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	B087135	A. BUILDING: _____ B. WING _____	10/28/2025

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MEADOWLARK ROBIN	254 S ROBIN ROAD 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
S 000	INITIAL COMMENTS The following citations represent the findings of an abbreviated survey for complaints numbers 197302, 197304, 197288, and 197294, at the above named facility conducted on 10/27/25 and 10/28/25.	S 000		
S5026 SS=J	26-42-101 (f) (1) Staff Treatment of residents ANE (f)The administrator or operator shall ensure that all of the following requirements are met: (1) No resident shall be subjected to any of the following: (A) Verbal, mental, sexual, or physical abuse, including corporal punishment and involuntary seclusion; (B) neglect; or (C) exploitation. This REQUIREMENT is not met as evidenced by: K.A.R. 26-42-101 (f) (1) (B) The facility reported a census of 6 residents. The sample included one "Resident" (R), and one closed record review. Based on record review and interview the Operator failed to ensure Certified Medication Aide (CMA) A notified the facility nurse when R2 had a notable change in cognition on 10/24/25 at approximately 09:30 AM. The facility further failed to notify the licensed nurse and owner/registered nurse that R2 likely ingested an unsecured, full two times normal strength, cleaning solution when she observed her with the bottle of the cleaning	S5026		

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

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solution and smelled it (very distinctly scented cleaner) on her breath and the resident passed away approximately two hours later. Facility staff left the cleaning solution in the unsecured common bathroom of the facility for approximately 7 hours and 23 minutes. Staff observed R2 with the bottle of cleaning solution at 05:43 PM, and CMA A reported smelling the distinctly scented chemical on R2's breath but neglected to call the facility nurse for approximately six minutes. CMA A then used an internet-based search to inquire on what she should do for R2 after drinking the cleaning solution, called poison control for guidance (05:51 PM, almost 10 minutes later), and neglected reporting to the Owner/ Registered Nurse (RN) B that she suspected R2 consumed the cleaning solution. Owner/RN B arrived at the facility approximately fourteen minutes after CMA A found R2 carrying the bottle of cleaning solution. The on-call nurse arrived at the facility at approximately 07:24 PM and pronounced R2 as deceased at 07:39 PM.

Findings included:

- Record review for R2 revealed an admission date of 11/01/22 with diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion), and encephalopathy (group of conditions that cause brain dysfunction such as confusion and memory loss).

Review of R2's "Functional Capacity Screen" (FCS) dated 09/13/25 revealed R2 required physical assistance with bathing, dressing, and toileting. R2 was independent with transferring, walking and eating. R2 had impaired short-term

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memory, impaired long-term memory, impaired memory recall, and impaired decision-making abilities. R2 could rarely or never make herself understood and she sometimes understood others. R2 had a risk for falls, impaired hearing, and used no mobility devices.

Review of R2's combined "Negotiated Service Agreement" (NSA)/" Health Service Plan" (HSP) instructed facility staff R2 was independent with transferring and walking/mobility and used no mobility device. R2 was alert to person and staff were to assist R2 in making simple "day to day decisions". Facility staff were informed R2 could understand staff and would occasionally respond randomly in two-to-three-word responses but was mostly non-verbal. Staff would know R2 explored the facility without boundaries. Staff were instructed to "offer [R2] diversional activities, snacks, and redirection using a calm voice." The facility identified R2 as at risk for "Wandering/Elopement" and staff were instructed to redirect R2, provide hourly visualization to ensure R2's safety, and ensure R2 remained in the secured facility under supervision.

Review of the facility provided, surveillance system dated/timed, video footage revealed the following events, which occurred on 10/24/25:

At 10:20 AM CMA A carried a mop, mop bucket, and a bottle of cleaning solution to the common bathroom located in the south hallway of the facility.

At 05:43:45 PM R2 walked out of the common bathroom located in the south hallway, carrying a

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bottle of cleaning solution with both hands. R2 walked toward the common living area of the home.

