STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N091002	A. BUILDING: _____ B. WING _____	10/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHEAT RIDGE ACRES	707 WHEATRIDGE CIRCLE GOODLAND, KS 67735

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS The following citations represent the findings of the licensure resurvey for the above named facility conducted on 10/13/25.	S 000		
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: KAR 26-41 204 (i) The census equaled 26 residents. The sample included 3 residents. Based on record review, interview and observation, Administrator A failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services in accordance with acceptable standards of practice for the use of bed assistive devices, which met the needs of 1 record review Resident (R)1. Findings included: - Record review for R1 revealed an admission date of 06/17/25 with diagnoses of type II diabetes mellitus, coronary artery disease, depression, epilepsy, Parkinson's Disease, hyperlipidemia, and obstructive sleep apnea. The "Assessment/Care Plan/Negotiated Service Agreement" dated 06/17/25 recorded the	S3171		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N091002	A. BUILDING: _____ B. WING _____	10/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHEAT RIDGE ACRES	707 WHEATRIDGE CIRCLE GOODLAND, KS 67735

(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
S3171	Continued From page 1	S3171		

resident was independent with toileting, transfer, walk/mobility and eating, required physical assistance with bathing and dressing and was unable to perform management of medications and treatments. R1 had short term memory impairment, usually understood communication, was at risk for falls/ unsteadiness, had impaired vision and used a walker for ambulation.

Review of R1's " Assessment/ Care Plan/Negotiated Service Agreement (NSA/HCSP) dated 06/17/25 recorded facility staff assisted R1 with dressing and bathing and administered medications and treatments.

The NSA failed to identify the use of a bed assistive device used for transfers and/or repositioning.

Record review lacked an assessment of the bed assistive device to confirm the device was not a restraint, an annual assessment of the resident to determine the purpose of the bedrail/assistive device and the resident's ability to safely use the device and an annual safety check assessment of the bedrail/assistive device to ensure the device was securely attached to the bed or bedframe and posed no risk for entrapment.

Observation on 10/13/25 at approximately 03:50 PM in R1's room revealed a bed assist device to the left side of his bed.

Interview on 10/13/25 at 01:56 PM with Licensed Nurse (LN) B confirmed a bed assistive device assessment was not completed for R1.

The FDA (food and drug administration) Hospital

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N091002	A. BUILDING: _____ B. WING _____	10/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHEAT RIDGE ACRES	707 WHEATRIDGE CIRCLE GOODLAND, KS 67735

(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
S3171	Continued From page 2 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. Facility's "Policy and Procedure: Bed Rails" policy (no date) recorded, "A licensed nurse or qualified staff member will assess the resident's physical and cognitive status to determine the appropriateness of bed rail use. The assessment will consider mobility needs, cognitive status, risk of falls versus risk of entrapment or injury, and alternative interventions." Administrator A failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services in accordance with acceptable standards of practice for the use of bed assistive devices, which met the needs of 1 record review Resident (R1).	S3171		
S3211 SS=E	26-41-205 (g) (3) OVER THE COUNTER DRUGS (3) A licensed nurse or medication aide may accept over-the-counter medication only in its original, unbroken manufacturer ' s package. A licensed pharmacist or licensed nurse shall	S3211		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N091002	A. BUILDING: _____ B. WING _____	10/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHEAT RIDGE ACRES	707 WHEATRIDGE CIRCLE GOODLAND, KS 67735

