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	N087088	A. BUILDING: _____ B. WING _____	11/18/2025

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OXFORD VISTA SENIOR LIVING	402 S MARTINSON STREET WICHITA, KS 67213

(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 197363, 197345, 197342, 197188, 197331, 197349, 197329, 197158, 196930, 196885, 196499, 196311, 196268, 196307, 196125, 197422, 197381, 197382, 197392, and 197377 at the above named assisted living conducted on 11/12/25, 11/13/25, 11/17/25, 11/18/25.	S 000		
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) The facility reported a census of 68 residents	S3085		

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

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with six residents included in the sample and nine focused reviews. Based on interview and record review the operator failed to ensure the "Negotiated Service Agreements" (NSAs) for Residents (R) 101, R106 and R107 described the services they received based on their "Functional Capacity Screens" (FCSs).

Findings included:

- Record review for R101 revealed an admission date of 03/07/25 with a diagnosis of dementia.

The 03/07/25 "FCS" (most recent made available to surveyors) failed to identify R101 was at risk for wandering and behaviors.

The 03/04/25 "NSA" (most recent signed "NSA" made available to surveyors) documented in the "Elopement Risk" section R101 would receive encouragement by staff to stay in the common area. The "NSA" failed to describe services R101 received for wandering behavior when she attempted to go into other residents' rooms.

The 10/08/25 at 05:00 PM "Incident Note" by Administrative Nurse D documented R101 wandered on the memory care unit and attempted to open the doors to other residents' rooms. She repeatedly opened and closed the door of a resident's room. The resident asked R101 several times to leave her room and became increasingly upset when R101 did not leave. The resident pushed R101 down and she suffered a skin tear on her right elbow. Staff intervened and separated R101 and the other resident. The nurse assessed R101 and notified

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her family and the nurse practitioner about the incident.

On 11/18/25 at approximately 04:35 PM Administrative Nurse C confirmed R101's "NSA" made available to surveyors failed to describe the services she received for wandering and disruptive behaviors.

- Record review for R106 revealed an admission date of 07/12/24 with a diagnosis of Alzheimer's disease.

The 01/29/25 and 07/25/25 "FCSs" identified R106 required physical assistance with management of medications.

The 01/29/25 "NSA" (most recent signed "NSA" made available to surveyors) failed to describe the services R106 received for management of medications.

On 11/18/25 at 05:01 PM Administrative Nurse C confirmed R106's "NSA" made available to surveyors failed to describe the services R106 received for management of medications.

- Record review for R107 revealed an admission date of 09/25/24 with a diagnosis of dementia.

The 03/25/25 "FCS" identified 107 required physical assistance with management of medications and treatments.

The 04/01/25 "NSA" (most recent signed "NSA" made available to surveyors) failed to describe the services she received for management of treatments.

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S3085	Continued From page 3 On 11/18/25 at 05:05 PM Administrative Nurse C confirmed R107's "NSA" failed to describe the services she received for management of treatments. The 10/21/23 "Assessment and Service Plan" policy documented each resident's individualized assistance plan would contain documentation at a minimum of what and how care/services would be provided with an expected outcome. The administrator failed to ensure the "NSAs" for R101, R106 and R107 described the services they received based on their "FCSs."	S3085		
S3092 SS=E	26-41-202 (d) Negotiated Service Agreement Revisions (d) Each administrator or operator shall ensure the review and, if necessary, revision of each negotiated service agreement according to the following requirements:(1) At least once every 365 days; (2) following any significant change in condition, as defined in K.A.R. 26-39-100; (3) at least quarterly, if the resident receives assistance with eating from a paid nutrition assistant; and (4) if requested by the resident or the resident ' s legal representative, facility staff, the case manager, or, if agreed to by the resident or the resident ' s legal representative, the resident ' s family. This REQUIREMENT is not met as evidenced by:	S3092		

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S3092	Continued From page 4 KAR 26-41-202(d)(1)(2) The facility reported a census of 68 residents. Based on interview, and record review the administrator failed to ensure the "Negotiated Service Agreement" (NSA) was revised annually for Resident (R)115 and revised after a significant change in condition for R101. Findings included: - R115's medical record revealed she moved into the facility on 07/22/24 with a diagnosis of dementia. An annual "Functional Capacity Screen" (FCS) was completed on 07/11/25. The most recent signed NSA completed for R115 was dated 12/09/24. On 11/19/25 at 03:16 PM an email response from Administrative Staff B confirmed the facility did not have a signed NSA that corresponded to the annual FCS completed on 07/17/25 for R115. The administrator failed to ensure R101's NSA was updated annually.	S3092		
S3101 SS=D	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	S3101		

