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	N087046S	A. BUILDING: _____ B. WING _____	06/25/2025

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PARK WEST PLAZA	505 N MAIZE ROAD WICHITA, KS 67212

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S 000	INITIAL COMMENTS The following citations represent the findings of a resurvey with a complaints 187742, 188922, 192068 and 194776 at the above named Assisted Living / State Licensed Nursing Facility conducted on conducted 06/23/25, 06/24/25 and 06/25/25.	S 000		
S 327 SS=D	28-39-151(h) RESIDENT ASSESSMENT (h) Comprehensive care plans. (1) The facility shall develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's physical, mental, and psychosocial needs that are identified in the comprehensive assessment. (2) The comprehensive care plan shall be: (A) Developed within seven days after completion of the comprehensive assessment; and (B) prepared by an interdisciplinary team including the attending physician, a registered nurse with responsibility for the care of the resident, and other appropriate staff in other disciplines as determined by the resident's needs, and with the participation of the resident, the resident's legal representative, and the resident's family to the extent practicable. This REQUIREMENT is not met as evidenced by: 0327	S 327		

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

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S 327	Continued From page 1 KAR 28-39-151(h)(1) The facility reported a census of 59 residents. Based on observation, interview and record review the administrator failed to ensure designated staff developed a comprehensive care plan that included measurable objectives concerning bathing needs for Resident (R)104. Findings included: - R104 admitted to the facility on 08/30/24 with diagnoses of diabetes mellitus and paraplegia. The 06/02/25 "Minimum Data Set" (MDS) documented R104 required substantial assistance with bathing. The 04/15/25 "Care Plan" documented R104 required extensive assistance from clinical staff for personal hygiene care. R104's care plan did not mention how often he was to receive a bath or that he required bed baths due to a pressure wound that was being treated. An observation on 06/24/25 at 01:53 PM revealed R104 was alert and oriented, he appeared to be clean and well groomed with no objectionable odors present in his room that indicated a lack of getting bathed. On 06/24/25 at 01:20 PM R104 stated he thought he was care planned to get a bath twice a week. On 06/24/25 at 02:56 PM "Certified Nurse Aide" (CNA) H stated staff provided peri-care nightly and R104 was given a bed bath at least once a week. CNA H stated staff cleaned R104's lower	S 327		

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S 327	Continued From page 2 body while R104 cleaned his upper body. On 06/25/25 at 12:39 PM Administrative Staff B stated R104's care plan did not address staff assistance with bathing. Administrative Staff B also stated R104 was only supposed to receive bed baths due to a pressure wound that was being treated. The administrator failed to ensure designated staff completed a comprehensive care plan to include a description of the services facility staff provided R104 concerning bathing.	S 327		
S 340 SS=D	28-39-152 QUALITY OF CARE Quality of care. Each resident shall receive and the nursing facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being in accordance with the comprehensive assessment and the plan of care. This REQUIREMENT is not met as evidenced by: 0340 KAR 28-39-152 The facility reported a census of 59 residents with three residents included in the sample and three focused reviews. Based on observation, interview, and record review the administrator failed to ensure designated staff completed an assessment for Resident (R) 104 to confirm his bed assist devices were not a restraint, to determine the purposes of the bed assist	S 340		

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S 340	Continued From page 3	S 340		

devices, to assess the residents' ability to use the bed assist devices safely, that the bed assist devices were securely attached to the bed or bedframe, and they posed no risk for entrapment.

Findings included:

- Record review for R104 revealed an admission date of 08/30/24 with a diagnosis of paraplegia.

The 06/02/25 "Minimum Data Set" (MDS) identified R104 required total assist from staff with transfers.

The 04/15/25 Care Plan identified R104 was a two-person transfer using a Hoyer lift and used bed canes. R104 had upper bed rails that he used for mobility while in bed to help with repositioning.

The 06/23/25 "Resident Roster" documented R104 was one of two residents marked for use of bed assist devices in the long-term care unit.

R104's medical records lacked evidence of documentation of a completed bed assist device assessment.

On 06/24/25 at 01:53 PM an observation of R104's room revealed there were bilateral bed rails appropriately mounted to the bedframe and within FDA guidelines.

