STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087296	A. BUILDING: _____ B. WING _____	01/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RESIDENCE BEGONIA II AT CRESTVIEW HOUSE 4	6403 E. MARJORIE STREET WICHITA, KS 67206

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS The following citations represent the findings of the licensure resurvey for the above named facility conducted on 01/27/26 and 01/28/26.	S 000		
S 225 SS=D	26-39-102 (a) Admission Policy (a) Each licensee, administrator, or operator shall develop written admission policies regarding the admission of residents. The admission policy shall meet the following requirements: (1) The administrator or operator shall ensure the admission of only those individuals whose physical, mental, and psychosocial needs can be met within the accommodations and services available in the adult care home. (A) Each resident in a nursing facility or nursing facility for mental health shall be admitted under the care of a physician licensed to practice in Kansas. (B) The administrator or operator shall ensure that no children under the age of 16 are admitted to the adult care home. (C) The administrator or operator shall allow the admission of an individual in need of specialized services for mental illness to the adult care home only if accommodations and treatment that will assist that individual to achieve and maintain the highest practicable level of physical, mental, and psychosocial functioning are available. (2) Before admission, the administrator or operator, or the designee, shall inform the prospective resident or the resident ' s legal representative in writing of the rates and charges for the adult care home's services and of the resident's obligations regarding payment. This information shall include the refund policy of the	S 225		

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

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S 225	Continued From page 1 adult care home.(3) At the time of admission, the administrator or operator, or the designee, shall execute with the resident or the resident ' s legal representative a written agreement that describes in detail the services and goods the resident will receive and specifies the obligations that the resident has toward the adult care home. (4) An admission agreement shall not include a general waiver of liability for the health and safety of residents. (5) Each admission agreement shall be written in clear and unambiguous language and printed clearly in black type that is 12-point type or larger. This REQUIREMENT is not met as evidenced by: K.A.R. 26-39-102 (a)(C) (3) The facility reported a census of 7 residents. Based on record review and interview the Operator failed to execute a written agreement with the legal representative for R3 that described in detail the services and goods the resident would receive and specified the obligations that R3 had toward the adult care home. Findings included: - Record review for R3 revealed an admission date of 07/31/25 with diagnoses of diabetes mellitus, disorder of the bile acid and cholesterol metabolism, autistic disorder, and cellulitis of other sites.	S 225		

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S 225	Continued From page 2 Review of R3's "Resident Agreement" revealed she admitted to the facility on 07/31/25. Under the section titled "Summary of Charges" there were not amounts identified for R3's obligation towards the home. The document was signed by R3's legal representative. Interview on 01/28/26 at approximately 03:30 PM with Operator B, Registered Nurse A, and business office manager C confirmed R3's "Resident Agreement" lacked the required specified obligation R3 had toward the adult care home. The Operator failed to execute a written agreement with the legal representative for R3 that described in detail the services and goods the resident would receive and specified the obligations that R3 had toward the adult care home.	S 225		
S5015 SS=F	26-42-101(c) Administration Position Description (c) Administrator and operator position description. Each licensee shall adopt a written position description for the administrator or operator that includes responsibilities for the following: (1) Planning, organizing, and directing the home; (2) implementing operational policies and procedures for the home; and(3) authorizing, in writing, a responsible employee who is 18 years old or older to act on the administrator ' s or operator's behalf in the absence of the administrator or operator.	S5015		

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S5015	Continued From page 3 This REQUIREMENT is not met as evidenced by: K.A.R. 26-42-101 (c) (3) The facility reported a census of 7 residents. Based on observation and interview the Operator failed to authorize in writing, a responsible employee who was 18 years old or older to act on the Operator's behalf in the absence of the Operator. Findings included: - Observation on 01/27/26 at approximately 12:00 PM facility staff were asked to call the facility Operator and Nurse to advise them that the department was at the facility, the staff responded that they were going to call facility owner D, on the southwest wall of the common living area the license for Operator B was hanging on the wall above the television. Interview on 01/27/26 at approximately 01:00 PM with Operator B stated she was "hardly ever at the facility" and "she owned her own facility". Interview on 01/27/26 at approximately 01:30 PM with business office manager C confirmed the Operator did not have in writing a responsible employee to act on the Operators behalf in the absence of the Operator.	S5015		
S5105 SS=E	26-42-202 (a) Negotiated Service Agreement a) The administrator or operator of each home plus shall ensure the development of a written negotiated service agreement for each resident,	S5105		

