showing their bed assist devices posed no risk for entrapment, confirmed the devices were not a restraint, and R's 1, 2, and 7's ability to safely use the bed assist devices.

The FDA (food and drug administration) "Bedrails in Assisted Living, Residential Health Care and Home Plus Facilities" recommended the following:

Complete an assessment of the resident to confirm that the device is not a restraint.

Complete an assessment of the resident to determine the purpose of the device and the resident's ability to safely use the device and document the findings in the resident's record.

Complete an assessment of the device using the recommendations in the FDA guidance to ensure the device is securely attached to the bed or bedframe and poses no risk for entrapment and document the findings in the resident record.

If the purpose of the device is to assist the resident with transfers, the FCS should document the resident's functional capacity based on the use of the device and should be

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| S3171 | Continued From page 25<br>listed in the comments section.<br><br>Include a description of the device, its purpose and special instructions on use and monitoring in the resident's NSA.<br><br>Document periodic reassessments of the resident's use of the device and their ability to use it safely and reassessment of the safety of the device in the resident's record. | S3171 | | |
| S3200 SS=E | 26-41-205 (d) (1-2) Facility Administration of Medications<br><br>(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 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:<br>(1) Only licensed nurses and medication aides shall administer and manage medications for which the facility has responsibility.<br>(2) Medication aides shall not administer medication through the parenteral route.<br><br>This REQUIREMENT is not met as evidenced by:<br>K.A.R. 26-41-205 (d) | S3200 | | |

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The facility reported a census of 87 residents. The sample included 6 "Residents'" (R)'s and 9 focused reviews. Based on record review and interview the Administrator failed to ensure that all medications the facility was responsible for were administered to each resident in accordance with the medical care provider's written order and professional standards of practice as defined in the 2013 Certified Medication Aid Curriculum; "Routine medications are to be administered withing an hour before or an hour after the scheduled time unless there are specific instructions ordered by the physician" for R1, R3, R4, and R5.

Findings included:

- Record review for R1 revealed an admission date of 08/15/25 with diagnoses of Alzheimer's disease, atherosclerotic heart disease, hypertension and type two diabetes mellitus.

Review of R1's "Functional Capacity Screen" (FCS) dated 02/26/26 revealed R1 required physical assistance with bathing and dressing. R1 was independent with toileting, transferring, walking, mobility, and eating. 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 decision making. R1 was able to make himself understood and he usually understood others. R1 was marked at risk for falls and impaired decision making. R1 used no walking mobility device.

Review of R1's "Negotiated Service Agreement"

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| S3200 | Continued From page 27<br>(NSA) dated 02/26/26 instructed facility staff to provide standby assistance with bathing and dressing. Under the section titled "Fall Risk" facility staff were instructed to monitor R1 to ensure that he had his "Cane" when ambulating in the hallways and provide redirection if R1 seemed confused. Under the section titled "Safety Check" facility staff were instructed to check on R1 at the following times: 3:00 PM, 7:00 PM, 10:00 PM, 10:00 AM, 12:00 PM, 2:00 PM, 6:00 PM, 9:00 PM, and as needed. Nursing staff will administer all medications. Nursing will dial the insulin pen and hand to R1 to self-inject.<br><br>Record review of R1's "electronic Medication Administration Record" (eMAR) dated 02/19/26 to 03/04/26 revealed he had eleven scheduled medications to be administered every day. The scheduled medication times were 08:00AM, 12:30PM, 04:00PM, and 05:00PM. The eMar revealed that there were 133 out of 222 administration times were documented as administered outside the defined professional standards of practice.<br><br>- Record review for R3 revealed an admission date of 09/30/24 with diagnoses of atherosclerosis of the coronary artery bypass grafts, basal cell carcinoma of the skin, hypertension, impaired fasting glucose, malignant neoplasm of the prostate, and type two diabetes mellites.<br><br>Review of R3's FCS dated 10/01/25 revealed R3 required supervision with bathing and dressing. He was independent with toileting, transferring, walking, mobility, and eating. R3 lacked the ability to manage his own medications and | S3200 | | |

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medical treatments, was occasionally incontinent, and had impaired short-term memory. R3 was able to make himself understood and he understood others. R3 was marked at risk for impaired decision making and used no mobility device.

Review of R3's NSA dated 09/02/25 instructed facility staff to provide stand by assistance for bathing, dressing, safety checks "with all cares", dialing the insulin pen for R3 to self-administer, and manage all other ordered medications.

Record review of R3's eMAR dated 02/19/26 to 03/04/26 revealed he had twelve scheduled medications to be administered every day. The scheduled medication times were 08:00AM, 12:00PM, and 08:00PM. The eMAR revealed that 61 out of 211 scheduled medication administration times were documented as administered outside the defined professional standards of practice.

- Record review for R4 revealed an admission date of 09/20/24 with diagnoses of dementia, anemia, heart failure, central retinal artery occlusion of the right eye, chronic kidney disease stage three, major depressive disorder, Parkinson's disease, peripheral vascular disease, and atrial fibrillation.