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S3101	Continued From page 5 representative. This REQUIREMENT is not met as evidenced by: KAR 26-41-202(h) The facility reported a census of 68 residents. Based on interview, and record review the administrator failed to ensure the "Negotiated Service Agreement" (NSA) for resident (R)112 was signed by all individuals involved in the development of the NSA. Findings included: - R112's medical record revealed he moved into the facility on 04/30/25 with a diagnosis of hemiplegia. The 04/30/25 NSA lacked documentation of signatures of those who developed/participated in the NSA. On 11/18/25 at 04:21 PM Administrative Nurse C confirmed R112's NSA was not signed by all individuals involved in the development of his admission NSA The "Assessment and Service Plan" policy revised 10/21/23 documented, "The...resident's individualized assistance plan...shall contain documentation of the...dated signature of the Licensed Nurse, the Director, and the resident or the resident's responsible party."	S3101		

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S3101	Continued From page 6 The administrator failed to ensure R112's NSA was signed by all individuals involved in the development of the NSA.	S3101		
S3165 SS=E	26-41-204 (d) Health Care Services (d) The negotiated service agreement shall contain a description of the health care services to be provided and the name of the licensed nurse responsible for the implementation and supervision of the plan. This REQUIREMENT is not met as evidenced by: KAR 26-41-204(d) The facility reported a census of 68 residents with six included in the sample and nine focused reviews. Based on interview and record review the administrator failed to ensure the "Negotiated Service Agreement" (NSAs) for Residents (R) 101, R106, R107, R114, and R115 named the licensed nurse responsible for implementing and supervising their "Healthcare Service Plans" (HSP). Findings included: - Record review for R101 revealed an admission date of 03/07/25 with a diagnosis of dementia. The 03/07/25 "Functional Capacity Screen " (FCS) (most recent made available to surveyors) identified R101 required physical assistance with management of medications and treatments. She	S3165		

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had short-term and long-term memory, memory/recall, decision-making cognitive difficulties and was at risk for falls and impaired decision-making. The "FCS" failed to document R101 was at risk for wandering.

The 03/24/25 "NSA" (most recent signed "NSA" made available to surveyors) identified facility staff provided R101 assistance with management of medications and provided scheduled treatments per physician's orders. Staff provided reminders to R101 for cognitive difficulties, encouragement to stay in common area, safety checks every two to three hours, and to observe her location in the facility for falls and elopement risk. R101 had a power of attorney (POA) for impaired decision-making.

R101's "NSA" documented LN H was "responsible for the implementation and supervision of the plan."

- Record review for R106 revealed an admission date of 07/12/24 with a diagnosis of Alzheimer's disease.

The 01/29/25 and 07/25/25 "FCSs" identified R106 required physical assistance with bathing and management of medications and treatments. He had short-term memory, memory/recall, and decision-making cognitive difficulties and was at risk for impaired decision-making. Both "FCSs" failed to document R106 was at risk for wandering.

The 01/29/25 "NSA" (most recent signed "NSA" made available to surveyors) identified facility staff provided R106 assistance with bathing and

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provided scheduled treatments per physician's orders. Staff provided reminders to R106 for cognitive difficulties and observed his location in the facility and provided safety checks every two to three hours for elopement risk. R106 had a POA for impaired decision-making

R106's "NSA" documented LN H was "responsible for the implementation and supervision of the plan."

- Record review for R107 revealed an admission date of 09/25/24 with a diagnosis of dementia.

The 03/25/25 "FCS" identified 107 required physical assistance with bathing and dressing and management of medications and treatments. She had short-term and long-term memory, memory/recall, and decision-making cognitive difficulties and was at risk for impaired vision and impaired decision-making.

The 04/01/25 "NSA" (most recent signed "NSA" made available to surveyors) identified facility staff provided R107 assistance with bathing and dressing performed scheduled treatments per physician's orders. Staff escorted R107 to activities due to poor vision and she had a POA for impaired decision-making.

