STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087116	A. BUILDING: _____ B. WING _____	02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRECIOUS GEMS HOMES AT POLO DR	5502 E POLO DRIVE WICHITA, KS 67208

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S 000	INITIAL COMMENTS The following citations represent the findings of an abbreviated survey for complaint number 197982 of the above named facility conducted on 02/05/26.	S 000		
S5026 SS=J	26-42-101 (f) (1) Staff Treatment of residents ANE (f)The administrator or operator shall ensure that all of the following requirements are met: (1) No resident shall be subjected to any of the following: (A) Verbal, mental, sexual, or physical abuse, including corporal punishment and involuntary seclusion; (B) neglect; or (C) exploitation. This REQUIREMENT is not met as evidenced by: K.A.R. 26-42-101 (f) (1) (A) (B) The facility reported a census of 7 residents. The sample included one resident and one focused review. Based on record review and interview the Operator failed to provide services for cognitively impaired Resident(R)1 on two occasions. On 12/31/25 R1 left the home unaccompanied by staff and did not return until 01/05/26. On 01/16/26 R1 left the facility unaccompanied. His whereabouts were still unknown at the time of the survey (21 days). The Operator continued with the neglect for services for cognitively impaired R2 when he was allowed to leave the facility unaccompanied by staff and allegedly	S5026		

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

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used illicit drugs. This placed R1 and R2 in immediate jeopardy. R2 also had documented inappropriate behavior towards other residents, failing to protect the other residents in the home from R2's verbal abuse .

Findings included:

- Record review for R1 revealed an admission date of 11/14/2025 with diagnoses of mild cognitive disorder, Alcohol/Cannabis/Amphetamine use disorder, personality disorder, hypertension, type two diabetes, and glaucoma.

Review of R1's "Functional Capacity Screen" (FCS) dated 11/14/25 revealed R1 required supervision with bathing, dressing, toileting, and eating. He lacked the ability to manage his own medications, shopping, and transportation. R1 was occasionally incontinent. R1 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 had with impaired vision.

Review of R1's "Negotiated Service Agreement" (NSA) dated 11/14/25 identified the facility would provide supervision for bathing assistance, dressing, and staff to assist "sometimes" with R1's incontinent products. The facility staff would monitor R1 for mobility as R1 "sometimes stumbles" when walking. The facility staff would supervise R1 when transferring. Staff were to provide services for R1's shopping. Facility staff would administer and manage R1's medications.

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S5026	Continued From page 2 R1's NSA lacked identification of health care services for transportation, and impaired cognition. Review of R1's "Health Service Plan" (HSP) dated 11/14/25 instructed facility staff to administer R1's medications and remind resident for dressing. Review of R1's electronic "Observation" notes revealed the following entries; On 11/14/25 at 01:30 PM R1 admitted to the home. On 11/17 25 at 07:00 PM R1 was "a little confused". On 11/19/25 at 12:15 PM R1 was "confused sometimes". On 11/24/25 at 08:00 PM R1 was as having a good day and being "a little confused". On 11/29/25 at 01:15 PM R1 argued with R2 and shouted at R3. On 12/03/25 at 01:00 PM R1 spoke about his money that was to come from "Release". Facility staff told R1 that they needed paperwork from the Parole Officer to get permission for R1 to be off the facility premises. On 12/31/25 at 12:15 PM it was documented that R1 ate and went outside. On 12/31/25 at 06:30 PM R1 was "out of the building the entire day".	S5026		

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S5026	Continued From page 3 On 01/01/26 at 06:30 PM R1 was "out of the building throughout the shift". On 01/02/26 at 06:15 PM that R1 was "out of the building throughout the shift". R1's "Observation" notes lack documentation of when he returned to the facility. The next entry on 01/05/26 at 08:30 PM revealed R1 required help to stand up and go to his bed. On 01/16/26 at 12:15 PM, R1 left the facility without signing out of the facility. On 01/16/26 at 06:15 PM R1 was out of the facility the entire shift. On 01/16/26 at 08:15 PM "Licensed Nurse" (LN) B documented that R1 left the facility with his friend earlier in the day. "Resident is able to sign himself in and out of the facility" per R1's Parole Officer. On 01/19/26 at 11:00 AM LN B documented that the local Parole office was notified that R1 went out of the building with a friend and has not returned. "Resident is able to sign himself in and out of the facility per parole order". R1 had not returned to the facility during the survey process on 02/05/26. Review of R1's medical record revealed the following; A letter from the "Department of Corrections" dated 09/29/25 revealed R1 had been in the	S5026		

