STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175562	A. BUILDING _____ B. WING _____	04/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANCH HOUSE SENIOR LIVING LLC	2900 CAMPUS DRIVE GARDEN CITY, KS 67846

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following citations represent the findings of a Health Recertification Survey and complaint survey KS00194154.	F 000		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: The facility reported a census of 36 residents. The 12 sampled residents included three dependent residents reviewed for activities of daily living (ADLs). Based on observation, interviews, and record review the facility failed to provide bathing opportunities and grooming of facial hair in accordance with the residents' preferred bathing schedule to ensure necessary services to maintain good personal hygiene for Resident (R)5 and R9. This placed the residents at risk for impaired dignity and poor hygiene. Findings included: - A review of R5's undated "Physician Orders," (POS), included diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure) and major depressive disorder (major mood disorder which causes persistent feelings of sadness). The "Annual Minimum Data Set" (MDS), dated 10/11/24, documented a Brief Interview for Mental Status (BIMS) score of eight, indicating moderate	F 677		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175562	A. BUILDING _____ B. WING _____	04/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 677	Continued From page 1	F 677		

cognitive impairment. He exhibited fluctuating behaviors of inattention and disorganized thinking and demonstrated other behavioral symptoms not directed toward others one to three days of the look-back period. The resident reported choosing his bath type was very important. He was dependent on staff for bathing and personal hygiene which included shaving.

The "Quarterly MDS" dated 04/04/25, documented the resident did not complete the BIMS interview.

The "Functional Abilities [Self-Care and Mobility] Care Area Assessment" (CAA)," dated 10/25/25, documented R5 was dependent on staff assistance for bathing and grooming/personal hygiene due to his diagnosis of Alzheimer's dementia noted by primary care physician (PCP) on 09/26/24. The facility planned to proceed to care planning and staff would continue to assist R5 with ADL.

R5's "Care Plan" (CP) dated 01/09/25, documented the resident was not able to perform his own ADL and was dependent on staff for bathing and grooming. The CP lacked the resident's preferences and schedule for bathing.

Review of R5's Electronic Medical Record (EMR) for "Tasks /ADL shower" dated 03/17/25 through 04/14/25, revealed the resident received one shower on 03/21/25.ThR5'sEMR lacked documentation of bathing opportunities offered, or refusals by the resident. The documentation in the "Task" section of the EMR documented bathing was not applicable on 03/26/25, 3/28, 03/31/25, 04/04/25, 04/07/25, 04/09/25, and 04/11/25 .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175562	A. BUILDING _____ B. WING _____	04/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANCH HOUSE SENIOR LIVING LLC	2900 CAMPUS DRIVE GARDEN CITY, KS 67846

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 2	F 677		

Review of R5's "Bath Sheets," dated 03/17/25 through 04/17/25, documented the following:
1. On 04/01/25, R5 was combative and refused a shower.
2. On 04/04/25, R5 refused a shower.
3. On 04/14/25 R5 refused a shower.

R5's entire clinical record reflected the staff offered four bathing opportunities, including shaves from 03/15/25 through 04/14/25, versus the required eight bathing opportunities as a minimum requirement, unless otherwise indicated as resident preference.

On 04/15/25 at 01:41 PM, R5 spoke incoherently while he rocked his wheelchair back and forth with his feet. He had prominent beard stubble on his face with irregular borders. R5 did not respond to direct questioning but continued to speak incoherently and repeating "ho."

On 04/16/25 at 12:40 PM, Certified Medication Aide (CMA) F confirmed R5's beard stubble. She reported residents were shaved with their shower/bath, and as needed. CMA F said staff should document baths in the EMR and complete bath sheets when baths are offered and if the residents refused their bath/shower, the refusal should be documented and reported to the charge nurse for follow-up. CMA F stated R5 liked his bath very early in the morning.

On 04/17/25 at 01:27 PM, Administrative Nurse B verified the above findings. She stated R5 was dependent on staff for bathing, grooming, and personal hygiene and he preferred to take a bath at 04:00 AM. Administrative Nurse B said R5 would refuse baths occasionally depending on his

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175562	A. BUILDING _____ B. WING _____	04/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANCH HOUSE SENIOR LIVING LLC	2900 CAMPUS DRIVE GARDEN CITY, KS 67846

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 3	F 677		

moods. She said if that happened, staff should go back and offer R5 other bathing opportunities. Administrative Nurse D said staff should offer to shave the resident with his bath/shower and document any offering and/or refusal. She stated staff should offer a minimum of two showers per week and/or in keeping with the resident's preferences and shaving assistance should be offered during baths/showers and as needed, as part of grooming and personal hygiene.

The facility policy "Activities of Daily Living," dated 04/27/2018, documentation included residents will be given the appropriate treatment and services to maintain or improve his/her ability to carry out the activities of daily living. The facility will provide care and services based on the comprehensive assessment of the resident and consistent with his/her needs or choice for following activities of daily living which include hygiene-bathing, and grooming. Residents who are unable to carry out activities of daily living and are dependent on staff will receive the necessary services to maintain grooming and personal hygiene.

- R9's Electronic Health Record (EHR) revealed diagnoses of diabetes mellitus (DM-when the body cannot use glucose, not enough insulin made, or the body cannot respond to the insulin) and end-stage renal disease (ESRD-a terminal disease of the kidneys).