At 05: 49 PM R2 sat at the common dining room table with the bottle of cleaning solution she was carrying sitting on the north island of the kitchen behind her. R1 was seated at the table to R2's right and then turned and looked at R1 when R1 stroked her cheek. CMA A was noted at the sink in the attached kitchen area, and she stated, "what do I do?". R1 then replied, "don't you have to call somebody?" CMA A replied, "I don't know", and then CMA A placed a glass of fluid in front of R2. CMA A took her phone out of her pocket and R2 using both hands lifted the glass of fluid and took a drink. CMA A read from her phone and stated ... "followed by eight ounces of clear water get medical attention". R1 replied "ok, she is drinking water".

At 05:50 PM CMA A stated, "I guess I could just call Poison Control; they don't come out ...I could just see what they say". R1 spoke to R2, and R2 looked at R1 then nodded her head in an up and down motion in response to R1.

At 05:53 PM R2 remained at the dining room table, as CMA A was on the phone and prepping the evening meal. The bottle of cleaning solution remained on the north counter behind R2 as CMA A stated "straight out of the container" to the person she was on the phone with.

At 05:56 PM CMA A answered the door to Owner/RN B, and he came into the home as CMA A remained on the phone.

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At 06:01 PM Agency Staff H arrived at the facility and Owner/RN B left the facility.

At 06:03 PM R2 remained seated at the dining room table and responded appropriately to R1, R2 looked around the room and appeared to take a small bite of food.

At 06:04 PM R2 took a bite of food, slightly lowered her head and then experienced no other movement.

At 06:08 PM CMA A stated Administrative Staff E was "sending someone" to the facility to assist. R2 remained seated at the dining room table with R1 sitting to the right of her. CMA A stated she "didn't know if it was from drinking that, or if something else was going on, this was exactly how she acted this morning on the toilet, then she went back to sleep and she acted perfectly fine after that". R2's head was down, and her chin appeared to be touching her chest.

At 06:24 PM CMA A told Agency Staff H that she was told if it made her feel better, she was to call RN F, and to get a set of vital signs. Agency Staff H reported R2 could not sit up on her own. R1 then stated R2 kept falling asleep on the toilet that morning.

At 06:25 PM R2 remained at the dining room table with a small blue waste basket sitting on the table in front of her. CMA A stood behind R2, held her in an upright position, and used her left hand to continue to hold R2 upright. R2s head hung down with her chin at her chest level.

At 06:26 PM CMA A gently shook R2, and asked

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S5026	Continued From page 5 R1 if R2 was breathing and she responded the resident was breathing, but very shallow. CMA A released R2's shoulder and she immediately leaned to the left. R2 could be heard making a grunting noise in the video. At 06:41 PM the video revealed staff had moved R2 from the dining chair and sat in a wheelchair at the dining room table with her head hanging down and with staff support to remain in an upright position. CMA A was on the phone and stated, "she sounds like she's sleeping ... it's making me nervous, she's not even like waking up or anything, not going to leave" CMA A stated she was not going to leave until LN D arrived at the facility. R1 then asked if they should call someone (unintelligible who R1 wanted to call), and CMA A responded "we will just wait until" until LN D arrives. CMA A then told R1 that they were being watched through the camera system by Administrative Staff E and R1 looked at the camera, waved, and said "hi" to Administrative Staff E. At 07:09 PM R2 remained in the wheelchair with oxygen being administered via nasal canula in place. R2 continued to be slumped to the left side of the wheelchair and was nonresponsive. At 07:15 PM CMA A asked an unidentified person on the phone if they should keep R2 in an upright position and the person on the phone could be heard stating "that would be my suggestion". The person on the phone then stated, "at least until she gets there" and "if you don't hear from her call us back, this is an urgent situation."	S5026		