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S5105	Continued From page 4 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: K.A.R. 26-42-202 (a) (1)(2)(3) The facility reported a census of 7 residents. The sample included 3 "Residents'" (R)'s. Based on record review and interview the Operator failed to ensure the "Negotiated Service Agreements" (NSA) for each resident contained a description of services the resident would receive, identification of the provider of the services the resident would receive, and identification of each party responsible for payment if outside resources provided service for R1 and R3. Findings included: - Record review for R1 revealed an admission date of 07/31/25 with diagnoses of Parkinsons disease, chronic obstructive pulmonary disease, delusional disorder, and seizure like activity.	S5105		

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S5105	Continued From page 5 Review of R1's "Functional Screen" (FCS) dated 07/31/25 revealed he was unable to perform bathing, dressing, toileting, transferring, walking/mobility, and eating. R1 lacked the ability to manage his own medications and medical treatments. R1 had a catheter and had impaired short-term memory, long-term memory, memory recall and decision making. R1 was usually able to make himself understood and he usually understood others. R1 was identified at risk for impaired decision making. R1 required a wheelchair and mechanical lift. Review of R1's "Negotiated Service Agreement" (NSA) dated 07/31/25 identified the facility staff would provide R1 physical assistance with bathing, toileting, and dressing. The local hospice agency would change the catheter as needed. Under the section titled "Meal preparation" staff were instructed to assist R1 with eating and "monitor resident for signs of choking". Facility staff were instructed to use a mechanical lift for transfers and provide assistance with R1's mobility when he was in his wheelchair. Under the section titled "Skin Care" it was written that R1 had a decubitus ulcer on his coccyx. Under the section titled "Management of Medical Treatments" it was written that R1 had services from a local hospice agency and the nurse would "sometimes give patient medications". The NSA lacked identification of who was responsible for the management of R1s pressure ulcer on the coccyx. Review of R1's "Health Service Plan" (HSP) were	S5105		

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S5105	Continued From page 6	S5105		

instructed to provide physical assistance with bathing, dressing, and administration of R1's medications. Under the section titled Activities of Daily living continued, it was documented that R1 had a catheter, and that the local hospice agency would change the catheter. Under the section titled "Mobility" in the section titled "Plan" "Hoyer Lift" was written.

- Record review for R3 revealed an admission date of 07/31/25 with diagnoses of diabetes mellitus, disorder of the bile acid and cholesterol metabolism, autistic disorder, and cellulitis of other sites.

Review of R3's FCS dated 07/31/25 revealed R3 required physical assistance with bathing, dressing, toileting, transferring, walking/mobility, and supervision with eating. R3 required physical assistance with the management of her medications and was unable to perform her own medical treatments. R3 was frequently incontinent, and had impaired short-term memory, long-term memory, memory/recall and decision making. She was sometimes able to make herself understood and she usually understood others. R3 was at risk for falls and impaired decision making. R3 used a walker and wheelchair mobility device.

Review of R3's NSA dated 07/31/25 identified facility staff would provide R3 physical assistance with bathing, dressing, toileting, walking, and transferring. Under the section titled "Health Care Services" qualified facility staff would manage R3's medications.

R3's NSA lacked documentation and

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S5105	Continued From page 7 identification of the outside home health provider managing R3's Mounjaro injection weekly. Review of R3's electronic "Medication Administration Record" (MAR) dated 01/26 revealed an order for Mounjaro Injection 5 milligrams/0.5 milliliters. Inject one time weekly for diabetes mellitus. Interview on 01/27/26 at approximately 03:00 PM with Registered Nurse A confirmed the outside home health agency managed R3's injection for the management of her diabetes. Interview on 01/28/26 with Operator B and Registered Nurse B confirmed the NSA's for R1 and R3 lacked identification of the outside providers. The Operator failed to ensure the "Negotiated Service Agreements" (NSA) for each resident contained a description of services the resident would receive, identification of the provider of the services the resident would receive, and identification of each party responsible for payment if outside resources provided service for R1 and R3.	S5105		
S5155 SS=E	26-42-204 (a) Health Care Services (a) The administrator or operator in each home plus shall ensure that a licensed nurse provides or coordinates the provision of necessary health care services that meet the needs of each resident and are in accordance with the functional capacity screening and the negotiated service agreement.	S5155		

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S5155	Continued From page 8 This REQUIREMENT is not met as evidenced by: K.A.R. 26-42-204 (a) The facility reported a census of 7 residents. The sample included 3 "Residents'" (R)'s. Based on record review and interview the Operator failed to ensure health care services met the needs in accordance with the "Functional Capacity Screen" (FCS) and the written "Negotiated Service Agreements'" (NSA)'s for R1's and R2. Findings included: - Record review for R1 revealed an admission date of 07/31/25 with diagnose of Parkinsons disease, chronic obstructive pulmonary disease, delusional disorder, and seizure like activity. Review of R1's "Functional Screen" (FCS) dated 07/31/25 revealed he was unable to perform bathing, dressing, toileting, transferring, walking/mobility, and eating. R1 lacked the ability to manage his own medications and medical treatments. R1 had a catheter and had impaired short-term memory, long-term memory, memory recall and decision making. R1 was usually able to make himself understood and he usually understood others. R1 was identified at risk for impaired decision making. R1 required a wheelchair and mechanical lift. Review of R1's "Negotiated Service Agreement"	S5155		