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correctional facility's "Medium Unit Long Term Care Facility". "Placement at an assisted living facility" was being pursued due to medical conditions of R1. R1 had recently been diagnosed with a mild neurocognitive disorder due to multiple etiologies. Psychological testing were completed due to R1's cognitive decline. He walked with a shuffle and was unable to walk far. R1 would oversleep and miss his medications. He could complete his own activities of daily living but he may need reminders to shower. R1's cognitive behavior had been problematic at times as he would become aggressive towards others. "He will not understand why he cannot help with the other residents". R1 had been seen urinating in the corner of the facility elevator.

Review of R1's medical record revealed an undated letter from the "Department of Corrections" that stated R1 was "free to leave the property escorted or non-escorted" as long as R1 informed staff of where R1 was going.

Interview on 02/05/26 at approximately 11:15 AM with "Certified Medication Aide" (CMA) A confirmed that R1 had left the facility on two occasions without letting facility staff know where he was going. CMA A stated, on 01/16/26 R2 arranged a ride for R1 and R2 to go out of the facility. CMA A further confirmed that R2 returned to the home and R1 continued to be out of the home, reporting he never returned from the outing with R2.

- Record review for R2 revealed an admission date of 05/14/25 with diagnoses of mixed bipolar affective disorder, depressive disorder, heart

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disease, disorder of the lung, and asthma.

Review of R2's FCS dated 12/17/25 revealed R2 required supervision with eating. R2 was independent with bathing, dressing, toileting, transferring, and walking. R2 lacked the ability to manage his own medications, and he was usually continent. R2 was identified to have impaired short-term memory, long-term memory, memory/recall and decision making. It was handwritten that R2 "was very impulsive and had poor decision-making skills". R2 was usually able to make himself understood and he usually understood others. R2 was at risk for falls and unsteadiness, had impaired vision and impaired decision making. R2 used a cane mobility device.

Review of R2's NSA dated 12/17/25 identified the facility staff would manage R2's medications. Under the section titled "Transportation" it noted that the facility staff or the outside agencies would provide medical transportation. The facility staff were instructed to "advise of risk with choices" and provide redirection.

Review of R2's HSP dated 12/17/25 included the diagnoses of "schizoaffective disorder, chronic pain, and chronic obstructive pulmonary disease. Facility staff to set up and orient R2 to his plate at meals, administer his medications and provide redirection. It was handwritten that R2 was "Very impulsive".

Review of R2's electronic "Medical Record" under the "Observation" notes tab revealed the following entries:

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S5026	Continued From page 6 On 12/08/25 at 09:00 AM R2 was in a "Bad Mood". On 12/10/15 at 03:30 PM LN B documented that she reached out to R2's medical provider due to R2 refusing his monthly Haloperidol 100 milligram/milliliter injections (medication for schizophrenia and severe behavior problems). On 12/11/25 at 10:30 AM LN B documented that R2 was seen for behavioral concerns and medication compliance. R2 had documented refusals of his medications from the local psychiatric department, and he had also exhibited some "violent behaviors at times. (yelling and cursing). Staff had to continually redirect R2. Medication/Treatment change start Geodon (medication for schizophrenia and bipolar disorders) 10 milligrams by mouth daily, Lorazepam (anti-anxiety medication) 2 milligrams intramuscular as needed. Staff to monitor for aggressive or unsafe behaviors. The note lacked documentation of the provider who gave the medication change orders. On 12/23/25 at 06:30 PM LN B documented that R2 had returned from a recent hospital stay for hypoglycemia. "A urine drug screening was completed during hospitalization. Results were positive for benzodiazepines and methamphetamine ". (Medications not on R2's medication administration list, indicating illegal drug use) On 01/05/25 at 08:30 R2 was in a "bad mood". On 01/06/26 at 06:00 PM R2 was out of the	S5026		

