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S 000	INITIAL COMMENTS The following citations represent the findings of an abbreviated survey for complaints #196693, 195451, 195457, and 193987, of the above named facility conducted on 08/26/25 and 08/27/25.	S 000		
S 225 SS=D	26-39-102 (a) Admission Policy (a) Each licensee, administrator, or operator shall develop written admission policies regarding the admission of residents. The admission policy shall meet the following requirements: (1) The administrator or operator shall ensure the admission of only those individuals whose physical, mental, and psychosocial needs can be met within the accommodations and services available in the adult care home. (A) Each resident in a nursing facility or nursing facility for mental health shall be admitted under the care of a physician licensed to practice in Kansas. (B) The administrator or operator shall ensure that no children under the age of 16 are admitted to the adult care home. (C) The administrator or operator shall allow the admission of an individual in need of specialized services for mental illness to the adult care home only if accommodations and treatment that will assist that individual to achieve and maintain the highest practicable level of physical, mental, and psychosocial functioning are available. (2) Before admission, the administrator or operator, or the designee, shall inform the prospective resident or the resident ' s legal representative in writing of the rates and charges for the adult care home's services and of the	S 225		

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

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S 225	Continued From page 1 resident's obligations regarding payment. This information shall include the refund policy of the adult care home.(3) At the time of admission, the administrator or operator, or the designee, shall execute with the resident or the resident ' s legal representative a written agreement that describes in detail the services and goods the resident will receive and specifies the obligations that the resident has toward the adult care home. (4) An admission agreement shall not include a general waiver of liability for the health and safety of residents. (5) Each admission agreement shall be written in clear and unambiguous language and printed clearly in black type that is 12-point type or larger. This REQUIREMENT is not met as evidenced by: K.A.R. 26-39-102 (a) (2) (3) The facility reported a census of 8 residents. The sample included 3 "Residents'" (R)'s and 2 closed record reviews. Based on record review and interview the Operator failed to inform the prospective resident or the resident's legal representative in writing of the rates and charges for the adult care home's services and of the resident's obligation regarding payment. The operator further failed to execute with the resident or the resident's legal representative a written agreement that described in detail the services and goods the resident would receive and specified the obligations that the resident had toward the adult care home for R5.	S 225		

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Findings included:

- Observation on 08/26/25 at approximately 01:30 PM of R5's medical record revealed that the complete record was damp and had a black substance on the pages and edges of the pages. The ink was smeared, and most pages were to damp to lift. The pages that were legible were prior medication administration record sheets, narcotic count sheets, and bathing sheets, and outside provider notes from 2024.

Record review for R5 revealed an admission date of 05/06/24 with a diagnoses of congestive heart failure.

Record review of the hospice outside provider notes provided by the outside provider during they survey revealed R5 discharged from the facility on 03/10/25.

Interview on 08/26/25 at approximately 01:30 PM with Operator A confirmed the chart had been out in a locked storage shed behind the facility and that the rain damaged the medical record. Operator A further confirmed the medical record lacked documentation of an admission agreement, functional capacity screen, and negotiated service agreement. Operator A stated R5's family paid R5's bill through an electronic payment application.

The Operator failed to inform the prospective resident or the resident's legal representative in writing of the rates and charges for the adult care home's services and of the resident's obligation

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S 225	Continued From page 3 regarding payment. The operator further failed to execute with the resident or the resident's legal representative a written agreement that described in detail the services and goods the resident would receive and specified the obligations that the resident had toward the adult care home for R5.	S 225		
S5026 SS=J	26-42-101 (f) (1) Staff Treatment of residents ANE (f)The administrator or operator shall ensure that all of the following requirements are met: (1) No resident shall be subjected to any of the following: (A) Verbal, mental, sexual, or physical abuse, including corporal punishment and involuntary seclusion; (B) neglect; or (C) exploitation. This REQUIREMENT is not met as evidenced by: K.A.R. 26-42-101 (f) (1) (A) (B) The facility reported a census of 8 residents. The sample included 3 "Residents" (R)'s, and 2 closed record reviews. Based on observation, interview and record review, the Operator failed to protect R1 from physical abuse and neglect when a "Certified Nurse Aide" CNA B was recorded on the facility's electronic monitoring system dragging R1 on his back from his bedroom approximately 10 feet to the facility's living room, where she left him on the floor until he was able to stand by himself. She then	S5026		

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proceeded to grab the back of the residents clothing and pull him backwards into a recliner, she placed her hand on R1's forehead and shoved his head backwards into the back recliner cushion. This placed R1 in immediate jeopardy for approximately one hour and nineteen minutes. Furthermore the Operator failed to protect the two person assist residents R2 and R3, from neglect when the facility investigation for the abuse of R1, revealed the second CNA was not in the home for approximately two hours., and failed to protect R4 from neglect when three facility staff noticed a change in R4's condition on 05/15/24, and failed to notify the facility nurse, resulting in R4 being taken by "Emergency Medical Services" (EMS) to a local hospital for evaluation and treatment.