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S5155	Continued From page 9 (NSA) dated 07/31/25 identified the facility staff would provide R1 physical assistance with bathing, toileting, and dressing. The local hospice agency would change the catheter as needed. Under the section titled "Meal preparation" staff were instructed to assist R1 with eating and "monitor resident for signs of choking". Facility staff were instructed to use a mechanical lift for transfers and provide assistance with R1's mobility when he was in his wheelchair. Under the section titled "Skin Care" it was written that R1 had a decubitus ulcer to his coccyx. Under the section titled "Management of Medical Treatments" it was written that R1 had services from a local hospice agency and the nurse would "sometimes give patient medications". Review of R1's "Health Service Plan" (HSP) were instructed to provide physical assistance with bathing, dressing, and administration of R1's medications. Under the section titled Activities of Daily living continued, it was documented that R1 had a catheter, and that the local hospice agency would change the catheter. Under the section titled "Mobility" in the section titled "Plan" "Hoyer Lift" was written. R1's NSA and HSP lacked the identification for the preservation of his skin, and prevention/worsening of pressure wounds. - Record review for R2 revealed an admission date of 11/26/25 with diagnoses of quadriplegia, neurogenic bladder and the presence of a urinary catheter.	S5155		

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S5155	Continued From page 10 Review of R2's FCS dated 11/26/25 revealed R2 was unable to perform bathing, dressing, toileting, transferring, walking/mobility, and eating. R2 lacked the ability to manage his own medications and medical treatments. R2 had a catheter and had impaired short-term memory and decision making. R2 was able to make himself understood and he understood others. R2 was identified at risk for impaired decision making. R2 required a wheelchair and mechanical lift. Review of R2's NSA dated 11/26/25 identified the facility would provide physical assistance for R2 with bathing, dressing, and toileting. R2's catheter would be cleaned and emptied by facility staff and a local home health agency would change the catheter as ordered by the physician. Facility staff would provide physical assistance for transfers using a mechanical lift, and facility staff were to "feed" R2. Facility staff were to manage and administer R2's medications and medical treatments. R2 was able to self-propel the electric wheelchair without staff assistance. Review of R2's HSP instructed facility staff to "Feed" R2, administer his ordered medications, provide full assistance with bathing and complete assistance with dressing. Facility staff were instructed to empty the catheter bag daily and provide catheter care and a local home health agency would change the catheter. Facility staff were instructed to use the mechanical lift for transferring R2. R2's NSA and HSP lacked the identification for the preservation of his skin, and prevention of	S5155		

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S5155	Continued From page 11 pressure wounds. Interview with Operator B and Registered Nurse A confirmed the NSA and HSP's for R's1 and R2 lacked health care services for the preservation and prevention of pressure wounds. The Operator failed to ensure health care services met the needs in accordance with the FCS's and the written NSA's for R1 and R2.	S5155		
S5171 SS=E	26-42-204 (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. 26-42-204 (i) The facility reported a census of 7 residents. The sample included 3 "Residents'" (R)'s. Based on record review and interview the Operator failed to ensure health care services were provided within professional standards of practice when the Operator failed to ensure an assessment was performed for R1 and R2 showing bed assist devices posed no risk for entrapment, confirmed the device was not a restraint, and R1 and R2's ability to safely use the bed assist devices. The Operator further failed to ensure a description of the device, the purpose of the device, and any special instructions on use and monitoring of the device in R1 and R2's "Negotiated Service Agreements'" (NSA)'s. The Operator continued to fail to ensure that health care services were	S5171		

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S5171	Continued From page 12 provided in accordance with professional standards of practice for R1when the outside hospice provider managed stage three pressure ulcer to the coccyx and the management of his urinary catheter, for R2 when the local home health agency managed his suprapubic catheter, and for R3 when the local home health agency managed the weekly injections of Tirzepatide for the treatment of diabetes. Findings included: - Record review for R1 revealed an admission date of 07/31/25 with diagnose of Parkinsons disease, chronic obstructive pulmonary disease, delusional disorder, and seizure like activity. Review of R1's "Functional Screen" (FCS) dated 07/31/25 revealed he was unable to perform bathing, dressing, toileting, transferring, walking/mobility, and eating. R1 lacked the ability to manage his own medications and medical treatments. R1 had a catheter and had impaired short-term memory, long-term memory, memory recall and decision making. R1 was usually able to make himself understood and he usually understood others. R1 was identified at risk for impaired decision making. R1 required a wheelchair and mechanical lift. Review of R1's "Negotiated Service Agreement" (NSA) dated 07/31/25 identified the facility staff would provide R1 physical assistance with bathing, toileting, and dressing. The local hospice agency would change the catheter as needed. Under the section titled "Meal preparation" staff were instructed to assist R1	S5171		