R107's "NSA" documented LN H was "responsible for the implementation and supervision of the plan."

On 11/19/25 at 10:32 AM in an email Administrative Staff B confirmed (LN) H terminated from employment at the facility on 08/28/25.

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S3165	Continued From page 9 - R114's medical record revealed she moved into the facility on 05/21/25 with a diagnosis of diabetes. The 05/21/25 FCS documented R114 required physical assistance with bathing, management of medications and management of treatments. R114's most recent signed NSA was completed on 05/21/25 and listed "Licensed Nurse" (LN) H was responsible for the implementation and supervision of the health care services. Review of R114's records failed to find a revised NSA or an addendum to the NSA that identified the current nurse responsible for the implementation and supervision of the health care services. On 11/18/25 at 04:17 PM Administrative Nurse C stated an addendum to R114's NSA was not completed to identify the current licensed nurse responsible for the implementation and supervision of the health care services plan. The administrator failed to ensure R114's NSA identified the current licensed nurse responsible for the implementation and supervision of the health care services plan. - R115's medical record revealed she moved into the facility on 07/22/24 with a diagnosis of dementia. The 07/11/25 FCS documented R115 required physical assistance with bathing, walking/mobility, management of medications,	S3165		

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S3165	Continued From page 10 and management of treatments. R115's most recent signed NSA was completed on 12/09/24 and listed LN H was responsible for the implementation and supervision of the health care services. Review of R115's records failed to find a revised NSA or an addendum to the NSA that identified the current nurse responsible for the implementation and supervision of the health care services. On 11/18/25 at 03:48 PM Administrative Nurse C stated an addendum to R115's NSA was not completed to identify the current licensed nurse responsible for the implementation and supervision of the health care services plan. The administrator failed to ensure R115's NSA identified the licensed nurse responsible for the implementation and supervision of the health care services plan. The 10/21/23 facility's "Assessment and Service Plan" policy did not address identification of the nurse responsible for implementing and supervising the "HSP." The administrator failed to ensure the "NSAs" for R101, R106, R107, R114 and R115 named the licensed nurse responsible for implementing and supervising their "HSP."	S3165		
S3171 SS=F	26-41-204 (i) Health Care Services Standards of Practice (i) All health care services shall be provided to	S3171		

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S3171	Continued From page 11 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 68 residents. Eighteen residents lived in the secured memory care unit and 50 residents lived on the assisted living side. Based on record review, observation, and interview the administrator failed to ensure the safety of six cognitively impaired wandering residents by providing pagers to direct-care staff to ensure staff were notified if an exit door was breached in the memory care unit. The administrator failed to ensure designated staff posted signs warning visitors to watch behind them and make sure no residents followed them out of the building as documented in a report to the department. The administrator also failed to ensure direct-care staff were able to meet the needs of the residents by providing pagers to all direct care staff on the assisted living side. Findings included: - The 07/17/25 "Investigation Report" to the department documented cognitively impaired Resident (R)101 was found outside of the building without supervision on 06/27/25 at approximately 07:00 PM. The corrective actions documented in the "Investigation Report" included a "stop" sign was put on the front door and a sign was posted on all exit doors warning	S3171		

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visitors to watch behind them and make sure no residents followed them out of the building.

Review of the resident roster provided by the facility during the survey revealed there were 18 residents in the memory care unit with six of them at risk for wandering. There were 50 residents on the assisted living side with 15 of them requiring physical assistance with activities of daily living (ADL's).

Observation on 11/12/25 at 03:59 PM revealed the east access door to the memory care unit was electromagnetically locked and required a keypad code to exit.

Observation on 11/12/25 at 04:12 PM revealed a main front entrance door was electromagnetically locked and required a keypad code to exit. The door lacked a "stop" sign and a sign warning visitors to watch behind them and make sure no residents followed them out of the building.

On 11/18/25 at 08:15 AM Certified Medication Aide (CMA) F stated she and one other staff who was training worked in the memory care on 06/27/25 when R101 was found outside without supervision. Neither one of them had a pager and they did not hear an alarm. The front door beeped when someone pushed against it, but they were busy in another resident's room and did not hear the front door alarm.

Observation on 11/18/25 at 10:55 AM revealed the main front entry/exit door to the memory care unit lacked a "stop" sign and a sign warning visitors to watch behind them and make sure no residents followed them out of the building.