(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
S3211	Continued From page 3 place the full name of the resident on the package. If the original manufacturer ' s package of an over-the-counter medication contains a medication in a container, bottle, or tube that can be removed from the original package, the licensed pharmacist or a licensed nurse shall place the full name of the resident on both the original manufacturer ' s medication package and the medication container. This REQUIREMENT is not met as evidenced by: KAR 26-41-205 (g) (3) The census totaled 26 residents. The sample included 3 residents. Based on observation and interview for 4 non-sampled Residents (R)4, R6, R7 and R9, Administrator A failed to ensure licensed nurses or pharmacists placed the full name of the resident on each package of the resident's over the counter medication. Findings included: - Observation on 10/13/25 at 10:00 AM with Certified Medication Aide (CMA) C revealed two locked medication carts in the hallway of the facility. The following over the counter medications were noted without first and last names: For R4, the cart contained one bottle of Stomach Relief, For R6, the cart contained one bottle of Ibuprofen (nonsteroidal anti-inflammatory drug), For R7. the cart contained one bottle of Zyrtec	S3211		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N091002	A. BUILDING: _____ B. WING _____	10/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHEAT RIDGE ACRES	707 WHEATRIDGE CIRCLE GOODLAND, KS 67735

(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
S3211	Continued From page 4 (allergic relief), For R9, the cart contained one bottle of multivitamins. Interview on 10/13/25 during observation of the medication cart with CMA C confirmed the above listed medications were without full first and last name for R4, R6, R7 and R9. Interview on 10/13/25 at 10:36 AM with Licensed Nurse B confirmed facility staff are to bring over the counter medications to her to label before placing in the medication cart. Facility's "Medication Policy" dated 08/10/03 recorded, " ... The pharmacist or licensed nurse shall place the full name of the resident on the package." Administrator A failed to ensure licensed nurses or pharmacists placed the full name of residents on each package of the resident's over the counter medication.	S3211		
S3215 SS=E	26-41-205 (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 facility in a locked medication room, cabinet, or medication cart. Licensed nurses and medication aides shall store	S3215		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N091002	A. BUILDING: _____ B. WING _____	10/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHEAT RIDGE ACRES	707 WHEATRIDGE CIRCLE GOODLAND, KS 67735

(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
S3215	Continued From page 5 controlled medications managed by the facility 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 facility. (4) A licensed nurse or medication aide shall not administer medication beyond the manufacturer ' s or pharmacy provider ' s recommended date of expiration. This REQUIREMENT is not met as evidenced by: KAR 26-41-205 (h) (4) The facility reported a census of 26 residents. The sample included 3 residents. Based on observation, record review and interview for 2 non-sampled residents (R)5 and R8, Administrator 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 and further failed to ensure medications were not administered beyond the	S3215		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N091002	A. BUILDING: _____ B. WING _____	10/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHEAT RIDGE ACRES	707 WHEATRIDGE CIRCLE GOODLAND, KS 67735

(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
S3215	Continued From page 6	S3215		

manufacturer's or pharmacy provider's recommended date of expiration.

Findings included:

- Observation during the initial tour on 10/13/25 at 10:00 AM with Certified Medication Aide (CMA) C revealed two medication carts in the hallway of the facility. The medication carts contained resident's medications. The following medications were noted expired:

For R5, the cart contained one Humalog insulin pen with a pharmacy label affixed to the plastic bag the insulin pen was stored in. The insulin pen recorded an open date of 09/10/25.

Current October 2025 MAR (medication administration record) recorded, "Humalog Insulin sliding scale, 3 times daily for diabetes." Medication signed off as administered three times daily from 10/10/25 through 10/12/25 by certified staff.

For R8, the cart contained one opened bottle of Pota Chloride ER 10 MEQ (milliequivalents) with a pharmacy label affixed to it. The pharmacy label recorded a use by date of 06/12/25.

Current October 2025 MAR recorded, "Potassium Chloride 10 MEQ 1 capsule twice daily by mouth for hypokalemia." Medication signed off as administered twice daily from 10/01/25 through 10/12/25 by certified staff.

Interview on 10/13/25 at 11:05 AM with Licensed Nurse (LN) B confirmed R5's Humalog pen was to be discarded after 30 days and further

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N091002	A. BUILDING: _____ B. WING _____	10/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHEAT RIDGE ACRES	707 WHEATRIDGE CIRCLE GOODLAND, KS 67735

(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
S3215	Continued From page 7	S3215		

confirmed R8's Potassium Chloride expired on 06/12/25.

