

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046066	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/03/2025
NAME OF PROVIDER OR SUPPLIER COLONIAL OAKS AT SPRING HILL		STREET ADDRESS, CITY, STATE, ZIP CODE 22550 S FRANKLIN STREET SPRING HILL, KS 66083		
(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 represents the findings of a resurvey with attached complaints 196559, 196517, 195769, 195064, 194579, 194106, 193458, 192072, 190071, 188115, and 187079 at the above named assisted living conducted on 10/28/25, 10/29/25, 10/30/24, 11/03/25.	S 000		
S 135 SS=D	26-39-103 (h) Resident Right Notification of Changes (h) Notification of changes. (1) The administrator or operator shall ensure that designated facility staff inform the resident, consult with the resident's physician, and notify the resident's legal representative or designated family member, if known, upon occurrence of any of the following: (A) An accident involving the resident that results in injury and has the potential for requiring a physician's intervention; (B) a significant change in the resident's physical, mental, or psychosocial status; (C) a need to alter treatment significantly; or (D) a decision to transfer or discharge the resident from the adult care home. (2) The administrator or operator shall ensure that a designated staff member informs the resident, the resident's legal representative, or authorized family members whenever the designated staff member learns that the resident will have a change in room or roommate assignment. This STANDARD is not met as evidenced by:	S 135		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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S 135	Continued From page 1 KAR 26-39-103(h)(1)(B) The facility reported a census of 45 residents with three residents included in the sample and three focused reviews. Based on interview and record review the operator failed to ensure licensed staff notified Resident (R) 1's designated family member when he developed a cough and congestion and was seen by the nurse practitioner. Findings included: - Record review for R1 revealed an admission date of 08/20/24 with diagnoses of dementia, legal blindness, and Parkinson's Disease. The 08/16/24 "FCS" identified R1 required physical assistance with bathing, dressing, toileting, transfer, walking/mobility, and eating. He was unable to perform management of medications and treatments. R1 was occasionally incontinent of urine and had short-term memory, memory/recall, and decision-making cognitive difficulties. He was at risk for falls, impaired vision, and impaired decision-making. The 08/26/24 "NSA" identified R1 received assistance with bathing by hospice. R1 received assistance by two facility staff with dressing, toileting, bladder incontinence, and transfers. He received assistance by one staff to propel his wheelchair for walking/mobility and one staff assistance with eating. R1 received assistance from staff for management of medications and face-to-face safety checks for falls. The "NSA"	S 135		

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S 135	Continued From page 2 failed to describe services R1 received for management of treatments, cognitive difficulties, impaired vision, and impaired decision making. The 04/12/25 at 12:46 PM late entry for 04/10/25 at 05:50 PM "Progress Notes" documented the nurse practitioner saw R1 on 04/10/25 and ordered a chest x-ray and Mucinex 600 milligrams (mg) by mouth twice daily for cough and congestion. Review of nursing progress notes from 02/01/25 to 04/28/25 lacked evidence of documentation a nurse notified R1's designated family member on or near 04/10/25. On 11/03/25 at 02:18 PM Administrative Nurse B confirmed R1's record lacked evidence of documentation his designated family member was notified when he developed a cough and congestion and was seen by the nurse practitioner. The operator failed to ensure licensed staff notified R1's designated family member when he developed a cough and congestion and was seen by the nurse practitioner.	S 135		
S3026 SS=J	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;	S3026		

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S3026	Continued From page 3 (B) neglect; or (C) exploitation. This REQUIREMENT is not met as evidenced by: KAR 26-41-101(f)(1)(B) The facility reported a census of 45 residents with three residents included in the sample and three focused reviews. Based on observation, interview, and record review the operator failed to protect Resident (R) 5 from neglect by the failure to ensure direct-care staff provided R5 timely checks of her wander management system bracelet to ensure it remained in place at all times. R5 removed her wander bracelet and exited the facility without staff knowledge. On 10/19/25 at approximately 07:00 PM another resident reported to staff she saw R5 walking outside. This placed R5 in Immediate Jeopardy. Findings included: - Record review for R5 revealed an admission date of 08/15/24 with diagnoses of dementia and history of falling. The 08/11/25 "Functional Capacity Screen" (FCS) documented R5 required supervision with transfers and walking/mobility and was at risk for falls and wandering. The 08/11/25 "Negotiated Service Agreement" (NSA) identified facility staff provided R5 supervision with transfers and walking/mobility. R5 received a wander management system bracelet for wandering. The "NSA" failed to	S3026		

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S3026	Continued From page 4 describe the services R5 received for falls and staff monitoring of wander management bracelet to ensure it remained on. The 09/15/25 at 09:08 PM "Progress Note" by Certified Medication Aide (CMA) C documented R5 exhibited exit-seeking behavior during the day and night with agitation. Staff attempted to redirect R5. The nurse administered a PRN (as needed) medication. Facility staff notified R5's unidentified family member who arrived at the facility to sit with R5. The 10/16/25 at 08:44 AM "Progress Note" by Administrative Nurse B documented R5 was up and ambulating with no change in gait. The 10/16/25 at 09:04 AM "Progress Note" by Administrative Nurse B documented R5 ambulated with a four-wheeled-walker with no change in gait. The 10/20/25 at 05:24 AM "Progress Note" by CMA D documented on 10/19/25 at approximately 07:00 PM during routine evening rounds staff could not find R5 in her room or common areas. Staff initiated a search of the building and grounds at 07:00 PM. Staff found R5 outside near the road-side exit walking toward the street and escorted R5 back into the building at 07:15 PM with no injuries observed. Staff notified the nurse at 07:15 PM. The 10/22/25 at 12:39 PM "Progress Note" by Administrative Nurse B documented R5 ambulated with a four-wheel-walker with no change in her gait.	S3026		