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S5171	Continued From page 13	S5171		

with eating and "monitor resident for signs of choking". Facility staff were instructed to use a mechanical lift for transfers and provide assistance with R1's mobility when he was in his wheelchair. Under the section titled "Skin Care" is was written that R1 had a decubiti's ulcer to his coccyx. Under the section titled "Management of Medical Treatments" it was written that R1 had services from a local hospice agency and the nurse would "sometimes give patient medications".

Review of R1's "Health Service Plan" (HSP) were instructed to provide physical assistance with bathing, dressing, and administration of R1's medications. Under the section titled Activities of Daily living continued, it was documented that R1 had a catheter, and that the local hospice agency would change the catheter. Under the section titled "Mobility" in the section titled "Plan" "Hoyer Lift" was written.

Review of R1's electronic "Medical Record" under the "Observation Notes" revealed the notes lacked documentation from the facility nurse related to the stage three pressure ulcer to R1's coccyx.

Interview on 01/28/26 at approximately 10:00 AM with business office manager C confirmed she had to call the local hospice agency to obtain the skilled nurse notes for R1.

- Record review for R2 revealed an admission date of 11/26/25 with diagnoses of quadriplegia, neurogenic bladder and the presence of a urinary catheter.

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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
S5171	Continued From page 14 Review of R2's FCS dated 11/26/25 revealed R2 was unable to perform bathing, dressing, toileting, transferring, walking/mobility, and eating. R2 lacked the ability to manage his own medications and medical treatments. R2 had a catheter and had impaired short-term memory and decision making. R2 was able to make himself understood and he understood others. R2 was identified at risk for impaired decision making. R2 required a wheelchair and mechanical lift. Review of R2's NSA dated 11/26/25 identified the facility would provide physical assistance for R2 with bathing, dressing, and toileting. R2's catheter would be cleaned and emptied by facility staff and a local home health agency would change the catheter as ordered by the physician. Facility staff would provide physical assistance for transfers using a mechanical lift, and facility staff were to "feed" R2. Facility staff were to manage and administer R2's medications and medical treatments. R2 was able to self-propel the electric wheelchair without staff assistance. Review of R2's HSP instructed facility staff to "Feed" R2, administer his ordered medications, provide full assistance with bathing and complete assistance with dressing. Facility staff were instructed to empty the catheter bag daily and provide catheter care and a local home health agency would change the catheter. Facility staff were instructed to use the mechanical lift for transferring R2. Review of R2's electronic "Medical Record"	S5171		

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RESIDENCE BEGONIA II AT CRESTVIEW HOUSE 4	6403 E. MARJORIE STREET WICHITA, KS 67206

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S5171	Continued From page 15 under the "Observation Notes" revealed the notes lacked documentation from the facility nurse related to the management of R2's suprapubic catheter. Interview on 01/28/26 at approximately 10:00 AM with business office manager C confirmed she had to call the local home health agency to obtain the skilled nurse notes for R2. - Record review for R3 revealed an admission date of 07/31/25 with diagnoses of diabetes mellitus, disorder of the bile acid and cholesterol metabolism, autistic disorder, and cellulitis of other sites. Review of R3's FCS dated 07/31/25 revealed R3 required physical assistance with bathing, dressing, toileting, transferring, walking/mobility, and supervision with eating. R3 required physical assistance with the management of her medications and was unable to perform her own medical treatments. R3 was frequently incontinent, and had impaired short-term memory, long-term memory, memory/recall and decision making. She was sometimes able to make herself understood and she usually understood others. R3 was at risk for falls and impaired decision making. R3 used a walker and wheelchair mobility device. Review of R3's NSA dated 07/31/25 identified facility staff would provide R3 physical assistance with bathing, dressing, toileting, walking, and transferring. Under the section titled "Health Care Services" qualified facility staff would manage R3's medications.	S5171		

