

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: B046091	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/29/2025
NAME OF PROVIDER OR SUPPLIER VILLA HEIGHTS LIVING LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 816 S MULBERRY STREET GARDNER, KS 66030		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS The following represents the findings of the initial survey with attached complaint #195833 at the above named home plus conducted on 07/28/25 and 07/29/25.	S 000		
S5025 SS=J	26-42-101 (f) Staff Treatment of Residents (f) Staff treatment of residents. Each administrator or operator shall ensure the development and implementation of written policies and procedures that prohibit the abuse, neglect, and exploitation of residents by staff. The administrator or operator shall ensure that all of the following requirements are met: This REQUIREMENT is not met as evidenced by: KAR 26-42-101(f)(1)(B) The facility reported a census of four residents with three residents included in the sample. Based on observation, interview, and record review the operator failed to protect Resident (R) 3 from neglect by the failure to ensure staff responded timely to an alarm activation on 06/05/25 between 06:00 and 06:30 AM when cognitively impaired R3 exited the facility without staff knowledge through the front door to the outside. This placed R3 in immediate jeopardy.	S5025		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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S5025	Continued From page 1 Findings included: - Record review for R3 revealed an admission date of 10/11/24 with diagnoses of dementia with behaviors, agitation/aggression, and diabetes mellitus type 2. The 03/18/25 (before the incident) "Functional Capacity Screen" (FCS) documented R3 required supervision with transfers and walking/mobility; she had short-term memory and decision-making cognitive difficulties; was at risk for falls and had impaired vision. The 03/18/25 "FCS" failed to document R3 was at risk for wandering and behaviors. The 06/05/25 (after the incident) "FCS" documented R3 required supervision with transfers and walking/mobility; she had short-term memory and decision-making cognitive difficulties; and was at risk for falls, impaired vision, and wandering. The 06/05/25 "FCS" failed to document R3 was at risk for behaviors. The 06/05/25 "Negotiated Service Agreement" (NSA) identified facility staff provided R3 assistance with transfers using a gait belt; stand-by assistance for walking/mobility; redirection, distraction, reapproached, offered treats or snacks, and administered medication as needed for cognitive difficulties; and staff monitored closely after toileting to prevent injury from falls. R3 was blind in her left eye with diminished vision in her right eye and staff ensured her glasses were in good repair, clean, and within her reach for impaired vision. Staff	S5025		

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S5025	Continued From page 2 provided supervision in the common area for wandering. Review of the "Charting Notes" from 10/11/24 to 06/20/25 revealed each note included two dates. The first column of dates was labeled "created" and the second column was labeled "observed." The "observed" on 11/21/24 at 05:02 PM nurse "Charting Note" created on 12/02/24 at 05:10 PM (11 days after observed) documented R3 took all her clothes out of the closet and placed them on her walker. She stated she wanted to return to the previous state she lived and be with her husband. The "observed" on 11/30/24 at 05:11 PM nurse "Charting Note" created on 12/01/24 at 05:18 PM (one day after observed) documented R3 took her clothes, placed them on her walker, and requested her suitcase. R3 refused to go to bed and stated she would miss her flight. The "observed" on 12/02/24 at 06:43 PM nurse "Charting Note" created on 12/02/24 at 06:48 PM documented R3 stated she was getting ready to go to the previous state she used to live. She was going to travel by bus. The "observed" on 12/03/24 at 07:36 PM nurse "Charting Note" created on 12/03/24 at 07:41 PM documented R3 went into other residents' rooms, took out their clothes, and stated she was looking for a suitcase. The "observed" on 12/04/24 at 04:54 PM nurse "Charting Note" created on 12/04/24 at 04:58 PM documented R3 went into other residents' rooms,	S5025		

