STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N063016	A. BUILDING: _____ B. WING _____	11/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAN VILLAS COFFEYVILLE ON 8TH	2904 W 8TH COFFEYVILLE, KS 67337

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS The following citations represent the findings of the licensure resurvey with attached complaint numbers 196639, 196368, 191432, and 190580 for the above named facility conducted on 11/03/25 and 11/04/25.	S 000		
S3026 SS=D	26-41-101 (f) (1) Staff Treatment of Residents ANE (f)The administrator or operator shall ensure that all of the following requirements are met: (1) No resident shall be subjected to any of the following: (A) Verbal, mental, sexual, or physical abuse, including corporal punishment and involuntary seclusion; (B) neglect; or (C) exploitation. This REQUIREMENT is not met as evidenced by: K.A.R. 26-41-101 (f) (1) (A) The facility reported a census of 29 residents. The sample included 3 "Residents'" (R)'s 1, 2, 3, and two closed record reviews for R4 and R5. Based on interview and record review, the Operator failed to protect R1 from verbal abuse from "Certified Medication Aide" (CMA) D, when R1 became upset that she missed an activity and yelled at CMA D and then R1 left the common area. CMA D followed R1 to her private room and yelled at R1 when another staff member came to R1's room to try and stop CMA D from continuing to yell at R1.	S3026		

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

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S3026	Continued From page 1 Findings included: - Record review for R1 revealed an admission date of 05/01/22 with diagnoses of vascular dementia, unspecified dementia, chronic diastolic congestive heart failure, and type two diabetes mellitus. Review of R1's "Functional Capacity Screen" (FCS) dated 10/14/24 revealed R1 was independent with bathing, transferring, walking/mobility, and eating. R1 required physical assistance with dressing and the management of her medications. R1 was occasionally incontinent and had impaired short-term memory, memory/recall and impaired decision making. R1 was able to make herself understood and she understood others. R1 used a walker and brace mobility devices. Review of R1's combined "Negotiated Service Agreement" (NSA) / "Health Service Plan" (HSP) dated 10/14/24 under the section titled "F.1 Memory Care" facility staff were instructed to put her physician appointments on her "board" due to R1 stated she did not remember when her appointments were. Under the section titled "Behavior Management" the following was typed "resident get's upset at times if she forgets something or if she thinks staff hasn't reminded her of things". R1's combined NSA/HSP lacked documentation of health services for staff to provide when R1 became upset over forgetting "things".	S3026		

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S3026	Continued From page 2 Review of R1's electronic "Medical Record" under the "Progress Notes" tab revealed the following entry: The 07/24/22 at 12:09 PM, "Administration Note" revealed that the writer of the note met with R1 to discuss the event that led to the allegation of abuse. R1 was frustrated about missing the activity and was mad and CMA D for yelling at her. R1 continued to tell the writer that she went to her room to calm down and staff "had been in her space". Review of the facility provided document titled "Reporting Facility" revealed the facility's full investigation that substantiated the allegation of abuse from CMA D to R1. The facility actions included: On 07/22/25 CMA D was suspended pending the investigation. On 07/24/24 CMA D was terminated for verbal abuse to R1. On 07/23/25 facility training on Abuse Neglect and Exploitation was provided to all staff. De-Escalation training was completed by 07/31/25 for all staff. The Operator failed to protect R1 from verbal abuse from CMA D, when R1 became upset that she missed an activity and yelled at CMA D and then R1 left the common area. CMA D followed R1 to her private room and yelled at R1 when another staff member came to R1's room to try and stop CMA D from continuing to yell at R1.	S3026		

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S3156	Continued From page 3	S3156		
S3156 SS=D	26-41-204 (b) Health Care Services (b) If the functional capacity screening indicates that a resident is in need of health care services, a licensed nurse, in collaboration with the resident, the resident ' s legal representative, the case manager, and, if agreed to by the resident or resident ' s legal representative, the resident ' s family, shall develop a health care service plan to be included as part of the negotiated service agreement. This REQUIREMENT is not met as evidenced by: K.A.R. 26-41-204 (b) The facility reported a census of 29 residents. The sample included 3 "Residents'" (R)'s 1, 2, 3, and two closed record reviews for R4 and R5. Based on interview and record review, the Operator failed to ensure health care services were developed and included in the "Negotiated Service Agreement" (NSA) for R3 when she was identified at risk for falls on the screening that determined her functional capacity. Findings included: - Record review for R3 revealed an admission date of 06/19/25 with diagnoses of type two diabetes mellitus, hypertension, atherosclerotic heart disease, and dysphagia.	S3156		

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S3156	Continued From page 4 Review of R3's FCS dated 06/19/25 revealed R3 required supervision with bathing and dressing. R3 was independent with toileting, transferring, walking, eating and the management of her medications. R3 was identified for being at risk for falls and had impaired hearing. R3 used a walker mobility device. Review of R3's combined NSA/HSP dated 06/19/25 instructed the facility staff to provider supervision for R3 for bathing and dressing. R3 preferred the facility to administer and manage her mediations. The section titled "Fall Interventions" had "None" documented. Review of R3's electronic "Medical Record" under the "Progress Notes" tab revealed the following entries; On 08/21/25 at 09:39 PM a "Fall Note" revealed R3 had become dizzy and lost her balance and had a witnessed fall after returning to the facility from having an eye procedure performed. It was documented that if resident had any other eye procedures the family would assist R3 to her room. Interview on 11/04/25 at approximately 04:30 PM with Operator A. Licensed Nurse B, and Regional Vice President Registered Nurse C, confirmed R3's NSA lacked health care services when R3's FCS identified R3 at risk for falls. The Operator failed to ensure health care services were developed and included in the NSA for R3 when she was identified at risk for falls on the screening that determined her	S3156		