Record review of R4's FCS dated 09/09/25 revealed R4 required physical assistance with bathing, dressing, toileting, transferring, walking, mobility, and supervision with eating. R4 lacked the ability to manage his own medications and medical treatments. R4 was frequently incontinent and had impaired short-term memory,

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long-term memory, memory/recall, and decision making. R4 was able to make himself understood and he understood others. R4 was marked at risk for falls, impaired vision, and impaired decision making. R4 used a walker and wheelchair mobility device.

Review of R4's NSA dated 01/01/25 revealed R4 was on hospice service with a local hospice provider. Facility staff were instructed to assist the hospice provider with bathing twice weekly. Facility staff were instructed to assist R4 in dressing daily, assist in setting up R4's meals, escort R4 to meals, provide hands on assistance for transferring, check on R4 evert two hours, assist with toileting and providing hygiene care, and administer medications.

Record review of R4's eMAR dated 02/19/26 to 03/04/26 revealed he had eight scheduled medications to be administered every day. The scheduled medication times were 08:00AM, 02:00PM, 05:00PM and 08:00PM.

R4's eMAR revealed an order for Carbidopa/Levodopa (a medication for treating Parkinson's disease). According to the professional standards of practice defined in the2013 Certified Medication Aid Curriculum; "Medication for treating Parkinson's disease must be administered in very specific time frames. Effort must be made to administer these mediations as close to possible and not more than 30 minutes before or after the scheduled times".

R4's Carbidopa/Levodopa was scheduled at 02:00PM three times daily. The eMar revealed

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| S3200 | Continued From page 30<br><br>26 out of 42 scheduled administration times were documented as administered outside the defined professional standards of practice, and there were 3 administration times that lacked documentation of the scheduled medication being administered.<br><br>R4's eMAR revealed that 71 out of 168 scheduled medication administration times were documented as administered outside the defined professional standards of practice.<br><br>- Record Review for R5 revealed an admission date of 12/17/25 with diagnoses of dementia, coronary artery disease, hearing loss, skin cancer of scalp and left ear.<br><br>Review of R5's FCS revealed R5 required physical assistance with bathing. R5 required supervision with dressing and toileting. R5 was independent with transferring, walking, mobility, and eating. R5 lacked the ability to manage his own medications and medical treatments. R5 was occasionally incontinent, and had impaired short-term memory, long-term memory, memory recall, and decision making. R5 was able to make himself understood and he understood others. R5 was marked at risk for impaired hearing, wandering, and impaired decision making. R5 used a walker mobility device.<br><br>Review of R5's NSA dated 12/17/25 instructed facility staff to provide assistance with all aspects of bathing and dressing. Facility staff were instructed to remind R5 to go to the bathroom at 10:00 AM, 02:00 PM, 07:00 PM, and as needed. Facility staff were instructed to manage and administer R5's medications. | S3200 | | |

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| S3200 | Continued From page 31<br><br>Record review of R5's eMAR dated 02/19/26 to 03/04/26 revealed he had three scheduled medications to be administered every day. The scheduled medication times were 08:00AM and 08:00PM. The eMAR revealed that 10 out of 42 scheduled medication administration times were documented as administered outside the defined professional standards of practice.<br><br>Interview on 03/05/26 at approximately 05:00PM with Administrator A and Licensed Nurse B confirmed the medication administration times documented were not within the defined professional standards of practice.<br><br>The Administrator failed to ensure that all medications the facility was responsible for were administered to each resident in accordance with the medical care provider's written order and professional standards of practice as defined in the 2013 Certified Medication Aid Curriculum; "Routine medications are to be administered withing an hour before or an hour after the scheduled time unless there are specific instructions ordered by the physician" for R1, R3, R4, and R5.<br><br>"Kansas Certified Medication Aide Curriculum" dated May 10, 2014. Page 172 "6. Right Time" | S3200 | | |
| S3310 SS=E | 26-41-207 (b) (5-6) (c) Infection Control Policies<br><br>(b) (5) prohibiting any employee with a communicable disease or any infected skin lesions from coming in direct contact with any resident, any resident ' s food, or resident care equipment until the condition is no longer | S3310 | | |

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| S3310 | Continued From page 32<br>infectious;<br>(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<br>(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<br><br>This REQUIREMENT is not met as evidenced by:<br>K.A.R. 26-41-207 (c)<br><br>The facility reported a census of 87 residents. The sample included 6 "Residents'" (R)'s and 9 focused reviews, and 5 newly hired employees. Based on record review and interview, the Administrator failed to ensure the facility's compliance with the department's "Tuberculosis" (TB) guidelines for adult care homes adopted by reference in K.A.R. 26-39-105 for R's 1 and 2.<br><br>Findings included:<br><br>- Record review for R1 revealed an admission date of 08/15/25 with diagnoses of Alzheimer's disease, atherosclerotic heart disease, hypertension and type two diabetes mellitus.<br><br>Review of R1's electronic "Medical Record" under the "Assessments" tab revealed and a TB screening questionnaire that was completed on 02/26/26. | S3310 | | |