The 03/28/25 "Annual Minimum Data Set" (MDS) did not have a Brief Interview for Mental Status (BIMS) score, or staff interview completed. The MDS documented that choosing his bath type was very important to R9. R9 required moderate assistance with personal hygiene which included

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175562	A. BUILDING _____ B. WING _____	04/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANCH HOUSE SENIOR LIVING LLC	2900 CAMPUS DRIVE GARDEN CITY, KS 67846

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 4	F 677		

shaving.

The 04/04/25 "Functional Abilities (Self-Care and Mobility) Care Area Assessment" (CAA) did not trigger.

The 01/03/25 "Quarterly MDS" documented the resident had a BIMS score of 10, which indicated moderately impaired cognition. R9's bathing and personal hygiene were not assessed.

R9's "Care Plan" documented an intervention dated 05/12/23 which directed staff that R9 preferred his mustache, and he would let staff know when he required shaving/trimming facial hair.

R9's "Bathing Task" in the EHR documented the staff offered six bathing opportunities, to include shaves from 03/25/25 through 04/15/25. R9 refused his showers on 04/01/25, 04/08/25 and 04/15/25. On 03/25/24 R9 was dependent on staff for bathing. On 03/27/25 and 04/03/25 staff documented bathing as non-applicable.

R9's "Personal Hygiene Task" described as the ability to maintain personal hygiene, including combing hair, and shaving reviewed from 03/24/25 thru 04/15/25 documented seven times that R9 was dependent on staff for personal hygiene. Additionally, nine times R9 required moderate to maximal assistance from the staff.

During an observation on 04/15/25 at 02:29 PM, R9 had prominent beard stubble on his face with irregular borders and a mustache. R9 reported that he required help to be shaved. R9 had visible involuntary movements of the right hand and arm.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175562	A. BUILDING _____ B. WING _____	04/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANCH HOUSE SENIOR LIVING LLC	2900 CAMPUS DRIVE GARDEN CITY, KS 67846

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 5	F 677		

During an observation on 04/16/25 at 12:30 M, R9 sat in his room with his beanie cap on and lightweight coat. R9 had involuntary movements of the hands and arms. R9 reported he was not cold, but he had just come back from dialysis. When asked, R9 reported he would like a shave.

During an interview on 04/16/25 at 12:40 PM, Certified Medication Aide (CMA) F reported residents were shaved with their shower/bath, and as needed. CMA F said staff should document baths in the EHR and complete bath sheets when baths are offered and if the residents refused their bath/shower, the refusal should be documented and reported to the charge nurse for follow-up.

During an interview on 04/17/25 at 08:10 AM, CMA K reported that R9 required more assistance with holding items like his cup of fluids when she administered his medications. CMA K reported that R9's tremors had progressively gotten worse for the past several months and that R9 required more assistance from the staff for shaving and combing his hair. CMA K reported that R9 would refuse his showers at times.

On 04/17/25 at 01:27 PM, Administrative Nurse B verified the above findings. She stated that R9 was dependent on staff for bathing, grooming, and personal hygiene. Administrative Nurse B reported that R9 would refuse baths occasionally dependent on his mood. She said if that happened, staff should go back and offer R9 other bathing opportunities. Administrative Nurse D said staff should offer to shave the resident with his bath/shower and document any offering and/or refusal. She stated staff should offer a minimum of two showers per week and/or in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175562	A. BUILDING _____ B. WING _____	04/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANCH HOUSE SENIOR LIVING LLC	2900 CAMPUS DRIVE GARDEN CITY, KS 67846

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 6 keeping with the resident's preferences and shaving assistance should be offered during baths/showers and as needed, as part of grooming and personal hygiene. The facility policy "Activities of Daily Living," dated 04/27/2018, documentation included residents will be given the appropriate treatment and services to maintain or improve his/her ability to carry out the activities of daily living. The facility will provide care and services based on the comprehensive assessment of the resident and consistent with his/her needs or choice for following activities of daily living which include hygiene-bathing, and grooming. Residents who are unable to carry out activities of daily living and are dependent on staff will receive the necessary services to maintain grooming and personal hygiene.	F 677		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by:	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175562	A. BUILDING _____ B. WING _____	04/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 7	F 686		

The facility identified a census of 36 residents, with 12 residents sampled, including two residents reviewed for pressure ulcers (localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction). Based on observation, interview, and record review, the facility failed to identify and implement measures consistent with in accordance with professional standards of practice to prevent the development of and promote the healing of pressure ulcers for Resident (R) 34 when staff failed to ensure R34's heels were offloaded and failed to develop a consistent repositioning plan. The facility further failed to ensure R24 received the required interventions including a low air loss mattress to prevent pressure ulcers. This placed the residents at risk for the development of new pressure ulcers, delayed healing, and worsening of existing ulcers.

Findings included:

- R34's Electronic Health Record (EHR) revealed diagnoses of pneumococcal arthritis of the right and left knees (a condition where the knee joints are infected with Streptococcus pneumoniae [bacteria] leading to inflammation and pain), diabetes mellitus (DM-when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin) and effusion (abnormal accumulation of fluid between tissues) of right and left knees.

The 03/25/25 "Admission Minimum Data Set" (MDS) documented the resident did not have a Brief Interview for Mental Status (BIMS) assessed and no staff interview was completed. R34

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175562	A. BUILDING _____ B. WING _____	04/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 8	F 686		

required total assistance with activities of daily living (ADL) including transfers, toileting hygiene, dressing, and applying footwear. R34 required maximal assistance for bed mobility, turning from side to side, and was frequently incontinent of urine. The MDS documented R34 had no turning and repositioning program.