Findings included:

-Review of the facility provided document titled "Resident Roster" revealed that R2 and R3 required the assistance of two staff members for transfers.

Record review for R1 revealed an admission date of 08/08/23 with diagnoses of self-care deficit, major neurocognitive disorder due to Alzheimer's disease with behavioral disturbance, and Parkinson's disease.

Review for R1's "Functional Capacity Screen" (FCS) dated 05/08/25 revealed R1 required physical assistance with bathing, dressing, and toileting. R1 required supervision with transferring, walking/mobility. R1 lacked the ability to manage his own medications and was

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frequently incontinent. R1 had impaired short-term memory, long-term memory, memory/recall and impaired decision making. R1 was usually able to make himself understood and he sometimes understood others. R1 was identified to be at risk for falls, impaired hearing, wandering, socially inappropriate disruptive behavior, and impaired decision making. R1 used a cane mobility device.

Review of R1's undated, unsigned, and combined "Negotiated Service Agreement" (NSA) / "Health Service Plan" (HSP) instructed facility staff to provide R1 physical assistance with bathing, dressing, and toileting. R1 required supervision with walking using a cane mobility device and transferring. Under the section titled "Health and Wellness Monitoring" facility staff were instructed to assist R1 with redirection and assist him with walking to reduce R1's risk for falls.

Review of R1's "Nursing Progress Notes" revealed an entry dated 08/01/25 that revealed the nurse received a call from Operator A regarding concern for R1. The nursing assessment revealed no injury and vital signs were within R1's normal limits. R1's provider and "Durable Power of Attorney" (DPOA) were notified.

Review of the facility provided self-report to the department dated 07/31/25 revealed on 07/30/25 it was reported to Operator A an incident of physical abuse that was recorded on the facility's electronic monitoring device and substantiated by the recorded video.

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S5026	Continued From page 6 Review of the facility provided witness statement dated 07/30/25, signed by CNA B and notarized on 08/01/25 revealed CNA B wrote that she was trying to get R1 to "stay in bed" and R1 "kept getting out of bed". CNA B continued to write that she was bringing R1 to the living room and the "threw himself on the floor", she "got him up" and R1 "did it again". CNA B wrote that she was "by herself" so she left R1 "there" when her "co-worker came back" "she called the nurse" and the nurse instructed staff to give R1 an as needed medication. CNA B wrote "She didn't give it to him, she said it wasn't working". Review of the facility provided un-notarized witness statement dated 08/18/25 and signed by CNA C revealed that CNA C was "outside" on her break. Upon CNA C's return from break CNA B told her that R1 was "tripping" and "that's why he was sitting in the living room." Review of the facility provided document titled "Witness Statement" dated 07/30/25 signed on behalf of R3 by "Certified Medication Aide" (CMA) D and notarized on 08/01/25 revealed R3 was wakened by a loud sound coming from the hallway. R3 stated he "saw someone being drug down the hallway". R3 stated he heard CNA B tell R1 "he was going to stay right there, and he wasn't going anywhere". R3 continued to report that he heard R1 asking for help to be "let up" off of the ground and CNA B replied to R1 that since R1 was trying to "hit me, this is what you get." R3 reported that he heard R1 "begging to get up multiple times." Review of the facility camera footage obtained from the local Police Department dated 07/30/25	S5026		

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S5026	Continued From page 7 and time stamped 00:00:00 revealed the following; At 00:00:13 there were unidentified body parts that appeared and disappeared in the door on the southwest wall of the hallway at the ground level. At 00:00:16 R1's head and right shoulder appeared in the southwest doorway, R1 was at floor level supporting himself on his extended right arm. At 00:00:18 The head of a CNA B appeared to be over R1 and his right arm buckled and R1 was supporting himself on his right elbow with his head lowered. At 00:00:19 The head of CNA B was behind R1's head while R1 remained at ground level. At 00:00:21 R1 appeared to be lifted into a standing position from someone behind him and his head disappeared into the southwest room and his left hand grabbed the door frame. At 00:00:25 R1 appeared to be pulled into the southwest room and his left hand remained holding onto the door frame. At 00:00:37 The staff's head appeared in what appeared to be a bent over position in the southwest doorway. At 00:00:39 R1's lower body was not visible, and he appeared to be on his knees supporting himself on his left hand with the left arm extended, staff appeared to be behind R1, and you saw the staff's left hand and arm under R1's	S5026		