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S5026	Continued From page 6 At 07:24 PM LN D assessed R2 who remained in the wheelchair, at the dining room table. At 07:39 PM LN D stated she was waiting on RN F to return her call and noted R2 was absent of vital signs. Review of the facility provided "Communication Notes" dated 10/27/25 at 04:44 PM a late entry for 10/24/25 signed by LN D revealed on 10/24/25 she received a call from Administrative Staff E reporting R2 had possibly ingested an unsecured cleaning solution, but they were not sure how much. The aide on duty and the nurse writer both contacted the Poison Control hotline. The hotline instructed staff to push R2 to drink water, noted she may be lethargic and may vomit, but otherwise "she should be just fine". LN D stated the aide on duty reported R2 had vomited. When LN D arrived at the facility at approximately 07:15 PM she observed R2 sitting in a wheelchair in the dining room and R2 was nonresponsive when LN D spoke to her. LN D asked Administrative Staff E if R2 had a do not resuscitate (DNR) order, and Administrative Staff E confirmed R2 did have a DNR order. LN D documented she was unable to get a blood pressure or oxygen reading for R2, and she attempted three times to hear a heartbeat. At 07:30 PM staff noted R2 was without vital signs. LN D documented she consulted with the RN about the facility procedure, and they obtained an order to send R2 to the mortuary. The Mortuary arrived at 08:45 PM and R2 was released to the mortuary representative. Review of the facility provided document titled "Witness Statement" dated 10/27/25 signed by	S5026		

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S5026	Continued From page 7 Owner/RN B revealed he arrived at the facility on 10/24/25 at approximately 05:56 PM and all of the residents were seated at the dining room table. Owner/RN B documented that staff did not notify him that R2 consumed the cleaning solution. Review of the facility "Witness Statement" dated 10/27/25 revealed LN D received a call on 10/24/25 at 06:33 PM from Administrative Staff E and CMA A that R2 may have ingested a cleaning solution. At 06:34 PM she stated she started driving to the home and she called the Poison Control hotline during her drive and asked them what to do. The Poison Control hotline instructed LN D to give R2 water and informed her that R2 may become lethargic and vomit. CMA A called her to let her know that R2 had just vomited. CMA A was told to "keep her upright and just monitor". LN D arrived at the home at 07:15 PM the same time as Administrative Staff E and when she entered the home R2 was sitting in the wheelchair in the dining room. LN D wrote that R2 was "slumped and grayish in color", R2 failed to respond when her name was called, and LN D was unable to obtain a pulse or vital signs. Review of the "Witness Statement" dated 10/27/25 and signed by CMA A revealed on 10/24/25 she forgot to retrieve the bottle of cleaning solution from the common bathroom. Later in the day CMA A observed R2 come out of the bathroom carrying the bottle of cleaning solution. CMA A noted she walked up to R2 and R2 had the cap off of the bottle in her hand. She took the bottle of cleaning solution from R2 and started reading the bottle for ingestion warnings.	S5026		

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CMA A noticed that R2 had spilled some of the cleaning solution on her shirt and pants and she smelled like it so CMA A "assumed" R2 drank some of it. CMA A noted there were no ingestion warnings on the label so she "googled" the chemical and the response was to call poison control. CMA A wrote that she called poison control at 05:51 PM and was told to keep R2 sitting up in case R2 vomited, and to give her water. CMA A wrote that she called RN F at 06:06 PM and RN F did not answer the phone. She called Administrative Staff E at 06:07 PM reported what happened and stated that Administrative Staff E would call LN D. She received a call back from Administrative Staff E at 06:15 PM and was told that LN D was on her way to the facility.