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S5025	Continued From page 3 took out their belongings, and hit staff. The "observed" on 12/05/24 at 01:47 PM nurse "Charting Note" created on 12/05/24 at 03:52 PM documented R3 became agitated when staff attempted to redirect her from entering other residents' rooms and taking their belongings. The "observed" on 12/05/24 at 01:52 PM nurse "Charting Note" created on 12/05/24 at 03:54 PM documented the nurse informed R3's Primary Care Provider (PCP) of R3's behavior and received an order to transfer R3 to a geriatric psychological unit for further evaluation. The "observed" on 12/17/24 at 04:02 PM nurse "Charting Note" created on 12/21/24 at 08:46 AM (four days after observed) documented R3 returned to the facility. She continued to ask to go home to the previous state where she lived. R3 stated a family member "just dumped her here." The "observed" on 03/12/25 at 03:37 PM nurse "Charting Note" created on 03/17/25 at 11:47 AM (five days after observed) documented R3 stated she had to go to the previous state she lived to be with her husband. She removed her clothes from the closet and moved them to her bed. The "observed" on 03/15/25 at 05:59 PM nurse "Charting Note" created on 03/17/25 at 12:04 PM (two days after observed) documented R3 became agitated, refused to eat, and was "seeking to return home." The "observed" on 03/26/25 at 12:15 PM nurse "Charting Note" created on 04/25/25 at 10:21 PM	S5025		

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S5025	Continued From page 4 (30 days after observed) documented R3 became aggressive, looked for her husband, and stated need to go the building next door find the senior center. Facility staff called R3's family member to speak to R3 for reassurance. The "observed" on 04/06/25 at 12:21 PM nurse "Charting Note" created on 04/25/25 at 10:46 PM (19 days after observed) documented R3 was "aggressive, demanding to exit building, hit left foot on the door post, and had an assisted fall by staff to a sitting position." The "observed" on 06/06/25 at 07:10 AM nurse "Charting Note" created on 06/09/25 at 08:40 AM (three days after observed) documented R3 exited the building without supervision. After R3 returned, staff implemented "constant observation." The "15 Minute Checks" log for documented facility staff visually checked R3 every 15 minutes from 06/06/25 at 07:00 AM until 06/18/25 at 08:45 AM. The 06/06/25 "Intake Information" documented the following: 1) R3 exited the facility through the front door. A motion sensor alarm activated but staff in the building did not hear the alarm. 2) Staff on duty at the facility notified the nurse by phone on 06/05/25 at approximately 06:30 AM they had searched the whole house and R3 was not in the building. 3) The nurse called Emergency Medical	S5025		

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S5025	Continued From page 5 Services (EMS) and R3's PCP (Primary Care Physician) and DPOA (Durable Power of Attorney) while on her way to the facility. 4) EMS called the nurse back and reported R3 was at the police station. A concerned person driving on the street in front of the facility saw R3 on the sidewalk, picked her up, and drove her to the police station. 5) The facility nurse transported R3 from the police station to the facility and completed an assessment with no injuries noted. 6) Facility staff provided R3 constant observation for 24 hours and then provided visual checks every 15 minutes until safety established. The 06/17/25 "Witness Statement" by Certified Nurse Aide (CNA) C reported she last saw R3 sleeping in bed during routine rounds at 06:00 AM. She and a co-worker provided another resident a shower. After the shower she went to get R3 ready for breakfast and noticed she was not in her room and immediately notified the nurse. She went outside to look for R3 while her co-worker remained inside with the other residents. The 06/17/25 "Witness Statement" by Certified Medication Aide (CMA) B reported she and a co-worker noticed R3 was not in her room after they finished providing another resident a shower. She remained with the residents while her co-worker went outside to look for R3. Review of facility's dementia training revealed a	S5025		

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S5025	Continued From page 6 handwritten note stating staff received training upon hire and annually. Review of the facility's quarterly reviews of the Emergency Management Plan revealed staff received training including missing resident before the incident on 09/24/24, 12/24/24, and 03/24/25. The 06/05/25 (after the incident) facility's quarterly review of the Emergency Management Plan revealed six staff signed they received training which included review of the facility's elopement policy. Observation on 07/28/25 at 12:51 PM revealed the front door alarm was audible in the resident's room farthest from the front door in the bathroom with shower water running. Observation on 07/28/25 at 04:35 PM revealed R3 sat in a recliner in the common area. She stated she was "going upstairs to get ready to go home." R3 did not attempt to stand. Observation on 07/28/25 revealed a possible route R3 took when she exited the facility without staff knowledge on 06/05/25. From R3's bed to the front door was 20 steps. The door had a keypad staff entered a code to unlock the door. The door alarm activated and did not shut off until staff locked the door. From the front door to the sidewalk next to the driveway where a stranger found R3 and picked her up was 30 steps. The facility was in a residential area with many houses and fenced yards. There were no mature trees or tall buildings to obstruct views of the street in both directions. Two houses away	S5025		