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S5026	Continued From page 7 facility the entire day. On 01/07/25 at 06:30 PM R2 was out of the facility throughout the entire shift. On 01/08/26 at 12:30 PM R2 was "Shouting at fellow residents over napkins". On 01/12/26 at 08:00 PM R2 was out with "Friends" and required treatment at a local emergency room for a thumb dislocation. On 01/13/26 R2 was out of the facility the entire shift. On 01/14/26 R2 told CMA A that while he was out of the facility, he fell trying to get away from a fight and he hurt his hand. He continued to tell CMA A that the local emergency room gave him three injections for pain and he refused an x-ray . On 01/16/26 R2 left the facility and refused to sign out of the facility. On 01/18/26 at 05:45 AM R2 was "not in good character from morning all the way to evening", R2 was aggressive, and de-escalation techniques did not work when used by staff. R2 left and when the next staff came into the building, staff reported a continuance of R2's inappropriate behavior. On 01/18/26 at 12:30 PM R2 was insulative towards staff and another resident. On 01/28/26 at 04:45 PM "Registered Nurse" (RN) C documented that R2's medical provider increased R2's Haldol. R2 continued to	S5026		

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occasionally exhibit violent verbal behavior threatening staff.

On 01/29/26 at 09:15 AM it was documented that R2 was violating the house rules and was found in another resident room smoking. "He was doing substance with another resident."

On 01/30/26 at 06:30 AM R2 had to be asked to leave another resident's room while the other resident was sleeping.

On 01/30/26 at 12:30 PM R2 continued to try and smoke in the home.

On 02/02/26 at 10:00 AM R2 ate some of his breakfast while "being volatile to the other residents, he finally calmed down and watched television."

Review of the facility provided, provider visit note, dated 12/11/25 revealed R2 was being seen regarding his psychiatric health. R2 had a history of street drug use including methamphetamine or cocaine with the most recent use reported on 12/11/25. R2 frequently skips his appointments at his primary care for his monthly injection of Haldol. Due to ongoing aggression Geodon 20 milligrams twice daily was added. "Concerns have been raised by the facility owner regarding his erratic behavior and its impact on other residents with potential consideration of issuing a 30-day notice for discharge if his behavior does not improve.

Review of the facility provided provider visit note dated 01/08/26 revealed R2 was seen for behavioral issues. Staff reported to the provider

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ongoing concerns regarding R2's behavior and suspected illicit drug use. On 01/08/26 R2 "exhibited a behavioral outburst directed at a female resident" who used a walker. R2 became very upset, screaming and yelling, cursing and calling the female resident names. R2 continued to be very agitated when the provider was leaving the building, stating that he might hurt the resident someday. "Staff are aware of the situation and are actively monitoring interactions between" R2 and the female resident, "ensuring they are seated separately and not left alone together".

Under the section titled "Assessment and Plan" the provider documented R2 continues to exhibit behavioral outburst, including verbal aggression and threats towards other residents.

Under the Section titled "Methamphetamine Abuse" the provider documented that R2 did not want treatment, he continued to use methamphetamine multiple times a week.

Review of the facility provided "30 Day Notice of Discharge" it revealed the official discharge date for R2 would be on 12/18/25 for R2's ongoing refusal to participate in his essential medical care and increasing behavioral episodes, "which have repeatedly placed staff and other residents at risk of harm." R2's continued frequent use of illegal substances in the home was a breach of house code of ethics. R2 had been advised and counselled on the matter multiple times. R2 continued to have a blatant disregard of the house rules. Because R2's behaviors and medical refusals "create a safety hazard that the facility is not equipped to

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manage" R2's continued residence at the home was not possible.

Interview on 02/05/26 at 01:45 PM. with CMA B confirmed that R1 and R2 left the facility together on 01/16/26. CMA B continued to confirm R2 was the only resident that returned to the home .

Interview on 02/05/25 at 12:30 PM with R2 revealed he and R1 were roommates. On the day R1 went missing R2 arranged for a Taxi. R2 stated R1 gave the driver directions and that when they got to an area where there were three churches on the corners, R1 asked the driver to stop and he got out of the taxi. R2 stated he thought R1 was going to meet a girl. R2 confirmed he continued to his friend's house.