On 06/25/25 at 12:39 PM Administrative Nurse B stated R104 requested the use of bed rails for mobility and safety. Administrative Nurse B

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S 340	Continued From page 4 stated this was included in R104's care plan but did not think an actual bed rail assessment was completed for the use of these bed rails The administrator failed to ensure designated staff completed an assessment for R104 to confirm his bed assist devices were not a restraint, to determine the purposes of the bed assist devices, to assess the residents' ability to use the bed assist devices safely, that the bed assist devices were securely attached to the bed or bedframe, and they posed no risk for entrapment.	S 340		
S 475 SS=F	28-39-153(c) RESIDENT AND FAMILY GROUPS (c) Participation in resident and family groups. (1) The facility shall afford each resident the right to organize and participate in resident groups in the facility. (2) The nursing facility shall afford each resident's family the right to meet in the facility with the families of other residents in the facility. (3) Staff or visitors may attend meetings at the group's invitation. (4) The facility shall designate a staff person responsible for providing assistance and responding to written requests that result from group meetings. (5) When a resident or family group exists, the facility shall consider the views, grievances, and recommendations of residents and their families concerning proposed policy and operational	S 475		

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S 475	Continued From page 5 decisions affecting resident care and life in the facility. The nursing facility shall maintain a record of the written requests and the facility responses or actions. This STANDARD is not met as evidenced by: 0475 KAR 28-39-153(c)(5) The facility reported a census of 59 residents. Based on record review and interview for all residents and all facility employees, the administrator failed to maintain a record of the written requests and the facility responses or actions to reported resident grievences. Findings included: - On 06/25/25 a copy of the facility grievance log was requested from Administrative Staff A. On 06/25/25 at 11:10 AM Administrative Staff A stated resident complaints and concerns were not currently written down in a formal grievance log. On 06/25/25 at approximately 02:14 PM Administrative Staff A stated resident grievances were addressed during resident council and all concerns were followed up on and resolved but were not documented on a "grievance log." The administrator failed to maintain a log of grievances and the facility response and outcomes for concerns reported by residents.	S 475		

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S 650	Continued From page 6	S 650		
S 650 SS=E	28-39-158(g) SANITARY CONDITIONS (F) The facility shall cover, label, and date each food item not stored in the original product container or package. (G) The facility shall tightly cover and date each opened food item stored in the original product container or package. (H) The facility shall not store prepared foods, dry or staple foods, single service ware, sanitized equipment or utensils and containers of food under exposed or unprotected sewer lines or water lines, except for automatic fire protection sprinkler heads. The facility shall not store food and service equipment or utensils in toilet rooms. (I) The facility shall store food not subject to further washing or cooking before serving in a way that protects the food against cross-contamination. (J) The facility shall not store packaged food subject to entry of water in contact with water or undrained ice. This REQUIREMENT is not met as evidenced by: KAR 28-39-158(g)(2)(F)(G) The facility reported a census of 59 residents. The facility had a main kitchen in the assisted living facility building where dietary staff stored, prepared, and served food and one satellite	S 650		

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S 650	Continued From page 7	S 650		

kitchen in the state licensed nursing facility building where staff stored and served food. Based on observation and interview the administrator failed to ensure designated staff stored food items under safe conditions in the satellite kitchen for 19 residents.

Findings included:

- Observation on 06/23/25 at approximately 12:01 PM of the state licensed nursing facility kitchen revealed one refrigerator. The following items in the refrigerator contained food items that lacked date labels when facility staff opened or prepared the items:

One serving-size bowl of a white substance that appeared like mashed potatoes
One serving-size bowl of a brown substance that appeared like gravy
One 64-ounce (oz) bottle of prune juice
One case-sized box of 75 single serving-sized chocolate-flavored Mighty Shakes with some servings missing off the top layer
One case-sized box of 75 single serving-served vanilla-flavored Mighty Shakes with some servings missing off the top layer. A handwritten number on the side of the box read "6/18."

Each single serving-size carton of Mighty Shakes contained a label which read "Store frozen. . . use product within 14 days of thawing. Keep refrigerated."

On 06/23/25 at approximately 12:01 PM Dietary Staff D stated the food items were for the residents and confirmed they lacked date labels.

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S 650	Continued From page 8 She stated the two case boxes of Mighty Shakes were frozen upon delivery. The handwritten "6/18" on the side of the vanilla-flavored Mighty Shakes box was the date they arrived at the facility. The 2014 facility's "Storage of Foods" policy documented staff would label all refrigerated food with the preparation date. Frozen foods would be put in the refrigerator to thaw overnight or a day or two ahead of using. The Kansas Department of Agriculture's 2024 "Focus on Food Safety" booklet documented food items must be date marked if they were time or temperature controlled for safety, ready-to-eat, prepared on-site, original container was opened, or held under refrigeration. The administrator failed to ensure designated staff stored food items under safe conditions.	S 650		
S 815 SS=F	28-39-161 INFECTION CONTROL (b) Preventing the spread of infection. (1) When a physician or licensed nurse determines that a resident requires isolation to prevent the spread of infection, the facility shall isolate the resident according to the policies and procedures developed. (2) The facility shall prohibit employees with a communicable disease or infected skin lesions from coming in direct contact with residents, any resident's food, or resident care equipment until the condition is resolved.	S 815		