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S3171	Continued From page 13 On 11/18/25 at 10:59 AM maintenance staff E stated memory care exit doors were alarmed and rang to pagers. On 11/18/25 at approximately 11:05 AM all staff in the memory care unit confirmed they did not have a pager. Observation on 11/18/25 at approximately 11:20 AM revealed maintenance staff E left the memory care unit and returned with three pagers for staff. On 11/18/25 at 11:35 AM state surveyor pushed against the main front entry/exit door. An audible alarm beeped. After approximately 15 seconds the door opened to the outside. Maintenance staff E confirmed the opened door alerted to the new pagers. On 11/18/25 at 12:13 PM CMA G stated she of the few times she worked in memory care she never had a pager. Today she worked in the assisted living and did not have a pager. There was only one pager for each floor on the assisted living side. When residents required assistance, they used a call light button that rang to the pagers. The 10/25/23 facility's "Provision of Services" policy documented care staff would respond to residents' needs including via call systems. The administrator failed to ensure the safety of six cognitively impaired wandering residents by providing pagers to direct-care staff to ensure staff were notified if an exit door was breached in the memory care unit. The administrator failed to	S3171		

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S3171	Continued From page 14 ensure designated staff posted signs warning visitors to watch behind them and make sure no residents followed them out of the building as documented in a report to the department. The administrator also failed to ensure direct-care staff were able to meet the needs of the residents by providing pagers to all direct care staff on the assisted living side.	S3171		
S3211 SS=E	26-41-205 (g) (3) OVER THE COUNTER DRUGS (3) A licensed nurse or medication aide may accept over-the-counter medication only in its original, unbroken manufacturer ' s package. A licensed pharmacist or licensed nurse shall place the full name of the resident on the package. If the original manufacturer ' s package of an over-the-counter medication contains a medication in a container, bottle, or tube that can be removed from the original package, the licensed pharmacist or a licensed nurse shall place the full name of the resident on both the original manufacturer ' s medication package and the medication container. This REQUIREMENT is not met as evidenced by: KAR 26-41-205 (g)(3) The facility reported a census of 68 residents. Based on observation and record review the administrator failed to ensure a licensed pharmacist or licensed nurse placed the full name of the resident on the original package of over the counter (OTC) medications.	S3211		

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S3211	Continued From page 15 Findings included: - On 11/12/25 at 03:04 PM an observation of the third-floor medication cart revealed the following OTC medications not labeled with the full name of the resident: One bottle of Members Mark Vitamin D3 One bottle of Qunol Ultra CoQ10 One bottle of Nature Mad Iron 65 milligrams (mg.) One bottle of DG Health Extra Strength Pain Relief One bottle of Swiss Kriss Herbal Laxative Tabs One bottle of Prevagen One bottle of Good Neighbor Acidophilus One bottle of Kroger Vitamin C 500 mg. On 11/12/25 at 03:27 PM an observation of the second-floor medication cart revealed the following OTC medications not labeled with the full name of the resident: One bottle of Centrum Silver Women 50 plus One bottle of Nature's Truth Hair, Skin and Nails On 11/12/25 at 04:28 PM an observation of the Memory Care Unit medication cart revealed the following OTC medications not labeled with the	S3211		

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S3211	Continued From page 16 full name of the resident: One container of CeraVe Moisturizing Cream Two bottles of Natural Factors Magnesium Glycinate 200 mg. One bottle of Kroger Complete Adults 50 plus One bottle Nature Made D3 One Nature Made Fish Oil One Nature Made C 1000 mg. The "Over-the-counter (OTC) Medications and Sample Medications" policy revised on 10/25/2023 documented, "OTC/Sample medications must be labeled with:..Resident name." The administrator failed to ensure all OTC medications were labeled by a pharmacist or licensed nurse with the resident's full name.	S3211		
S3261 SS=E	26-41-105 (f) (11) Resident Record Documentation of Incidents (f) (11) documentation of all incidents, symptoms, and other indications of illness or injury including the date, time of occurrence, action taken, and results of the action This REQUIREMENT is not met as evidenced by: KAR 26-41-105(f)(11)	S3261		

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The facility reported a census of 68 residents with six residents included in the sample and nine focused reviews. Based on interview and record review the administrator failed to ensure licensed staff documented all incidents, symptoms, indications of illness or injury including the dates, times, actions taken, and results of the actions for Residents (R) 101, R107, R109, R110, and R115.