The 03/31/25 "Pressure Ulcer/Injury Care Area Assessment " (CAA) documented R34 had an open area on her left buttock when she admitted from the hospital that healed in one week; R34 had no other pressure injuries. The CAA noted risk was present due to decreased independent mobility. R34 was assisted with turning and positioning and pressure injury prevention will be care planned.

R34's "Care Plan" documented R34 did not want to develop any pressure injuries and included interventions dated 03/31/25 that directed staff to provide R34 with turning from side to side; staff were instructed to reposition R34 from side to side in bed and to move R34 in her chair at least every two to three hours. The plan noted R34 could move herself but could not fully change position without help.

R34's "Tasks Roll Left and Right" in EHR the staff documented 17 times from 03/25/25 through 04/17/25 that R34 required total dependent on staff to roll left to right side in bed.

R34's "Tasks" in the EHR lacked a turn and repositioning program.

R34's "Physician's Orders" documented the following:
Low air loss mattress ordered 03/20/25.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175562	A. BUILDING _____ B. WING _____	04/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 9	F 686		

Wound care one time a day every other day for left heel pressure wound. Apply Medi-Honey (a medical-grade wound care dressing that incorporates manuka honey to promote wound healing) to the wound bed, cover with Opti foam dressing (a type of foam wound dressing designed to promote healing by absorbing wound fluid, protecting the wound bed, and providing a comfortable environment for healing) and as needed if the dressing is soiled, or missing, ordered 04/15/25.

Review of the "Braden Scale" (a tool used to assess a patient's risk for developing a pressure injury) documented on 03/25/25 and 04/01/25 R34 was at risk with a score of 16 which indicated mild risk. The assessment performed on 04/08/25 R34 was at risk with a score of 17 which indicated mild risk.

The 03/28/25 at 04:30 PM "Weekly Wound Assessment" documented a small pressure ulcer to the back of the left heel when the assessment was completed that measured 0.5 centimeters (cm) by 0.5 cm, stage two. This was the first observation of an open area. Interventions in place was a low loss air mattress, pressure relieving cushion in wheelchair and recliner.

The 04/01/25 at 08:28 AM "Progress Note" documented R34's left heel was brown, red and discoloration noted.

The 04/07/25 "Weekly Wound Assessment" documented R34's left heel was unchanged, with very little improvement. It measured 0.5 cm by 0.4 cm. The assessment directed staff to continue with the same treatment.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175562	A. BUILDING _____ B. WING _____	04/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANCH HOUSE SENIOR LIVING LLC	2900 CAMPUS DRIVE GARDEN CITY, KS 67846

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 10	F 686		

The 04/14/25 "Weekly Wound Assessment" documented R34's left heal improved, measured 0.5 cm by 0.4 cm. The assessment noted a very slight improvement in size, and the color was better; the physician assessed the wound and a new order was received. Interventions in place was a low loss air mattress, pressure relieving cushion in wheelchair and recliner.

During an interview on 04/15/25 at 01:52 PM, R34 reported the facility provided her with an air mattress a couple of days after she was admitted for her back pain.

During an interview on 04/16/25 at 12:20 PM, R34 reported that she did have an open area on her left heel. R34 reported the facility had not provided an offloading bootie and revealed she was told the booties had been ordered. R34 reported she required staff to assist her with repositioning in the bed. R34 pulled her sheet back from off her legs; her right leg was elevated on a pillow, and her left leg was positioned directly on the air mattress.

During an interview on 04/16/25 at 01:30 PM, Certified Nurse Aide (CNA) G reported that R34 had no open areas and did not have a turn and reposition schedule on her assigned tasks on the EHR that staff were to document the care provided. Additionally, CNA G reported R34 did not have offloading booties and staff would position heels off the bed with a pillow. CNA G reported R34 was able to reposition herself independently.

During an interview on 04/17/25 at 09:00 AM Administrative Nurse C reported that R34's open area on her left heel was not observed until

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175562	A. BUILDING _____ B. WING _____	04/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANCH HOUSE SENIOR LIVING LLC	2900 CAMPUS DRIVE GARDEN CITY, KS 67846

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 11	F 686		

03/31/25. Administrative Nurse C reported that the physician had requested a sheepskin bootie for R34's left heel and forgot to place an order for the bootie. Additionally, Administrative Nurse C reported that R34's left heel was healing slowly and was unaware if the CNAs were required to document a turn and position program in the EHR.

During an interview on 04/17/25 at 10:00 AM Administrative Nurse B reported she expected staff to document a turn and position intervention in the EHR. She also expected the staff to order the medical interventions to help prevent or heal skin occurrences.

The facility's policy "Wound Assessment, Prevention, And Treatment" dated 11/28/17 documented on admission, assessment of resident's skin will be documented on the admission assessment. The Braden Scale would be completed at the time of admission, the first four weeks after admission, quarterly, and with any significant change. The wound nurse would complete an initial wound assessment of any newly identified skin issue by the end of the next working day. A care plan would be developed for a resident with a skin issue with specific wound healing interventions and an individualized turning/repositioning scheduled as indicated.

- R24's Electronic Health Record (EHR) revealed diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), and depression.