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S 815	Continued From page 9 (3) Tuberculosis skin testing shall be administered to each new resident and employee as soon as residency or employment begins, unless the resident or employee has documentation of a previous significant reaction. Each facility shall follow the centers for disease control recommendations for "prevention and control of tuberculosis in facilities providing long-term care to the elderly," as published in morbidity and mortality weekly report, July 13, 1990. This REQUIREMENT is not met as evidenced by: 0815 KAR 28-39-161(b)(3) The facility reported a total census of 59 residents. The sample included three residents and three abbreviated record reviews. Based on interview and record review for three residents and five new employee records, the administrator failed to ensure the facility remained in compliance with the department's tuberculosis (TB) guidelines for adult care homes adopted by reference in K.A.R. 26-39-105. This failure effected all residents who lived in the state licensed nursing facility. Findings included: - Resident (R)104 moved into the facility on 08/30/24 with a diagnosis of diabetes mellitus. Review of R104's medical record lacked	S 815		

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S 815	Continued From page 10	S 815		

evidence a TB Symptom Screen Questionnaire and a two-step TB Skin Test (TST) was completed upon admission to the facility.

On 06/25/25 at 12:39 PM Administrative Nurse B confirmed that neither a TB Symptom Screen Questionnaire nor a two-step TST was completed for R104 upon admission to the facility.

The 06/2013 "Tuberculosis (TB) Guidelines for Adult Care Homes" documented, "Each new resident ...shall have an initial TB symptom screen that includes the components of the Tuberculosis Symptom Screen Questionnaire within 7 days of residency ...Each new resident ...shall receive a two-step TST or an IGRA for Mycobacterium tuberculosis within 7 days of residency ..."

The administrator failed to ensure compliance with the department's tuberculosis guidelines for adult care homes adopted by reference in K.A.R. 26-39-105.

- Review of five newly hired employee files revealed the following:

Review of facility personnel records revealed Certified Nurse Aide (CNA) E was hired on 04/29/25 but lacked evidence a two-step TB skin test was completed.

Licensed Nurse (LN) G was hired on 03/05/25 and provided a negative TB blood test on 04/09/25, which was 33 days late.

The 06/2013 "Tuberculosis (TB) Guidelines for

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S 815	Continued From page 11 Adult Care Homes" documented, "Each new ...employee shall receive a two-step TST or an IGRA for Mycobacterium tuberculosis within 7 days of ...employment ..." The administrator failed to ensure the facility remained in compliance with the department's tuberculosis guidelines for adult care homes adopted by reference in K.A.R. 26-39-105.	S 815		
S1485 SS=D	28-39-163 Clinical Records (2) Clinical records shall be retained according to the following schedule: (A) At least five years following the discharge or death of a resident; or (B) for a minor, five years after the resident reaches 18 years of age. (3) Resident records shall be the property of the facility. This REQUIREMENT is not met as evidenced by: 28-39-163(m)(2)(A) The facility reported a census of 59 residents with three residents included in the sample and three closed record reviews. Based on record review and interview the administrator failed to ensure maintenance of admission and significant change Minimum Data Sets (MDS) for Residents (R) 103 for at least five years after her discharge. Findings included:	S1485		

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S1485	Continued From page 12 - Record review for R103 revealed an admission date of 03/14/24 with diagnoses of dementia and Parkinson's Disease. Review of R103's medical record revealed a lack of any "MDS" On 06/24/25 at 02:59 PM Administrative Staff A confirmed R103 had discharged. Staff had looked in on-site facility storage for an "MDS" but could not find any. On 06/24/25 at 04:20 PM Administrative Staff A stated an off-site storage company delivered 20 boxes of resident records. Facility staff searched them and could not find any "MDS" for R103. The 2012 "Records Security and Release" policy documented the facility maintained resident records after discharge in compliance with applicable state statutes. The administrator failed to ensure maintenance of admission and significant change MDS for R103 for at least five years after her discharge.	S1485		
S3261 SS=D	26-41-105 (f) (11) Resident Record Documentation of Incidents (f) (11) documentation of all incidents, symptoms, and other indications of illness or injury including the date, time of occurrence, action taken, and results of the action	S3261		