Findings included:

- Record review for R101 revealed an admission date of 03/07/25 with a diagnosis of dementia.

The 03/07/25 "FCS" (most recent made available to surveyors) failed to identify R101 was at risk for wandering and behaviors.

The 03/04/25 "NSA" (most recent signed "NSA" made available to surveyors) documented in the "Elopement Risk" section R101 would receive encouragement by staff to stay in the common area. The "NSA" failed to describe services R101 received for wandering behavior when she attempted to go into other residents' rooms.

The 10/08/25 at 05:00 PM "Incident Note" by Administrative Nurse D documented R101 wandered on the memory care unit and attempted to open the doors to other residents' rooms. She repeatedly opened and closed the door of a resident's room. The resident asked R101 several times to leave her room and became increasingly upset when R101 did not leave. The resident pushed R101 down and she suffered a skin tear on her right elbow. Staff intervened and separated R101 and the other

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resident. The nurse assessed R101 and notified her family and the nurse practitioner about the incident.

The "Incident "Note" failed to document the actions and results of the actions when R101 wandered, attempted to enter other residents rooms, and refused to leave a resident's room when the resident requested which caused the resident to become upset and push R101 down which resulted in a skin tear.

On 11/18/25 at approximately 04:35 PM Administrative Staff B stated staff reported in witness statements that R101's behavior became worse the last two hours of the evening shift. She rattled resident's door handles attempting to get inside their rooms. Staff attempted to redirect R101 several times and tried to get her to go to her own room.

- Record review for R107 revealed an admission date of 09/25/24 with a diagnosis of dementia.

The 03/25/25 "FCS" identified 107 required physical assistance with bathing and dressing and management of medications and treatments. She had short-term and long-term memory, memory/recall, and decision-making cognitive difficulties and was at risk for impaired vision and impaired decision-making.

The 04/01/25 "NSA" (most recent signed "NSA" made available to surveyors) identified facility staff provided R107 assistance with bathing and dressing performed scheduled treatments per physician's orders. Staff escorted R107 to activities due to poor vision and she had a POA

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S3261	Continued From page 19 for impaired decision-making. The 08/05/25 at 04:31 PM "Health Status Note" documented R107 had increased confusion and fatigue which contributed to a fall in her room. Review of nursing progress notes from 04/07/25 to 08/05/25 revealed R107's record lacked evidence of documentation of a fall, indications of injury, actions taken and results of the actions when R107 fell. - Record review for R109 revealed an admission date of 02/26/25 with diagnoses of dementia and epilepsy. The 03/27/25 "FCS" identified R109 required physical assistance with management of medications and treatments, had short-term memory and memory/recall cognitive difficulties, and was at risk for falls. The 03/27/25 "NSA" identified R109 received staff assistance to manage medications and treatments. The "NSA" failed to describe the services he received to prevent injury from falls. The 06/21/25 at 10:54 AM "Health Status Note" documented R109 was observed by a hospice nurse for change of condition. Facility staff would assist with keeping him comfortable and notify hospice with any changes. The 06/23/25 at 01:03 PM "Move Out Note" documented R109 was without a pulse, respirations, and bowel sounds at 10:36 AM. Hospice was notified.	S3261		

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S3261	Continued From page 20 Review of R109's nursing progress notes from 06/21/25 to 06/23/25 lacked evidence of documentation facility staff monitored R109 through the dying process from 06/21/25 at 10:54 AM until 06/23/25 at 01:03 PM which was approximately 2 days and 2 hours. On 11/18/25 at 05:18 PM Administrative Nurse C confirmed R109's record lacked evidence of documentation from 06/21/25 at 10:54 AM until 06/23/25 at 01:03 PM. - Record review for R110 revealed an admission date of 12/23/24 with a diagnosis of Alzheimer's disease. The 12/23/24 "FCS" identified R110 required physical assistance with management of medications and treatments. She had short-term and long-term memory, memory/recall, and decision-making cognitive difficulties and was at risk for wandering. The 07/28/24 "NSA" (most recent "NSA" made available to state surveyors) identified facility staff provided assistance with management of medications and treatments. The "NSA" failed to describe the services R110 received for cognitive difficulties and wandering. The 06/26/25 at 02:09 PM "Communication with Physician" note documented staff reported that R110 had removed her soft cast and hit her right arm against the wall. The on-call clinician and R110's Power of Attorney (POA) were notified. Review of R110's nursing progress notes lacked evidence of documentation of any incidents,	S3261		

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symptoms, indications of illness or injury including the dates, times, actions taken, and results of the actions.