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S3026	Continued From page 5 The 10/24/25 at 01:41 PM Late Entry for 10/23/25 at 05:00 PM "Progress Note" by Administrative Nurse B documented due to increased agitation, confusion, and exit seeking behavior, the nurse practitioner ordered R5 be administered new medication Seroquel 12.5 milligrams (mg) by mouth twice daily for dementia with psychosis. The 08/27/25 "Elopement Procedure" training was signed by eight staff. Review of facility records revealed 29 staff currently worked at the facility at the time of the survey. The 10/30/25 notarized witness statement by CMA D reported on 10/19/25 at about 07:00 PM R9 reported a resident was outside of the facility. CMA D checked outside and noticed it was R5 and she did not have her wander management bracelet on. He notified the supervisor of the incident and put a new wander bracelet on R5. The 10/30/25 notarized witness statement by Administrative Staff A reported she received a text message from CMA D on 10/19/25 at 07:02 PM that R5 was exit-seeking and had gone out the door. The 10/30/25 notarized witness statement by Administrative Nurse B reported Administrative Staff A notified her at 07:03 PM R5 was exit-seeking. Administrative Nurse B had not heard from CMA D and called him at 07:06 PM. CMA D informed her he had escorted R5 back into the building and her wander management bracelet was off. Administrative Nurse B called R5's DPOA (Durable Power of Attorney) and requested she come to the facility to provide	S3026		

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S3026	Continued From page 6 one-on-one supervision until R5 was asleep. At 07:11 PM Administrative Nurse B called another facility staff member and directed her to put a new wander bracelet on R5 and to administer PRN medication for anxiety. The undated witness statement by CMA I reported Administrative Nurse B called her on 10/19/25 at approximately 07:20 PM while she was administering medications in the memory care unit. She was unaware at that time that R5 had eloped. After the call, CMA I left the memory care unit and went to front area and asked CMA D what happened. CMA D told CMA I that R9 reported she saw R5 walking outside the building. CMA D went outside and found R5 walking without her wander bracelet on. CMA D brought R5 back inside the building and put a new wander bracelet on her. The 10/30/25 notarized witness statement by maintenance staff J reported Administrative Staff A called and directed him to come to the facility and check the wander management system. He arrived at the facility at 07:53 PM, checked, and tested the doors and alarms. Everything was operational, including the pagers. Observations on 10/28/25 during the initial tour revealed all exit doors from the assisted living side of the facility were armed with door alarms and a wander management system alarm. On 10/28/25 at approximately 10:22 AM Administrative Staff H stated all exit doors in the assisted living were armed with a wandering management system alarm and another alarm that rang on staff pagers.	S3026		

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S3026	Continued From page 7 Observation on 10/28/25 at 02:31 PM revealed R5 sat at a table in the dining area with an unidentified family member who was visiting. A walker was nearby. R5 independently drank a beverage with prompting from her family member. R5 stated her name but appeared confused and could not answer other questions appropriately. A wander management system bracelet was on her left wrist. On 10/29/25 at 11:40 AM Certified Nurse Aid (CNA) F stated she had a pager. She was not aware it had activated for a call light until she pulled it out of her pocket and checked it. She did not know how to change the settings from silent to ring so she could hear when a call light or door alarm activated. Observation on 10/29/25 at 11:42 AM revealed Administrative Nurse B asked two Certified Nurse Aides (CNA) and one CMA to show her their pagers. Only CNA F carried a pager. On 10/30/25 at approximately 11:36 AM CMA D stated he worked the night shift from 10/19/25 to 10/20/25. He provided R5 visual checks every two hours by going into her room to ensure her oxygen nasal cannula was still in place and checked her oxygen levels with an oximeter placed on her finger. He carried a pager that was set to ring when activated. If a resident attempted to go through a door the alarm sounded audibly in the building. He was administering medications to the residents in the assisted living when he last saw R5 sitting in the dining area at dinner time. A few minutes later he noticed R5 was not in the dining area but was not concerned	S3026		

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S3026	Continued From page 8 as she "walked all the time." Another resident, R9, reported a resident was outside. CMA D stated he did not hear a door alarm, wander management system alarm, or could not recall if his pager activated. CMA D stated he looked out the front door and saw R5 in the parking lot past the large tree on the north side of the parking lot. R5 was walking toward the street. CMA D re-directed R5 back into the building. He found a wander management bracelet on the floor in the dining area and notified Administrative Staff A. R5 had exited the building once before, but his coworker, CMA I saw her and brought her back in the building. There were other residents that also wore wander management bracelets. He rarely routinely checked the wander bracelets for placement and could not recall the last time he was provided with elopement training. On 10/30/25 at 01:16 PM R9 stated she walked outside often. One time she saw R5 in the middle of the street by the second house to the right of the parking lot. She asked the resident what she was doing outside, and she replied that she didn't know. R9 stated she became afraid for R5 and had to tell staff right away. She went into the facility and informed staff that a resident was in the street. She was glad it was a Sunday and there was not a lot of traffic. On 10/30/25 at 02:03 PM during a phone interview, R5's unidentified family member R5 frequently exhibited exit-seeking behavior. R5 took her wander management bracelet off and went outside without staff knowing. Another resident saw her and reported to staff R5 was outside. R5 did not cut the bracelet off, she "ripped" it off. She stated CMA I notified her	S3026		

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S3026	Continued From page 9 about a month earlier she heard the door alarm and saw R5 outside and brought her back into the building. On 10/30/25 at approximately 02:45 PM documentation for the facility wander management system routine checks, door alarms routine checks, and wander management bracelet placement checks was requested which the facility failed to provide. On 10/30/25 at approximately 02:45 PM Administrative Staff A stated maintenance was responsible for ensuring the wander management system was operational and the alarms at all the doors worked. Clinical staff were responsible for checking wander bracelet placement. Administrative Staff A confirmed facility records lacked evidence of documentation, the wander management system and door alarms were checked. Administrative Staff A confirmed six resident's records, including R5, lacked evidence of documentation wander bracelets were checked for placement. The weather on 10/19/25 according to Wunderground.com was 58 degrees Fahrenheit with a wind speed of nine miles per hour (mph) at 06:53 PM near the time R5 exited the facility. The sun had set at 06:37 PM and it was twilight. Observation of the neighborhood surrounding the facility revealed a small pond approximately 625 feet north of the facility's front door through the parking lot. A walking trail surrounded the pond with a steep hill down to the water. Approximately 1700 feet west of the facility through a residential neighborhood, was a four-lane highway with a speed limit of 65 mph.	S3026		

