STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087042	A. BUILDING: _____ B. WING _____	09/25/2025

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THE HOMESTEAD OF WICHITA	12221 W MAPLE ST WICHITA, KS 67235

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S 000	INITIAL COMMENTS The following citations represent the findings of the licensure resurvey with attached complaint numbers 192700 and 187715, for the above named facility conducted on 09/24/25 and 09/25/25.	S 000		
S3026 SS=D	26-41-101 (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. 26-41-201 (f) (1) (A) The facility reported a census of 40 residents. The sample included 3 "Resident" (R). Based on interview and record review the Operator failed to ensure R3 was not subjected to verbal abuse by dining room staff. Findings included: - Record review for R3 revealed an admission date 07/28/21 with diagnoses of chronic obstructive pulmonary disease, diastolic congestive heart failure, depression, glaucoma,	S3026		

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

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S3026	Continued From page 1	S3026		

dementia, and chronic pain.

Review of R3's combined "Functional Capacity Screen" (FCS)/"Negotiated Service Agreement" (NSA) dated 12/12/24 revealed R3 required staff physical assistance with bathing and toileting. R3 required supervision with dressing, transferring, walking, and eating. R3 was incontinent, and had impaired short-term memory, memory/recall and impaired decision making. R3 was able to maker herself understood and she sometimes could make herself understood.

Review of the facility provided document titled "Reporting Facility" dated 01/17/25 revealed that on 01/01/25 R3 was the victim of alleged verbal abuse from dietary staff G. The facility investigation confirmed that Dietary staff G refused to serve breakfast due to R3 being late to the dining room, and yelled at R3. R3 was provided breakfast by the "Certified Nurse Aide" (CNA) who assisted R3 to the dining room. Dietary staff G was suspended on 01/03/25 and terminated on 01/06/25 after the substantiation of the allegation of verbal abuse to R3.

.Review of the facility provided policy titled "Abuse, Neglect, and Exploitation" dated 11/28/17 and signed by Dietary staff G on 07/31/23 revealed the following statement acknowledged by Dietary Staff G; "Any suspected occurrences of abuse, neglect, and exploitation or reasonable suspicion of a crime will be immediately reported to the administrator or his/her designee to assist with conducting a full investigation.

Review of the facility provided document titled

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S3026	Continued From page 2 "Witness Statement" signed by Dietary staff G and dated 01/01/25 revealed that Dietary staff G approached R3 stating that she was not going to "feed her because it was after breakfast". Dietary staff G wrote that R3 yelled at her and she yelled back. The Operator failed to ensure R3 was not subjected to verbal abuse by dining room staff.	S3026		
S3085 SS=D	26-41-202 (a) Negotiated Service Agreement (a) The administrator or operator of each assisted living facility or residential health care facility 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 payment if outside resources provide a service. This REQUIREMENT is not met as evidenced by: K.A.R. 26-41-202 (a) (1) (2) (3) The facility reported a census of 40 residents.	S3085		

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S3085	Continued From page 3	S3085		

The sample included 3 "Resident" (R). Based on interview and record review the Operator failed to ensure the "Negotiated Service Agreement" (NSA) for R2 provided a description of services the resident would receive, identification of the provider of each service, and identification of each party responsible for payment when an outside resource was used.

Findings included:

- Record review for R2 revealed an admission date of 07/16/21 with diagnoses of mild cognitive impairment, chronic obstructive pulmonary disease, peripheral vascular disease, acute kidney failure, other specified anxiety disorder, unspecified asthma, and Sjogren Syndrome.

Review of R2's combined "Functional Capacity Screen" (FCS)/"Negotiated Service Agreement" (NSA) dated 08/26/25 revealed R2 required physical assistance from staff or bathing, dressing, toileting, transferring, walking/mobility, and management of her medications and medical treatments. R2 required supervision with eating, and she had impaired memory/recall. R2 was able to make herself understood and she understood. R2 was marked at risk for falls, impaired vision, and inappropriate behavior.

R2's combined FCS/NSA lacked documentation the provider of services, a description of services the outside provider would provide, and the payor source for the outside provider.

Review of R2's electronic "Medical Record" under the "Miscellaneous" tab revealed a document titled "Facility Communication" dated

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S3085	Continued From page 4 09/18/25 from and outside home health provider. Interview on 09/25/25 at approximately 04:00 PM with Regional Nurse C confirmed R2 was receiving services from an outside provider, she further confirmed the combined FCS/NSA for R2 lacked documentation of the description of services the outside provider would provide, identification of the provider of those services, and the payor source for the outside provider services. The Operator failed to ensure the "Negotiated Service Agreement" (NSA) for R2 provided a description of services the resident would receive, identification of the provider of each service, and identification of each party responsible for payment when an outside resource was used.	S3085		
S3171 SS=D	26-41-204 (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: K.A.R. 26-41-204 (i) The facility reported a census of 40 residents. The sample included 3 "Residents'" (R)'s. Based on observation, record review and interview the Operator failed to ensure health care services were provided within professional standards of	S3171		

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S3171	Continued From page 5	S3171		

practice when the Operator failed to ensure R1's bed assist device posed no risk for entrapment and was securely attached to the bed.