The 06/28/24 "Annual Minimum Data Set" (MDS) documented the resident had a Brief Interview for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175562	A. BUILDING _____ B. WING _____	04/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANCH HOUSE SENIOR LIVING LLC	2900 CAMPUS DRIVE GARDEN CITY, KS 67846

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 12	F 686		

Mental Status (BIMS) score of zero, which indicated severely impaired cognition. R24 required maximal assistance with activities of daily living (ADL) including bed mobility, standing, and transfers. The MDS noted R24 had no skin issues and was at risk for development of pressure ulcer injuries.

The 07/15/24 "Pressure Ulcer/Injury Care Area Assessment" (CAA) documented R24 had no skin issues at that time. R24 was incontinent and required briefs. R24 had a pressure relieving mattress and pressure relieving cushion in the recliner and wheelchair.

The 03/07/25 "Quarterly MDS" documented R24 had a BIMS of zero,. R24 was totally dependent for all ADLs except required moderate assistance with ambulation of 10 feet required. The MDS noted R24 had no skin issues and was at risk for development of pressure ulcer injuries.

R24's "Care Plan" documented an intervention dated 08/07/23 that directed staff to provide a low air loss mattress on R24's bed and pressure relieving cushion in her chair.

R24's "Tasks" and "Care Plan" in the EHR lacked a turn and repositioning program.

R24's "Braden Scale" (a tool used to assess a patient's risk for developing a pressure injury) documented on 08/03/23, R24 was at risk with a score of 17 which indicated mild risk for pressure injuries.

Review of the "Physician Orders" lacked an order for treatment and/or monitoring for any skin conditions.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175562	A. BUILDING _____ B. WING _____	04/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANCH HOUSE SENIOR LIVING LLC	2900 CAMPUS DRIVE GARDEN CITY, KS 67846

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 13	F 686		

The 03/09/25 at 04:34 AM "Skin/Wound Note" documented that staff notified the nurse of a wound on R24's right inner buttock; staff observed a broken blister, and the wound bed was pink. No measurements were documented. Staff applied a GentilFoam (a foam wound dressing designed to provide a moist wound healing environment) dressing to the area.

The 03/09/25 at 04:37 AM "Skin/Wound Note" documented the wound care nurse was notified at that time.

The 04/05/25 at 05:33 PM "Skin/Wound Note" documented a small open area was noted approximately one quarter inch on both the right and left gluteal (buttock) folds.

The 04/17/25 at 11:14 AM "Skin/Wound Note" documented Administrative Nurse C was requested to assess R24's wound to the right lower shin and a small pressure ulcer to the right buttock. The note documented dressings were placed to both areas, and a wound assessment was opened.

During an observation on 04/16/25 at 12:05 PM, R24 sat in a recliner in the lounge area. Further observation revealed R24's bed had a regular mattress instead of a low air loss mattress. A hydrocolloid dressing (a type of wound dressing that creates a moist healing environment) in a packet laid on her dresser.

During an interview on 04/16/25 at 01:54 PM Certified Nurse Aide (CNA) H reported that R24 did not have any open areas on her skin when he completed incontinent care prior to lunch. He said

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175562	A. BUILDING _____ B. WING _____	04/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANCH HOUSE SENIOR LIVING LLC	2900 CAMPUS DRIVE GARDEN CITY, KS 67846

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 14	F 686		

that R24 did not have any wound dressing noted on her skin either. CNA H reported that R24 had never had an air mattress on her bed.

During an interview on 04/16/25 at 02:05 PM, Licensed Nurse (LN) L reported that Administrative Nurse C would complete the weekly wound assessments in the EHR for residents who had a skin concern that required monitoring. LN L reported that if a resident would have a new open area noted, Administrative Nurse C would be notified to assess the area during the week and if an open area occurred when Administrative Nurse C was not at work, the nurse would use a standing order for a treatment and leave Administrative Nurse C a note to assess the area when she worked next.

During an interview on 04/16/25 at 02:22 PM, CNA G reported that R24 did not have any open wounds, skin conditions, or dressings noted on her skin when she assisted with incontinent care that day. CNA G reported that if a resident did have a skin concern, she would notify the nurse. CNA G reported that if the resident's dressing came off they would notify the nurse. CNA G reported that the staff were required to reposition R24 every two to three hours.

During an observation on 04/17/25 at 09:26 AM, R24 had an open area on her right buttock with approximate measurement of 0.8 centimeter (cm) by 1.0 cm. and an open area on the right lower shin, approximate measurement of 0.8 cm by 0.5 cm.

During an interview on 04/17/25 at 10:00 AM, Administrative Nurse C reported that R24 had a chronic surgical wound on her lower back that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175562	A. BUILDING _____ B. WING _____	04/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 15 would re-open and close from time to time and that area would never heal. Administrative Nurse C reported that the pressure ulcer she observed on R24's right buttock was the first time she had been notified of an open area. Administrative Nurse C reported she was unaware of the progress notes written on 03/09/25 and 04/05/25. Administrative Nurse C revealed the hydrocolloid dressing that was in R24's room was used on the chronic surgical area on R24's lower back when it would get red. Administrative Nurse C verified that R24 did not have an air mattress on her bed as documented on R24's "Care Plan." Administrative Nurse C said R24 did not have a physician's order to have an air mattress and was unaware if the CNAs were required to document a turn and position program in her. Administrative Nurse C reported R24 was unable to reposition herself in her room. The facility's policy "Wound Assessment, Prevention, And Treatment" dated 11/28/17 documented on admission, assessment of resident's skin will be documented on the admission assessment. The Braden Scale would be completed at the time of admission, the first four weeks after admission, quarterly, and with any significant change. The wound nurse would complete an initial wound assessment of any newly identified skin issue by the end of the next working day. A care plan would be developed for a resident with a skin issue with specific wound healing interventions and an individualized turning/repositioning scheduled as indicated.	F 686		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents.	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175562	A. BUILDING _____ B. WING _____	04/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANCH HOUSE SENIOR LIVING LLC	2900 CAMPUS DRIVE GARDEN CITY, KS 67846

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 16	F 689		

The facility must ensure that -
§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and

§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 36 residents with 12 residents in the sample and seven residents reviewed for accidents. Based on observation, interview, and record review, the facility failed to provide an environment free from accident hazards for two residents. The facility failed to complete an investigation to determine causative factors and implement interventions to prevent further falls for Resident (R) 24. This failure placed the affected resident at risk for further falls, accidents, and related injuries.

