STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N011011	A. BUILDING: _____ B. WING _____	02/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE AUTUMN PLACE MEMORY CARE UNIT	315 SOUTH EAST AVENUE COLUMBUS, KS 66725

(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 a resurvey with a complaint 196614 at the above named Residential Health Care Facility conducted on 02/04/26.	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: 3085 KAR 26-41-202(a)(1) The facility reported a census of seven residents with three residents included in the sample with one abbreviated record review. Based on interview, and record review the operator failed	S3085		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N011011	A. BUILDING: _____ B. WING _____	02/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE AUTUMN PLACE MEMORY CARE UNIT	315 SOUTH EAST AVENUE COLUMBUS, KS 66725

(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
S3085	Continued From page 1	S3085		

to ensure the "Negotiated Service Agreement" (NSA) was fully developed based on the resident's "Functional Capacity Screen" (FCS), service needs, and preferences for Resident (R)101, R103 and R104.

Findings included:

- R101's medical record revealed she moved into the facility on 04/07/24 with a diagnosis of Alzheimer's Disease.

The 04/07/25 FCS identified R101 had impaired vision wandered and had impaired decision making.

The 04/07/25 NSA did not address what services staff provided R101 concerning her impaired vision, wandering or decision-making abilities.

On 02/04/26 at 03:58 PM "Licensed Nurse" (LN) B confirmed R101's NSA did not address all that triggered on the FCS.

The operator failed to ensure R101's NSA was fully developed to include all items that triggered on the FCS, her service needs, and preferences.

- R103's medical record revealed he moved into the facility on 10/01/25 with a diagnosis of Alzheimer's Disease.

The 10/01/25 FCS identified R103 had impaired cognition with short-term memory, was at risk for falls and had impaired decision-making abilities.

The 010/01/25 NSA did not address what

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N011011	A. BUILDING: _____ B. WING _____	02/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE AUTUMN PLACE MEMORY CARE UNIT	315 SOUTH EAST AVENUE COLUMBUS, KS 66725

(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
S3085	Continued From page 2 services staff provided R103 concerning his impaired cognition, falls and decision-making abilities. On 02/04/26 at 03:51 PM LN B confirmed R103's NSA did not address all that triggered on his FCS. The operator failed to ensure R103's NSA was fully developed to include all items that triggered on the FCS, his service needs, and preferences. - R104's medical record revealed she moved into the facility on 08/28/25 with a diagnosis of Alzheimer's Disease. The 08/28/25 FCS identified R104 triggered for impaired cognition, impaired vision, and impaired decision making. The 08/28/25 NSA did not address what services staff provided R104 concerning all that triggered on her FCS On 02/04/26 at 04:00 PM LN B confirmed R104's NSA did not address all that triggered on her FCS. The operator failed to ensure R104's NSA was fully developed to include all items that triggered on the FCS, her service needs, and preferences.	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	S3092		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N011011	A. BUILDING: _____ B. WING _____	02/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE AUTUMN PLACE MEMORY CARE UNIT	315 SOUTH EAST AVENUE COLUMBUS, KS 66725

(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
S3092	Continued From page 3 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: 3092 KAR 26-41-202(d)(2) The facility reported a census of seven residents. The sample included three residents and one abbreviated record review. Based on interview and record review the operator failed to ensure the "Negotiated Service Agreement" (NSA) for Resident (R)103, and R104 were revised if additional services were provided. Findings included: - Resident (R)103 was admitted to the facility on 10/01/25 with a diagnosis of Alzheimer's Disease. The most recent NSA completed for R103 was dated 10/01/25. The 10/03/25 "Nurses' Note" documented R103	S3092		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N011011	A. BUILDING: _____ B. WING _____	02/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE AUTUMN PLACE MEMORY CARE UNIT	315 SOUTH EAST AVENUE COLUMBUS, KS 66725

(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
S3092	Continued From page 4	S3092		

was admitted to a local hospice provider.