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S5025	Continued From page 7 was a vehicle turnabout area where the street curved and continued north. The sidewalk along the street appeared well maintained with no trip hazards. A fire department building was in line of sight behind the facility. A moderately traveled street with a speed limit of 35 miles per hour (mph) was approximately 885 feet (per Google maps) from the facility. A small pond was approximately 925 feet (per Google maps) to the east of the facility and another pond was within walking distance but further away from the facility. On 07/28/25 at 12:28 PM Administrative Staff A stated she installed a new alarm system on the front door that required staff to enter a keycode to exit the front door. On 07/28/25 at 12:44 PM Administrative Staff A stated staff were busy providing a shower to another resident and did not hear the motion sensor alarm at the front door activate when R3 exited. After R3 went out the front door, she walked down the driveway. A nurse who lived in the neighborhood passed by and saw R3 on the sidewalk. The nurse picked up R3 and drove her 15 minutes away to a police station. On 07/28/25 at 02:40 PM Administrative Staff A stated R3 wore sweatpants and a sweatshirt and carried a handbag when she exited the facility. On 07/28/25 at 03:07 PM CMA B stated she worked the morning R3 exited the facility. She and her co-worker were giving another resident a shower. He had to have two staff provide a shower too keep him safe because he often tried to stand up. They did not hear the front door	S5025		

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S5025	Continued From page 8 alarm. Prior to R3 exiting the facility, she "always said 'I'm going, I'm going' and tried doors. She notified the nurse of R3's behaviors and all staff already knew about it. They had to call R3's family member everyday who talked to R3 and calmed her down. R3 tried the doors often during the day, sometimes every hour all day. She exhibited this behavior from first day of admission to the facility. The last elopement training she received was "last year." On 07/28/25 at 03:22 PM Administrative Staff A stated R3 frequently said she wanted to go home or to the senior center. Facility staff called R3's family member who calmed her down over the phone. R3 was admitted to geriatric psychological unit when she exhibited behaviors of wandering into other residents' room and rummaged through their belongings, said she wanted to go back to the previous state she used to live, and took her clothes out of the closet and put them on her walker. R3 stayed at the geriatric psychological unit about three weeks until her medications stabilized. On 07/28/25 at 04:52 PM Administrative Staff A stated the alarm system on the front door prior to R3 exiting was a motion sensor alarm positioned above the door and aimed down to capture when someone got close to the door. When the alarm activated it was still possible to open the door from inside the facility. The new alarm system had a keypad code and continued to alarm until someone addressed it. She confirmed facility records lacked evidence of documentation staff received training how to use the keypad and set the alarm.	S5025		

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S5025	Continued From page 9 The weather on 06/05/25 according to Wunderground.com was 63 degrees Fahrenheit with a wind speed of 6 mph at 06:20 AM. Sunrise time was 05:56 AM. The facility's undated "Missing Resident" policy documented the operator assigned team members to conduct a search. No more than 30 minutes should lapse between the time the search for a missing resident began and local law enforcement and the resident's family were notified. The operator failed to protect R3 from neglect by the failure to ensure staff responded timely to an alarm activation on 06/05/25 between 06:00 and 06:30 AM when cognitively impaired R3 exited the facility through the front door to the outside. The facility implemented the following actions on 06/05/2025, prior to the surveyors arrival: - On 06/05/25 at 07:00 AM R3 was transported back to the facility at immediately received constant observation for 24 hours. - On 06/05/25 at 07:00 AM elopement training provided to staff. - On 06/05/25 at 07:00 AM the operator contacted a company regarding installing a new front door alarm system. - On 06/05/25 at 07:20 AM R3's DPOA was present in the facility. - On 06/06/25 at 07:00 AM facility staff initiated visual checks every 15 minutes for R3 which continued until 06/18/28 at 08:45 AM. - On 06/06/25 front door video monitoring system installed. - On 06/18/25 a technician installed the new door alarm system, electronic keypad, and	S5025		