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S5026	Continued From page 8 left axillary region. At 00:00:44 staff is no longer visible on the video and R1 is at ground level. R1 appeared to be trying to look at something and then the staff's head is visible over R1. At 00:00:50 R1 was no longer visible on the screen and the CNA B appeared in the southwest room doorway bent at the waist and the CNA B appeared to be pulling on something in front of CNA B. At 00:00:54 CNA B was standing bent at the waist in the doorway of the southwest room and CNA B dragged R1 from the southwest room into the hallway. R1 was on the floor in a seated position with R1's back to the front of CNA Bs legs, R1's left arm was extended with his left hand on the floor and his right arm was raised and bent at the elbow, CNA B appeared to be grabbing the back of R1's shirt at shoulder level from behind him on the right anterior side and her right hand appeared to be grabbing the top of R1's sleeve from the anterior right side. CNA B dragged R1 in the seated position approximately five feet where his left arm bumped the small plastic trash can sitting in the doorway on the southeast side of the hall, and she appeared to lose her grip on R1's clothing, R1 was then on his back and tilted sightly on the left side with CNA B standing at R1's head in a bent over position where CNA B then grabbed R1's clothing at the waist with her right hand and placed her left hand on the wall, and stepping backwards proceeded to drag R1 approximately three feet to the facility living room. CNA B left R1 on his left side where R1 appeared to be	S5026		

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almost laying on his stomach, CNA B stood up, stepped over R1's legs and proceeded down the hallway approximately three feet where she moved a plastic trash can out of the middle of the southeast hallway door.

At 00:01:12 R1 remained on the floor, and CNA B walked back up the hallway to the facility living room and stepped over R1's legs and sat on the arm of the recliner. She appeared to be speaking to R1.

At 00:01:57 CNA B remained seated on the arm of the recliner located in the facility living room while R1 rolled to his stomach and supported by his arms lifted his head and chest off of the floor.

At 00:02:04 R1 pushed his upper body up and attempted to get to his knees.

At 00:02:09 CNA B remained seated on the arm of the recliner located in the facility living room while R1 continued to try and get to his knees, she reached over and grabbed R1's walker.

At 00:02:12 CNA B remained seated on the arm of the recliner located in the facility living room while R1 continued to attempt to get to his knees, she placed R1's walker to his left side. R1 grabbed the lower bar of the left side of the walker, and she leaned back and watched R1.

At 00:02:21 CNA B remained seated on the arm of the recliner and held R1's walker in place on the left side while R1 lifted his right hand to grab the right-hand grip on the walker.

At 00:02:27 R1 is on his knees with his left hand

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on the lower support bar of the left side of his walker and his right hand on the walker's right-hand grip. CNA B remained seated on the arm of the recliner to R1's left side and appeared to be speaking to R1.

At 00:02:31 CNA B stands to R1's left side, grabbed him in the left axillary area and then grabbed the back of his pants. She pulled R1 into a standing position while R1's walker slid to the left; the back of his pants extended approximately eight inches from his bod. R1 was in a standing position with his left arm fully extended holding onto the left-hand grip of the walker and his right arm was bent approximately 45 degrees holding onto the right handgrip of the walker. CNA B continued to hold the back of R1's pants in her right hand and used her left hand to remove something from the seat of the recliner.

At 00:02:39 R1 attempted to take a step forward and CNA B standing behind R1, holding onto the back of R1's pants, used both hands of the back of R1's pants to pull him in the recliner. R1 resisted and CNA B forcefully pulled him backwards and to the left into the recliner, this resulted in R1's walker falling, and the left-hand grip landed on R1's left shin. She then forcefully pulled the walker out of R1's right hand and takes R1's walker out of the living room and leaves R1 sitting in the recliner until she returned at 00:03:37.

