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HEARTFUL HOMES CORPORATION	1301 S SEVILLE AVE WICHITA, KS 67209

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S 000	INITIAL COMMENTS The following citations represent the findings of the licensure resurvey with attached complaint numbers 196658, 195768, 195389, and 194504, for the above named facility conducted on 09/17/25 and 09/18/25.	S 000		
S5028 SS=E	26-42-101 (f) (3) Staff Treatment of Residents Reporting (f) (3) Each allegation of abuse, neglect, or exploitation shall be reported to the administrator or operator of the home as soon as staff is aware of the allegation and to the department within 24 hours. The administrator or operator shall ensure that all of the following requirements are met: (A) An investigation shall be started when the administrator or operator, or the designee, receives notification of an alleged violation. (B) Immediate measures shall be taken to prevent further potential abuse, neglect, or exploitation while the investigation is in progress. (C) Each alleged violation shall be thoroughly investigated within five working days of the initial report. Results of the investigation shall be reported to the administrator or operator. (D) Appropriate corrective action shall be taken if the alleged violation is verified. (E) The department ' s complaint investigation report shall be completed and submitted to the department within five working days of the initial report. (F) A written record shall be maintained of each investigation of reported abuse, neglect, or exploitation.	S5028		

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

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S5028	Continued From page 1 This REQUIREMENT is not met as evidenced by: K.A.R. 26-42-101 (f) (3) (E) (F) The facility reported a census of 5 residents. Based on interview and record review the Operator failed to ensure each allegation of abuse or neglect was reported to the department withing 24 hours. The Operator further failed to submit the completed full investigation report to the department within 5 working days of the initial report and maintain a written record of each investigation. Findings included: - Record review for R4 revealed an admission date of 03/14/24 with diagnosis of unspecified sequalae of cerebral infarction, hypertension, muscle weakness, anemia, and unspecified hearing loss, senile dementia. Review of R4's FCS dated 03/10/24 identified R4 required staff supervision with bathing, dressing, toileting and transferring. R4 was documented at risk for falls/unsteadiness and was continent of bladder. R4 had impaired hearing, impaired decision making, and was at risk for wandering. R4 was marked with "Very Poor Cognition" and poor memory recall. R4 lacked the ability to manage her own medications and medical treatments. Review of R4's NSA dated 03/14/24 identified facility staff would provide R4 with staff	S5028		

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S5028	Continued From page 2	S5028		

supervision for bathing, dressing, and toileting and supervision/stand by assist of one staff member for walking and mobility. Facility staff would manage R4's medications and the home health and facility staff would manage R4's treatments.

Review of R4's HSP dated 08/13/25 instructed facility staff to provide one staff member for assistance with meals and administer R4's medications. One facility staff would provide assistance with dressing, bathing, toileting, and mobility.

Record review of the facility provided document titled "Report #121974" dated 06/17/25, revealed that R4 had an unwitnessed fall in her room. Facility staff found R4 on the floor near her closet in a seated position. R4 was sent to the local emergency room where she was diagnosed with a non-displaced fracture of the pelvis. R4 was sent back to the facility with no surgical intervention.

Interview on 09/18/25 at approximately 02:00 PM with Operator A confirmed she did not obtain signed and notarized witness statements, and she had no investigative notes ruling out neglect. Operator A confirmed she thought she had submitted the report to the department. Operator A further confirmed it was discovered during the survey process she did not submit the report to the "Hotline".

- Record review for R2 revealed an admission date of 11/15/24 with diagnosis of type two diabetes, lumbar laminectomy, cardiac stents,

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S5028	Continued From page 3	S5028		

adult failure to thrive, muscle weakness, chronic pain syndrome, decreased insight and judgement needs assistance with activities of daily living, unspecified dementia with mood disorder.

Review of R2's FCS dated 11/15/24 revealed R2 required supervision with bathing, dressing and toileting. R2 required physical assistance with transferring, walking and mobility. R2 was independent with eating and continent of bladder. R2 was at documented with impaired vision, falls, and R2 had "very poor short term and long-term memory". R2 lacked the ability to manage her own medications and medical treatments.

Review of R2's NSA dated identified the facility would provide R2 one staff assistance for bathing, dressing, toileting, and instructed staff to use a gait belt during transfers. Facility staff were to encourage R2 to use her wheelchair or walker. Facility staff were to remind R2 about toileting. Facility staff would provide cueing with eating. Facility staff would administer R2's medications/medical treatments.

Review of R2's HSP dated 12/12/25, instructed facility staff to administer R2'smedications. Facility staff would provide reminders for R2 to change her clothes and to put her clothes in the laundry. Facility staff would provide one staff assistance for bathing. Facility staff were to stay with R2 when she was outside on the patio.