Findings included:

- R24's Electronic Health Record (EHR) revealed diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), and depression.

The 06/28/24 "Annual Minimum Data Set" (MDS) documented the resident had a Brief Interview for Mental Status (BIMS) score of zero, which indicated severely impaired cognition. R24 required maximal assistance with activities of daily living (ADL) including bed mobility, standing, and transfers. R24 required supervision for ambulation for 10 feet. The MDS documented R24 had one fall which resulted in a major injury.

The 07/15/24 "Falls Care Area Assessment "

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175562	A. BUILDING _____ B. WING _____	04/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANCH HOUSE SENIOR LIVING LLC	2900 CAMPUS DRIVE GARDEN CITY, KS 67846

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 17	F 689		

(CAA) documented R24 was at risk for falls and had a fall the past quarter. The care plan was updated to direct staff to assist R24 with toileting after meals and to offer her a recliner after meals. R24 had a diagnosis of dementia (a progressive mental disorder characterized by failing memory, and confusion) and was forgetful and will try to transfer and ambulate by herself.

The 03/07/25 "Quarterly MDS" documented R24 had a BIMS of zero. R24 was totally dependent for all ADL except moderate assistance with ambulation of 10 feet required. The MDS noted R24 had no falls.

R24's "Care Plan" documented an intervention dated 07/09/24 which directed staff to assist R24 to the recliner after mealtimes. An intervention dated 09/13/24 directed staff to provide a gait belt when transferring R24 to the bathroom. An intervention dated 11/20/24 directed staff to keep a close eye on R24 until the resident's behaviors were resolved.

R24's "Care Plan" documented an intervention initiated on 05/22/24 and resolved on 10/03/24 that documented R24 had a fractured toe on her left foot and wore a boot for healing which allowed the resident to bear weight.

R24's EHR documented a "Fall Risk Assessments" dated 01/12/24 which a documented R24 was at high fall risk and staff were to provide frequent checks and maintain R24's bed in the lowest position.

The 05/11/24 at 07:22 AM "Progress Note" documented R24 was transferred to the hospital as R24 was found leaning in her wheelchair

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175562	A. BUILDING _____ B. WING _____	04/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANCH HOUSE SENIOR LIVING LLC	2900 CAMPUS DRIVE GARDEN CITY, KS 67846

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 18	F 689		

unresponsive with labored breathing.

The 05/11/24 at 10:38 AM "Emergency Department Encounter Note" documented R24 reportedly had an unresponsive episode that occurred just prior to arrival. Her extremities were symmetrical, full passive range of motion. Final diagnosis documented: cystitis (inflammation of the bladder, often caused by a bacterial infection), alteration in mental status, chronic kidney disease (a condition where the kidneys are damaged and cannot filter blood effectively), and systemic inflammatory response syndrome (SIRS- a widespread, exaggerated inflammatory response to an insult, like infection, trauma, or surgery, that involves changes in body temperature, heart rate, respiratory rate, and white blood cell count.

The 05/11/24 at 11:25 AM "Progress Note" documented R24 transferred back to the facility and received orders for Keflex (an antibiotic).

R24's EHR did not have any progress notes for 05/12/24.

The 05/13/24 at 03:53 AM "Progress Note" documented R24's left lower extremity was swollen, warm and painful to touch. R24 had groaned out in pain when the left foot was rotated.
The 05/13/24 at 05:10 PM "Progress Note" documented X-ray results returned that noted a fracture of fifth metatarsal (bone of the foot on the outer edge of foot behind the small toe).

The 05/13/24 "X-ray Report" documented a nondisplaced hairline fracture of the distal (situated away from the center of the body)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175562	A. BUILDING _____ B. WING _____	04/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANCH HOUSE SENIOR LIVING LLC	2900 CAMPUS DRIVE GARDEN CITY, KS 67846

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 19	F 689		

aspect of the fifth metatarsal bone and a subtle fracture at the base of the proximal (nearer to the center of the body) fifth phalanx (toe).

The 05/15/24 at 10:45 AM "Orthopedic Consult Note" documented R24 had a fracture related to an assisted fall on 05/11/24 per the resident's husband.

A "Physician's Order" dated 05/16/24 noted an order for a bunion (painful swelling of the first joint of the big toe) shoe when ambulating, weight bearing as tolerated for a diagnosis of fifth metatarsal fracture. The order was discontinued on 07/31/24 due to the foot was well healed per the note.

The "Care Plan Review and Progress Note" dated 07/11/24 documented R24 was doing very well and continued to wear her boot due to her toe fracture. The note recorded R24 saw her orthopedic doctor and he requested R24 wear her boot for another two weeks and then follow up on her progress.