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S3026	Continued From page 10 The facility's 08/2025 "Elopement" policy documented if staff were unable to locate a resident they alerted the CMA and the Director of Health Services Immediately. All CNA's searched their assigned hallway by physically entering each room, closets, restrooms, and other rooms on the hall. Administrative Staff searched the grounds and surrounding areas. The Executive Director called to report to the state's department of aging and disability services. When the resident was located, the Executive Director informed everyone involved and the Regional Operations Director. The CMA or the nurse determined if there was any injury, completed an incident report, and notified the resident's physician. The Executive Director completed an investigation report and submitted it to the proper authorities and ensured all required documentation was completed. The Immediate Jeopardy was removed on 10/19/25 when the following actions documented by the facility in their Removal Plan were implemented and accepted by the department on 11/03/25 at 01:42 PM. 1) CMA D escorted R5 back inside the facility. 2) A replacement wander management system was applied at 07:03 PM 3) Staff supervised R5 in the dining area until her DPOA arrived. 4) DPOA arrived at the facility at 08:00 PM and stayed until 10:30-11:00 PM 5) R5 remained on two-hour safety checks which were documented in the electronic medical record/medication administration record EHR/MAR. 6) Maintenance inspected exit alarms, wander	S3026		

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S3026	Continued From page 11 management system receivers, and pagers and confirmed were operational at 08:17 PM. 7) Staff increased frequency of rounds for the remainder of the shift. 8) Staff reminded to notify ED/DON immediately for any elopement concerns. 9) Elopement procedure training completed withing 72 hours of plan acceptance. 10) Wander management bracelet checks added to two-hour rounds effective 10/31/25 documented in EHR/MAR. 11) Wander management system policy created on 11/03/25 12) Instant in-services created for elopement, wander bracelet placement with completion within 72 hours required for staff. 13) Full resident wander management system review completed. 14) Monthly wander management system functionality tests documented. 15) Monthly exit door alarm testing completed by maintenance. 16) Monthly full systems inspection performed. 17) Elopement drills conducted withing 30 days and ongoing thereafter. 18) Weekly review for exit-seeking incidents and trends. 19) Staff competency validation completed within 7 days of training.	S3026		
S3028 SS=D	26-41-101 (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 facility as soon as staff is aware of the allegation and to the department within 24 hours. The administrator or operator	S3028		

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S3028	Continued From page 12 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: KAR 26-41-101(f)(3)(A)(C) The facility reported a census of 45 residents with three residents included in the sample and three focused reviews. Based on interview and record review the operator failed to ensure an allegation of neglect was reported to the department within 24 hours and failed to start an investigation when staff notified the operator of the allegation. The operator further failed to	S3028		

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S3028	Continued From page 13 complete an investigation and submit it within five working days of the alleged neglect. Findings included: Record review for R5 revealed an admission date of 08/15/24 with diagnoses of dementia and history of falling. The 08/11/25 "Functional Capacity Screen" (FCS) documented R5 required supervision with transfers and walking/mobility and was at risk for falls and wandering. The cognition score section was blank. The 08/11/25 "Negotiated Service Agreement" (NSA) identified facility staff provided R5 supervision with transfers and walking/mobility. R5 received a wander management system bracelet for wandering. The "NSA" failed to describe the services R5 received for cognitive difficulties, falls and staff monitoring of wander management bracelet to ensure it remained on. The 10/20/25 at 05:24 AM "Progress Note" by CMA D documented on 10/19/25 at approximately 07:00 PM during routine evening rounds staff could not find R5 in her room or common areas. Staff initiated a search of the building and grounds at 07:00 PM. Staff found R5 outside near the road-side exit walking toward the street and escorted R5 back into the building at 07:15 PM with no injuries observed. Staff notified the nurse at 07:15 PM. The 10/30/25 notarized witness statement by CMA D reported on 10/19/25 at about 07:00 PM	S3028		

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NAME OF PROVIDER OR SUPPLIER COLONIAL OAKS AT SPRING HILL		STREET ADDRESS, CITY, STATE, ZIP CODE 22550 S FRANKLIN STREET SPRING HILL, KS 66083		
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S3028	Continued From page 14 R9 reported a resident was outside of the facility. CMA D checked outside and noticed it was R5 and she did not have her wander management bracelet on. He notified the supervisor of the incident and put a new wander bracelet on R5. The 10/30/25 notarized witness statement by Administrative Staff A reported she received a text message from CMA D on 10/19/25 at 07:02 PM that R5 was exit-seeking and had gone out the door. The 10/30/25 notarized witness statement by Administrative Nurse B reported Administrative Staff A notified her at 07:03 PM R5 was exit-seeking. Administrative Nurse B had not heard from CMA D and called him at 07:06 PM. CMA D informed her he had escorted R5 back into the building and her wander management bracelet was off. Administrative Nurse B called R5's DPOA (Durable Power of Attorney) and requested she come to the facility to provide one-on-one supervision until R5 was asleep. At 07:11 PM Administrative Nurse B called another facility staff member and directed her to put a new wander bracelet on R5 and to administer PRN medication for anxiety. The facility's 08/2025 "Elopement" policy documented if staff were unable to locate a resident, they alerted the CMA and the Director of Health Services Immediately. The Executive Director called to report to the state's department of aging and disability services. The Executive Director completed an investigation report and submitted it to the proper authorities and ensured all required documentation was completed.	S3028		

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NAME OF PROVIDER OR SUPPLIER COLONIAL OAKS AT SPRING HILL		STREET ADDRESS, CITY, STATE, ZIP CODE 22550 S FRANKLIN STREET SPRING HILL, KS 66083		
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S3028	Continued From page 15 The operator failed to ensure an allegation of neglect was reported to the department within 24 hours and failed to start an investigation when staff notified the operator of the allegation. The operator failed to complete an investigation and submit it within five working days of the alleged neglect.	S3028		
S3082 SS=E	26-41-201 (d) Functional Capacity Screen Accurate d) Designated facility staff shall ensure that each resident ' s functional capacity at the time of screening is accurately reflected on that resident ' s screening form. This REQUIREMENT is not met as evidenced by: KAR 26-41-201(d) The facility reported a census of 45 residents with three residents included in the sample and three focused reviews. Based on interview and record review the operator failed to ensure designated staff ensured the "Functional Capacity Screen" (FCS) for Residents (R) 4, R5, and R6 accurately reflected their functional capacity. Findings included: - Record review for R4 revealed an admission date of 03/10/25 with diagnoses of hypertension and atrial fibrillation. The 08/12/25 "FCS" identified R4 was	S3082		