Review of the "Witness Statement" dated 10/28/25 signed by RN F revealed on 10/24/25 at 06:06 PM she noted a missed call from CMA A and texted CMA A back at 06:14 PM to see if CMA A still needed her. At 06:16 PM RN F attempted to return CMA A's phone call. At 06:17 PM CMA A reported that R2 may have consumed cleaning solution. CMA A reported to RN F that R2 carried the bottle of cleaning solution around, and that CMA A called poison control. She was told to keep R2 upright and to have R2 drink water. RN F instructed CMA A to call Administrative Staff E to "get the nurse on site". RN F then told CMA A she was going to review the cameras in the home. RN F noted at 07:35 she received a call from Administrative Staff E stating staff suspected R2 was deceased, and that LN D was at the home. RN F wrote that she reviewed the cameras and confirmed R2 carried the bottle of cleaning solution in her hands. CMA

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A stated to the RN that R2 had slumped over and was "out of it for a minute, she went to bed and woke up and was better after a nap." At 07:43 RN F contacted R2's family and reported R2 "had passed away sitting at the table, that she had experienced a syncopal episode that morning, and that she was going to investigate everything".

Review of the facility provided document titled "Witness Statement" dated 10/27/25 and signed by Administrative Staff E revealed on 10/24/25 at 06:07 PM she was notified by CMA A that R2 ingested a cleaning solution, she then notified LN D at 06:08 PM of the incident. She stated she spoke to CMA A at 06:15 PM and at 06:38 PM to inquire if R2 had any changes, and CMA A reported that R2 was throwing up. She spoke to LN D at 06:32 and LN D reported she was on the way to the home. She and LN D arrived to the home at 07:20 PM. Administrative Staff E wrote that R2 did not look well, and that RN F was called at 07:34 PM

Review of the "Witness Statement" dated 10/28/25 signed by CMA A revealed on 10/24/25 between 09:30 AM and 10:00 AM R2 went limp during morning cares and was unable to hold herself upright. When CMA A finished assisting her, she stood R2 up and R2 was unable to "stand up completely". CMA A wrote that she assisted R2 in getting back to bed where "she slept for a while and when she got up, she was acting herself." CMA A confirmed she did not notify the nurse of R2's change of condition at the time of R2's change of condition.

Review of the facility provided undated policy

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titled "Storage and Management of Chemicals/Hazardous Materials" revealed the following:

"Purpose; to set forth guidelines for the storage and management of chemicals/hazardous materials to protect exposure from accidental contact/exposure."

"Policy; Staff will ensure that all chemicals will be properly secured in a locked cabinet or designated secured area when not in use or continuously monitored when in use."

Review of the facility provided document titled "Daily Tasks" facility staff were instructed "no chemicals out".

Interview on 10/27/25 at approximately 05:29 PM CMA A confirmed she observed R2 carrying the bottle of cleaning solution out of the bathroom and she went to R2 and took the cleaning solution from R2, and stated she suspected R2 may have consumed some of it. She stated that she did not report anything to Owner/RN B because R2 was acting normal while he was in the building. She stated that after Owner/RN B left and upon arrival of Agency Staff H, R2 experienced a change in her condition. CMA A stated she "Googled" what do to in the case of cleaning solution ingestion and then she called poison control.

Interview on 10/27/25 at approximately 06:02 PM with Owner/RN confirmed he was an RN and he was unaware R2 may have ingested the cleaning solution, he further confirmed that he was in the home on 10/24/25 at approximately 06:00 PM

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and that CMA A failed to report to him the incident and that if he would have known he could have provided immediate guidance to CMA A and assistance for R2. He further confirmed the incident had not been investigated or reported to the State Agency.

Interview on 10/27/25 at approximately 07:16 PM with LN D revealed she was covering for RN F while RN F was on vacation. She stated that upon her arrival to the facility on 10/24/25 R2 appeared to have already passed away, as she was absent of vitals signs. She confirmed she did not call emergency services at this time.

Owner/RN B was notified on 10/27/25 at approximately 06:20 PM that R2 had been placed in immediate jeopardy on 10/24/25 when CMA A failed to notify the facility nurse of a change in R2's change in condition at approximately 10:00 AM, and she was further placed in immediate jeopardy when CMA A left a bottle of cleaning solution in the facility common bathroom at approximately 10:20 AM. At approximately 05:43 PM CMA A found R2 with the bottle of cleaning solution and suspected R2 may have ingested the chemical. CMA A further failed to notify the facility nurse immediately when she instead "Googled" what to do, and then called poison control.