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S3261	Continued From page 13 This REQUIREMENT is not met as evidenced by: 3261 KAR 26-41-105(f)(11) The facility reported a census of 59 residents. The sample included three residents and three focused record reviews. Based on interview and record review the administrator failed to ensure Resident (R)106's medical record contained documentation of all incidents, symptoms, and other indications of illness or injury. Findings included: -R106's medical record revealed she moved into the facility on 05/13/21 with a diagnosis of mild cognitive impairment. The 05/12/25 "Functional Capacity Screen" (FCS) identified R106 required physical assistance with bathing, dressing, toileting, and transfers and required total assistance with mobility. Staff managed R106's treatments. R106 had cognitive impairments with memory recall and decision making. The 05/12/25 "Negotiated Service Agreement" (NSA) lacked documentation R106 had a pressure wound and who was responsible for treatment of this wound. Review of R106's medical record and progress notes included the following documentation: 04/15/25 "Nursing Note" documented, "Resident has an open area to her coccyx measuring 0.5 centimeters (cm) x 0.5 cm, an order for	S3261		

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S3261	Continued From page 14 Calmoseptine twice a day (BID) and as needed (PRN) requested." 05/18/25 "Nursing Note" documented, "...the resident had a small sore on her mid-back. Noted 2.0 cm x 1.0 cm sore on mid to lower back. Cleansed with normal saline (NS) and 2x2 Meplex foam padded bandage applied..." 05/20/25 "Nursing Note" documented, "New wound care orders received...for stage two lumbar spine..." 05/21/25 "Nursing Note" documented hospice nurse was in the facility to see resident provided dressing change to wound on spine measuring 2.0 cm x 1.9 cm x 0.1 cm. Review of R106's record from 01/01/25 to the date of the survey lacked documentation by the facility nursing staff or hospice nurses of regular skin monitoring to include interventions to prevent pressure wounds by licensed facility staff prior to pressure wounds and lacked evidence of frequent documentation of the pressure wounds after they developed, including time of origin, wound sizes (length, width, and depth), odor, tissue characteristics (including drainage, granulation), any signs of infection, plan for treatment, and outcome. On 06/24/25 at approximately 11:07 AM Administrative Nurse C stated R106 was on hospice. The hospice staff communicated verbally with the facility nurse at each visit and wrote notes on a form which were kept in an overflow chart. Administrative Nurse C stated R106 had a pressure wound on her bottom and	S3261		

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	N087046S	A. BUILDING: _____ B. WING _____	06/25/2025

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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) COMPLETE DATE
S3261	Continued From page 15 on her lumbar spine, as well as wounds on her right calf, and on her left lower leg. Administrative Nurse C could not recall how large these wounds were and stated the hospice nurse managed R106's wounds and changed dressings at each visit. Administrative Nurse C stated she expected all wounds to be documented on the hospice notes "Third Party Coordination Form." Administrative Nurse C stated she could not find any recent nursing notes regarding R106's wounds in the nursing notes located in her electronic medical records. The administrator failed to ensure designated staff included documentation of all incidents, symptoms and other indications of illness or injury including the dated, time of occurrence, action taken, and results of the action.	S3261		
S3280 SS=F	26-41-104 (d) Disaster and Emergency Preparedness (d) Each administrator or operator shall ensure disaster and emergency preparedness by ensuring the performance of the following: (1) Orientation of new employees at the time of employment to the facility ' s emergency management plan; (2) education of each resident upon admission to the facility regarding emergency procedures; (3) quarterly review of the facility ' s emergency management plan with employees and residents; and (4) an emergency drill, which shall be conducted at least annually with staff and residents. This drill shall include evacuation of the residents to a secure location.	S3280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087046S	A. BUILDING: _____ B. WING _____	06/25/2025

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S3280	Continued From page 16 This REQUIREMENT is not met as evidenced by: 3280 KAR 26-41-104(d)(3) The facility reported a census of 59 residents. Based on record review and interview for all residents and all facility employees, the operator failed to ensure disaster and emergency preparedness by ensuring performance of quarterly review of the facility's "Emergency Management Plan" (EMP) with employees and residents. Findings included: - On 06/23/25 at approximately 12:00 PM during an entrance conference with Administrative Staff A documentation was requested of quarterly reviews of the EMP with staff and residents. On 06/24/25 at 02:59 PM Administrative Staff A confirmed records lacked evidence of documentation quarterly reviews of EMP were completed with residents and staff. The administrator failed to ensure the completion of quarterly reviews covering all of the required items of the EMP with employees and residents.	S3280		