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NAME OF PROVIDER OR SUPPLIER COLONIAL OAKS AT SPRING HILL		STREET ADDRESS, CITY, STATE, ZIP CODE 22550 S FRANKLIN STREET SPRING HILL, KS 66083		
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S3082	Continued From page 16 independent with dressing, toileting, transfers, and walking/mobility. The 08/12/25 "NSA" identified R4 received physical assistance with dressing, toileting, transfers. On 11/03/25 at 02:18 PM Administrative Staff A stated R4 required physical assistance with dressing, toileting, transfers and confirmed her "FCS" was not accurate. - Record review for R5 revealed an admission date of 08/15/24 with diagnoses of dementia and history of falling. The 08/11/25 "FCS" for R5 cognition score section was blank. On 11/03/25 at 02:32 PM Administrative Nurse B confirmed the cognition section was blank on R5's "FCS." - Record review for R6 revealed an admission date of 03/07/24 with diagnoses of type two diabetes mellitus and disorder of skin and subcutaneous tissue. The 08/12/25 "FCS" for R6 cognition score section was blank. On 11/03/25 at 02:42 PM Administrative Nurse B confirmed the cognition section was blank on R5's "FCS." The 07/15/18 "Resident Assessment and Negotiated Service Agreement" policy documented designated facility staff would	S3082		

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S3082	Continued From page 17 ensure that each resident's capacity was accurately reflected on the screening form. The operator failed to ensure designated staff ensured the ensured the "FCS" for R4, R5, and R6 accurately reflected their functional capacity.	S3082		
S3085 SS=E	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: KAR 26-41-202(a)(1)(2) The facility reported a census of 45 residents with three residents included in the sample and three focused reviews. Based on interview and record review the operator failed to ensure the	S3085		

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S3085	Continued From page 18 "Negotiated Service Agreements" (NSAs) for Residents (R) 1, R3, R4, R5, and R6 described the services they received based on their "Functional Capacity Screens" (FCSs) and R6's "NSA" named the provider for wound care. Findings included: - Record review for R1 revealed an admission date of 08/20/24 with diagnoses of dementia, legal blindness, and Parkinson's Disease. The 08/16/24 "FCS" identified R1 was unable to perform management of treatments. He had short-term memory, memory/recall, and impaired decision-making cognitive difficulties and was marked at risk for impaired vision and impaired decision-making. The 08/26/24 "NSA" failed to describe services R1 received for management of treatments, cognitive difficulties, impaired vision, and impaired decision making. On 10/29/25 at 03:38 PM Administrative Staff A confirmed R1's "NSA" failed to describe the services she received for management of treatments, cognitive difficulties, impaired vision, and impaired decision making. - Record review for R3 revealed an admission date of 12/03/23 with a diagnosis of low back pain. The 12/06/23 "FCS" identified R3 was unable to perform management of treatments. She had short-term and long-term memory,	S3085		

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S3085	Continued From page 19 memory/recall, and impaired decision-making cognitive difficulties. R3 was marked at risk for impaired vision, impaired hearing, and impaired decision-making. The 01/14/24 "NSA" failed to describe services R3 received for management of treatments, cognitive difficulties, and impaired vision, impaired hearing, and impaired decision-making. On 10/29/25 at 03:51 PM Administrative Staff A confirmed R3's "NSA" failed to describe services she received for management of treatments, cognitive difficulties, impaired vision, impaired hearing, and impaired decision making. - Record review for R4 revealed an admission date of 03/10/25 with diagnoses of hypertension and atrial fibrillation. The 08/12/25 "FCS" identified R4 required physical assistance with management of treatments. The 08/12/25 "NSA" failed to describe services R4 received for management of treatments. On 11/03/25 at 02:18 PM Administrative Staff A confirmed R4's "NSA" failed to describe services she received for management of treatments. - Record review for R5 revealed an admission date of 08/15/24 with diagnoses of dementia and history of falling. The 08/11/25 "FCS" identified R5 required physical assistance with toileting, was occasionally incontinent of bladder, and was at	S3085		

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S3085	Continued From page 20 risk for falls and wandering. The cognition score section was blank. The 08/11/25 "NSA" identified R5 was independent with toileting and failed to describe services she received for bladder incontinence. R5 received a wander management system bracelet for wandering. The "NSA" failed to describe the services R5 received for cognitive difficulties, falls, and staff monitoring of wander management bracelet to ensure it remained on. On 11/03/25 at 02:32 PM Administrative Staff A and Administrative Nurse B confirmed R5 required physical assistance with toileting and bladder incontinence. They confirmed her "NSA" failed to describe services R5 received for toileting, bladder incontinence, cognitive difficulties, falls, and staff monitoring of wander management bracelet to ensure it remained on. - Record review for R6 revealed an admission date of 03/07/24 with diagnoses of type two diabetes mellitus and disorder of skin and subcutaneous tissue. The 08/12/25 "FCS" identified R6 was unable to perform management of treatments. The 08/12/25 "NSA" failed to describe the services R6 received for management of treatments. The "NSA" identified R6 received wound care services by a third party provider but failed to name the provider. On 11/03/25 at 02:42 PM Administrative Nurse B confirmed R6's NSA failed to describe the services he received for management of	S3085		