Interview on 02/05/26 at approximately 03:00 PM with LN B and CMA A confirmed the NSAs for cognitively impaired R1 and R2 lacked health care services for leaving the facility and returning safely. LN B and CMA A continued to confirm that R2 had targeted three other residents, and that the facility staff have staggered the mealtimes so that they are not in the dining room together. CMA A continued to confirm that when R2 is not in a good mood she encourages the other residents to not go to the common area if R2 is in the common area.

The Operator failed to provide services for cognitively impaired Resident(R)1 on two occasions. On 12/31/25 R1 left the home unaccompanied by staff and did not return until 01/05/26. On 01/16/26 R1 left the facility unaccompanied. His whereabouts were still unknown at the time of the survey (21 days). The

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S5026	Continued From page 11 Operator continued with the neglect for services for cognitively impaired R2 when he was allowed to leave the facility unaccompanied by staff and allegedly used illicit drugs. This placed R1 and R2 in immediate jeopardy. R2 also had documented inappropriate behavior towards other residents, failing to protect the other residents in the home from R2's verbal abuse . On 02/05/26 at 03:30 PM LN B was informed that cognitively impaired R1 was in immediate jeopardy on 12/31/24 when he was allowed to leave the home unaccompanied and was not documented back into the home until 01/05/26, and when R1 left the home again on 01/16/26 and has not returned at the time of the survey (21 days). Cognitively impaired R2 was in immediate jeopardy when he left the home unattended and allegedly used illicit drugs. The home's residents were not protected from verbal abuse from R2. The removal plan accepted on 02/09/26 included the following: Cognitively impaired R1 and R2 will not leave the facility unattended starting on 02/06/26 for R2, and upon R1's return to the facility. R1 and R2's resident FCS's and NSA's will be updated to reflect the service the facility will provide by 02/09/26. Any refusal of supervision for R1 and R2 will be documented and reported immediately starting on 02/06/26. Staff are to continue to follow the points from the	S5026		

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S5026	Continued From page 12 De-escalation training that was completed on 12/01/25 to assist R2 with his behaviors. R2 will continue to have peer support and weekly counseling. Residents will continue to sit separately for meals to reduce confrontation with other residents. Implemented on 02/02/26. Staff will intervene promptly when staff observe verbal abuse. R2 will be redirected to a quiet area or an alternate activity. Staff will be instructed on these steps in written form on 02/06/26.	S5026		
S5028 SS=D	26-42-101 (f) (3) Staff Treatment of Residents Reporting (f) (3) Each allegation of abuse, neglect, or exploitation shall be reported to the administrator or operator of the home as soon as staff is aware of the allegation and to the department within 24 hours. The administrator or operator shall ensure that all of the following requirements are met: (A) An investigation shall be started when the administrator or operator, or the designee, receives notification of an alleged violation. (B) Immediate measures shall be taken to prevent further potential abuse, neglect, or exploitation while the investigation is in progress. (C) Each alleged violation shall be thoroughly investigated within five working days of the initial report. Results of the investigation shall be	S5028		

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S5028	Continued From page 13 reported to the administrator or operator. (D) Appropriate corrective action shall be taken if the alleged violation is verified. (E) The department ' s complaint investigation report shall be completed and submitted to the department within five working days of the initial report. (F) A written record shall be maintained of each investigation of reported abuse, neglect, or exploitation. This REQUIREMENT is not met as evidenced by: K.A.R. 26-42-101 (f) (3) The facility reported a census of 7 residents. The sample included 1" Resident" (R) and one focused review. Based on record review and interview the Operator failed to report to the department an allegation of neglect when cognitively impaired R1 left the facility without ever returning to the facility with his whereabouts still unknown. Findings included: - Record review for R1 revealed an admission date of 11/14/2025 with diagnoses of mild cognitive disorder, Alcohol/Cannabis/Amphetamine use disorder, personality disorder, hypertension, type two diabetes, and glaucoma. Review of R1's "Functional Capacity Screen"	S5028		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087116	A. BUILDING: _____ B. WING _____	02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRECIOUS GEMS HOMES AT POLO DR	5502 E POLO DRIVE WICHITA, KS 67208