On 11/18/25 at 05:23 PM Administrative Nurse C confirmed R110's nursing progress notes lacked evidence of documentation of any incidents, symptoms, indications of illness or injury including the dates, times, actions taken, and results of the actions when R110 had a soft cast on her arm.

-R115's medical record revealed she moved into the facility on 07/22/24 with a diagnosis of dementia.

The 07/11/25 FCS documented R115 was independent with transfers, required physical assistance with walking and used a walker for mobility.

The 10/24/25 "Incident Note" documented the front desk contacted nursing staff stating that R115 was seen down on the ground in the courtyard outside of the first-floor assisted living dining area. EMS was contacted due to R115 having visible blood loss coming from the back of her head. R115 was sent to a local hospital for evaluation.

Review of R115's medical records failed to locate any follow-up nursing documentation describing treatment or the condition of R115 post-fall.

On 11/18/25 at 11:09 AM R115 stated she was independent with transfers and walking using a four-wheeled walker. She stated a few weeks past she went outside to the courtyard to let her

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S3261	Continued From page 22 dog go potty. As she bent down to pick up something she slid and fell backwards hitting her head on the ground. R115 stated staff called EMS and ended up getting staples to the back of her head. On 11/18/25 at 03:48 PM Administrative Nurse C stated it was her expectation there to be follow-up documentation completed by nursing staff after R115 returned from the hospital. The operator failed to ensure designated staff included documentation of all incidents, action taken, and results of the action. The 10/21/23 facility's "Assessment and Service Plan" documented documentation of general occurrences or other items of note can be recorded in the progress notes. The administrator failed to ensure licensed facility staff documented all incidents, symptoms, and other indications of illness or injury including date, time of occurrence, actions taken, and results of the actions for R101, R107, R109, R110 and R115.	S3261		
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;	S3280		

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S3280	Continued From page 23 (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 68 residents. Based on interview and record review the administrator failed to provide evidence of documentation designated staff provided reviews of the facility's emergency management plan with residents and staff every quarter. Findings included: - Documentation of quarterly reviews of the facility's emergency management plan were requested which the facility failed to provide. On 11/12/25 at 04:57 PM Administrative Staff B confirmed facility lacked records documenting designated staff provided reviews of the facility's emergency management plan with staff and residents every quarter. The 10/25/23 facility's "Emergency Preparedness" policy documented team members would be trained in emergency	S3280		

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S3280	Continued From page 24 preparedness procedures. The policy did not address timing of emergency management plan reviews or reviews of the plan with residents. The administrator failed to provide evidence of documentation designated staff provided reviews of the facility's emergency management plan with residents and staff 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 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 had a census of 68 residents. All 68 residents ate food prepared in the same kitchen.	S3298		

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S3298	Continued From page 25 The administrator failed to ensure food items were served at the proper temperature. Findings included: - On 11/12/25 at 02:18 PM an observation of the first-floor assisted living kitchen failed to locate food temperature logs. On 11/12/25 at 02:39 PM an observation of the second-floor assisted living kitchen failed to locate food temperature logs. On 11/12/25 at 02:48 PM an observation of the third-floor assisted living kitchen failed to locate food temperature logs. On 11/17/25 at 10:56 AM an observation of the main kitchen revealed a food temperature log for November 2025 was not completed from 11/12/25 to 11/17/25. On 11/17/25 at 11:17 AM Administrative Staff B stated dietary staff should document food temperatures before food was sent out of the kitchen and before meals were served on each unit. Review of the "Food Storage" policy revised on 10/25/2023 documented, "...Hot food must be kept at 140 degrees Fahrenheit or above during preparation and serving." The administrator failed to ensure food items were served at the proper temperature.	S3298		