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S3085	Continued From page 21 treatments and failed to name the provider of wound care services. The 07/15/18 "Resident Assessment and Negotiated Service Agreement" policy documented the "NSA" for each resident would provide a description of the services the resident will receive and identify the provider of each service based on the "FCS," service needs, and preferences. The administrator failed to ensure the "NSAs" for R1, R3, R4, R5, and R6 described the services they received and the provider of services on their "FCSs" and R6's "NSA" named the provider for wound care.	S3085		
S3101 SS=E	26-41-202 (h) NSA Signatures (h) Each individual involved in the development of the negotiated service agreement shall sign the agreement. The administrator or operator shall ensure that a copy of the initial agreement and any subsequent revisions are provided to the resident or the resident's legal representative. This REQUIREMENT is not met as evidenced by: KAR 26-41-202(h) The facility reported a census of 45 residents with three residents included in the sample and three focused reviews. Based on interview and record review the operator failed to ensure designated staff ensured each individual	S3101		

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S3101	Continued From page 22 involved in the development of the "Negotiated Service Agreement" (NSA) signed the agreement for Residents (R) 4 and R6. Findings included: - Record review for R4 revealed an admission date of 03/10/25 with diagnoses of hypertension and atrial fibrillation. The 08/12/25 "FCS" identified R4 required physical assistance with bathing and management of medications and treatments. The 08/12/25 "NSA" identified R4 received physical assistance with dressing, toileting, transfers, walking/mobility, and management of medications. The "NSA" failed to describe the services R4 received for treatments. The 08/12/25 "NSA" lacked signatures of the resident and/or their legal representative - Record review for R6 revealed an admission date of 03/07/24 with diagnoses of type two diabetes mellitus and disorder of skin and subcutaneous tissue. The 08/12/25 "FCS" for identified R6 required physical assistance with bathing, dressing, toileting, and was unable to manage medications and treatments and was occasionally incontinent of bladder. The 08/12/25 "NSA" identified R5 received physical assistance by facility staff with bathing, dressing, and toileting. Staff assisted with	S3101		

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S3101	Continued From page 23 management of medications. The "NSA" failed to describe the services R6 received for management of treatments. The 08/12/24 "NSA" lacked signatures of the resident and/or their legal representative. On 11/03/25 at approximately 02:30 PM Administrative Staff A and Administrative Nurse B confirmed the "NSAs" for R4 and R6 were not signed were by all individuals involved in their development. The 07/15/18 facility's "Resident Agreement and Negotiated Service Agreement" policy documented the "NSA" would be printed and signed and dated by the community representative and the resident and/or their legal representative. The operator failed to ensure designated staff ensured each individual involved in the development of the "NSA" signed the agreement for R4 and R6.	S3101		
S3145 SS=E	26-41-203 (e) Routine Maintenance (e) Maintenance. Designated staff shall provide routine maintenance, including the control of pests and rodents, and repairs in each resident's bedroom and common areas inside and outside the facility as specified in the admission agreement. This REQUIREMENT is not met as evidenced by: KAR 26-41-203(e)	S3145		

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S3145	Continued From page 24 The facility reported a census of 45 residents. Based on observation and interview the operator failed to ensure designated staff changed bulbs in a kitchen light and repaired broken window blinds in a resident's room which left her without privacy within sight of the outside including a public walking trail. Findings included: - Observation on 10/28/25 at approximately 09:35 AM revealed a light fixture recessed into the ceiling of the main kitchen area bulbs were out. - On 10/28/25 at approximately 09:35 AM dietary staff K confirmed the light fixture was not working. He stated he did not know if it had been reported to the maintenance director. It was dietary staff M's responsibility to report maintenance issues. - Observation on 10/28/25 at 11:28 AM revealed room #107 window blinds were broken and hanging loosely with large gaps in the view to the outside of the facility. - On 10/28/25 at approximately 11:28 AM Administrative Nurse B stated there was a walking trail outside near the facility. She confirmed the blinds were broken. - The undated facility's "Maintenance" policy documented the facility would perform all necessary routine maintenance and repairs of residents' apartments at their own expense	S3145		

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S3145	Continued From page 25 including repairs in common areas inside and outside of the facility. They may charge residents for repairs related to damage. The operator failed to ensure designated staff repaired broken window blinds in a resident's room which left her without privacy within sight of the outside including a public walking trail.	S3145		
S3171 SS=F	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 facility reported a census of 45 residents with three included in the sample and three focused reviews. Based on observation and interview the operator failed to ensure designated staff provided timely response when residents activated their call button for assistance. Findings included: - On 10/29/25 at 11:27 AM state surveyor activated a call light in Resident (R) 7's room. At 11:39 AM (12 minutes later) Certified Nurse Aide (CNA) E arrived to R7's room and reminded her it was almost time for lunch.	S3171		

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S3171	Continued From page 26 On 10/29/25 at approximately 11:39 AM CNA E stated she was unaware R7's call light was activated and stated she did not have a pager to alert her when residents activated their call buttons for assistance. She stated a pager broke and there were only two working pagers. At 11:40 AM Certified Medication Aide (CMA) G stated she did not have a pager. At 11:40 AM CNA F stated she had a pager but was not aware R7's call light was activated until she pulled the pager out of her pocket and checked it. The pager was set to "buzz" but she did not feel it. At 11:42 AM Administrative Nurse B stated the facility had four or five pagers. An extra one was on her desk to use for back up. Observation on 10/29/25 at 11:42 PM revealed Administrative Staff B instructed three staff members present On 10/29/25 at 11:57 AM Administrative Nurse B stated she found two pagers on the dining table in the memory care unit and another pager in a cabinet. They were functioning, set to ring, and assigned to staff present in the facility. On 10/29/25 at 10:10 AM during a phone interview, an unidentified family member of a resident stated the failure to answer call lights timely was an on-going issue. Staff always had an excuse why the call lights had not been answered.	S3171		

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S3171	Continued From page 27 The operator failed to ensure designated staff provided timely response when residents activated their call button for assistance.	S3171		
S3215 SS=F	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 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.	S3215		