Record review of the facility provided document titled "Report #121169" dated 06/04/25, revealed that R2 had an "Elopement". The document revealed that after R2 had been on an outing

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S5028	Continued From page 4 with her family she returned to the facility and asked to sit out on the enclosed patio. R2 had done this in the past without incident. The patio had glass doors and R2 could be observed by staff. R2 went to the second set of sliding glass doors and was witnessed by Operator A to open them. Operator A asked for staff assistance in bringing R2 back in the home. When the facility staff went to R2, R2 had walked approximately 15 yards to the back southeast corner of the property. The fence in the southeast corner of the property was pulled back leaving an opening in the fence approximately 5 feet tall and 4 feet wide. R2 was assisted back to the home where she sat outside for a while longer with staff before she agreed to re-enter the home. Interview on 09/18/25 at approximately 02:00 PM with Operator A confirmed she did not obtain signed and notarized witness statements, and she had no investigative notes ruling out neglect. Operator A confirmed she thought she had submitted the report to the department. Operator A further confirmed it was discovered during the survey process she did not submit the report to the "Hotline". The Operator failed to ensure each allegation of abuse or neglect was reported to the department withing 24 hours. The Operator further failed to submit the completed full investigation report to the department within 5 working days of the initial report and maintain a written record of each investigation.	S5028		
S5029 SS=F	26-42-101 (g) Availability of policies and procedures	S5029		

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S5029	Continued From page 5 (g) Availability of policies and procedures. Each administrator or operator shall ensure that policies and procedures related to resident services are available to staff at all times and are available to each resident, legal representatives of residents, case managers, and families during normal business hours. A notice of availability shall be posted in a place readily accessible to residents. This REQUIREMENT is not met as evidenced by: KAR 26-42-101(g) The facility reported a census of five residents. Based on observation and interview, Operator A failed to ensure policies and procedures were always available to staff and were available to visitors during normal business hours. Operator A further failed to ensure a notice of availability of policies and procedures was posted in a place readily accessible to residents. Findings included: - Observation on 09/17/25 at 08:40 AM during the initial tour lacked a notice of availability of policies and procedures posted in a place readily accessible to residents. Interview on 09/17/25 at 08:40 AM during the initial tour with Certified Medication Aide (CMA) B stated she did not know where the facility's policies and procedures were located nor how to access them. Interview on 09/17/25 at approximately 09:10 AM with Operator A confirmed a notice of availability	S5029		

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S5029	Continued From page 6 of policies and procedures was not posted in a place readily accessible to residents. Operator A further confirmed policies and procedures were not printed and available to staff or visitors. Operator A failed to ensure policies and procedures were always available to staff and were available to others during normal business hours. Operator A further failed to ensure a notice of availability of policies and procedures was posted in a place readily accessible to residents.	S5029		
S5085 SS=D	26-42-201 (c) Functional Capacity Screen Reassessment (c) Designated staff shall conduct a screening to determine each resident ' s functional capacity according to the following requirements: (1) At least once every 365 days; (2) following any significant change in condition as defined in K.A.R. 26-39-100; and (3) at least quarterly if the resident receives assistance with eating from a paid nutrition assistant. This REQUIREMENT is not met as evidenced by: KAR 26-42-201(c)(1) The facility reported a census of five residents. The sample included 3 "Residents'" (R), and one focused review. Based on interview and record review the operator failed to ensure designated staff shall conduct a screening to determine each resident's "Functional Capacity Screen" (FCS) at least every 365 days.	S5085		

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S5085	Continued From page 7 Findings included: - Record review for R3 revealed an admission date of 08/07/24 with diagnosis of dementia, Post Traumatic Stress Disorder, mixed anxiety, depressive disorder, intermittent vertigo, arthritis, diabetes, hearing loss, muscle weakness, insomnia, history of falling, hypertension, hyperlipidemia. Review of R3's 08/03/24 FCS revealed R3 required assistance with bathing, dressing, toileting, transferring, walking and mobility. R3 was independent with eating and was occasionally incontinent of bladder. R3 was identified at risk for falls/unsteadiness, impaired vision, and had impaired short-term memory, memory recall and impaired decision making. R3 lacked the ability to manage her own medications. On 09/18/25 at 09:06 AM Operator A confirmed R3's record lacked documentation that designated staff shall conduct a screening to determine each resident's FCS every 365 days. Record lacked a FCS completed since 08/03/24. The facility's "Resident Functional Capacity Screen" undated policy documented that, "Primary reason for screen, Admission-the FCS performed prior to or at admission to the facility. Significant change-the functional capacity screen performed due to a significant change in condition which necessitates amendment of the NSA. Annual-a functional capacity screen	S5085		

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S5085	Continued From page 8 performed at least annually. There has been approximately 365 days since the most recent screen was performed". Operator A failed to ensure designated staff shall conduct a screening to determine each resident's FCS at least every 365 days.	S5085		
S5116 SS=D	26-42-202 (d) NSA revisions (d) Each administrator or operator shall ensure the review and, if necessary, revision of each negotiated service agreement according to the following requirements: (1) At least once every 365 days;(2) following any significant change in condition, as defined in K.A.R. 26-39-100; (3) at least quarterly if the resident receives assistance with eating from a paid nutrition assistant; and (4) if requested by the resident or the resident ' s legal representative, staff, the case manager, or, if agreed to by the resident or the resident ' s legal representative, the resident ' s family. This REQUIREMENT is not met as evidenced by: KAR 26-42-202(d)(1) The facility reported a census of 5 residents. The sample included 3 residents with 1 focused review. Based on record review and interview, Operator A failed to ensure designated staff reviewed and if necessary, revised the "Negotiated Service Agreement"(NSA) for "Resident" (R) 3 at least once every 365 days.	S5116		