Upon request, the facility was unable to provide additional documentation including evidence an investigation was conducted and causative factors identified.

During an observation on 04/16/25 at 12:05 PM, Certified Nurse Aide (CNA) G and CNA H assisted R24 up from the recliner to the wheelchair, staff used a gait belt though R24 appeared to have difficulty with straightening out her legs to bear weight when she stood up.

During an interview on 04/16/25 at 03:45 PM Administrative Staff A said he looked for the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175562	A. BUILDING _____ B. WING _____	04/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANCH HOUSE SENIOR LIVING LLC	2900 CAMPUS DRIVE GARDEN CITY, KS 67846

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F 689	Continued From page 20 report with all the facility reported incidents, but he could not locate the investigation regarding the fractures that R24 sustained in May 2024. During an interview on 04/16/25 at 03:50 PM Administrative Nurse B reported that she could not locate a fall investigation in the EHR for R24. Additionally, she reported that she could not locate any investigation for the regarding R24's left foot. During an interview on 04/17/25 at 08:54 AM Licensed Nurse (LN) I could not recall if R24 had ever had a fractured foot. During an interview on 04/17/25 at 09:41 AM, Certified Medication Aide (CMA) J reported that R24 had a fractured foot in May 2024, CMA J could not recall how R24 fractured her foot. During an interview on 04/17/25 at 10:30 AM Administrative Staff A reported that he expected staff to complete an investigation for all incidents and report them, if needed, to the state agency, The facility's policy "Fall Management" dated 10/19/20 documented all fall occurrences will be documented and thoroughly investigated using risk management.	F 689		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including	F 757		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175562	A. BUILDING _____ B. WING _____	04/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANCH HOUSE SENIOR LIVING LLC	2900 CAMPUS DRIVE GARDEN CITY, KS 67846

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 757	Continued From page 21	F 757		

duplicate drug therapy); or

§483.45(d)(2) For excessive duration; or

§483.45(d)(3) Without adequate monitoring; or

§483.45(d)(4) Without adequate indications for its use; or

§483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or

§483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 36 residents, with 12 residents selected for review which included six residents reviewed for unnecessary medications. Based on observation, interview, and record review, the facility failed to ensure the residents remained free from unnecessary medications when the facility failed to follow physician orders related to blood pressure monitoring and related parameters for three residents, Resident (R)10, R25, and R9. This placed the resident at risk for adverse medication effects.

Findings included:

- R10's Electronic Health Records (EHR) recorded an undated "Physician Orders" (POS) that documented diagnoses which included Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure) and hypertension (high blood

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175562	A. BUILDING _____ B. WING _____	04/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANCH HOUSE SENIOR LIVING LLC	2900 CAMPUS DRIVE GARDEN CITY, KS 67846

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 757	Continued From page 22	F 757		

pressure).

The "Admission Minimum Data Set" (MDS) dated 09/17/24, documented a Brief Interview for Mental Status (BIMS) score of nine, indicating moderate cognitive impairment.

The "Functional Abilities (Self Care Mobility) Care Area Assessment" (CAA) and "Falls CAA" dated 09/17/24 documented R10 recently admitted to the facility with a diagnosis of Alzheimer's disease. She lived on her own and was independent prior to a fall on 08/17/24, for which she was hospitalized. The reason for her fall was unknown. R10 was admitted to skilled services for physical therapy and occupational therapy (PT/OT) for strengthening and safety with activities of daily living (ADL), with plans to return home independently.

R10's "Care Plan" (CP) dated 03/26/25 directed staff to administer medications as ordered by the physician and monitor for side effects and adverse reactions of medication. The CP heading included "Special Instruction" for parameters which included notifying the physician if the systolic blood pressure (SBP- top number, the force your heart exerts on the walls of your arteries each time it beats) was less than 80 millimeters (mm) of Mercury (Hg) or greater than 200 mm/Hg.

R10's "Physician Orders" documented the following cardiac and blood pressure medication orders:
Cozaar (medication used to treat high blood pressure) tablet 50 milligrams (mg); give 50 mg by mouth daily for hypertension and hold for blood pressure (BP) of less than 130/80 mm/Hg,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175562	A. BUILDING _____ B. WING _____	04/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANCH HOUSE SENIOR LIVING LLC	2900 CAMPUS DRIVE GARDEN CITY, KS 67846

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 757	Continued From page 23	F 757		

ordered 02/22/25.

A review of R10's 02/22/25 through 04/15/25, "Medication Administration Record" (MAR), revealed the Cozaar was given outside of the prescribed physician order for 45 of 54 doses as follows:
On 02/22/25 through 02/27/25, six doses,
On 03/02/25 through 03/16/25, 16 doses,
On 03/18/25 through 03/30/25, 12 doses,
On 04/01/25 through 04/05/25, four doses
On 04/09/25 and 04/10/25, two doses,
On 04/12/25 through 04/16/25, five doses.

On 04/17/25 at 09:09 AM R10 sat at the dining room table feeding herself. Certified Medication Aide (CMA) K checked R10's BP which was 159/90 mm/Hg then administered the resident her medications which included Cozaar. R10 took her medications without question or hesitation. CMA K verified the medication should be given in keeping with the physician-prescribed orders. CMA K stated if the resident's BP was less than 130/80 mm/Hg, she should hold the medication, notify the charge nurse, and await further instructions.