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NAME OF PROVIDER OR SUPPLIER COLONIAL OAKS AT SPRING HILL		STREET ADDRESS, CITY, STATE, ZIP CODE 22550 S FRANKLIN STREET SPRING HILL, KS 66083		
(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 28 This REQUIREMENT is not met as evidenced by: KAR 26-41-205(h)(1) The facility reported a census of 45 residents. Based on observation and interview, the operator failed to ensure designated staff stored controlled medications in separately locked compartments within a locked medication room, cabinet, or medication cart. Findings included: - Observation on 10/28/25 at 11:07 AM revealed a small, unlocked refrigerator in a room with the door left open and unlocked. There were controlled medications inside the refrigerator that were not stored in a locked compartment. The medications were accessible to anyone without keys including all staff, residents, and visitors. On 10/28/25 at approximately 11:07 AM Certified Medication Aide (CMA) G confirmed the controlled medications were locked and accessible to anyone without keys including all staff, residents, and visitors. On 10/28/25 at approximately 11:07 AM Administrative Nurse B confirmed the controlled medications were locked and accessible to anyone without keys including all staff, residents, and visitors. The 07/15/18 facility's "Medication Storage of	S3215		

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S3215	Continued From page 29 Centrally Stored Medications" policy documented all medications were always kept in locked storage. Controlled medications were stored in separately locked compartments within a locked medication room, cabinet, or cart. Only licensed nurses and medication aides would have access to stored medications. The operator failed to ensure designated staff stored controlled medications in separately locked compartments within a locked medication room, cabinet, or medication cart.	S3215		
S3216 SS=F	26-41-205 (i) Disposition of Medication (i) Accountability and disposition of medications. Licensed nurses and medication aides shall maintain records of the receipt and disposition of all medications managed by the facility in sufficient detail for an accurate reconciliation. (1) Records shall be maintained documenting the destruction of any deteriorated, outdated, or discontinued controlled medications and biologicals according to acceptable standards of practice by one of the following combinations: (A) Two licensed nurses; or (B) a licensed nurse and a licensed pharmacist. (2) Records shall be maintained documenting the destruction of any deteriorated, outdated, or discontinued non-controlled medications and biologicals according to acceptable standards of practice by any of the following combinations: (A) Two licensed nurses; (B) a licensed nurse and a medication aide; (C) a licensed nurse and a licensed pharmacist; or (D) a medication aide and a licensed pharmacist.	S3216		

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S3216	Continued From page 30 This REQUIREMENT is not met as evidenced by: KAR 26-41- 205(i)(1) The facility reported a census of 45 residents. Based on observation and interview the operator failed to ensure designated staff maintained records of controlled medications for accurate reconciliation. Findings included: - Observation on 10/28/25 at 03:57 PM revealed Certified Medication Aide (CMA) G unlocked and opened medication cart #2 which contained medications for the residents. Inside the medication cart was a separate locked compartment which contained controlled medications. One liquid bottle of lorazepam had 14.0 milliliters (mL) of medication. Review of the medication reconciliation count sheet revealed facility staff documented the liquid lorazepam had 16.0 mL of medication. On 10/28/25 at approximately 03:57 PM CMA G confirmed there were 2.0 mL missing and the morning shift count was incorrect. The off-going CMA reported to her the bottle had leaked and the nurse was aware. On 10/28/25 at approximately 03:59 PM Administrative Nurse B confirmed the lorazepam bottle was missing 2.0 mL of medication that was	S3216		

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S3216	Continued From page 31 unaccounted for. She was not aware the bottle had leaked out medication. Observation on 10/28/25 at approximately 10:54 AM revealed CMA L unlocked and opened the memory care medication cart which contained medications for the residents. Inside the medication cart was a separate locked compartment which contained controlled medications. On 10/28/25 at approximately 10:54 AM CMA L stated one box of lorazepam was not in the medication cart because it was in the medication storage refrigerator. She did not count the mL of lorazepam during shift change with the off-going CMA because the refrigerator was outside of the memory care unit on the assisted living side. The operator failed to ensure designated staff maintained records of controlled medications for accurate reconciliation.	S3216		
S3270 SS=F	26-41-104 (b) Written Emergency Plan (b) Each administrator or operator shall ensure the development of a detailed written emergency management plan to manage potential emergencies and disasters, including the following: (1) Fire; (2) flood; (3) severe weather; (4) tornado; (5) explosion; (6) natural gas leak; (7) lack of electrical or water service; (8) missing residents; and	S3270		

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S3270	Continued From page 32 (9) any other potential emergency situations. This REQUIREMENT is not met as evidenced by: KAR 26-41-104(b)(8) The facility reported a census of 45 residents. Based on interview and record review the operator failed to ensure the written emergency management plan included how to manage a potential emergency if a resident went missing from the facility. Findings included: - Review of the facility's emergency management plan lacked evidence of a detailed written plan to manage a missing resident emergency. On 10/28/25 at 01:15 PM Administrative Staff A confirmed the emergency management plan failed to include missing residents. The undated facility's "Disaster and Emergency Preparedness" policy documented the operator ensured the development of a detailed written emergency management plan to manage potential emergencies including missing residents. The operator failed to ensure the written emergency management plan included how to manage a potential emergency if a resident went missing from the facility.	S3270		

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S3280 SS=F	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) The facility reported a census of 45 residents. Based on interview and record review the operator failed to provide evidence of documentation reviews of the facility's emergency management plan covered all eight required topics with residents every quarter. Findings included: - Review of the facility's emergency management plan from 3/25/24 to 10/28/ lacked	S3280		

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S3280	Continued From page 34 evidence of documentation reviews of the facility's emergency management plan covered all eight required topics with residents every quarter. On 04/14/25 at approximately 01:18 PM Administrative Staff A confirmed facility records lacked evidence of documentation reviews of the facility's emergency management plan covered all eight required topics with residents every quarter. The undated facility's "Disaster and Emergency Preparedness" policy documented each administrator or operator would ensure quarterly reviews of the facility's emergency management plan with residents. The operator failed to provide evidence of documentation reviews of the facility's emergency management plan covered all eight required topics with residents every quarter.	S3280		
S3298 SS=F	26-41-206 (d) Food Preparation (d) Food preparation. 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 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	S3298		

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S3298	Continued From page 35 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 26-41-206(d) The facility reported a census of 45 residents. The facility had a main kitchen where dietary staff stored, prepared, and served food and a satellite kitchen where food was served. Based on observation and interview the operator failed to ensure dietary staff documented food temperatures. Findings included: - Observation on 10/28/25 at approximately 09:35 AM revealed the facility's kitchen where dietary staff stored, prepared, and served food for the residents. Review of the "Food Temperature Log" on 10/28/25 revealed it was in table form with columns for each meal for each day of the week and rows for each meal item. Ror example: eggs, hot cereal, protein #1, #2, and #3, starch #1 and #2, vegetable #1 and #2, soup, dessert, hot beverage and cold beverage. Across the top of the log were handwritten numbers 20 - 29 that appeared to correspond to days of the month. The log lacked month and year labels.	S3298		