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S5025	Continued From page 10 emergency release button.	S5025		
S5095 SS=D	26-42-201 (d) Functional Capacity Screen Accurate (d) Designated staff shall ensure that each resident ' s functional capacity at the time of screening is accurately reflected on that resident ' s screening form. This REQUIREMENT is not met as evidenced by: KAR 26-42-201(d) The facility reported a census of four residents with three included in the sample. Based on interview and record review the operator failed to ensure the "Functional Capacity Screen" (FCS) for Resident (R) 3 accurately reflected her functional capacity at the time of screening for cognition and wandering. Findings included: - Record review for R3 revealed an admission date of 10/11/24 with diagnoses of dementia with behaviors, agitation/aggression, and diabetes mellitus type 2. The 03/18/25 (before she eloped) "FCS" identified R3 had short-term memory and decision-making cognitive difficulties. The "NSA" failed to identify R3 was at risk for wandering.	S5095		

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S5095	Continued From page 11 The 06/05/25 (after the incident) "FCS" identified R3 had short-term memory and decision-making cognitive difficulties, and she was at risk for wandering. The 06/05/25 (after the incident) "Negotiated Service Agreement" identified facility staff provided R3 supervision in the common area for wandering. The "Cognition - Memory, Recall" section of R3's "NSA" documented cognitive impairment for short-term and long-term memory, memory/recall, and decision-making cognitive difficulties. Review of the "Charting Notes" from 10/11/24 to 06/20/25 revealed each note included two dates. The first column of dates was labeled "created" and the second column was labeled "observed." The "observed" on 11/21/24 at 05:02 PM nurse "Charting Note" created on 12/02/24 at 05:10 PM (11 days after observed) documented R3 took all her clothes out of the closet and placed them on her walker. She stated she wanted to return to the previous state she lived and be with her husband. The "observed" on 11/30/24 at 05:11 PM nurse "Charting Note" created on 12/01/24 at 05:18 PM (one day after observed) documented R3 took her clothes, placed them on her walker, and requested her suitcase. R3 refused to go to bed and stated she would miss her flight. The "observed" on 12/02/24 at 06:43 PM nurse "Charting Note" created on 12/02/24 at 06:48 PM documented R3 stated she was getting ready to go to the previous state she used to live. She	S5095		

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S5095	Continued From page 12 was going to travel by bus. The "observed" on 12/03/24 at 07:36 PM nurse "Charting Note" created on 12/03/24 at 07:41 PM documented R3 went into other residents' rooms, took out their clothes, and stated she was looking for a suitcase. The "observed" on 12/04/24 at 04:54 PM nurse "Charting Note" created on 12/04/24 at 04:58 PM documented R3 went into other residents' rooms, took out their belongings, and hit staff. The "observed" on 12/05/24 at 01:47 PM nurse "Charting Note" created on 12/05/24 at 03:52 PM documented R3 became agitated when staff attempted to redirect her from entering other residents' rooms and taking their belongings. The "observed" on 12/05/24 at 01:52 PM nurse "Charting Note" created on 12/05/24 at 03:54 PM documented the nurse informed R3's Primary Care Provider (PCP) of R3's behavior and received an order to transfer R3 to a geriatric psychological unit for further evaluation. The "observed" on 12/17/24 at 04:02 PM nurse "Charting Note" created on 12/21/24 at 08:46 AM (four days after observed) documented R3 returned to the facility. She continued to ask to go home to the previous state where she lived. R3 stated a family member "just dumped her here." The "observed" on 03/12/25 at 03:37 PM nurse "Charting Note" created on 03/17/25 at 11:47 AM (five days after observed) documented R3 stated she had to go to the previous state she lived to	S5095		