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S5171	Continued From page 16 Review of R3's electronic "Medication Administration Record" (MAR) dated 12/25 revealed an order for Mounjaro Injection 5 milligrams/0.5 milliliters. Inject one time weekly for diabetes mellitus. On 12/06/25, 12/13/25, 12/20/25 and 12/27/25 the CMA documented that the medication was not administered "other problems". Review of R3's electronic "Medication Administration Record" (MAR) dated 01/26 revealed an order for Mounjaro Injection 5 milligrams/0.5 milliliters. Inject one time weekly for diabetes mellitus. On 01/03/26 and 01/10/25 the CMA documented that the medication was not administered "other problems". Interview on 01/27/26 at approximately 03:00 PM with Registered Nurse A confirmed the outside home health agency managed R3's injection for the management of her diabetes. Interview on 01/28/26 at approximately 10:00 AM with business office manager C confirmed she had to call the local home health agency to obtain the skilled nurse notes for R3. Interview on 01/28/26 at approximately 03:30 PM with Operator B and Registered Nurse A confirmed the medical records for R1 and R2 lacked an assessment showing the bed assist devices posed no risk for entrapment, confirmed the devices were not a restraint, and R1 and R2's ability to safely use the bed assist devices. Operator B and Registered Nurse A further	S5171		

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S5171	Continued From page 17 confirmed the NSA's for R1 and R2 lacked description of the devices, the purpose of the devices, and any special instructions on use and monitoring of the devices in R1 and R2's NSA's. Operator B and Registered Nuse A further confirmed the lack of documentation for R1, R2, and R3 that showed the outside providers were providing care in accordance with professional standards of practice. The Operator failed to ensure health care services were provided within professional standards of practice when the Operator failed to ensure an assessment was performed for R1 and R2 showing bed assist devices posed no risk for entrapment, confirmed the device was not a restraint, and R1 and R2's ability to safely use the bed assist devices. The Operator further failed to ensure a description of the device, the purpose of the device, and any special instructions on use and monitoring of the device in R1 and R2's NSA's. The Operator further failed to ensure the outside providers for R1, R2, and R3 were providing care in accordance with professional standards of practice.	S5171		
S5230 SS=F	26-42-207 (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;	S5230		

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S5230	Continued From page 18 (c) Each administrator or operator shall ensure the home ' 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: K.A.R. 26-42-207 (c) The facility reported a census of 7 residents. The sample included 3 "Residents'" (R)'s, and 4 newly hired employees. Based on record review and interview, the Operator failed to ensure the home's compliance with the department's "Tuberculosis" (TB) guidelines for adult care homes adopted by reference in K.A.R. 26-39-105 for newly hired Operator B and R2. Findings included: - Record review for R2 revealed an admission date of 11/26/25 with diagnoses of quadriplegia, neurogenic bladder and the presence of a urinary catheter. Review of R2's Medical Record revealed a document titled TB symptom screen dated 11/26/25. On the bottom of the document, it was written that R2 would require a chest Xray. R2's Medical Record lacked documentation of a chest X ray being performed. Interview on 01/28/26 at approximately 03:30 PM with Registered Nurse A confirmed R2 had not	S5230		

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S5230	Continued From page 19 had the chest X ray performed. - Record review for newly hired Operator B revealed she began her employment on 07/23/25. Review of Operator B's personnel record lacked documentation of the required 2 step TB skin test being performed within seven days of employment. Interview on 01/28/26 at approximately 03:30 PM with Registered Nurse A confirmed the required 2 step TB skin test had not been completed for Operator B. The Operator failed to ensure the home's compliance with the department's TB Guidelines for adult care homes adopted by reference in K.A.R. 26-39-105 for newly hired Operator B and R2.	S5230		
S5251 SS=E	26-42-105 (f) (11) Resident Records 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: K.A.R. 26-42-105 (f) (11) The facility reported a census of 7 residents. The sample included 3 "Residents'" (R)'s. Based on	S5251		

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S5251	Continued From page 20	S5251		

record review and interview the Operator failed to ensure the documentation of all incidents, symptoms, and other indications of illness or injury including the date, time of occurrence, action taken, and results of the actions for R1 and R2.

Findings included:

- Record review for R1 revealed an admission date of 07/31/25 with diagnose of Parkinsons disease, chronic obstructive pulmonary disease, delusional disorder, and seizure like activity.

Review of R1's "Functional Screen" (FCS) dated 07/31/25 revealed he was unable to perform bathing, dressing, toileting, transferring, walking/mobility, and eating. R1 lacked the ability to manage his own medications and medical treatments. R1 had a catheter and had impaired short-term memory, long-term memory, memory recall and decision making. R1 was usually able to make himself understood and he usually understood others. R1 was identified at risk for impaired decision making. R1 required a wheelchair and mechanical lift.