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S5116	Continued From page 9 Findings included: - Record review for R3 revealed an admission date of 08/07/24 with diagnoses of dementia, PTSD, mixed anxiety, depressive disorder, intermittent vertigo, arthritis, diabetes, hearing loss, muscle weakness, insomnia, history of falling, hypertension, hyperlipidemia. Review of R3's Functional Capacity Screen dated 08/03/24 revealed resident was independent with eating, required physical assistance with bathing, dressing, toileting, transferring and walk/mobility and was unable to manage medications and treatments. R3 and was occasionally incontinent of bladder. R3 was identified at risk for falls/unsteadiness, impaired vision, and had impaired short-term memory, memory/ recall and impaired decision making. Review of R3's NSA dated 08/08/24 identified facility staff would provide one staff assistance for bathing, dressing, transferring and toileting. Facility staff would manage R3's medications. The outside home health provider and the facility would manage R3's medical treatments. Record lacked a NSA completed since 08/08/24. Interview on 09/18/25 at 09:06 AM with Operator A confirmed R3's record lacked a NSA completed at least once every 365 days. The facility's "Negotiated Service Agreement" undated policy recorded, "the following timeline applies for additional NSA's, annual basis on or	S5116		

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S5116	Continued From page 10 before date of admission, following any significant change in condition, at least quarterly if the resident receives assistance with eating from a paid nutrition assistant. Upon request of competent resident, family and or legal representative, any noted change in the FCS". Operator A failed to ensure designated staff reviewed and if necessary, revised the NSA for R3 at least once every 365 days.	S5116		
S5165 SS=F	26-42-204 (e) Delegation of Duties (e) A licensed nurse may delegate nursing procedures not included in the nurse aide or medication aide curriculums to nurse aides or medication aides, respectively, under the Kansas nurse practice act, K.S.A. 65-1124 and amendments thereto. This REQUIREMENT is not met as evidenced by: KAR 26-42-204(e) The facility reported a census of 5 residents. The sample included 3 residents. Based on record review and interview for 2 sampled Residents (R)2 and R3 requiring "accuchecks" (blood sugar monitoring with a glucometer), a nursing procedure not included in the medication aide curriculum, Operator A failed to ensure the licensed nurse delegated the procedure to medication aides under the Kansas nurse practice act, K.S.A. 65-1124 and amendments thereto. Findings included:	S5165		

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S5165	Continued From page 11 - Record review for R2 revealed an admission date of 11/15/24 with diagnosis of type two diabetes. The 11/15/24 "Functional Capacity Screen"(FCS) identified R2 was unable to perform management of treatments. The 12/12/24 "Negotiated Service Agreement" (NSA) identified facility staff were to complete treatments. The "NSA" failed to address blood glucose monitoring. Review of R2's current September 2025 "Medication Administration Record"(MAR) revealed the following "Blood glucose fasting (before breakfast) If greater than 180 call nurse, Blood glucose 2 hours after evening meal if BS is >275 call nurse" performed by a Certified Medication Aide (CMA) (including CMA B and CMA C) or a "Licensed Nurse" (LN) twice daily from 09/01/25 through 09/17/25. - Record review for R3 revealed an admission date of 08/07/24 with diagnosis of type two diabetes. The 11/15/24 FCS identified R3 was unable to perform management of treatments. The 12/12/24 NSA failed to address management of treatments and management of blood glucose monitoring. Review of R3's current September 2025 MAR revealed the following , "**Accucheck order**	S5165		

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check fasting blood sugar every morning x 2 weeks and notify provider of results" performed by a CMA (including CMA B and CMA C) or a LN once daily from 09/01/25 through 09/17/25.

Review of sampled personnel records on 09/17/25 recorded the following CMAs recently hired, competency exams for accuchecks were requested.

CMA E, hire date 08/21/25.

CMA F, hire date 06/25/24.

CMA G, hire date 06/12/25

Interview on 09/18/25 at 11:00 AM Operator A confirmed competencies for CMAs to obtain accuchecks were not completed for CMA E, CMA F and CMA G.

The state department's 06/02/09 "Delegation of Nursing Tasks to Medication Aides and Nurse Aides Position Statement" documented the following:

"(f) The designated nurse aide or medication aide to whom the nursing task is delegated shall be adequately identified by name, in writing, for each delegated task.
(g) The licenses nurse shall orient and instruct the nurse aide or medication aide in the performance of the nursing task. The nurse aide's or medication aide's demonstration of the competency necessary to perform the delegated task shall be documented in writing. The designated nurse aide or medication aide shall co-sign the documentation indicating the

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S5165	Continued From page 13 person's concurrence with this competency evaluation. (h) The licensed nurse will: (1) be accountable and responsible for the delegated nursing task. (2) participate in periodic and joint evaluations of the services rendered. (3) record and monitor recorded services; and (4) adequately supervise the performance of the delegated nursing task in accordance with the following conditions. . ." The facility's "Delegation of Nursing Tasks Policy HS05-001" (no date) documented that "The Nurse Manager and or designee will ensure that appropriate procedures are followed for the delegation of nursing tasks in accordance with licensing regulations and the Kansas State Board of Nursing regulations. The decision to provide individualized staff training (delegation) for assisting with health-related services should be based upon the following, State licensing regulations and the Kansas Nurse Practice Act." Operator A failed to ensure the licensed nurse delegated the procedure to medication aides under the Kansas nurse practice act, K.S.A. 65-1124 and amendments thereto.	S5165		
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	S5192		