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S3298	Continued From page 36 The "Food Temperature Log" from 10/20/25 - 10/29/25 revealed the following: 10/22/25 - breakfast: eggs were 171 degrees Fahrenheit (F), protein #1 was 180 degrees F, starch #1 was 187 degrees F, hot beverage was 200 degrees F, and cold beverage was 200 degrees F. The cold beverage for breakfast was not in normal range for cold food items. 10/22/25 - lunch: protein #1 was 175 degrees F. All other items were blank. 10/22/25 - dinner: all rows for meal items were blank. 10/23/25 - breakfast: eggs were 171 degrees F. All other rows for breakfast food items were blank. Lunch and dinner lacked food temperatures. 10/24/25 - 10/28/25 lacked food temperatures for all meals. 10/29/25 (one day in the future at time of review) - breakfast lacked food temperatures. Lunch: protein #1 was 202 degrees F, starch #1 was 145 degrees F, vegetable #1 was 210 degrees, hot beverage was 200 degrees F, and cold beverage was 35 degrees F. Rows for mechanical soft and pureed specialized diets were all blank. On 10/30/25 the "Food Temperature Log" was requested a second time. Review of the log revealed the same food temperatures with	S3298		

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S3298	Continued From page 37 following changes: Handwritten at the top was the month and year. 10/22/25 - lunch: temperatures added for vegetable #1, hot beverage and cold beverage. 10/23/24 - breakfast: temperatures added for protein #1, hot beverage, and cold beverage. 10/24/25 - 10/26/25: temperatures added for protein #1, hot beverage, and cold beverage for all three meals, eggs for breakfast, and vegetable #1 for lunch and dinner. The rows for mechanical soft diet had handwritten numbers at the top: 27, 28, 29, 30, 31 that appeared to correspond to days of the month. Temperatures were added for protein, starch and vegetable for three meals each day with dessert temperatures added for lunch and dinner on 10/27/25. The page for 10/27/25 - 10/30/25 was missing. State surveyor requested the missing page which the facility failed to provide. On 10/28/25 at approximately 09:35 AM dietary staff K stated he did not obtain temperatures of food items for breakfast. He confirmed the food temperature log lacked temperatures from 10/22/25 to present. On 10/29/25 at 03:06 PM Administrative Nurse B stated no residents were on a mechanical soft diet or any other specialized diet. The undated facility's "Temping of Food During	S3298		

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S3298	Continued From page 38 Food Preparation" policy documented prior to service all hot and cold foods would be temped to ensure were the appropriate temperature. The "Dietary Guidelines for Americans 2005 recommended to make sure food was cooked to and held at proper temperatures and to keep cold food cold. Keep food out of the "danger zone" (40 degrees Fahrenheit to 140 degrees Fahrenheit) where bacteria can multiply rapidly. The operator failed to ensure dietary staff documented food temperatures.	S3298		
S3299 SS=F	26-41-206 (e) (1) Facility Food Storage (e) Food storage. Facility staff shall store all food under safe and sanitary conditions. (1) Containers of poisonous compounds and cleaning supplies shall not be stored in the areas used for food storage, preparation, or serving. This REQUIREMENT is not met as evidenced by: KAR 26-41-206(e) The facility reported a census of 45 residents. Based on observation and interview the operator failed to ensure designated staff stored food items under safe conditions. Findings included: - Observation on 10/28/25 at approximately	S3299		

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S3299	Continued From page 39 09:35 AM of the facility's main kitchen revealed the following: A cardboard box on the floor had packages of Hawaiian rolls inside with half of the packages missing. One of the packages' plastic covering was twisted shut but lacked a tie to ensure it remained closed. On the floor next to the box of rolls and touching it on one corner, was a large multi-mouse mouse trap. Also next to the box of rolls was a blower with three soiled and dried towels. A shelving rack with large cans had dark-colored debris scattered on the floor in the corners behind the rack that appeared had not been recently cleaned. Reach-in refrigerator #1 had a water puddle on the bottom shelf. A cardboard box sat in the water with 27 individually paper-wrapped 1-pound size packages of butter. The box appeared soaked over the entire bottom. Three packages of butter appeared to have mold growth. Reach-in refrigerator #2 contained the following items: One fresh whole watermelon on the bottom shelf with a thawing/thawed log of raw ground meat which was not in a pan. One bag of garlic bread that was open and unsealed. One package with 14 muffins inside that was open and unsealed. One package of five other muffins inside that was open and unsealed.	S3299		

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S3299	Continued From page 40 On 10/28/25 at approximately 09:25 AM Administrative Staff H stated the mouse trap was last checked on 08/07/25 (82 days prior) by an outside pest control company. He confirmed the butter in refrigerator #1 appeared to be moldy and garlic bread and muffins in refrigerator #2 were opened and unsealed and a fresh watermelon intended to be eaten uncooked was on the same shelf as thawed/thawing meat. Observation on 10/28/25 at 11:20 AM of the memory care kitchen revealed a refrigerator that contained food items for the residents. A temperature log posted on the outside of the refrigerator lacked temperatures for 24 out of 27 days so far in October. On 10/28/25 at approximately 11:20 AM Administrative Nurse B confirmed the refrigerator temperature log in the memory care lacked temperatures for 24 out of 27 days so far in October. The undated facility's "Food Storage" policy documented dry or staple food items would be stored at least six inches above the floor on clean surfaces to protect the food from contamination. Food not subject to entry of water would not be stored in contact with water or undrained ice. Raw meats were stored on the bottom shelf in a pan deep enough to prevent contamination of other foods. If food went out of appropriate temperature, it must be discarded. The operator failed to ensure designated staff stored food items under safe conditions.	S3299		