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S5095	Continued From page 13 be with her husband. She removed her clothes from the closet and moved them to her bed. The "observed" on 03/15/25 at 05:59 PM nurse "Charting Note" created on 03/17/25 at 12:04 PM (two days after observed) documented R3 became agitated, refused to eat, and was "seeking to return home." The "observed" on 03/26/25 at 12:15 PM nurse "Charting Note" created on 04/25/25 at 10:21 PM (30 days after observed) documented R3 became aggressive, looked for her husband, and stated need to go the building next door find the senior center. Facility staff called R3's family member to speak to R3 for reassurance. The "observed" on 04/06/25 at 12:21 PM nurse "Charting Note" created on 04/25/25 at 10:46 PM (19 days after observed) documented R3 was "aggressive, demanding to exit building, hit left foot on the door post, and had an assisted fall by staff to a sitting position." The "observed" on 06/06/25 at 07:10 AM nurse "Charting Note" created on 06/09/25 at 08:40 AM (three days after observed) documented R3 exited the building without supervision. After R3 returned, staff implemented "constant observation." On 07/28/25 at 03:22 PM Administrative Staff A stated R3 frequently said she wanted to go home or to the senior center. Facility staff called R3's family member who calmed her down over the phone. On 07/28/25 at 03:07 PM Certified Medication	S5095		

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NAME OF PROVIDER OR SUPPLIER VILLA HEIGHTS LIVING LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 816 S MULBERRY STREET GARDNER, KS 66030		
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S5095	Continued From page 14 Aide (CMA) B stated R3 "always said 'I'm going, I'm going' and tried doors." She notified the nurse of R3's behaviors and "all staff already knew about it." They had to call R3's family member everyday who talked to R3 and calmed her down. R3 tried the doors often during the day, sometimes every hour all day. She exhibited this behavior from first day of admission to the facility. On 07/29/25 at approximately 02:24 PM Administrative Staff A confirmed R3's "FCS" and "NSA" for cognitive difficulties did not match. She also stated the facility did not have an "FCS" policy. The operator failed to ensure the "FCS" for R3 accurately reflected her functional capacity at the time of screening for cognition and wandering.	S5095		
S5105 SS=E	26-42-202 (a) Negotiated Service Agreement a) The administrator or operator of each home plus shall ensure the development of a written negotiated service agreement for each resident, based on the resident ' s functional capacity screening, service needs, and preferences, in collaboration with the resident or the resident ' s legal representative, the case manager, and, if agreed to by the resident or the resident ' s legal representative, the resident ' s family. The negotiated service agreement shall provide the following information: (1) A description of the services the resident will receive; (2) identification of the provider of each service; and (3) identification of each party responsible for	S5105		

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S5105	Continued From page 15 payment if outside resources provide a service. This REQUIREMENT is not met as evidenced by: KAR 26-42-202(a)(1)(2) The facility reported a census of four residents with three included in the sample. Based on interview and record review the operator failed to ensure the "Negotiated Service Agreements" (NSA) for Residents (R) 1 and R2 described the services they received based on their "Functional Capacity Screens" (FCS). Findings included: - Record review for R1 revealed an admission date of 12/22/24 with a diagnosis of dementia with behaviors. The 03/03/25 "FCS" identified R1 was unable to perform bathing. The 03/03/25 "NSA" identified facility staff provided R3 a bed bath twice a week for bathing. A hospice provider monitored "progression." The 03/03/25 "NSA" failed to describe the services R1 received for assistance of two staff for bathing and the services he received from hospice. On 07/29/25 at 12:33 PM Administrative Staff A confirmed R1's "NSA" failed to identify the provider of bed baths and R1 received the services of two staff for bathing.	S5105		