Facility's "Medication Policy" dated 08/10/03 recorded, "All drugs managed by the facility shall be stored safely, securely and properly, following manufacturer's recommendations or those of the supplier in accordance with federal and state laws and regulations."

Facility's "Policy and Procedure: Insulin Pen Storage, Administration, and Disposal" (no date) recorded, " ...2. Labeling: Each insulin pen must include: ...Date opened and beyond-use date (per manufacturer, typically 28-56 days depending on product)."

- Observation on 10/13/25 at 11:05 AM with LN B revealed a medication refrigerator inside a locked medication room. The refrigerator contained tuberculosis solution and insulin pens.

Review of the "Temperature Log" affixed to the medication refrigerator revealed the medication refrigerator temperature had not been recorded since 09/11/25.

Interview on 10/13/25 at 11:05 AM with LN B stated the medication refrigerator temperature was to be checked and recorded weekly.

Facility's "Policy and Procedure: Medication Refrigerator Temperature Checks" (no date) recorded, "1. Temperature Monitoring: The temperature of the medication refrigerator will be checked and recorded twice daily-once during the morning shift and once during the evening shift-on the Medication Refrigerator Temperature

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N091002	A. BUILDING: _____ B. WING _____	10/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHEAT RIDGE ACRES	707 WHEATRIDGE CIRCLE GOODLAND, KS 67735

(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
S3215	Continued From page 8 Log." Administrator 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 and further failed to ensure medications were not administered beyond the manufacturer's or pharmacy provider's recommended date of expiration.	S3215		
S3280 SS=E	26-41-104 (d) Disaster and Emergency Preparedness (d) Each administrator or operator shall ensure disaster and emergency preparedness by ensuring the performance of the following: (1) Orientation of new employees at the time of employment to the facility ' s emergency management plan; (2) education of each resident upon admission to the facility regarding emergency procedures; (3) quarterly review of the facility ' s emergency management plan with employees and residents; and (4) an emergency drill, which shall be conducted at least annually with staff and residents. This drill shall include evacuation of the residents to a secure location. This REQUIREMENT is not met as evidenced by: KAR 26-41-104 (d) (3)	S3280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N091002	A. BUILDING: _____ B. WING _____	10/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHEAT RIDGE ACRES	707 WHEATRIDGE CIRCLE GOODLAND, KS 67735

(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
S3280	Continued From page 9 The census equaled 26 residents. The sample included 3 residents and review of 5 newly hired employee records. Based on record review and interview, Administrator A failed to ensure disaster and emergency preparedness by ensuring the performance of quarterly review of the facility's entire "Emergency Management Plan" with staff and residents. Findings included: - Review of the facility "Emergency Management Plan" revealed the plan contained procedures to manage potential emergencies and disasters including fire, flood, severe weather, tornado, explosion, natural gas leak, lack of electrical, or water service, and missing residents. Review on 10/13/25 of the facility's quarterly reviews of the emergency management plan with staff revealed the following reviews completed: On 11/07/24, the facility reviewed natural gas leak, explosion and loss of electrical services. The facility failed to review the procedures to manage potential emergencies including fire, floor, tornado, severe weather and missing resident for the fourth quarter of 2024. On 04/15/25, the facility reviewed tornado and severe weather. The facility failed to review the procedures to manage potential emergencies including fire, flood, explosion, natural gas leak, loss of electrical or water services and missing resident	S3280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N091002	A. BUILDING: _____ B. WING _____	10/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHEAT RIDGE ACRES	707 WHEATRIDGE CIRCLE GOODLAND, KS 67735

(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
S3280	Continued From page 10	S3280		

for the second quarter of 2025.

The facility failed to provide documentation regarding emergency management plan reviews with staff for the third quarter of 2025.