Findings included:

- Record review for R1 reveled an admission date of 06/30/25 with diagnoses of type two diabetes mellitus, non-infective gastroenteritis and colitis, reduced mobility, non-pressure ulcer of other part of unspecified foot limited to skin, and chronic obstructive pulmonary disease.

Review of R1's combined "Functional Capacity Screen" (FCS)/"Negotiated Service Agreement" (NSA) dated 08/05/25 revealed R1 required physical assistance with bathing and toileting. Facility staff were identified to provide physical assistance for R1 with bathing and toileting needs. R1 required supervision with dressing, transferring, walking/mobility, and eating. Facility staff were instructed to provide supervision for R1 for dressing, transferring, walking/mobility and eating. R1 managed some of his own medications and facility staff were instructed to administer R1's some of R1's medications. R1 was able to self-inject his own insulin. R1 had impaired memory/recall and impaired decision making. R1 was documented at risk for falls and impaired vision.

Under the section titled "Managed Risk Agreement due to bed device being used" it was documented that a "bed cane" was being utilized on the right and left side of R1's bed to define the perimeter of the mattress/bed edge to promote safety, assist with repositioning, and stabilize R1

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S3171	Continued From page 6 during transfers. R1 had been assessed for appropriate use and safety of the device, and the rail was documented as "secure against the bed frame/mattress to prevent entrapment of appendage". Observation on 09/25/25 at approximately 03:30 PM of R1's bed revealed the head of the bed sat against the north wall of the room. The bed appeared to be a queen-sized mattress. On each side of the bed were an inverted "U" shaped bed assist device that slid under the mattress and had legs that extended to the floor. The device measured approximately 39 inches from the floor to the top of the device, and the middle of the device had an opening approximately 14.5 inches in width. The device on the west side of the bed had a canvas pocket secured to the device to close the 14.5-inch opening. The device on the east side of the bed lacked the canvas pocket, and the 14.5-inch area was opened. Both devices pulled freely from the side of the bed. Interview on 09/25/25 at approximately 03:30 PM with Regional Nurse C and Regional Nurse F confirmed R1 and his wife slept in the same bed. They further confirmed the bed assist devices pulled freely from the bed and that device on the east side of the bed lacked a canvas pocket that closed the 14.5-inch opening. The FDA (food and drug administration) "Bedrails in Assisted Living, Residential Health Care and Home Plus Facilities" recommended the following:	S3171		

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S3171	Continued From page 7 Complete an assessment of the device using the recommendations in the FDA guidance to ensure the device is securely attached to the bed or bedframe and poses no risk for entrapment and document the findings in the resident record. The FDA (food and drug administration) Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment dated 3/10/06 listed 4 zones of greatest concern with specific measurements to reduce the risk of entrapment as follows: Zone 1 within the rail should measure less than 4 and 3/4 inches Zone 2 under the rail, between the rail supports or next to a single rail support should measure less than 4 and ¾ inches Zone 3 between the rail and the mattress should measure less than 4 and 3/4 inches Zone 4 under the rail at the ends of the rail should measure less than 2 and 3/8 inches. Include a description of the device, its purpose and special instructions on use and monitoring in the resident's NSA. The Operator failed to ensure health care services were provided within professional standards of practice when the Operator failed to ensure R1's bed assist device posed no risk for entrapment and was securely attached to the bed.	S3171		
S3310 SS=F	26-41-207 (b) (5-6) (c) Infection Control Policies (b) (5) prohibiting any employee with a	S3310		

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S3310	Continued From page 8 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; and (c) Each administrator or operator shall ensure the facility ' 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. 26-41-207 (c) The facility reported a census of 40 residents. The sample included 3 "Residents'" (R)'s and 5 newly hired employees. Based on record review and interview the Operator failed to ensure the facility's compliance with the department's "Tuberculosis" (TB) guidelines for adult care homes adopted by reference in K.A.R. 26-39-105 for newly hired "Certified Medication Aides'" (CMA)'s A and B. Findings included: - Record review for CMA A revealed she began her employment on 09/12/24. Review of CMA A's personnel record revealed a document titled "TB	S3310		

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S3310	Continued From page 9 Symptom Screen" dated 09/12/24. CMA A's personnel record lacked documentation of the required two step TB skin test being performed within seven days of employment. - Record review for CMA B revealed she began her employment on 04/10/25. Review of CMA B's personnel record revealed a document titled "TB Symptom Screen" dated 05/12/25. CMA B's personnel record lacked documentation of the required two step TB skin test being performed within seven days of employment. Interview on 09/25/25 at approximately 04:30 PM with Regional Nurse's C, D, and E confirmed the personnel records for CMA's A and B lacked the documentation of the required two step TB skin test being performed within seven days of employment. The Operator failed to ensure the facility's compliance with the department's TB guidelines for adult care homes adopted by reference in K.A.R. 26-39-105 for newly hired CMA's A and B.	S3310		