Review of R1's "Negotiated Service Agreement" (NSA) dated 07/31/25 identified the facility staff would provide R1 physical assistance with bathing, toileting, and dressing. The local hospice agency would change the catheter as needed. Under the section titled "Meal preparation" staff were instructed to assist R1 with eating and "monitor resident for signs of choking". Facility staff were instructed to use a mechanical lift for transfers and provide

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assistance with R1's mobility when he was in his wheelchair. Under the section titled "Skin Care" is was written that R1 had a decubiti's ulcer to his coccyx. Under the section titled "Management of Medical Treatments" it was written that R1 had services from a local hospice agency and the nurse would "sometimes give patient medications".

Review of R1's "Health Service Plan" (HSP) were instructed to provide physical assistance with bathing, dressing, and administration of R1's medications. Under the section titled Activities of Daily living continued, it was documented that R1 had a catheter, and that the local hospice agency would change the catheter. Under the section titled "Mobility" in the section titled "Plan" "Hoyer Lift" was written.

The HSP lacked instructions to staff to assist R1 with eating, and the HSP further lacked instructions for facility staff to monitor R1 for signs of choking.

Review of R1's electronic "Medical Record" under the "Observations" tab were the following entries;

On 11/05/25 at 08:45 PM "Certified Medication Aide" (CMA) F documented that R1 "could not eat his blended super because he was choking. Nurse notified."

The record lacked documentation of actions taken and results of the actions taken for R1 nutrition after choking.

On 11/15/25 at 04:45 AM CMA H documented

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that R1 kept coughing for a while, stopped and then resumed coughing. CMA H continued to document that when R1 started coughing it seemed "like the other times, he struggles a bit when breathing".

The record lacked documentation of the nurse being notified for symptom of coughing and struggling to breath. The record further lacked documentation of actions taken and the results of the actions for R1's cough and struggling a "a bit when breathing".

- Record review for R2 revealed an admission date of 11/26/25 with diagnoses of quadriplegia, neurogenic bladder and the presence of a urinary catheter.

Review of R2's FCS dated 11/26/25 revealed R2 was unable to perform bathing, dressing, toileting, transferring, walking/mobility, and eating. R2 lacked the ability to manage his own medications and medical treatments. R2 had a catheter and had impaired short-term memory and decision making. R2 was able to make himself understood and he understood others. R2 was identified at risk for impaired decision making. R2 required a wheelchair and mechanical lift.

Review of R2's NSA dated 11/26/25 identified the facility would provide physical assistance for R2 with bathing, dressing, and toileting. R2's catheter would be cleaned and emptied by facility staff and a local home health agency would change the catheter as ordered by the physician. Facility staff would provide physical

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assistance for transfers using a mechanical lift, and facility staff were to "feed" R2. Facility staff were to manage and administer R2's medications and medical treatments. R2 was able to self-propel the electric wheelchair without staff assistance.

Review of R2's HSP instructed facility staff to "Feed" R2, administer his ordered medications, provide full assistance with bathing and complete assistance with dressing. Facility staff were instructed to empty the catheter bag daily and provide catheter care. Facility staff were instructed to use the mechanical lift for transferring R2.

Record review of R2's electronic "Medical Records" under the "Observation" tab revealed the following entries;

On 12/28/25 at 08:45 PM CMA F documented R2 would only take his Gabapentin and Oxycodone. R2 had refused all other medications.

The notes lacked documentation of the facility nurse being notified of the refusal of his medications and the actions taken, and results of the actions for his medication refusal.

On 12/29/25 at 07:45 PM CMA F documented R2 was "shouting and screaming" because he wanted to get out of bed. CMA F documented that she was assisting another resident, and R2 replied "He wanted my colleague to get him out using the Hoyer lift and when she said she can't do that alone he started shouting and asking if she wanted to keep her job. He said he knows what he can do to make her lose her job. He

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S5251	Continued From page 24 asked her if she ever went to school". The notes lacked documentation of actions taken and the results of actions taken to assist R2 in getting out of bed, and the note further lacked documentation of the staffs actions taken and result so the actions taken from the verbal interactions with R2. On 12/31/25 at 12:30 PM CMA F documented that R2 was "very hostile" to the aides working. CMA F documented that R2 was refusing to take his medications and R2 stated he did "not trust" the CMA's. CMA F continued to document that R2 expected the CMA's not only know what the "medication is for but more which when told the doctor can expatriate he goes to the point" where he stated he is fed up ... The notes lacked documentation of the actions taken for R2's concern that the facility CMA's were not trusted by R2, the continued to lack documentation of the nurse being notified of R2's refusal to take his ordered medications, and the note continued to lack the results of the actions taken by staff of reassuring R2 of the facility's CMA's knowledge of his medications. Review of R2's electronic "Medical Record" revealed a document titled "Encounter Note" dated 12/29/25 and was signed by "Advanced Practice Registered Nurse" (APRN) G in the "History of present illness" section she documented that R2 was presenting for medication review and management of chronic conditions. APRN G included that R2 reported a non-adherence to several prescribed medications, including folic acid, vitamin D,	S5251		