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S5105	Continued From page 16 - Record review for R2 revealed an admission date of 09/24/24 with a diagnosis of dementia. The 01/15/25 "FCS" identified R2 was at risk for wandering. The 01/15/25 "NSA" failed to describe the services R2 received for wandering. On 07/29/25 at approximately 01:18 PM Administrative Staff a confirmed R2's "NSA" failed to describe services she received for wandering. On 07/29/25 at approximately 02:15 PM Administrative Staff A stated the facility did not have an "NSA" policy. The operator failed to ensure the "NSAs" for R1 and R2 described the services they received based on their "FCS."	S5105		
S5171 SS=F	26-42-204 (i) Health Care Services Standards of Practice (i) All health care services shall be provided to residents by qualified staff in accordance with acceptable standards of practice. This REQUIREMENT is not met as evidenced by: KAR 26-42-204(i) The facility reported a census of 4 residents with three residents included in the sample. Based on interview and record review the operator failed to ensure designated staff documented in a timely manner for Residents (R) 1, R2, and R3.	S5171		

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S5171	Continued From page 17 Findings included: - Record review for R1 revealed an admission date of 12/22/24 with a diagnosis of dementia with behaviors. The 03/03/25 "Functional Capacity Screen" (FCS) identified R1 was unable to perform bathing, dressing, toileting, transfers, walking/mobility, eating, management of medications and treatments and was incontinent of bladder. He had short-term and long-term memory, memory/recall, and impaired decision-making cognitive difficulties. R1 was rarely or never understandable and rarely or never understood others during communication and was at risk for impaired vision. The 03/03/25 "Negotiated Service Agreement" (NSA) identified facility staff provided R3 physical assistance twice a week for bathing, assistance with dressing, check and change every two hours for toileting and bladder incontinence, and assistance of two staff and mechanical lift for transfers. Facility staff propelled R1 in a reclining wheelchair for walking/mobility and provided feeding assistance and held drinks with a straw close to his mouth for eating. Facility staff managed medications and treatments. Facility staff reoriented frequently, offered photos, and reminisced past events for cognitive difficulties. Staff cleaned his glasses and placed them for R1 for impaired vision. Review of nursing "Charting Notes" from admission on 10/22/24 to 07/23/25 revealed the	S5171		

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S5171	Continued From page 18 following: 1) Each note included two dates. The first column of dates read "created" and the second column read "observed." 2) The "observed" on 03/21/25 "Charting Note" documented Administrative Staff A created the note on 04/25/25 which was 35 days later. 3) Administrative Staff A created 10 nursing notes on 06/09/25 for observations that occurred on 10/24/24, 10/26/24, 11/25/24, 12/08/24, 12/09/24, 12/10/24, 01/10/25, 03/22/25, 03/23/25, and 02/24/25 which was 228 days later from the earliest observation. 4) The "observed" on 07/10/25 "Charting Note" documented Administrative Staff A created the note on 07/20/25 which was 10 days later. - Record review for R2 revealed an admission date of 09/24/24 with a diagnosis of dementia. The 01/15/25 "FCS" identified R2 required physical assistance with bathing, dressing, toileting, transfers, and eating. She was unable to perform management of medications and treatments and was incontinent of bladder. She had short-term and long-term memory, memory/recall, and impaired decision-making cognitive difficulties. R2 was sometimes understandable and sometimes understood others during communication and was at risk for falls and wandering. The 01/15/25 "NSA" identified facility staff provided physical assistance twice a week for bathing, physical assistance with dressing and toileting and check and change every two hours for toileting and bladder incontinence. Facility	S5171		