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| S3310 | Continued From page 33<br><br>R1's electronic "Medical Record" lacked documentation of the required two step TB skin test being administered within seven days of admission to the facility.<br><br>- Record review for R2 revealed an admission date of 08/15/25 with diagnoses of anxiety, erosive arthritis, and Parkinson's disease.<br><br>Review of R2's electronic "Medical Record" under the "Assessments" tab revealed and a TB screening questionnaire that was completed on 02/26/26.<br><br>R2's electronic "Medical Record" lacked documentation of the required two step TB skin test being administered within seven days of admission to the facility.<br><br>Interview on 03/05/26 at approximately 05:00 PM with Administrator A and Licensed Nurse B confirmed the electronic Medical Records for R1 and R2 lacked documentation of the required two step TB skin test being administered within seven days of hire.<br><br>The Administrator failed to ensure the facility's compliance with the department's TB guidelines for adult care homes adopted by reference in K.A.R. 26-39-105 for R's 1 and 2. | S3310 | | |
| S3320 SS=F | 28-39-254 CONSTRUCTION<br><br>(a) The assisted living facility or residential health care facility shall be designed, constructed, equipped and maintained to protect the health and safety of residents, personnel and the public. | S3320 | | |

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| S3320 | Continued From page 34<br><br>(b) All new construction, renovation, remodeling and changes in building use in existing buildings shall comply with building and fire codes, ordinances and regulations enforced by city, county, and state jurisdictions, including the state fire marshal.<br><br>(c) New construction, modifications and equipment shall conform to the following codes and standards:<br><br>(1) Title III of the Americans with disabilities act, 42 U.S.C. 12181, effective as of January 26, 1992; and<br><br>(2) "Food Service Sanitation Manual," health, education, and welfare (HEW) publication no. FDA 78-2081, as in effect on July 1, 1981.<br><br>This REQUIREMENT is not met as evidenced by:<br>K.A.R. 28-39-254 (a)<br><br>The facility reported a census of 87 residents. The sample included 6 "Residents'" (R)'s and 9 focused reviews. 28 residents resided in the secured specialty unit. Based on observation and interview, the Administrator failed to ensure the secured specialty unit was maintained to protect the health and safety of the residents.<br><br>Findings included:<br><br>- Record Review for R4 revealed an admission date of 09/30/24 with diagnoses of dementia, anemia, atherosclerotic heart disease, central | S3320 | | |

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| S3320 | Continued From page 35 | S3320 | | |

retinal artery occlusion of the right eye, chronic kidney disease stage 3, heart failure, major depressive disorder, Parkinson's disease, peripheral vascular disease, atrial fibrillation, and unsteadiness on feet.

Review of R4's "Functional Capacity Screen" (FCS) dated 09/09/25 revealed R4 required physical assistance with bathing, dressing, toileting, transferring, walking, mobility, and supervision with eating. R4 lacked the ability to manage his own medications and medical treatments. R4 was frequently incontinent and had impaired short-term memory, long-term memory, memory/recall, and decision making. R4 was able to make himself understood and he understood others. R4 was marked at risk for falls, impaired vision, and impaired decision making. R4 used a walker and wheelchair mobility device.

Observation on 03/05/26 at approximately 04:00 PM of R4's room revealed a small table sat in the middle of his room with a bottle of Medline Antifungal Powder next to his chair. In R4's bathroom in the cabinets in the southwest corner of the room were a bottle of Lysol Spray cleaner and a spray bottle of Bona floor cleaner.

- Record review for R6 revealed an admission date of 12/01/25 with diagnoses of Alzheimer's disease and age-related osteoporosis.

Review of R6's FCS dated 02/02/26 revealed R6 required supervision with bathing and walking and mobility. R6 was independent with dressing, toileting, transferring, and eating. R6 lacked the ability to manage her own medications, she was

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| S3320 | Continued From page 36<br><br>continent, and R6 had impaired short-term memory, long-term memory, memory/recall, and decision making. R6 was able to make herself understood and she understood others. R6 was at risk for wandering and impaired decision making. R6 required no mobility device.<br><br>Observation on 03/03/26 at approximately 04:15 PM of R6s' bathroom revealed a set of cabinets on the northwest wall. In the cabinets were the following "Over-the-Counter" (OTC) medications: 1 bottle of Ibuprofen 200 milligrams and 1 bottle of Vitamin D3 Gummies 50 Micrograms. The cabinet contained 1 container of Clorox Wipes and 1 spray bottle of Dawn Power wash.<br><br>Observation on 03/05/26 at approximately at 04:30 PM, a can of Great Value Disinfectant Spray sat on the edge of the nurse desk in the common area.<br><br>Interview on 03/05/26 at approximately 05:00 PM with Administrator A and Licensed Nurse B confirmed all OTC medications and chemicals in the secured specialty unit were to be secured.<br><br>The Administrator failed to ensure the secured specialty unit was maintained to protect the health and safety of the residents. | S3320 | | |