The removal plan was accepted on 10/28/25 and included the following:
10/27/25 Staff were reeducated on securing chemicals.
10/28/25 Staff were reeducated on when to call the nurse.
10/28/25 Staff were re-educated on the

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S5026	Continued From page 12 procedure for notifying administration and calling 911 in case of an emergency.	S5026		
S5028 SS=F	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. This REQUIREMENT is not met as evidenced by:	S5028		

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(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
S5028	Continued From page 13 K.A.R. 26-42-101 (f) (3) (A) (B) The facility reported a census of 6 Residents. The sample included 1 "Resident" (R) R1, and one closed record review R2. Based on record review and interview the Operator failed to report to the department within 24 hours an allegation of neglect when CMA A left a bottle of "Pine-Sol" in the common bathroom of the home. Cognitively impaired R2 was then observed with the bottle of "Pine-Sol" by staff and R2 experienced a change of condition. R2 was absent of vital signs approximately 2 hours after she was observed by staff to have the opened bottle of "Pine-Sol". The Operator continued to fall to start a full investigation when staff reported to the manager that R2 had been observed with an opened bottle of "Pine-Sol", and the Operator further failed to take immediate actions to prevent further potential neglect when the bottle of "Pine-Sol" remained on the north kitchen island while CMA A was preparing the homes evening meal. Findings included: - Record review for R2 revealed an admission date of 11/01/22 with diagnoses of dementia, hypertension, osteoporosis, encephalopathy, chronic obstructive pulmonary disease, and weight loss. Review of R2's "Functional Capacity Screen" (FCS) dated 09/13/25 revealed R2 required physical assistance with bathing, dressing, and toileting. R2 was independent with transferring, walking and eating. R2 lacked the ability to	S5028		

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	B087135	A. BUILDING: _____ B. WING _____	10/28/2025

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manage her own medications and was incontinent. R2 had impaired short-term memory, long-term memory, memory recall, and impaired decision making. R2 could rarely or never make herself understood and she sometimes understood others. R2 was identified to be at risk for falls, impaired hearing, and impaired decision making. R2 used no mobility device.

Review of R2's combined "Negotiated Service Agreement" (NSA)/" Health Service Plan" (HSP) instructed facility staff to cut her food into bite sized pieces and encourage fluids, provide one staff assistance for bathing, dressing, and toileting. R2 was independent with transferring and walking/mobility. R2 used no mobility device. R2 was alert to person and staff were instructed to assist R2 in making simple "day to day decisions". Facility staff were informed that R2 would occasionally respond randomly in two to three words and was mostly non-verbal. R2 understood staff "but may not respond verbally". Facility staff were instructed to provide and administer all of R2's medications. Under the section titled "Mental Health Interventions/Crisis Management" it was documented that R2 would explore without boundaries and would sit on the floor. Facility staff were further instructed to "offer diversional activities, snacks, and redirection using a calm voice." R2 was identified to be at risk for "Wandering/Elopement". Facility staff were instructed to redirect R2, provide hourly visualization to ensure R2's safety, and ensure that R2 remained in secured facility under supervision.

Review of the facility provided "Communication Notes" revealed the following entries;