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S5192	Continued From page 14 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 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 five residents. The sample included 3 residents. Based on observation, record review and interview Operator A failed to ensure designated staff prepared food using safe methods that conserve the nutritive value, flavor, and appearance and shall be served at the proper temperature. Findings included: - Observation during the survey on 09/17/25 and 09/18/25 for breakfast and lunch meal service revealed designated facility staff did not obtain food item temperatures in the food temperature logbook. Review of the "Food Temperature Logbook" provided by the facility lacked evidence that designated staff obtained temperatures for any meals served in the facility.	S5192		

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S5192	Continued From page 15 Interview on 09/17/25 at approximately 09:05 AM Operator A confirmed the food temperature log lacked evidence of documentation that designated staff served food at the proper temperature for all meals served in the facility. The facility's undated policy "Food Sanitation F01-004" documented that "food must be served at appropriate temperatures. To measure food temperatures, a probe thermometer may be used. Serve hot foods at the following temperatures to ensure they arrive at the table hot, vegetables 160-170 degrees Fahrenheit (F), beef or pork 145 degrees F for 15 seconds/roasts 145 degrees F for four minutes, ground meat 155 degrees F for 15 seconds, hot soup/hot beverages 140-190 degrees F, poultry 165 degrees F for 15 seconds". 2005 Dietary Guidelines for Americans recommends: Bacteria grow most rapidly in the range of 40°F and 140°F. To keep food out of this danger zone, keep cold food cold (below 40°F) and hot food hot (above 140°F). F Operator A failed to ensure designated staff prepared food using safe methods that conserve the nutritive value, flavor, and appearance and shall be served at the proper temperature.	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.	S5195		

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S5195	Continued From page 16 (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 5 residents. The facility had a kitchen where staff stored, prepared, and served food to the residents. Based on observation, interview and record review Operator A failed to ensure designated staff stored food items under safe conditions. Findings included: - Observation of the facility's "Fridge" temperature log lacked evidence that the facility obtained any cold food storage temperatures for the entire month of August 2025 and September 1st through the 17th 2025 review period. Interview on 09/17/25 at approximately 09:03 AM Operator A states the "temperature logs are something I've been struggling with, they should be doing them, they know they are supposed to do them". The operator confirms the facility lacked documentation that cold food was stored under safe conditions. Review of the facility's undated "Food Sanitation F01-00" documented care staff in charge of preparing meals and or food service staff shall prepare and serve meals in a safe and sanitary manner and in accordance with all applicable	S5195		

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S5195	Continued From page 17 government regulations. 2005 Dietary Guidelines for Americans recommends: Bacteria grow most rapidly in the range of 40°F and 140°F. To keep food out of this danger zone, keep cold food cold (below 40°F) and hot food hot (above 140°F). F The refrigerator should be set at no higher than 40°F and the freezer at 0°F, and these temperatures should be checked with an appliance thermometer. Operator A failed to ensure staff stored food under safe conditions.	S5195		
S5215 SS=F	26-42-104 (d) Disaster and Emergency Preparedness Education (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 home ' s emergency management plan; (2) education of each resident upon admission to the home regarding emergency procedures; (3) quarterly review of the home ' 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. This REQUIREMENT is not met as evidenced by:	S5215		

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S5215	Continued From page 18 KAR 26-42-104(d)(1) The facility reported a census of five residents. The sample included 3 residents and record review of 5 newly hired employees. Based on record review and interview, Operator A failed to provide documentation at orientation of new employees at the time of employment to the home's emergency management plan. Findings included: - Record review for "Certified Nurse Aide" (CNA) D revealed a hire date of 10/19/24. The facility lacked evidence of documentation at orientation of new employees at the time of employment to the home's emergency management plan. Record review for "Certified Medication Aide" (CMA) E revealed a hire date of 08/21/25. The lacked evidence of documentation at orientation of new employees at the time of employment to the home's emergency management plan. Record review for Licensed Nurse H revealed a hire date of 04/01/24. The facility lacked evidence of documentation at orientation of new employees at the time of employment to the home's emergency management plan. Record review for CMA F revealed a hire date of 06/25/24. The facility lacked evidence of documentation at orientation of new employees at the time of employment to the home's emergency management plan. Record review for CMA G revealed a hire date of	S5215		

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S5215	Continued From page 19 06/12/25. The facility lacked evidence of documentation at orientation of new employees at the time of employment to the home's emergency management plan. Interview on 09/17/25 at 02:10 PM with Operator A confirmed the facility lacked documentation at orientation of new employees to the home's emergency management plan for CNA D, CMA E, CMA F, CMA G and Licensed Nurse H. Operator A failed to provide documentation at orientation of new employees at the time of employment to the home's emergency management plan for five of five sampled staff.	S5215		
S5230 SS=F	26-42-207 (b)(5)(6) (c) Infection Control Policies (b)(5) prohibiting any employee with a communicable disease or any infected skin lesions from coming in direct contact with any resident, any resident ' s food, or resident care equipment until the condition is no longer infectious; (6) providing orientation to new employees and employee in-service education at least annually on the control of infections in a health care setting; (c) Each administrator or operator shall ensure the home ' s compliance with the department ' s tuberculosis guidelines for adult care homes adopted by reference in K.A.R. 26-39-105. This REQUIREMENT is not met as evidenced by: K.A.R. 26-42-207 (c)	S5230		