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S5171	Continued From page 19 staff provided assistance to get in and out of bed, ensured appropriate footwear was on and used a belt during transfers. Staff cut up foods and provided cuing for eating. Facility staff provided management of medications and treatments and monitoring, redirection, distraction, reapproached, and offered treats and snacks for cognitive difficulties. Staff pointed out tasks, followed cues, and used simple and concise sentences for communication. Facility staff monitored closely, followed cues, offered toileting to prevent injury from falls. The "NSA" failed to describe services provided for wandering. Review of nursing "Charting Notes" from 01/11/25 to 07/23/25 revealed the following: - Each note included two dates. The first column of dates read "created" and the second column read "observed." - Administrative Staff A created four nursing notes on 03/01/25 for observations that occurred on 01/11/25 at 03:01 PM and 09:08 PM, 01/15/25, and 01/17/25 which was 49 days later from the earliest observation. - The "observed" on 03/13/25 "Charting Note" documented Administrative Staff A created the note on 06/09/25 which was 88 days later. - The "observed" on 03/21/25 "Charting Note" documented Administrative Staff A created the note on 04/25/25 which was 35 days later. - Administrative Staff A created 11 nursing notes on 06/06/25 for observations that occurred on 01/16/25, 01/17/25, 02/01/25, 03/22/25, 03/23/25 at 09:19 PM and 09:25 PM, 03/26/25, 04/01/25, 04/15/25, 05/06/25, and 06/01/25 which was 141 days later from the earliest observation.	S5171		

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S5171	Continued From page 20 6) The "observed" on 07/10/25 "Charting Note" documented Administrative Staff A created the note on 07/20/25 which was 10 days later. - Record review for R3 revealed an admission date of 10/11/24 with diagnoses of dementia with behaviors, agitation/aggression, and diabetes mellitus type 2. The 06/05/25 (after the incident) "FCS" documented R3 required physical assistance with bathing, dressing, and toileting. She required supervision with transfers and walking/mobility. R3 was unable to perform management of medications and treatments. She was frequently incontinent of bladder and had short-term memory and decision-making cognitive difficulties, and was at risk for falls, impaired vision, and wandering. The 06/05/25 "NSA" identified facility staff provided R3 moderate assistance twice a week with bathing, assistance with dressing, toileting, and bladder incontinence. Staff assisted with transfers using a gait belt; stand-by assistance for walking/mobility; redirection, distraction, reapproached, offered treats or snacks, and administered medication as needed for cognitive difficulties; and staff monitored closely after toileting to prevent injury from falls. R3 was blind in her left eye with diminished vision in her right eye and staff ensured her glasses were in good repair, clean, and within her reach for impaired vision. Staff provided supervision in the common area for wandering. Review of nursing "Charting Notes" from admission on 10/11/24 to 07/23/25 revealed the	S5171		

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S5171	Continued From page 21 following: 1) Each note included two dates. The first column of dates read "created" and the second column read "observed." 2) Administrative Staff A created 10 nursing notes on 12/01/24 for observations that occurred on 10/29/24, 11/10/24, 11/15/24 at 09:32 AM and 04:39 PM, 11/16/24, 11/18/24, 11/21/24 at 11:57 AM, 01:52 PM, and 05:02 PM; and 11/23/24 which was 33 days later at the earliest observation. 3) Administrative Staff A created four nursing notes on 03/17/25 for observations that occurred on 03/06/25 at 05:15 PM, 07:28 PM, and 09:35 PM; and 03/10/25 which was 11 days later at the earliest observation. 4) Administrative Staff A created 10 nursing notes on 04/25/25 for observations that occurred on 03/18/25, 03/19/25, 03/26/25, 04/06/25, 04/07/25, 04/08/25 at 09:20 AM, 12:01 PM, and 05:27 PM; 04/11/25, and 04/12/25 which was 38 days from earliest observation. 5) Administrative Staff A created 28 nursing notes on 06/09/24 for observations that occurred seven times in October 2024 on 10/12/24, 10/13/24, 10/14/24, 10/18/24, 10/19/24, 10/30/24, and 10/31/24; seven times in November 2024 on 11/01/24, 11/02/24, 11/03/24, 11/04/24, 11/17/24, 11/22/24, and 11/26/24; on 12/17/24, 12/18/24, 01/09/25, and 02/10/25; seven times in March 2025 on 03/07/25, 03/08/25, 03/09/25, 03/11/25, 03/20/25, 03/21/25, and 03/27/25; and on 04/01/25, 04/11/25, and 05/01/25 which was 240 days later at the earliest observation. 6) The "observed" on 07/10/25 "Charting Note" documented Administrative Staff A created the	S5171		