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S3299	Continued From page 26	S3299		
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 had a census of 68 residents. All 68 residents ate food prepared in the same kitchen. The administrator failed to ensure food items were stored under safe and sanitary conditions by ensuring food was appropriately covered and dated according to food safety guidelines. Findings included: - On 11/12/25 at approximately 02:39 PM an observation of the second-floor assisted living back kitchen revealed a large two-door refrigerator that contained an undated or labeled partially covered cookie sheet with sandwiches. There was a second uncovered, undated cookie sheet with a mound of white bread slices and partially prepared sandwich halves with lettuce and tomatoes. On 11/17/25 at approximately 10:56 AM an observation of the main dietary kitchen revealed a walk-in cooler with a plastic food storage	S3299		

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S3299	Continued From page 27 container of cut cantaloupe that was not dated. There was a large food storage container of an unknown spread no dated or labeled. There was a large metal pot covered with plastic wrap that contained ground beef that was not dated. There were three sealed packages of beef round located on the bottom shelf with no thaw date. The attached walk-in freezer contained three large uncovered, undated and unlabeled metal bowls that contained what appeared to be a red gelatin dessert. There was a large metal steam table pan containing what appeared to be sliced sausages covered with plastic wrap but not dated or labeled. There was a large metal steam table pan which contained what appeared to be some sort of meat covered with plastic wrap was not dated or labeled. On 11/17/25 at 11:17 AM Administrative Staff B stated it was her expectation that foods be covered and dated. The "Food Storage" policy revised 10/25/2023 documented, "All food will be labeled and dated with an expiration date. Leftovers will be labeled and dated. Any foods that are potentially hazardous foods shall be used, or disposed of, within twenty-four (24) hours. Non-potentially hazardous leftovers that have been heated or cooked may be refrigerated for up to forty-eight (48) hours." The administrator failed to ensure food items were stored under safe and sanitary conditions.	S3299		
S3305 SS=F	26-41-207 (a) (b) Infection Control (a) The administrator or operator of each	S3305		

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S3305	Continued From page 28 assisted living facility or residential health care facility shall ensure the provision of a safe, sanitary, and comfortable environment for residents. (b) Each administrator or operator shall ensure the development of policies and implementation of procedures to prevent the spread of infections. These policies and procedures shall include the following requirements: (1) Using universal precautions to prevent the spread of blood-borne pathogens; (2) techniques to ensure that hand hygiene meets professional health care standards; (3) techniques to ensure that the laundering and handling of soiled and clean linens meet professional health care standards; (4) providing sanitary conditions for food service; (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 (7) transferring a resident with an infectious disease to an appropriate health care facility if the administrator or operator is unable to provide the isolation precautions necessary to protect the health of other residents. This REQUIREMENT is not met as evidenced by:	S3305		

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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
S3305	Continued From page 29 KAR 26-41-207(a) The facility had a census of 68 residents with 50 residents living in three separate assisted living units. Based on observation and interview the administrator failed to ensure the provision of a sanitary environment for resident, staff and visitors by not providing disposable towels for use to dry off hands after washing them. Findings included: - On 11/12/25 at approximately 02:18 PM an observation of the first-floor dining room revealed there were no disposable towels available by a sink for individuals to dry their hands after washing them. On 11/12/25 at approximately 02:18 PM Maintenance Staff E commented he never realized there were no paper towels available by the dining room sink. On 11/12/25 at approximately 02:39 PM an observation of the second-floor dining room revealed there were no disposable towels available by a sink for individuals to dry their hands after washing them. On 11/12/25 at approximately 02:55 PM an observation of the third-floor dining room revealed there were no disposable towels available by a sink for individuals to dry their hands after washing them. The administrator failed to ensure the provision of a sanitary environment for all individuals who washed their hands at sinks located on all three	S3305		

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	N087088	A. BUILDING: _____ B. WING _____	11/18/2025

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S3305	Continued From page 30 assisted living unit dining rooms.	S3305		
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 68 residents with six residents included in the sample and nine focused reviews. Based on interview and record review the administrator 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 two residents and one of five sampled staff. Findings included:	S3310		