Review on 10/13/25 of the facility's quarterly reviews of the emergency management plan with residents revealed the following reviews completed:

In January 2025 and March 2025, the facility reviewed flood and severe weather.

The facility failed to review the procedures to manage potential emergencies including fire, tornado, explosion, natural gas leak, loss of electrical or water services and missing resident for the first quarter of 2025.

On 04/30/35, the facility reviewed fire, tornado and loss of water services,
In May 2025, the facility reviewed flood and severe weather,
In June 2025, the facility reviewed fire, tornado and loss of water services.

The facility failed to review the procedures to manage potential emergencies including missing resident, explosion and natural gas leak for the second quarter of 2025.

In July 2025, the facility reviewed fire, tornado and loss of water services,
In August 2025 and September 2025, the facility reviewed flood and severe weather.

The facility failed to review the procedures to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N091002	A. BUILDING: _____ B. WING _____	10/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHEAT RIDGE ACRES	707 WHEATRIDGE CIRCLE GOODLAND, KS 67735

(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
S3280	Continued From page 11 manage potential emergencies including missing resident, explosion and natural gas leak for the third quarter of 2025. Interview on 10/13/25 at 04:02 PM with Administrator A stated she was not aware all eight topics of the emergency management plan were required to be reviewed every quarter with residents and staff. Facility's "Emergency Preparedness and Disaster Procedures" policy dated 08/10/03 recorded, "Every two months, the following procedures will be reviewed with all employees and all residents to assure continuing knowledge of what to do in these events ...Flood Procedure ...Severe Weather Procedure ...Tornado Procedure ...Explosion Procedure ... Natural Gas Leak ...Power Outage-Lack of Electricity ...Lack of Water Services..." Fire and missing resident procedures were not listed. Administrator A failed to ensure disaster and emergency preparedness by the failure to ensure the performance of quarterly reviews of the facility's entire emergency plan with staff and residents.	S3280		
S9999	Final Observations Kansas Statute 39-981. scope/severity of F Authorized electronic monitoring; reasonable accommodations; notice; consent; use as evidence; prohibitions. (d) A resident, or such resident's guardian or legal representative, who wishes to conduct	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N091002	A. BUILDING: _____ B. WING _____	10/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHEAT RIDGE ACRES	707 WHEATRIDGE CIRCLE GOODLAND, KS 67735

(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
S9999	Continued From page 12	S9999		

authorized electronic monitoring shall notify the adult care home on a form prescribed by the secretary for aging and disability services.
(i) Each adult care home shall post a conspicuous notice at the entrance to the adult care home and each resident's room stating that the rooms of some residents may be monitored electronically by or on behalf of the room's resident or residents.

This Requirement is not met as evidenced by:

The census equaled 26 residents. The sample included 3 residents. Based on observation and interviews, for all residents, the facility failed to post a conspicuous notice at the entrance to the adult care home and each resident's room stating that the rooms of some residents may be monitored electronically by or on behalf of the room's resident or residents.

- Observation on 10/13/25 at 09:41 AM during the initial tour revealed no sign posted at the entrance of the facility and at every resident's room stating video surveillance may be in progress.

Interview on 10/13/25 at 10:41 AM with Administrator A and Licensed Nurse (LN) B confirmed Resident (R)2 had a surveillance camera in her room. Administrator A confirmed no sign was posted on each resident's room stating video surveillance may be in progress and further confirmed no sign was posted on the entrance door.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N091002	A. BUILDING: _____ B. WING _____	10/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHEAT RIDGE ACRES	707 WHEATRIDGE CIRCLE GOODLAND, KS 67735

(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
S9999	Continued From page 13 For all residents, the facility failed to post a conspicuous notice at the entrance to the adult care home and each resident's room stating that the rooms of some residents may be monitored electronically by or on behalf of the room's resident or residents.	S9999		