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S5251	Continued From page 25 Atorvastatin, duloxetine and Seroquel. APRN G continued to document that R2 "expressed concern and fear that staff are not qualified to dispense his medications correctly and he did not understand the purpose of some medications". Interview on 01/28/26 at approximately 03:30 PM with Operator B and Registered Nurse A confirmed the "Observation Notes" for R's 1 and 2 lacked documentation of all incidents, and other indications of illness or injury, including the date, time occurrence, action taken and results of the actions for R1 and R2. The Operator failed to ensure the documentation of all incidents, symptoms, and other indications of illness or injury including the date, time of occurrence, action taken, and results of the actions for R1 and R2.	S5251		
S5327 SS=F	26-42-205 (l) (2) Medication Regimen Review Variance Report (l) (2) The licensed pharmacist or licensed nurse shall notify the medical care provider upon discovery of any variance identified in the medication regimen review that requires immediate action by the medical care provider. The licensed pharmacist shall notify a licensed nurse within 48 hours of any variance identified in the resident ' s regimen review that does not require immediate action by the medical care provider and specify a time within which the licensed nurse must notify the resident ' s medical care provider. The licensed nurse shall seek a response from the medical care provider	S5327		

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S5327	Continued From page 26 within five working days of the medical care provider ' s notification of a variance. This REQUIREMENT is not met as evidenced by: K.A.R. 26-42-205 (l) (2) The facility reported a census of 7 residents. The sample included 3 "Residents'" (R)'s. Based on record review and interview the Operator failed to ensure the licensed nurse was provided the pharmacy provided quarterly Medication Regimen review within 48 hours of receiving the review and the operator further failed to ensure the licensed nurse sought a response from the medical are provider within five working days of the medical care providers notification of a variance. The operator further failed to ensure the medication regimen review was kept in each resident chart. Findings included: - Record review for R1 revealed an admission date of 07/31/25 with diagnose of Parkinsons disease, chronic obstructive pulmonary disease, delusional disorder, and seizure like activity. Review of R1's "Functional Screen" (FCS) dated 07/31/25 revealed he was unable to perform bathing, dressing, toileting, transferring, walking/mobility, and eating. R1 lacked the ability to manage his own medications and medical treatments. R1 had a catheter and had impaired short-term memory, long-term memory, memory recall and decision making. R1 was usually able to make himself understood and he usually	S5327		

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understood others. R1 was identified at risk for impaired decision making. R1 required a wheelchair and mechanical lift.

Review of R1's "Negotiated Service Agreement" (NSA) dated 07/31/25 identified the facility staff would provide R1 physical assistance with bathing, toileting, and dressing. The local hospice agency would change the catheter as needed. Under the section titled "Meal preparation" staff were instructed to assist R1 with eating and "monitor resident for signs of choking". Facility staff were instructed to use a mechanical lift for transfers and provide assistance with R1's mobility when he was in his wheelchair. Under the section titled "Skin Care" it was written that R1 had a decubitus ulcer to his coccyx. Under the section titled "Management of Medical Treatments" it was written that R1 had services from a local hospice agency and the nurse would "sometimes give patient medications".

Review of R1 medical record revealed a document titled "Consultant Pharmacist Drug Regimen Review Log" with the last medication review date documented as 07/28/25.

Interview on 01/27/26 at approximately 01:00 PM with business office manager C stated the facility had not received the communication from the pharmacy for the fourth quarter of 2025 pharmacy reviews.

- Record review for R2 revealed an admission date of 11/26/25 with diagnoses of quadriplegia, neurogenic bladder and the presence of a

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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
S5327	Continued From page 28 urinary catheter. Review of R2's FCS dated 11/26/25 revealed R2 was unable to perform bathing, dressing, toileting, transferring, walking/mobility, and eating. R2 lacked the ability to manage his own medications and medical treatments. R2 had a catheter and had impaired short-term memory and decision making. R2 was able to make himself understood and he understood others. R2 was identified at risk for impaired decision making. R2 required a wheelchair and mechanical lift. Review of R2's NSA dated 11/26/25 identified the facility would provide physical assistance for R2 with bathing, dressing, and toileting. R2's catheter would be cleaned and emptied by facility staff and a local home health agency would change the catheter as ordered by the physician. Facility staff would provide physical assistance for transfers using a mechanical lift, and facility staff were to "feed" R2. Facility staff were to manage and administer R2's medications and medical treatments. R2 was able to self-propel the electric wheelchair without staff assistance. R2's medical record lacked documentation of a pharmacy review being performed in the fourth quarter of 2025. Interview on 01/27/26 at approximately 01:00 PM with business office manager C stated the facility had not received the communication from the pharmacy for the fourth quarter of 2025 pharmacy reviews.	S5327		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087296	A. BUILDING: _____ B. WING _____	01/28/2026