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S5230	Continued From page 20 The facility reported a census of 5 residents. The sample included 3 "Residents'" (R)'s, one closed record review, and 5 newly hired employees. Based on record review and interview the operator failed to ensure the home's compliance with the department's "Tuberculosis" (TB) guidelines adopted by reference in K.A.R. 26-39-105 for R's 1, 2, 3, newly hired "Registered Nurse" H, "Certified Medication Aides'" (CMA)'s E, F, G, and "Certified Nurse Aide" (CNA) D. Findings included: - Record review for R1 revealed an admission date of 11/01/24 with diagnoses of adult failure to thrive, anorexia, cachexia, and anemia. Review of R1's "Medical Record" revealed a document titled "TB/Other Screening Report" dated 11/04/24 revealed R1 had received the first step of the required two step TB skin test on 09/17/24 that read negative on 09/18/24, and R1 received the required second step on 10/01/24 that read negative on 10/04/24. Review of R1's "Medical Record" revealed an undated document titled "TB Screening Questionnaire" that lacked documentation of the questionnaire being completed at the time of admission. - Record review for R2 revealed an admission date of 11/15/24 with diagnoses of hypertension, depression, chronic obstructive pulmonary disease, type two diabetes, and cognitive	S5230		

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S5230	Continued From page 21 deficits. Review of R2's "Medical Record" revealed a document dated 12/09/24 and titled "Immunization Report", revealed R2 received the first step of the required two step TB test on 11/15/24 that was documented as "negative". The second step of the required two step TB test was implanted on 11/24/24 and the document lacked a date of the second step of the required two step TB skin test being read. Record review of R2's "Medical Record" lacked documentation of the required TB Screening Questionnaire being performed at the time of admission. - Record review for R3 revealed an admission date of 08/08/24 with diagnoses of hypertension, post traumatic stress disorder, mixed anxiety depressive disorder, intermittent vertigo, arthritis, dementia, diabetes, cognitive communication deficit, and muscle weakness. Review of R3's "Medical Record" revealed a document titled "TB Screening Questionnaire" dated 08/08/24. R3's "Medical Record" lacked documentation of the "TB Screening Questionnaire" being performed annually. Personnel record review for Registered Nurse (RN) H revealed she began employment on 04/01/24. The employee record contained a document for the first step of the required two step TB test that read negative om 02/20/25. The personnel record for RN H lacked documentation of the required second step of the two step TB	S5230		

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S5230	Continued From page 22 test being administered. - Personnel record review for "Certified Medication Aide" (CMA) E revealed she began employment on 08/01/25. The employee record lacked documentation of the first step of the required two step TB skin test being administered within one to seven days of employment. Personnel record review for CMA F revealed she began employment on 06/25/24. The employee record lacked documentation of the required two step TB skin test being performed. Personnel record review for CMA G revealed she began employment on 06/12/25. The employee record revealed the first step of the required two step TB skin test was implanted on 06/23/25. The record lacked documentation of the first step being read within 48 to 72 hours after being administered. The record further lacked documentation of the required second step of the two step TB skin test being performed. Personnel record review for "Certified Nurse Aide" (CNA) D revealed she began employment on 10/19/24. The employee record lacked documentation of the required two step TB skin test being performed. Interview on 09/17/25 at 02:10 PM with Operator A confirmed R1 and R3's "Medical Record" lacked documentation of the required TB Screening Questionnaire being performed at the time of admission and R2 not receiving the first step of the required two step TB skin test and the TB Screening Questionnaire being performed at	S5230		

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S5230	Continued From page 23 the time of admission. Operator A continued to confirm the personnel record for RN H lacked documentation of the second step of the required two step TB skin test, CMA's E, F and CNA D's personnel records lack of documentation of the required two step TB skin test, and CMA G's first step of the required two step TB skin test being read and the lack of documentation of the required second step being administered. Review of the facility provided undated policy titled "Tuberculosis Screening" revealed the following: "A. Symptom Screen. Each new resident and new employee shall have an initial TB symptom screen ...within seven days of residency or employment or at the time of the administration of the Tuberculin skin test ..." "B. TB infection testing. Each new resident nan new employee shall receive a two step TB skin test ...withing seven days of residency or employment." "2. A. Symptom Screen. Each resident and employee shall have an annural TB symptom screen ..." The operator failed to ensure the home's compliance with the department's TB guidelines adopted by reference in K.A.R. 26-39-105 for R's 1, 2, 3, and newly hired RN H, CMA's E, F, G, and CNA D.	S5230		
S5246 SS=F	26-42-105 (c) Resident Record Safeguards (c) Each administrator or operator shall ensure	S5246		

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S5246	Continued From page 24 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) (4) (5) The facility reported a census of 5 residents. Based on observation and interview the Operator failed to ensure the safeguarding of resident records against loss, destruction, theft, and unauthorized use. Findings included: - Observation on 09/17/25 during the initial facility tour, in the resident open dining area located on the southwest corner next sat a small cabinet. On the top of the cabinet was a stack of resident records that was approximately 5 inches high. The stack included "Medication Administration" pages from the pharmacy and discharge orders from the local emergency room. The cabinet had a set of double doors with a locking mechanism that was in the unlocked position and the doors freely opened. In the cabinet was a plastic 3 ringed binder for each resident. Interview on 09/18/24 with Operator A confirmed the resident records were to be secured.	S5246		