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S5028	Continued From page 15 On 09/18/25 at 04:35 PM and signed by RN C revealed R2 would walk around the house and would open doors, enter rooms and sleep in un-occupied beds. R2 did not respond to questions and was alert with confusion. On 10/11/25 at 10:08 AM a late entry for 10/07/25 and signed by RN C revealed R2 was alert and appropriate for assessment with smiles noted with questions asked. R2 got out of bed and began ambulation without staff assistance needed. Resident verbalized words that were not understandable. R2contined to ambulate in the hallway periodically during the visit. On 10/27/25 at 04:44 PM a late entry for 10/24/25 signed by "Licensed Nurse" (LN) D revealed that on 10/24/25 she had received a call from Administrative Staff E, that R2 had possibly ingested some "Pine Sol. They are not sure if and how much. Poison Control contacted by the aide" at the home and by "this nurse. They said to push water, be lethargic and she may vomit, but otherwise she should be just fine. Spoke with the aide while in route to the facility and patient had vomited". LN D documented that she arrived at the home at approximately 07:15 PM and she observed R2 sitting in a wheelchair in the dining room. R2 was "non-responsive" when LN D spoke to her. LN D asked Administrative Staff E if R2 had a "Do Not Resuscitate" (DNR) order, and Administrative Staff E confirmed that R2 had a DNR order. LN D continued to document that she was unable to get a blood pressure or pulse oxygen reading, and she attempted three times to hear a heartbeat, and at 07:30 PM R2 was without vital	S5028		

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signs. LN D documented that she consulted with "RN" about procedure and an order was obtained to send R2 to the mortuary. "RN contacted the family" and identified the mortuary. Mortuary arrived at 08:45 PM and R2 was released to the mortuary representative.

On 10/28/25 at 11:37 AM a note signed by LN D revealed a "Late Entry Correction from previous note", that revealed Order to release R2 to the mortuary was given by RN F on 10/24/25.

Review of the facility document titled "Patient Care Order" revealed the order was dated for 10/25/25 at 08:00 PM "May release body to the funeral home of choice". The order was signed by RN F and "Nurse Practitioner" (NP) G on 10/28/25 at 11:25 AM.

Review of the facility provided video footage with audio, date and time stamped by the video system revealed the following on 10/24/25;

At 10:20:01 AM CMA A heard the doorbell and carried the mop, mop bucket, and a bottle of cleaning solution to the common bathroom located in the south hallway of the home.

At 05:43:45 PM R2 was walking out of the common bathroom located in the south hallway, and R2 was carrying a bottle of cleaner with both hands, and in her left hand was a yellow piece of cloth. R2 was walking toward the common living area of the home.

At 05:53:46 PM R2 was at the dining room table, and CMA A was on the phone while she prepped the evening meal. The bottle of cleaning solution

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S5028	Continued From page 17 remained on the north counter behind R2, CMA stated "straight out of the container". At 19:39:39 LN D stated that she was waiting on RN F to return her call and R2 was absent of vital signs. Review of the facility provided document titled "Witness Statement" dated 10/27/25 and signed by CMA A and notarized revealed that on 10/24/25 revealed CMA A wrote that she got the bottle of "Pine-Sol" to add to the mop water and she mopped the common bathroom and one of the residents' private bathrooms, and she forgot to retrieve the bottle of "Pine-Sol". Later in the day CMA A wrote that she was doing another residents nails and she observed R2 come out of the bathroom and was carrying the bottle of "Pine-Sol". CMA A wrote that she walked up to R2 and R2 had the cap off of the bottle. CMA A wrote that she took the bottle from R2 and started reading the bottle for ingestion warnings. CMA A noticed that R2 had spilled some of the Pine-Sol on her shirt and pants and she smelled like the chemical so CMA A "assumed" R2 drank some of it. CMA A wrote that there were no ingestion warnings on the label so she "googled" the chemical the" google" response was to call poison control. CMA A wrote that she called poison control at 05:51 PM and when was told to keep R2 sitting up in case R2 vomited, and to give her water. CMA A wrote that she called RN F at 06:06 PM and RN F did not answer the phone. CMA A then wrote that she called Administrative Staff E at 06:07 PM and reported what had happened and that Administrative Staff E would call LN D. CMA A wrote that she received a call	S5028		