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S3310	Continued From page 41	S3310		
S3310 SS=F	26-41-207 (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; 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: KAR 26-41-207(c) The facility reported a census of 45 residents with three residents included in the sample and three closed record reviews. Based on interview and record review the operator failed to ensure the facility remained in compliance with the department's tuberculosis (TB) guidelines for adult care homes adopted by reference in KAR 26-39-105 for three residents and one of five sampled staff. Findings included: - Record review for Resident (R) 4 revealed an	S3310		

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S3310	Continued From page 42 admission date of 03/10/25 with diagnoses of hypertension and atrial fibrillation. R4's record lacked evidence of documentation of a TB symptom screen questionnaire within seven days of admission. - Record review for R5 revealed an admission date of 08/15/24 with diagnoses of dementia and history of falling. R5's record lacked evidence of documentation of a TB symptom screen questionnaire within seven days of admission. - Record review for R6 revealed an admission date of 03/27/24 with diagnoses of type two diabetes mellitus and disorder of skin and subcutaneous tissue. R6's record lacked evidence of documentation of a TB symptom screen questionnaire within seven days of admission. On 11/03/25 at 01:48 PM Administrative Staff A confirmed the facility did not complete TB symptom screen questionnaire for any residents within seven days of admission. - Review of Certified Medication Aide (CMA) D's employee record revealed a hire date of 06/23/25. His record lacked evidence of documentation of a TB symptom screen questionnaire within seven days of hire. On 10/29/25 at approximately 03:08 PM Administrative Staff A confirmed CMA D's employee record lacked evidence of	S3310		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046066	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/03/2025
NAME OF PROVIDER OR SUPPLIER COLONIAL OAKS AT SPRING HILL		STREET ADDRESS, CITY, STATE, ZIP CODE 22550 S FRANKLIN STREET SPRING HILL, KS 66083		
(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
S3310	Continued From page 43 documentation he completed two-step TB skin test within seven days of hire. The undated facility's "Infection Control-Tuberculosis" policy documented that each resident would have an annual TB symptom screen questionnaire, and each new employee would have initial TB testing unless satisfactory documentation was provided within six months prior to employment. The policy failed to address TB symptom screen questionnaires for new residents. The June 2013 department's "Tuberculosis (TB) Guidelines for Adult Care Homes" documented each new employee and each new resident shall receive a two-step TB skin test and symptom screen questionnaire within seven days of employment or admission. The operator failed to ensure the facility remained in compliance with the department's tuberculosis guidelines for adult care homes adopted by reference in KAR 26-39-105.	S3310		
S3320 SS=F	28-39-254 CONSTRUCTION (a) The assisted living facility or residential health care 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	S3320		

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S3320	Continued From page 44 the state fire marshal. (c) New construction, modifications and equipment shall conform to the following codes and standards: (1) Title III of the Americans with disabilities act, 42 U.S.C. 12181, effective as of January 26, 1992; and (2) "Food Service Sanitation Manual," health, education, and welfare (HEW) publication no. FDA 78-2081, as in effect on July 1, 1981. This REQUIREMENT is not met as evidenced by: KAR 28-39-254(a) The facility reported a census of 45 residents. Based on observation and interview the operator failed to ensure the facility was maintained to protect the health and safety of the residents and visitors by ensuring all chemicals were stored within locked areas. Findings included: - Observation on 10/28/25 at approximately 10:11 AM revealed an unlocked door to enter the laundry area. A cabinet under the sink's lock mechanism was unsecured. A sign on the cabinet read "Leave cabinet door locked at all times." The unlocked cabinet contained the following chemicals with labels that read "Keep out of reach of children:" Two quart-sized spray bottles of glass cleaner	S3320		

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S3320	Continued From page 45 One quart-sized spray bottle of bathroom cleaner One quart-sized spray bottle of multi-purpose cleaner One spray can of stainless steel cleaner. On 10/28/25 at approximately 10:11 AM Administrative Staff H confirmed the chemicals in the laundry area were stored in an unlocked location. Observation on 10/28/25 at approximately 10:19 AM revealed an unlocked cabinet in the activities area with the following chemicals with labels that read "Keep out of reach of children:" One quart-sized bottle of neem oil fungicide, insecticide, miticide One bottle of Miracle Grow garden fertilizer On 10/28/25 at approximately 10:11 AM Administrative Staff H confirmed the chemicals in the activities area were stored in an unlocked location. Observation on 10/28/25 at approximately 11:20 AM revealed an unlocked cabinet under the sink in the kitchen of the memory care unit. The unlocked cabinet contained the following chemicals: Two spray bottles of odor counteractant with a label that read "Keep out of reach of children" One unlabeled spray bottle that contained a peach-colored clear liquid One unlabeled spray bottle that contained a red-colored clear liquid One spray bottle of disinfectant with a loose lid that was empty and dripped out clear liquid One gallon of Shurguard Plus disinfectant with a label that read "Keep out of reach of children"	S3320		

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S3320	Continued From page 46 One gallon of blue-colored clear dishwashing liquid On 10/28/25 at approximately 11:20 AM Administrative Nurse B confirmed the memory care unit had unlocked chemicals under the kitchen sink. The operator failed to ensure the building was maintained to protect the health and safety of the residents and visitors by ensuring all chemicals were stored within locked areas.	S3320		
S9999	Final Observations KSA 39-928 Upon receipt of an application for license, the licensing agency with the approval of the state fire marshal shall issue a license if the applicant is fit and qualified and if the adult care home facilities meet the requirements established under this law. A license, unless sooner suspended or revoked, shall remain in effect upon filing by the licensee, and approval by the licensing agency and the state fire marshal or their duly authorized agents, of an annual report upon such uniform dates and containing such information in such form as the licensing agency prescribes and payment of an annual fee. S/S level F Findings included: Department records revealed the facility failed to file and pay the 2024 annual renewal licensing	S9999		

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S9999	Continued From page 47 fees. Interview on 10/28/25 at 12:18 PM with Administrative Staff A confirmed the facility had been working with the department on the facility's failure to provide the required requested information to the department, and the further failure to pay the renewal fee to the department for 2024. The facility failed to file and pay the 2024 annual renewal licensing fee to the department as required by KSA 39- 928.	S9999		