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S3310	Continued From page 31 - Review of Administrative Nurse D's employee record revealed a hire date of 09/04/25. Her record lacked evidence of documentation she completed a second-step of the two-step TB skin test and a TB symptom screen questionnaire within seven days of hire. - R112's medical record revealed he moved into the facility on 04/30/25 with a diagnosis of hemiplegia. Review of R112's medical records revealed the first step of the two-step TB skin test was administered approximately 70 days late on 07/16/25. The second step of the two-step TB skin test was administered approximately 40 days late on 09/18/25. On 11/18/25 at 04:21 PM Administrative Nurse C acknowledged R112's TB skin test was administered late. The June 2013 "Tuberculosis (TB) Guidelines for Adult Care Homes" documented, "Each new resident ...shall receive a two-step TST or an IGRA ...within 7 days of residency ...The first TST shall be read within 48-72 hours of administration. If the first TST is read as not positive, a second TST shall be administered within 1 to 3 weeks." -R114's medical record revealed she moved into the facility on 05/21/25 with a diagnosis of diabetes. Review of R114's medical records revealed the first step of the two-step TB skin test was	S3310		

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S3310	Continued From page 32	S3310		

administered approximately 49 days late on 07/16/25. The second step of the two-step TB skin test was administered approximatley 40 days late on 09/18/25.

On 11/18/25 at 04:17 PM Administrative Nurse C acknowledged R114's TB skin test was administered late.

The June 2013 "Tuberculosis (TB) Guidelines for Adult Care Homes" documented, "Each new resident ...shall receive a two-step TST or an IGRA ...within 7 days of residency ...The first TST shall be read within 48-72 hours of administration. If the first TST is read as not positive, a second TST shall be administered within 1 to 3 weeks."

The administrator failed to ensure the compliance with the department's tuberculosis guidelines for adult care homes adopted by reference in K.A.R. 26-39-105.

-R115's medical record revealed she moved into the facility on 07/22/24 with a diagnosis of dementia.

Review of R115's medical records revealed the TB symptom screen questionnaire was completed on 10/11/24 which was approximately 11 months late. The first step of the TB skin test was administered on 07/23/24. The second step of the TB skin test was completed on 12/18/24 approximately 127 days late. A TB symptom screen questionnaire was not completed annually for 2025.

On 11/18/25 at 03:48 PM Administrative Nurse C

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S3310	Continued From page 33 acknowledged the second step of R115's two-step TB skin test was administered late and stated it was her expectation that a TB symptom screen questionnaire be completed upon admission and then annually. The June 2013 "Tuberculosis (TB) Guidelines for Adult Care Homes" documented, "Each new resident ...shall have an initial TB symptom screen ...within 7 days of residency ...The first TST shall be read within 48-72 hours of administration. If the first TST is read as not positive, a second TST shall be administered within 1 to 3 weeks ...Each resident ...shall have an annual TB symptom screen ..." The 10/25/23 facility's "Screening for Tuberculosis" policy documented tuberculosis screening was provided for all team members and residents who lived in the community in compliance with state guidelines. 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 administrator 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=E	28-39-254 CONSTRUCTION (a) The assisted living facility or residential health care facility shall be designed,	S3320		

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S3320	Continued From page 34 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 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 68 residents. Based on observation, interview and record review the administrator failed to ensure staff secured all chemicals to maintain the safety of all residents and visitors. Findings included: - Observations during initial tour on 05/21/24 at	S3320		

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S3320	Continued From page 35 03:41 PM revealed the following: On 11/12/25 at approximately 02:39 PM an observation of the second-floor kitchenette of the assisted living unit revealed the following unlocked chemicals: One spray bottle of ECOLAB Oasis 100 Neutral Citrus All Purpose Cleaner On 11/12/25 at approximately 02:48 PM an observation of the third-floor closet of the assisted living unit revealed the following unlocked chemicals: One 32 fluid ounce spray bottle of Resolve Urine Destroyer. On 11/12/25 at approximately 02:55 PM an observation of the third-floor kitchenette revealed: One 1.5-gallon container of ProPower Mechanical Warewash Detergent In an email correspondence dated 11/20/25 at 01:03 PM Administrative Staff B stated it was the expectation that chemicals be kept behind a locked door or cabinet. The "Housekeeping and Laundry Services" policy revised on 10/25/2023 documented, "Housekeeping and laundry supplies, equipment, and chemicals will be locked at all times when not in use and are not to be left unattended by team members." The administrator failed to ensure staff kept chemicals locked for resident and visitor safety.	S3320		