At 00:03:49 CNA B appeared to be speaking to R1 and she picked up a blanket from another recliner in the living room and tossed the blanket onto R1's lap moved the recliner away from the wall and pushed the recliner into a reclined

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position. R1grabbed the arms of the recliner and appeared to resist being put into the reclined position and she roughly adjusted R1's bilateral lower legs in the chair. She then pulled the chair out from the and using both hands pushed the chair into a reclining position. She then used her right opened hand and pushed R1's head back into the recliner, and covered R1's upper body with a blanket.

At 00:04:17 CNA B stepped away from R1, turned and bent at the waist facing R1 and appeared to be speaking to R1. R1 turns his head to the right side and closed his eyes, she continued to appear to speak to R1 and he moved his left arm to push her away from being so close to his face and she appeared to be purposefully pushing the blanket into R1's face as he was using both hands to push her away. She then bent down to the right of the recliner, picked the blanket up off of the floor. R1 had both hands in a fist and both arms were bent at a 45-degree angle, she appeared to say something to R1 and then walked out of the living room and at 00:05:12 the living room lights were turned out.

From 00:04:18 until 00:14:57 CNA B walks in front of R1 four times and appeared to be speaking to R1 while he remained on the recliner in the living room with the lights in the living room off.

At 00:14:56 R1 put the recliner into a sitting position and leaned forward looking around.

At 00:15:03 CNA B came from what appeared to be the kitchen and appeared to be speaking to

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S5026	Continued From page 12 R1 using hand gestures. She walked over to the right side of the recliner and pushed with her left hand on the recliner her right hand appeared to be pushing on R1's upper right shoulder to put the recliner back into the reclined position. R1 then immediately put the recliner into a sitting position she took a few steps away from R1, turned and raised her hand and appeared to be speaking to R1. She then took two steps towards R1 pointing at R1 and continued to appear to be speaking to him. She then took another step forward toward R1 and was standing to the right and over R1 while he remained seated in the recliner. The staff continued to appear to be speaking to R1 when the back of CNA Bs left upper arm quickly moved forward and then R1's upper body appeared to jerk to the left and he simultaneously raised his right arm bent at 45 degrees across his upper chest while she remained standing over him and to his right. She continued to stand over R1and continued to speak to him with her left arm continuing to move toward R1as R1 continued to raise his right arm to put between him and CNA B. She had her left hand down at the resident right wrist and with her hand and wrist she was observed to be bumping as she was speaking to R1. At 00:15:49 CNA B turned and put her left hand down to her side and walked away from R1. R1 remained in the recliner in the living room from 00:15:50 until 01:17:18 while staff swept and mopped the floor of the home. There appeared to be minimal verbal interaction and staff did not offer R1 anything to eat or drink during this time.	S5026		

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S5026	Continued From page 13 At 01:17:19 R1 attempted to stand from the recliner in the living room and sat back down as his feet slid on the floor. He achieved a standing position without his walker or cane on his second attempt to stand. R1 reached for the east wall of the hallway that was approximately three feet from his recliner and used the wall and recliner to walk himself to the unlit hallway where he used the walls as support to reach the room on the southwest side of the hallway approximately ten feet from the recliner he was sitting in, R1 went into the room and the light came on in the room. No staff observed in the video during R1's return to his room. Review of the facility provided companywide electronic "Message Wall" dated 06/27/25 revealed the following notice to staff: " ...we do not leave our shift at night not even going on lunch. This is a two-person house and needs to have two people here at all times please." Interview 08/26/25 at approximately 11:30 AM with R2 confirmed that on 07/30/25 he was awakened by a loud noise. He stated that at first, he was not sure if he was dreaming or not. He stated that he used his cell phone to call the house phone to tell staff if he needs assistance. R2 stated that when the event happened, he did try and call the house phone and that was when he realized CNA C was not in the house. R2 continued to state he thought CNA C was "sleeping in her car". R2 stated that when CNA B realized that R2 was awake, she "backed off" of R1. R2 stated he reported the incident when the staff came on the next shift and told them to	S5026		

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	B087267	A. BUILDING: _____ B. WING _____	08/27/2025