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S3156	Continued From page 5 functional capacity.	S3156		
S3171 SS=E	26-41-204 (i) Health Care Services Standards of Practice (i) All health care services shall be provided to residents by qualified staff in accordance with acceptable standards of practice. This REQUIREMENT is not met as evidenced by: K.A.R. 26-41-204 (i) The facility reported a census of 29 residents. The sample included 3 "Residents'" (R)'s 1, 2, 3, and two closed record reviews for R4 and R5. Based on observation, interview and record review, the Operator failed to ensure health care services were provided within professional standards of practice when the Operator failed to ensure the bed assist device for R2 was securely attached to the bed. The Operator further failed to provide health care services within professional standards of practice for R3 when the Operator failed to ensure R3's "Negotiated Service Agreement" (NSA) contained a description of the bed assist device, the purpose of the bed assist device, and any special instructions on use and monitoring of the bed assist device. Findings included: - Record review for R2 revealed an admission date of 05/01/22 with diagnoses of heart failure,	S3171		

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S3171	Continued From page 6	S3171		

chronic obstructive pulmonary disease, unspecified dementia, and insomnia.

Review of R2's "Functional Capacity Screen" (FCS) dated 05/07/25 revealed R2 required physical assistance with bathing and her medications. R2 was independent with dressing, toileting, transferring, and walking/mobility. R2's cognition was intact, and she was able to make herself understood and she understood others. R2 was at risk for falls and had impaired hearing. R2 used a walker and wheelchair mobility device. In the "Comments" section it was typed that R2 had a bed cane to assist with bed mobility.

Review of R2's combined NSA/"Health Service Plan" (HSP) dated 05/27/25 under the section titled "Ambulation and Transfer Needs, Preferences and Frequency" instructed facility staff that R2 was independent with bed mobility and transferred from the bed with the use of a bed assist rail.

Observation on 11/04/25 at approximately 03:00 PM of R2's bed revealed the head of the bed sat against the east wall of the room. On the northeast side of the bed was an inverted "U" shaped device that slid under the mattress and measured approximately 20 inches in width between the two legs of the "U" shaped device, and 18 inches in height. The device freely moved when pulled. On the southeast side of the bed was an inverted "U" shaped device that slid under the mattress and measured approximately 11.5 inches between the two legs of the "U" shaped device and was approximately 19.5 inches in height. The device was securely

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S3171	Continued From page 7	S3171		

attached to the bed and there was a nylon pocket in place over the approximately 11.5-inch space.

Interview on 11/04/25 at approximately 03:00 PM with "Licensed Nurse" (LN) B confirmed the bed assist device on the northeast side of R2's bed was not securely attached to the bed.

- Record review for R3 revealed an admission date of 06/19/25 with diagnoses of type two diabetes mellitus, hypertension, atherosclerotic heart disease, and dysphagia.

Revie of R3's FCS dated 06/19/25 revealed R3 required supervision with bathing and dressing. R3 was independent with toileting, transferring, walking, eating and the management of her medications. R3 was identified for being at risk for falls and had impaired hearing. R3 used a walker mobility device.

The "Comments" section of R3's FCS lacked documentation of R3 having a bed assist device.

Review of R3's combined NSA/HSP dated 06/19/25 instructed the facility staff to provider supervision for R3 for bathing and dressing. R3 preferred the facility to administer and manage her mediations.

R3's combined NSA/HSP lacked documentation of a description of the bed assist device, the purpose of the bed assist device, and any special instructions on use and monitoring of the bed assist device.

Observation on 11/04/25 at approximately 03:15 PM of R3's bed revealed the head of the bed sat

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S3171	Continued From page 8 against the east wall of the room with one side of the bed against the southeast wall. On each side of the bed there were bed assist devices that were securely attached to the frame of the bed that measured approximately 25 inches in width and 17.5 inches in height. There were no large openings that posed a risk for entrapment. Interview on 11/04/25 with Operator A, LN B, and Regional Vice President Registered Nurse C confirmed R3's NSA lacked a description of the bed assist device, the purpose of the bed assist device, and any special instructions on use and monitoring of the bed assist device. The FDA (food and drug administration) "Bedrails in Assisted Living, Residential Health Care and Home Plus Facilities" recommended the following: Complete an assessment of the resident to confirm that the device is not a restraint. Complete an assessment of the resident to determine the purpose of the device and the resident's ability to safely use the device and document the findings in the resident's record. Complete an assessment of the device using the recommendations in the FDA guidance to ensure the device is securely attached to the bed or bedframe and poses no risk for entrapment and document the findings in the resident record. If the purpose of the device is to assist the resident with transfers, the FCS should document the resident's functional capacity based on the use of the device and should be	S3171		

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S3171	Continued From page 9 listed in the comments section. Include a description of the device, its purpose and special instructions on use and monitoring in the resident's NSA. Document periodic reassessments of the resident's use of the device and their ability to use it safely and reassessment of the safety of the device in the resident's record. The Operator failed to ensure health care services were provided within professional standards of practice when the Operator failed to ensure the bed assist device for R2 was securely attached to the bed. The Operator further failed to provide health care services within professional standards of practice for R3 when the Operator failed to ensure R3's NSA contained a description of the bed assist device, the purpose of the bed assist device, and any special instructions on use and monitoring of the bed assist device.	S3171		