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S5246	Continued From page 25 The Operator failed to ensure the safeguarding of resident records against loss, destruction, theft, and unauthorized use.	S5246		
S5300 SS=D	26-42-205 (d) (1-2) Facility Administration of Medications (d) Home administration of resident ' s medications. If a home is responsible for the administration of a resident ' s medications, the administrator or operator shall ensure that all medications and biologicals are administered to that resident in accordance with a medical care provider ' s written order, professional standards of practice, and each manufacturer ' s recommendations. The administrator or operator shall ensure that all of the following are met: (1) Only licensed nurses and medication aides shall administer and manage medications for which the home has responsibility. (2) Medication aides shall not administer medication through the parenteral route. This REQUIREMENT is not met as evidenced by: KAR 26-42-205(d) The facility reported a census of 5 residents. The sample included 3 residents with 1 one focused record review. Based on record review and interview Operator A failed to ensure facility staff administered all medications to "Resident" (R) 3 in accordance with medical care provider's orders.	S5300		

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S5300	Continued From page 26 Findings included: - Record review for R3 revealed an admission date of 08/07/24 with diagnosis of dementia, PTSD, mixed anxiety, depressive disorder, diabetes, hypertension and hyperlipidemia. The 08/03/24 "Functional Capacity Screen" (FCS) identified R3 was unable to perform management of medications. The 08/08/24 "Negotiated Service Agreement" (NSA) identified facility staff would administer medications as ordered. Record review for the September 2025 "Medication Administration Record" (MAR) for R3 revealed that R3 was prescribed "losartan potassium 50 milligram(mg) by mouth twice daily for hypertension and to hold if systolic blood pressure was less than 110". The MAR lacked blood pressure recordings. Record review of R3's "Vital Signs Flow Sheet" further revealed designated facility staff recorded R3's most recent blood pressure on 06/02/25. Interview on 09/18/25 at 09:33 AM Operator A confirmed R3's record lacked documentation of systolic blood pressure results prior to administration of losartan potassium 50mg in accordance with her medical care provider's orders. Operator A failed to ensure facility staff administered all medications to R3 in accordance	S5300		

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S5300	Continued From page 27 with her medical care provider's orders.	S5300		
S5301 SS=E	26-42-205 (d) (3) Facility Administration of Medications (d) (3) A licensed nurse or medication aide shall perform the following: (A) Administer only the medication that the licensed nurse or medication aide has personally prepared; (B) identify the resident before medication is administered; (C) remain with the resident until the medication is ingested or applied; and (D) document the administration of each resident ' s medication in the resident ' s medication administration record immediately before or following completion of the task. If the medication administration record identifies only time intervals or events for the administration of medication, the licensed nurse or medication aide shall document the actual clock time the medication is administered. This REQUIREMENT is not met as evidenced by: K.A.R. 26-42-205 (d) (3) (D) The facility reported a census of 5 residents. The sample included 3 "Residents'" (R)'s, and one closed record review. Based on record review and interview the operator failed to ensure the "Licensed Nurse" (LN) and the "Certified Medication Aides" (CMA)s documented the administration of each resident's medication in each residents "Medication Administration Record" (MAR), immediately before or following	S5301		

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S5301	Continued From page 28	S5301		

completion of the task.

Findings included:

- Record review for R1 revealed an admission date of 11/01/24 with diagnoses of adult failure to thrive, anorexia, cachexia, and anemia.

Review of R1's "Functional Capacity Screen" (FCS) dated 10/24/24 revealed R1 required supervision with bathing, dressing, toileting, transferring, walking/mobility, and eating. R1 lacked the ability to manage his own medications/medical treatments. 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 usually understood others. R1 was documented to be at risk for falls and impaired decision making. R1 used no walking mobility device.

Review of R1's "Negotiated Service Agreement" (NSA) dated 11/01/24 under the section titled "7. Management of Medications" the facility staff would administer R1's medications.

Review of R1's "Health Service Plan" (HSP) dated 11/01/24 under the section titled "Medications" facility staff were instructed to administer R1's medications.

Review of R1's MAR dated 09/25 revealed the following:

An undated order for "Warm Moist Compress to left eye" twice daily to cleanse eye lid. Ordered for 08:00 AM and 08:00 PM. 09/08/25 and

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HEARTFUL HOMES CORPORATION	1301 S SEVILLE AVE WICHITA, KS 67209

(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
S5301	Continued From page 29 09/09/25 at 0800 PM lacked documentation on the MAR. An order for Haloperidol 0.5 milligrams twice daily by mouth for anxiety. Ordered for 08:00 AM and 08:00 PM. 09/01/25 lacked documentation on the MAR. An order or Thera Tears 0.25% Instill one to two drops into the left eye three times daily for dry eye. Ordered to be performed at 08:00 AM, 02:00 PM ad 08:00 PM. 09/10/25 at 02:00 PM lacked documentation on the MAR. - Record review for R2 revealed an admission date of 11/15/24 with diagnoses of hypertension, depression, chronic obstructive pulmonary disease, type two diabetes, and cognitive deficits. Review of R2's FCS dated 11/15/24 revealed R2 required supervision for bathing, dressing, and toileting. R2 required supervision for transferring and walking/mobility. R2 lacked the ability to manage her own medications/medical treatments. R2 had impaired short term memory, long term memory, memory/recall, and impaired decision making. R2 could make herself understood and she sometimes could make herself understood. R2 was marked with impaired vision and used a wheelchair mobility device. Review of R2's NSA dated 12/12/24 under the section titled "7. Management of Medications" the facility staff would administer R1's medications.	S5301		