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S5028	Continued From page 18 back from Administrative Staff E at 06:15 PM and was told that LN D was on her way to the home. CMA A wrote that approximately five minutes after Owner/ RN B left the home that R2 started vomiting. Review of the facility provided document titled "Witness Statement" dated 10/27/25 signed by LN D and notarized revealed LN D received a call on 10/24/25 at 06:33 PM from Administrative Staff E and CMA A that R2 may have ingested some "Pine-Sol". At 06:34 LN D wrote that she started driving to the home and she called Poison Control during her drive and asked them what to do. LN D wrote that she was instructed to give R2 water, and that R2 may become lethargic and vomit. LN D continued that at CMA A called her to let her know that R2 had just vomited. LN D wrote that CMA A was told to "Keep her upright and just monitor". LN D arrived at the home at 07:15 PM the same time as Administrative Staff E and when she entered the home R2 was sitting in the wheelchair in the dining room. LN D wrote that R2 was "slumped and grayish in color", R2 failed to respond when her name was called, and LN D was unable to obtain a pulse. LN D wrote that she was unable to obtain vital signs. LN D then placed a call to RN F and was instructed to do what "you normally do in the case of a death. RN F gave the order to release the body per the NP. LN D wrote that the Aide told her that "this happened earlier", R2 was real lethargic and did not act herself. LN D concluded her written statement with she did not smell anything on R2 breath nor in the bucket where she vomited, then LN D arrived.	S5028		

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S5028	Continued From page 19 Review of the facility provided document titled "Witness Statement" dated 10/27/25 signed by Administrative Staff E revealed that on 10/24/25 at 06:07 PM she was notified by CMA A that R2 "ingested Pine-Sol", and she notified LN D at 06:08 PM of the incident. Administrative Staff E continued to write that she spoke to CMA A at 06:15 PM and 06:38 PM to inquire on if R2 had any changes, and it was reported by CMA A that R2 was throwing up. Administrative Staff E wrote that she spoke to LN D at 06:32 and that LN D reported she was on the way to the home. Administrative Staff E continued to write that she and LN D arrived at the same time to the home at 07:20 PM. Administrative Staff E wrote that R2 did not look well, and that RN F was called at 07:34 PM. Interview on 10/27/25 at approximately 05:29 PM with CMA A confirmed she observed R2 carrying the bottle of "Pine-Sol" out of the bathroom and that she suspected that R2 may have drunk some of it. She stated that she did not report anything to Owner/RN B because R2 was acting normal while he was in the building. She stated that after Owner/RN B left and upon arrival of Agency Staff H was when R2 experienced a change in her condition. CMA A stated she "Googled" what do to in the case of "Pine-Sol" Ingestion and then she called poison control. Interview on 10/27/25 at approximately 06:02 PM with Owner/RN confirmed he was an RN and he was unaware that R2 may have ingested "Pine-Sol", he further confirmed that he was in the home on 10/24/25 at approximately 06:00 PM and that CMA A failed to report to him the incident and that if he would have known he	S5028		

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S5028	Continued From page 20 could have provided immediate guidance to CMA A and assistance for R2. He further confirmed the incident had not been opened for investigation or reported to the department. Interview on 10/28/25 at approximately 01:00 PM with RN F confirmed she had been on vacation and had just returned. RN F stated she thought Owner/RN B new about the incident and had taken the steps to open the investigation. RN F confirmed she did not know Owner/RN B was unaware that R2 may have ingested Pine-Sol. She further confirmed that all calls made to the nurse from the home's staff goes to a non-licensed person who then calls the nurse for the facility staff. The Operator failed to report to the department within 24 hours an allegation of neglect when CMA A left a bottle of "Pine-Sol" in the common bathroom of the home. Cognitively impaired R2 was then observed with the bottle of "Pine-Sol" by staff and R2 experienced a change of condition. R2 was absent of vital signs approximately 2 hours after she was observed by staff to have the opened bottle of "Pine-Sol". The Operator continued to fall to start a full investigation when staff reported to the manager that R2 had been observed with an opened bottle of "Pine-Sol", and the Operator further failed to take immediate actions to prevent further potential neglect when the bottle of "Pine-Sol" remained on the north kitchen island while CMA A was preparing the homes evening meal.	S5028		