04/17/25 11:32 AM, Administrative Nurse B reviewed R10's MAR for 02/22/25 through 3/31/25 and confirmed the antihypertensive medications during that time frame (as noted above) were given outside of the physician's prescribed parameter. She stated the Cozaar should have been held by the CMA until such time the charge nurse and the physician were notified to provide further instructions.

The facility policy "Unnecessary Medications," dated 12/04/24, documentation included each

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175562	A. BUILDING _____ B. WING _____	04/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANCH HOUSE SENIOR LIVING LLC	2900 CAMPUS DRIVE GARDEN CITY, KS 67846

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 757	Continued From page 24	F 757		

resident's drug regimen must be free of unnecessary drugs. An unnecessary drug is any drug when used in excessive doses.

- R25's Electronic Health Records (EHR) recorded an undated "Physician Orders" (POS) that documented diagnoses which included agoraphobia (anxiety disorder that causes fear of places and situations that might cause panic, helplessness, or embarrassment), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), and hypertension (high blood pressure) heart disease with heart failure.

The "Annual Minimum Data Set" (MDS) dated 08/23/24, documented a Brief Interview for Mental Status (BIMS) score of 15, indicating cognitively intact. She received diuretics (a medication used to promote the formation excretion of urine) and anti-anxiety medication.

The "Quarterly MDS," dated 04/08/25 documented changes from above which included sR25 received anti-depressant (medication used to treat depression) medication, opioid (narcotic pain medication), and antibiotics (class of mediation used to treat bacterial infections) in addition to the above medications.

The " Psychotropic Drug Use Care Area Assessment" (CAA) dated 09/10/24 documented R25 had diagnoses that included anxiety and agoraphobia. The CAA noted R25 received Xanax (anti-anxiety medication) daily and the dose was recently increased to manage symptoms. R25 scored a 15 on her BIMS during the lookback. Staff monitored for adverse side

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175562	A. BUILDING _____ B. WING _____	04/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANCH HOUSE SENIOR LIVING LLC	2900 CAMPUS DRIVE GARDEN CITY, KS 67846

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 757	Continued From page 25	F 757		

effects of medications and the pharmacist reviewed medications per regulatory requirements.

R25s "Care Plan" (CP) dated 03/26/25, directed staff to administer medications as ordered by the physician and monitor for side effects and adverse reactions of medication. The CP heading included "Special Instruction" for parameters which included notifying the physician if the systolic blood pressure (SBP- top number, the force your heart exerts on the walls of your arteries each time it beats) was less than 80 millimeters (mm) of Mercury (Hg) or greater than 200 mm/Hg.

R25's "Physician Orders" documented the following cardiac and blood pressure medication order:
Norvasc tablet 2.5 milligrams (mg), by mouth, daily for hypertension. Hold if SBP was less than 120 mm/Hg, ordered 09/08/23.

Review of R25's "Medication Administration Record" (MAR) and EHR for the time frame from 02/01/25 through 04/15/25, revealed the resident's BP was not obtained on 74 occasions prior to the administration of the prescribed antihypertensive medication as ordered (Norvasc) .

On 04/17/25 at 08:44 AM, observation revealed Certified Medication Aide (CMA) K administered R25's morning medications which included the Norvasc. She stated R25's MAR did not include monitoring for R25's blood pressure.

On 04/17/25 at 09:09 AM CMA K verified R25's medication should be given in keeping with the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175562	A. BUILDING _____ B. WING _____	04/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 757	Continued From page 26	F 757		

physician prescribed orders. CMA K stated if R25's orders indicated the medication should be monitored for specific values, then the blood pressure should be obtained prior to giving a resident the medication. CMA K said if the medication was held, the nurse should be notified and provide further instructions.

On 04/17/25 at 11:32 AM, Administrative Nurse B reviewed R25's MAR for 02/01/25 through 04/16/25 and confirmed the blood pressure was not monitored prior to the administration of the antihypertensive medication as ordered by the physician.

The facility policy "Unnecessary Medications," dated 12/04/24, documentation included each resident's drug regimen must be free of unnecessary drugs. An unnecessary drug is any drug when used in excessive doses.

- R9's Electronic Health Record (EHR) revealed diagnoses of diabetes mellitus (DM-when the body cannot use glucose, not enough insulin made, or the body cannot respond to the insulin), end-stage renal disease (ESRD-a terminal disease of the kidneys) and hypertension (HTN-elevated blood pressure)

The 03/28/25 "Annual Minimum Data Set" (MDS) did not have a Brief Interview for Mental Status (BIMS) score or staff interview completed. R9 required moderate assistance with personal hygiene which included shaving.

The 04/04/25 "Functional Abilities (Self-Care and Mobility) Care Area Assessment" (CAA) did not trigger.

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	175562	A. BUILDING _____ B. WING _____	04/17/2025

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F 757	Continued From page 27	F 757		

The 01/03/25 "Quarterly MDS" documented the resident had a BIMS score of 10, which indicated moderately impaired cognition. R9's bathing and personal hygiene were not assessed.

R9's "Care Plan" documented an intervention dated 05/01/23 that directed staff to monitor for indicated reactions of medications and notify the physician right away if any were noted.

A "Physician's Order" dated 09/19/24 noted an order for Procardia Extended Release (ER) (a medication used to treat hypertension) tablet 30 milligrams (mg), give one tablet by mouth, daily for hypertension. Contact the physician for a blood pressure (B/P) greater than 160/90 millimeters (mm) of Mercury (Hg).