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S5327	Continued From page 29 - Record review for R3 revealed an admission date of 07/31/25 with diagnoses of diabetes mellitus, disorder of the bile acid and cholesterol metabolism, autistic disorder, and cellulitis of other sites. Review of R3's FCS dated 07/31/25 revealed R3 required physical assistance with bathing, dressing, toileting, transferring, walking/mobility, and supervision with eating. R3 required physical assistance with the management of her medications and was unable to perform her own medical treatments. R3 was frequently incontinent, and had impaired short-term memory, long-term memory, memory/recall and decision making. She was sometimes able to make herself understood and she usually understood others. R3 was at risk for falls and impaired decision making. R3 used a walker and wheelchair mobility device. Review of R3's NSA dated 07/31/25 identified facility staff would provide R3 physical assistance with bathing, dressing, toileting, walking, and transferring. Under the section titled "Health Care Services" qualified facility staff would manage R3's medications. Review of R3's medical record revealed a document titled "Consultant Pharmacist Drug Regimen Review Log" with the last medication review date documented as 07/28/25. Interview on 01/27/26 at approximately 01:00 PM with business office manager C stated the facility had not received the communication from the pharmacy for the fourth quarter of 2025	S5327		

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S5327	Continued From page 30 pharmacy reviews. Interview on 01/28/26 at approximately 01:00 PM with Licensed Pharmacist E revealed she provided a pharmacy consult in 10/25. Licensed Pharmacist E confirmed that Owner of the facility D was who the medication regimen reviews were sent to. Licensed Pharmacist E continued to confirm Owner of the facility D failed to provide the name or the electronic mail address of the facility nurse to Licensed Pharmacist E. Review of the electronic mail provided by Licensed Pharmacist E to Owner of the facility D dated 10/10/25 revealed the electronic mail had an attachment that was the quarterly consulting reports for the facility. Licensed Pharmacist E included in the electronic mail to Owner of the facility D that there was a concern about the documentation of a controlled medication. Interview on 01/28/26 at approximately 03:30 PM with Operator B confirmed she was unaware of any issues of the Licensed Nurse not receiving the pharmacy reviews. Interview on 01/28/26 with Registered Nurse A confirmed she was not provided the pharmacy communication from Owner of the facility D, and that the pharmacy recommendations that were made in 10/25 were not followed up on. The Operator failed to ensure the licensed nurse was provided the pharmacy provided quarterly Medication Regimen review within 48 hours of receiving the review and the operator further failed to ensure the licensed nurse sought a response from the medical are provider within	S5327		

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S5327	Continued From page 31 five working days of the medical care providers notification of a variance. The operator further failed to ensure the medication regimen review was kept in each resident chart.	S5327		
S5335 SS=F	28-39-437 Construction (a) Each home-plus 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 the state fire marshal. This REQUIREMENT is not met as evidenced by: K.A.R. 28-39-437 (a) The facility reported a census of 7 residents. Based on observation and interview the Operator failed to ensure the home was maintained to protect the health and safety of residents. Findings included: - Observation on 01/27/26 at approximately 12:15 PM during the facility tour, in the bathroom located on the southeast end of the home was a can of glade air freshener sitting on the counter next to the bathroom sink. In the common shower hanging on the handrail on the north side of the shower was a urinal that was labeled with Resident 2's name, and on top of the cabinets on	S5335		

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S5335	Continued From page 32 the southeast wall of the bathroom was a box of Equate Denture cleaning tablets that contained the warning to "...keep this product out of reach of children. This product contains persulfates, which are a known allergen ...". In the back hallway located on the southwest corner of the home were as set of wall cabinets that did not contain doors. On the shelves of the cabinet were a bottle of Dermal wound cleanser, a tube of lubricating jelly, a can of glade air freshener, and a can of Premium Butane. In the open laundry room located on the northwest wall was a lower cabinet that the door freely slid open and contained the following unsecured chemicals; 2 large containers of Windfresh Oxi laundry detergent, 1 bottle of liquid Pine Sol, 1 gallon bottle of bleach, 1 spray bottle of Lysol, 1 spray bottle of Lysol foam, 3 cans of Lysol spray, 1 spray bottle of Googone, and 1 large container of Liquid Plumer. Interview on 01/27/26 at 01:00 PM with "Registered Nurse" (RN) A confirmed all chemicals were to be secured. The Operator failed to ensure the home was maintained to protect the health and safety of residents.	S5335		