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S5026	Continued From page 14 check the cameras in the home. Review of the facility provided written disciplinary action dated 07/30/25 and signed by CNA C and Operator A revealed that a final warning was being provided for the "Violation" of the following: "carelessness, unsatisfactory performance, safety violation and work quality". In the section titled "Violation Description" the following was handwritten; "On 07/30/25 it was observed and reported" that CNA C was "outside the facility for approximately two hours, leaving residents unattended during that time". The behavior was identified as a "serious violation of company policy, neglect of assigned duties and a direct breach of resident safety protocols. Leaving residents is unacceptable under any circumstance". Interview on 08/26/25 with Operator A, "Registered Nurse" (RN) E, and CMA D confirmed on 07/31/25 upon CNA F's arrival to work on 07/31/25 R2 reported to her the incident that happened during the night shift with CNA B and R1, they further confirmed the cameras were checked at 09:00 AM and an investigation was opened, the allegation of abuse was confirmed. They continued to confirm that CNA C was not in the home during the time of the abuse and that CNA C was out of the home for approximately two hours during her assigned shift, leaving only CNA B in the home. On 08/27/25 at approximately noon Operator A was informed that R1 was the victim of physical abuse and neglect placing him in immediate jeopardy on 07/30/25 from approximately 12:00 AM until approximately 01:20 AM from CNA B,	S5026		

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S5026	Continued From page 15 while CNA C was absent from the inside of the home for approximately two hours, which left R2 and R3 without the required two staff assistance for needs. The facility implemented the following actions prior to the surveyor's arrival and submitted the following removal plan on 08/27/25. On 07/30/25 At 10:18 CNA B was suspended pending investigation At 10:29 RN E was notified of allegation At 12:00 PM CNA C received written disciplinary action. At 01:48 PM the department was notified of the incident On 08/01/25 At 08:40 AM the local police department was notified Exterior Camera in the facility driveway was installed on 08/19/25. Door monitors were put into place and at night after 11:00 PM the door alarms are set to Operator A's phone to alert if the doors are being opened. In-service on 08/06/25 on Abuse, Neglect, and Exploitation (ANE) provided to all staff. Prior Inservice on ANE was provided on 05/20/25 -Record review for R4 revealed an admission date of 06/20/24 with diagnoses of hypertension, deep vein thrombosis, gout, and chronic kidney disease.	S5026		

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S5026	Continued From page 16 Review of R4's FCS dated 05/12/25 revealed R4 required physical assistance with bathing, dressing, toileting, transferring, and mobility. R4 was independent with eating. R4 lacked the ability to manage her own medications and was incontinent. R4 had impaired short-term memory, long-term memory, memory/recall and impaired decision making. R4 was usually able to make herself understood and she understood others. R4 was identified to have impaired vision. R4 required a wheelchair and a mechanical lift. Review of R4's combined NSA/HSP instructed facility staff to provide physical assistance with bathing, dressing, toileting, mobility, and R4 required a two-person transfer. R4 was on a regular diet with thin liquids. Review of R4's "Nursing Progress Notes" revealed the following entry; On 05/15/25 at 06:15 (AM/PM not identified) signed by Operator/CMA A revealed R4's family came and R4 was sitting up getting ready for dinner. R4's family stated they felt R4 was "acting different" and the family requested R4 be sent to the hospital for evaluation and treatment. R4's family called 911 and EMS responded and took R4 to a local hospital for evaluation and treatment. "her vitals was good when we took them." R4's record lacked documentation of the facility staff notifying the facility nurse of a possible change of condition. Review of the facility provided undated and unnotarized written statement signed by CMA G	S5026		

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S5026	Continued From page 17	S5026		

revealed that around 05:15 AM on 05/15/25 when CMA G woke R4 she "was very confused like more then normal". CMA G wrote that he obtained R4's vital signs and "they were normal". CMA G continued to write that he administered R4's medications and she took them, "but wasn't verbally responsive". CMA G wrote that he asked R4 questions, and she didn't say anything. "She just looked at me no words, it was like her eyes were open, but she wasn't there. After a couple of seconds" R4 covered up her arm and closed her eyes. CMA G wrote that he reported the behavior to on coming staff at shift change.

CMA G's statement lacked documentation that he called the nurse or the medical provider when he noticed a change in R4's condition.

Review of the facility provided unnotarized document titled "Witness Statement" dated 05/15/25 and signed by CNA H revealed she arrived for her shift at approximately 03:00 PM and she checked on R4 and asked R4 if she was ok. R4 responded in a whisper to CNA H and she asked R4 what was wrong? CNA H wrote that she noticed that R4 "was not herself". CNA H continued to write that she could not understand what R4 was saying, so CNA H stood back, and just stood there and R4 looked down, "wasn't normal to me, especially the crying, but I walked out and finished my rounds".

CNA H's statement lacked documentation that she called the nurse or the medical provider when she noticed a change in R4's condition.