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S5171	Continued From page 22 note on 07/20/25 which was 10 days later. On 07/28/25 at 03:46 PM Administrative Staff A stated the electronic "Charting Notes" system allowed her to enter the date of an observation. When she logged into the system, the created date changed to when she accessed a resident's electronic record. On 07/28/25 at 04:24 PM Pharmacy Staff D stated during a phone interview she could access the resident's electronic records to verify the history of nursing documentation. Pharmacy Staff D stated she used the "observed" on 10/12/24 "Charting Note" for R3 as an example and confirmed the note was created on 06/09/25. The operator failed to ensure designated staff documentated in a timely manner for R1, R2, and R3.	S5171		
S5192 SS=F	26-42-206 (e) Food Preparation (e) Food shall be prepared using safe methods that conserve the nutritive value, flavor, and appearance and shall be served at the proper temperature. (1) Food used by facility staff to serve to the residents, including donated food, shall meet all applicable federal, state, and local laws and regulations.(2) Food in cans that have significant defects, including swelling, leakage, punctures, holes, fractures, pitted rust, or denting severe enough to prevent normal stacking or opening with a manual, wheel-type can opener, shall not be used. (3) Food provided by a resident ' s family or friends for individual residents shall not be	S5192		

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S5192	Continued From page 23 required to meet federal, state, and local laws and regulations. This REQUIREMENT is not met as evidenced by: KAR 26-42-206(e) The facility reported a census of four residents. Based on record review and interview the operator failed to ensure designated staff served all cold food items within safe temperatures. Findings included: Review of the food temperature log provided by the facility for the months of May 2025 and June 2025 and from 07/01/25 to 07/27/25 revealed the row for documenting a temperature for cold items was blank. Observation on 07/28/25 at approximately 11:38 AM revealed a refrigerator in the kitchen that contained a container of prepared chicken salad and a container of prepared coleslaw with a handwritten open date which read 07/18/25. On 07/28/25 at 12:09 PM Administrative Staff A confirmed the food temperature log lacked evidence of documentation staff served all cold food items to the residents at a safe temperature. Dietary guidelines for Americans 2005 recommends using a clean thermometer that measures the internal temperature of foods and to hold at proper temperatures to keep food out of the "danger zone" (40 degrees Fahrenheit to	S5192		

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S5192	Continued From page 24 140 degrees Fahrenheit) where bacteria can multiply rapidly. The operator failed to ensure designated staff served all cold food items within safe temperatures.	S5192		
S5195 SS=F	26-42-206 (f) (g) Facility Food Storage (f) Staff shall store all food under safe and sanitary conditions. Containers of poisonous compounds and cleaning supplies shall not be stored in the areas used for food storage, preparation, or serving. (g) Each home shall maintain at least a three-day supply of food to meet the requirements of the planned menus. This REQUIREMENT is not met as evidenced by: KAR 26-42-206(f) The facility reported a census of four residents. The facility had a kitchen where food was stored, prepared, and served. Based on observation and interview the operator failed to ensure designated staff stored food items under safe conditions. Findings included: - Observation on 07/28/25 at approximately 11:38 AM revealed a refrigerator in the kitchen that contained the following food items for the residents:	S5195		

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S5195	Continued From page 25 One 16-ounce (oz) plastic container of fresh salsa, dated 07/11/25 One three-liter (L) bottle of opened cranberry-apple juice, undated One 24-oz container of cottage cheese, undated One container of prepared chicken salad, dated 07/18/25 One container of prepared coleslaw, dated 07/18/25 One small personal-sized container of what appeared to be whole cooked corn, unlabeled and undated One small personal-sized container of what appeared to be fresh chopped tomatoes, unlabeled and undated On 07/26/25 at 12:01 PM Administrative Staff A confirmed some food items in the refrigerator lacked labels indicating dates and/or contents inside. Some dated foods were past seven days since preparation or opening the containers. Dietary Guidelines for Americans 2005 states "refrigerated leftovers may become unsafe within 3 to 4 days. Despite the appearance of a food, it may not be safe to eat." The operator failed to ensure designated staff stored food items under safe conditions.	S5195		