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S5301	Continued From page 30 Review of R2's HSP updated on 04/18/25 under the section titled "Medications" facility staff were instructed to administer R2's medications. Review of R2's MAR dated 09/25 revealed the following; An order for Aspirin 81 milligrams Chewable tablets to be administered one time a day. Ordered for 08:00 AM. 09/01/25, 09/02/25 and 09/03/25 lacked documentation on the MAR. An order to obtain a Blood Glucose two hours after the evening meal. If blood sugar is greater then 275 to call the nurse. 09/01/25 and 09/04/25 lacked documentation on the MAR. An order for Lidocaine Pain Relief patches 4%. Apply one patch to area of pain every day. Keep on for 12 hours then remove for 12 hours. Ordered for 08:00 AM. The MAR lacked documentation of the order being performed during 09/25. An order for Venlafaxine HCL extended release 75 milligrams. Take 3 capsules by mouth every morning. Ordered for 08:00 AM. 09/07/25 lacked documentation on the MAR. An order for Verapamil 120 milligrams. Take one tablet every morning. Ordered for 08:00 AM. 09/10/25 lacked documentation on the MAR. An order for Acetaminophen extended-release tablets 650 milligrams. Take two tablets by mouth at bedtime. Ordered for 08:00 PM. 09/01/25 and 09/10/25 lacked documentation on the MAR.	S5301		

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S5301	Continued From page 31 An order for Atorvastatin 20 milligrams, take 1 tablet by mouth daily at bedtime. Ordered for 08:00 PM. 09/10/25 lacked documentation on the MAR. An order for Divalproex 125 milligrams. Take one tablet by mouth daily at bedtime for dementia. Ordered for 08:00 PM. 09/01/25, 09/04/25, and 09/10/25 lacked documentation on the MAR. - Record review for R3 revealed an admission date of 08/08/224 with diagnoses of hypertension, post traumatic stress disorder, mixed anxiety depressive disorder, intermittent vertigo, arthritis, dementia, diabetes, cognitive communication deficit, and muscle weakness. Review of R3's FCS dated 08/03/24 revealed R3 required physical assistance with bathing, dressing, toileting, transferring, and walking/mobility. R3 lacked the ability to manage her own medications/medical treatments. R3 had impaired short term memory, memory/recall and impaired decision making. R3 could make herself understood and R3 understood others. R3 was documented with poor vision, impaired hearing and impaired decision making. R3 used a walker and wheelchair mobility device. Review of R3's NSA dated 08/08/24, under the section titled "7. Management of Medications" the facility staff would administer R3's medications. Review of R3's "Health Service Plan" (HSP) updated 08/08/25, under the section titled	S5301		

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S5301	Continued From page 32 "Medications" facility staff were instructed to administer R3's medications. Review of R3's MAR dated 09/25 revealed the following; An order for Acetaminophen Extended Release 650 milligrams. Take one tablet twice daily. Ordered for 08:00 AM and 05:00 PM. 09/03/25 at 05:00 PM lacked documentation on the MAR. An order for Losartan Potassium 50 milligrams. Take 2 tablet by mouth two times a day. Ordered at 08:00 AM and 05:00 PM. 09/03/25 lacked documentation on the MAR. An order for Prazosin 1 milligram. Take one capsule by mouth twice daily. Ordered at 08:00 AM and 05:00 PM. 09/03/25 at 05:00 PM lacked documentation on the MAR. An order for Tizanidine 2 milligrams. Take one tablet by mouth two times a day. Ordered at 08:00 AM and 05:00 PM. 09/03/25 at 05:00 PM lacked documentation on the MAR. An order for Vitamin C 500 milligrams. Take one tablet two times a day. Ordered at 08:00 AM and 05:00 PM. 09/03/25 at 05:00 PM lacked documentation on the MAR. Interview on 09/18/25 at approximately 02:00 PM with Operator A confirmed the MARs for R1, R2 and R3 had missing documentation after the administration of their medications. The operator failed to ensure the LN and the CMAs documented the administration of each	S5301		

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S5301	Continued From page 33 resident's medication in each resident MAR, immediately before or following completion of the task.	S5301		
S5315 SS=F	26-42-205 (h) Medication Storage (h) Storage. Licensed nurses and medication aides shall ensure that all medications and biologicals are securely and properly stored in accordance with each manufacturer ' s recommendations or those of the pharmacy provider and with federal and state laws and regulations. (1) Licensed nurses or medication aides shall store non-controlled medications and biologicals managed by the home in a locked medication room, cabinet, or medication cart. Licensed nurses and medication aides shall store controlled medications managed by the home in separately locked compartments within a locked medication room, cabinet, or medication cart. Only licensed nurses and medication aides shall have access to the stored medications and biologicals. (2) Each resident managing and self-administering medication shall store medications in a place that is accessible only to the resident, licensed nurses, and medication aides. (3) Any resident who self-administers medication and is unable to provide proper storage as recommended by the manufacturer or pharmacy provider may request that the medication be stored by the home. (4) A licensed nurse or medication aide shall not administer medication beyond the manufacturer ' s or pharmacy provider ' s recommended date of expiration.	S5315		