Review of R103's medical record failed to locate an amendment to the NSA that identified R103 received hospice care services.

On 02/04/26 at 03:50 PM Administrative Staff A stated R103's NSA was not amended to include services provided by hospice.

The operator failed to ensure R103's NSA was updated when additional services were provided.

- R104 was admitted to the facility on 08/28/25 with a diagnosis of Alzheimer's Disease.

The most recent NSA completed for R104 was dated 08/28/25.

Review of the 11/20/25 "Nurses' Note" revealed R104 started physical therapy services.

Review of the 12/04/25 "Nurses' Note" documented that R104 refused to participate in physical therapy she would be discharged from receiving physical therapy services.

Review of the 12/31/25 "Nurses' Note" documented R104 was admitted to a local hospice.

Review of R104's medical records failed to locate documentation R104's NSA was amended to include physical therapy and hospice services.

On 02/04/26 at 04:00 PM "Licensed Nurse" (LN) B stated R104's NSA was not amended when she started physical therapy and when she was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N011011	A. BUILDING: _____ B. WING _____	02/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE AUTUMN PLACE MEMORY CARE UNIT	315 SOUTH EAST AVENUE COLUMBUS, KS 66725

(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
S3092	Continued From page 5 discharged from physical therapy. LN B also stated R104's NSA was not amended when she was admitted to hospice care. The operator failed to ensure R104's NSA was amended to include services provided by physical therapy and hospice care.	S3092		
S3261 SS=D	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: 3261 KAR 26-41-105(f)(11) The facility reported a census of seven residents. The sample included three residents and one abbreviated record review. Based on interview and record review the operator failed to ensure documentation of all incidents, symptoms, and other indications of illness or injury for Resident (R)103. Findings included: -R103's medical record revealed he moved into the facility on 10/01/25 with a diagnosis of Alzheimer's Disease.	S3261		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N011011	A. BUILDING: _____ B. WING _____	02/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE AUTUMN PLACE MEMORY CARE UNIT	315 SOUTH EAST AVENUE COLUMBUS, KS 66725

(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
S3261	Continued From page 6	S3261		

The 10/01/25 "Functional Capacity Screen" (FCS) documented that R103 was unable to manage his medical treatments.

The 10/01/25 "Negotiated Service Agreement" (NSA) documented qualified staff administered R103's medical treatments but did not indicate that he received treatments for a pressure wound to his left heel.

Review of R103's medical record and progress notes included the following documentation:
10/01/25 "Nurses' Notes" documented a pressure wound to the left ankle that measured 0.5 centimeters (cm) long, 0.5 cm wide, and 0 cm deep and a left heel wound that measured 0.5 cm long, 0.5 cm wide, and 0 cm deep.

10/03/25 "Nurses' Notes" documented R103 was admitted to Harry Hynes Hospice.

10/03/25 "Harry Hynes Hospice Clinical Note" documented a pressure wound to the left ankle. The wound measured 0.5 cm long, 0.5 cm wide, and 0 cm deep. Treatment was to keep the wound clean and dry. Apply Opti foam dressing: change every other day.

10/09/25 "Harry Hynes Hospice Clinical Note" documented left ankle pressure wound measurement of 1.0 cm long x 1.0 cm wide, 0 cm deep.

10/16/25 "Nurses' Note" documented that the left heel wound was completely healed.

There was no documentation concerning

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N011011	A. BUILDING: _____ B. WING _____	02/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE AUTUMN PLACE MEMORY CARE UNIT	315 SOUTH EAST AVENUE COLUMBUS, KS 66725

(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
S3261	Continued From page 7 pressure wounds of the left ankle after 10/09/25. On 02/04/26 at 03:51 PM Licensed Nurse B confirmed R103 currently had a pressure wound to his left ankle but there was no follow-up documentation concerning pressure wounds since 10/16/25. The operator failed to ensure designated staff included documentation of all incidents, symptoms and other indications of illness or injury including the dated, time of occurrence, action taken, and results of the action.	S3261		