R9's "Vital Signs" tab and "Medication Administration Record" (MAR) in R9's EHR were reviewed for the dates 09/19/24 through 04/17/25. The records lacked evidence of a BP assessment prior admisnitration of the Procardia.

During an observation on 04/17/25 at 08:02 AM, Certified Medication Aide (CMA) K administered R9's Procardia ER 30 mg tablet without checking R9's B/P. CMA K reported that R9 did not require a B/P check for any medications, only a pulse.

During an interview on 04/17/25 at 08:40 AM, CMA K reported that if a B/P did not show up on the computer screen for her to complete a B/P, she would not check the B/P. CMA K reviewed the Procardia order on the electronic MAR and reported she was aware of the comment to notify the physician for the specified B/P but said she

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F 757	Continued From page 28 did not really pay attention to it as the B/P was not scheduled to be taken. During an interview on 04/17/25 at 08:47 AM, Licensed Nurse (LN) I reviewed the order for the Procardia on the MAR and orders in the EHR and reported that R9 should have had a B/P taken before the medication was administered. LN I reviewed the B/P in R9's EHR and confirmed that he did not have the B/P taken before the medication was given since it was ordered on 09/19/24. LN I reported that the nurse should place the supplemental documentation that the physician required on the MAR so that it would alert the staff to complete it. During an interview on 4/17/25 at 10:00 AM, Administrative Nurse B stated they expected the vital signs parameters that the physician ordered to be placed on the supplemental documentation of the order and the staff to obtain those vital signs. The facility policy "Unnecessary Medications," dated 12/04/24, documentation included each resident's drug regimen must be free of unnecessary drugs. An unnecessary drug is any drug when used in excessive doses.	F 757		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic;	F 758		

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F 758	Continued From page 29 (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for	F 758		

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F 758	Continued From page 30	F 758		

the appropriateness of that medication.
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 36 residents with 12 residents selected for review which included six residents reviewed for unnecessary medications. Based on observation, interview, and record review, the facility failed to complete an industry-accepted assessment for abnormal movements related to antipsychotic (class of medications used to treat major mental conditions that cause a break from reality) use for Resident (R) 24 who received Zyprexa (antipsychotic). This deficient practice placed the affected resident at risk for adverse effects associated with the use of psychotropic (alters mood or thoughts) medications.

Findings include:

- R24's Electronic Health Record (EHR) revealed diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), and depression.

The 06/28/24 "Annual Minimum Data Set" (MDS) documented the resident had a Brief Interview for Mental Status (BIMS) score of zero, which indicated severely impaired cognition. R24 required maximal assistance with activities of daily living (ADL) including bed mobility, standing, and transfers. R24 required supervision for ambulation for 10 feet. The MDS documented R24 received antipsychotics, antianxiety (a class of medications that calm and relax people), and antidepressants (a class of medications used to treat mood disorders) on a routine basis.

The 07/15/24 " Psychotropic Drug Use Care Area

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F 758	Continued From page 31	F 758		

Assessment " (CAA) documented R24 was prescribed multiple medications to manage her anxiety and behaviors due to her dementia (a progressive mental disorder characterized by failing memory, and confusion). The MDS noted R24 had been taking Ativan (an antianxiety medication), Zoloft (an antidepressant medication), and Zyprexa (an antipsychotic medication) and tolerated the medications well with no adverse reactions; interventions were in place and no other changes were noted at that time.

The 03/07/25 "Quarterly MDS" documented R24 had a BIMS of zero. R24 was totally dependent on staff for all ADLs except with ambulation for which she required moderate assistance from staff. The MDS noted R24 received an antipsychotic, antianxiety, and antidepressants on a routine basis.

R24's "Care Plan" documented interventions on 08/07/23 which directed staff to monitor side effects such as sedation, and tardive dyskinesia (an abnormal condition characterized by involuntary repetitive movements of the muscles of the face, limbs, and trunk) from Zyprexa and Zoloft. Staff were instructed to update the physician of any increased behaviors.

R24's EHR lacked evidence of an assessment completed to identify abnormal movements related to medication use.

R24's "Physician's Orders" documented an order for Zyprexa five milligram (mg) tablet, give five mg tablet by mouth, one time a day at bedtime for aggressive behaviors such as hitting related to Alzheimer's, date ordered 01/09/24.

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F 758	Continued From page 32	F 758		

R24's "Medication Regimen Review" (MRR) dated 10/01/24 through 03/31/25 lacked evidence of a recommendation for an assessment for abnormal movements to be completed.

During an observation on 04/16/25 at 12:05 PM, Certified Nurse Aide (CNA) G and CNA H assisted R24 up from the recliner to the wheelchair. Staff used a gait belt though R24 appeared to have difficulty with straightening out her legs to bear weight when she stood up.

During an interview on 04/17/25 at 08:54 AM Licensed Nurse (LN) I reported that the administrative nurses would complete any required assessments in the EHR. LN I reported she had never been requested to complete an assessment to identify abnormal movements.

During an interview on 04/17/25 at 01:17 PM Administrative Nurse B reported she expected had never received resident-specific reminders for abnormal movement assessments to be completed on the MRR. Administrative Nurse B reported she did not know what an Abnormal Involuntary Movement Scale (AIMS-a rating scale to measure involuntary movements associated with the use of some medications) assessment was until 04/16/25.

The facility's policy "Unnecessary Medications" dated 12/04/24 documented each resident's drug regime must be free from unnecessary medications. An unnecessary medication is any drug when used without adequate monitoring, or without adequate indications for the use of the medications.