Review of the facility provided electronic email from CMA I revealed she worked the 07:00 AM to

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S5026	Continued From page 18 03:00 PM shift on 05/15/25 and it was reported to her that R4 was being "more quiet then usual", and that "carried on into the day. She did not speak much besides one-word answers. CNA I's email lacked that she notified the facility nurse when prior staff noted a change in R4's condition, and CNA I further lacked documentation showing she called the nurse when she noticed a change in R4's condition. Review of the undated facility policy titled "Certified Nurse Aide/Certified Medication Aide" Under the section titled "Responsibilities. 8. Record and report any changes in the resident's behavior or appearance to supervising nurse". Interview on 08/27/25 at approximately 12:30 PM with Operator A and RN E confirmed CNA's G, H and I failed to call the facility nurse when they noted a change in R4's condition. The Operator failed to protect R4 from neglect when three facility staff failed to call the facility nurse when they noticed a significant change in her condition	S5026		
S5105 SS=D	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	S5105		

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S5105	Continued From page 19 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 payment if outside resources provide a service. This REQUIREMENT is not met as evidenced by: K.A.R. 26-42-202 (a) The facility reported a census of 8 residents. The sample included 3 "Residents'" (R)'s and 2 closed record reviews. Based on record review and interview the Operator failed to ensure the development of R1's "Negotiated Service Agreement" (NSA) was based on R1's functional capacity screening. Findings included: - Record review for R1 revealed an admission date of 08/08/23 with diagnoses of self-care deficit, major neurocognitive disorder due to Alzheimer's disease with behavioral disturbance, and Parkinson's disease. Review for R1's "Functional Capacity Screen" (FCS) dated 05/08/25 revealed R1 required physical assistance with bathing, dressing, and toileting. R1 required supervision with transferring, walking/mobility. R1 lacked the ability to manage his own medications and was frequently incontinent. R1 had impaired	S5105		

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S5105	Continued From page 20	S5105		

short-term memory, long-term memory, memory/recall and impaired decision making. R1 was usually able to make himself understood and he sometimes understood others. R1 was identified to be at risk for falls, impaired hearing, wandering, socially inappropriate disruptive behavior, and impaired decision making. R1 used a cane mobility device.

Review of R1's undated, unsigned, and combined "Negotiated Service Agreement" (NSA) / "Health Service Plan" (HSP) instructed facility staff to provide R1 physical assistance with bathing, dressing, and toileting. R1 required supervision with walking using a cane mobility device and transferring. Under the section titled "Health and Wellness Monitoring" facility staff were instructed to assist R1 with redirection and assist him with walking to reduce R1's risk for falls.

Review of the facility provided untitled document dated 02/13/25 identified R1 required assistance of one person for bathing, dressing, toileting, and supervision with eating. R1 was documented as independent with transferring, and he required supervision with independent mobility.

Interview on 08/27/25 with Operator A and Registered Nurse E confirmed the medical record lacked documentation of the development of a written NSA based on R1's FCS dated 05/08/25.

The Operator failed to ensure the development of R1's "Negotiated Service Agreement" (NSA) was based on R1's functional capacity screening.

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S5246	Continued From page 21	S5246		
S5246 SS=D	26-42-105 (c) Resident Record Safeguards (c) Each administrator or operator shall ensure the safeguarding of resident records against the following: (1) Loss; (2) destruction; (3) fire; (4) theft; and (5) unauthorized use. This REQUIREMENT is not met as evidenced by: K.A.R. 26-42-105 (c) (1) (2) The facility reported a census of 8 residents. The sample included 3 "Residents'" (R)'s and 2 closed record reviews. Based on record review and interview the Operator failed to ensure the safeguarding of resident records against loss and destruction for R5. Findings included: - Observation on 08/26/25 at approximately 01:30 PM of R5's medical record revealed that the complete record was damp and had a black substance on the pages and edges of the pages. The ink was smeared, and most pages were to damp to lift. The pages that were legible were prior medication administration record sheets, narcotic count sheets, and bathing sheets, and outside provider notes from 2024. Record review for R5 revealed an admission date of 05/06/24 with a diagnoses of congestive heart failure.	S5246		

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S5246	Continued From page 22 Record review of the hospice outside provider notes provided by the outside provider during they survey revealed R5 discharged from the facility on 03/10/25. Interview with Operator A confirmed the chart had been out in a locked storage shed behind the facility and that the rain damaged the medical record. Operator A further confirmed the medical record lacked documentation of an admission agreement, functional capacity screen, and negotiated service agreement. The Operator failed to ensure the safeguarding of resident records against loss and destruction for R5.	S5246		