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S5315	Continued From page 34 This REQUIREMENT is not met as evidenced by: KAR 26-42-205(h) The facility reported a census of 5 residents. The sample included 3 residents. Based on observation and interview for all residents living in the facility and receiving medication services, Operator A failed to ensure medications and biologicals were securely and properly stored in accordance with each manufacturer's recommendations or those of the pharmacy provider and with federal and state laws and regulations. Findings included: - Observation on 09/17/25 of the "Resident Roster" included 5 residents and noted no residents self-administered medications. Observation during the initial tour on 09/17/25 at 08:40 AM revealed an unsupervised and unlocked medication cart in the common living area of the facility. The unlocked medication cart revealed drawers containing medication cards, a glucometer, and injection needles. Interview on 09/17/25 at 09:03 AM with Operator A stated the medication cart is "often unlocked". The facility's "Storage of Medications Policy HS04-001" (no date) documented that all medications centrally stored by the home must	S5315		

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S5315	Continued From page 35 be locked. Operator A failed to ensure medications and biologicals were securely and properly stored in accordance with each manufacturer's recommendations or those of the pharmacy provider and with federal and state laws and regulations.	S5315		
S5335 SS=F	28-39-437 Construction (a) Each home-plus facility shall be designed, constructed, equipped, and maintained to protect the health and safety of residents, personnel, and the public. (b) All new construction, renovation, remodeling, and changes in building use in existing buildings shall comply with building and fire codes, ordinances, and regulations enforced by city, county, and state jurisdictions, including the state fire marshal. This REQUIREMENT is not met as evidenced by: KAR 28-39-437 (a) The facility reported a census of five residents. The sample included three residents. Based on observation and interview, Operator A failed to ensure that the facility was equipped and maintained to protect the health and safety of residents, personnel, and the public regarding unlocked chemicals, unsecured exit door to garage, and an unsecured basement gate. Findings included: - Observation on 09/17/25 at 08:40 AM during	S5335		

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S5335	Continued From page 36 the initial tour of the facility open access kitchen revealed an unsecured cabinet under the kitchen sink contained the following unsecured chemicals: One bottle foaming bathroom cleaner 32-ounce(oz) spray bottle One bottle foam shower tub and tile cleanser 32 oz spray bottle Two bottles of acidic toilet bowl cleaner 32 oz One spray bottle of linen fresh air freshener 8 oz One bottle of dish washing soap 40 oz One bottle of multi-purpose cleaner 1 quart(qt) One round plastic container of disinfecting wipes 75 count One bottle of clog destroyer gel 2.5 qt Observation on 09/17/25 at approximately 08:50 AM "Certified Medication Aid" (CMA) B, freely opened the garage exit door which revealed a large step down with a one-gallon plastic container of bleach sitting on the table to the left of the washing and drying machine. Interview on 09/17/25 at approximately 08:50 AM CMA B confirmed the garage exit door wasn't locked because she had just been in there when the doorbell rang. Observation on 09/17/25 at approximately 09:02 AM surveyor approached the basement stairs which revealed a metal swing gate at the top of the staircase with a broken latch which would not secure the gate closed. Interview on 09/17/25 at approximately 09:25 AM Operator A confirmed the cabinet under the kitchen sink was not secured, the garage exit	S5335		

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S5335	Continued From page 37 door had not been secured, and the latch to the basement stairs was not secured. Operator A failed to ensure the facility was equipped and maintained to protect the health and safety of residents, personnel, and the public regarding unlocked chemicals, unsecured garage exit door, and unsecured basement gate.	S5335		
S9999	Final Observations KAR 26-42-103 (c) The facility reported a census of 5 residents. The sample included 3 residents and review of 5 newly hired employees. Based on record review and interview, Operator A failed to ensure the provision of employee orientation and in-service education upon hire and annually thereafter for 5 (Certified Nurse Aide (CNA) D, Certified Medication Aide (CMA) E, CMA F, CMA G and Licensed Nurse (LN) H of 5 sampled employees on the treatment and appropriate response to persons who exhibit behaviors associated with dementia and Alzheimer's, with the potential to affect all residents. scope/severity of F Findings included: - Record review for CNA D revealed a hire date of 10/19/24. The record lacked evidence of documentation of dementia and Alzheimer's training upon hire. Record review for CMA E revealed a hire date of 08/21/25. The record lacked evidence of	S9999		

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S9999	Continued From page 38	S9999		

documentation of dementia and Alzheimer's training upon hire.

Record review for LN H revealed a hire date of 04/01/24. The record lacked evidence of documentation of dementia and Alzheimer's training upon hire and annually thereafter.

Record review for CMA F revealed a hire date of 06/25/24. The record lacked evidence of documentation of dementia and Alzheimer's training upon hire and annually thereafter.

Record review for CMA G revealed a hire date of 06/12/25. The record lacked evidence of documentation of dementia and Alzheimer's training upon hire.

Interview on 09/17/25 at 02:10 PM Operator A confirmed CNA D, CMA E, LN H, CMA F and CMA G's record lacked documentation of dementia and Alzheimer's training upon hire and annually.

Operator A failed to ensure the provision of employee orientation and in-service education upon hire and annually thereafter for 5 of 5 sampled employees on the treatment and appropriate response to persons who exhibit behaviors associated with dementia and Alzheimer's, with the potential to affect all residents.