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S5028	Continued From page 14 (FCS) dated 11/14/25 revealed R1 required supervision with bathing, dressing, toileting, and eating. He lacked the ability to manage his own medications, shopping, and transportation. R1 was occasionally incontinent. R1 was identified to have 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 documented with impaired vision. Review of R1's "Negotiated Service Agreement" (NSA) dated 11/14/25 identified the facility would provide supervision for bathing assistance, dressing, and staff to assist "sometimes" with R1's incontinent products. The facility staff would monitor R1 for mobility as R1 "sometimes stumbles" when walking. The facility staff would supervise R1 when transferring. Staff were identified to provide services for R1's shopping. Facility staff were identified to administer and manage R1's medications. R1's NSA lacked identification of health care services for transportation, and the NSA further lacked health care services for R1's impaired cognition. Review of R1's "Health Service Plan" (HSP) dated 11/14/25 instructed facility staff to administer R1's medications and remind resident in dressing. Review of R1's electronic "Observation" notes revealed the following entries; On 11/14/25 at 01:30 PM R1 admitted to the home.	S5028		

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S5028	Continued From page 15 On 11/17 25 at 07:00 PM R1 was documented as "a little confused". On 11/19/25 at 12:15 PM R1 was documented as "confused sometimes". On 11/24/25 at 08:00 PM R1 was documented as having a good day and being "a little confused". On 11/29/25 at 01:15 PM R1 argued with R2 and shouted at R3. On 12/03/25 at 01:00 PM R1 spoke about his money that was to come from "Release". Facility staff told R1 that they needed paperwork from the Parole Officer to get permission for R1 to be off the facility premises. On 12/31/25 at 12:15 PM it was documented that R1 ate and went outside. On 12/31/25 at 06:30 PM it was documented that R1 was "out of the building the entire day". On 01/01/26 at 06:30 PM it was documented that R1 was "out of the building throughout the shift". On 01/02/26 at 06:15 PM it was documented that R1 was "out of the building throughout the shift". R1's "Observation" notes lack documentation of when he returned to the facility. The next entry on 01/05/26 at 08:30 PM revealed R1 required help to sand up and go to his bed. On 01/16/26 at 12:15 PM it was documented that	S5028		

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S5028	Continued From page 16 R1 left the facility without signing out of the facility. On 01/16/26 at 06:15 PM R1 was documented out of the facility the entire shift. On 01/16/26 at 08:15 PM "Licensed Nurse" (LN) B documented that R1 left the facility with his friend earlier in the day. "Resident is able to sign himself in and out of the facility" per R1's Parole Officer. On 01/19/26 at 11:00 AM LN B documented that the local Parole office was notified that R1 went out of the building with a friend and has not returned. "Resident is able to sign himself in and out of the facility per parole order". R1 had not returned to the facility during the survey process on 02/05/26 (21 days). Review of R1's medical record revealed the following; A letter from the "Department of Corrections" dated 09/29/25 revealed R1 had been in the correctional facilities "Medium Until Long Term Care Facility". "Placement at an assisted living facility" was being pursued due to medical conditions of R1. R1 had recently been diagnosed with a mild neurocognitive disorder due to multiple etiologies. Psychological testing was completed due to R1's cognitive decline. R1 walked with a shuffle. R1 was unable to walk far. R1 would oversleep and miss his medications. R1 could complete his own activities of daily living but he may need reminders to shower. R1's cognitive behavior had been problematic at times as he would become more aggressive towards	S5028		

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S5028	Continued From page 17 others. "He will not understand why he cannot help with the other residents" and R1 had been seen urinating in the corner of the facility elevator. Review of R1's medial record revealed an undated letter from the "Department of Corrections" that stated R1 was "free to leave the property escorted on non-escorted" as long as R1 informed staff of where R1 was going. Interview on 02/05/26 at approximately 11:15 AM with "Certified Medication Aide" (CMA) A confirmed that R1 had left the facility on two occasions without letting facility staff know where he was going. CMA A stated that on 01/16/26 that R2 arranged the ride for R1 and R2 to go out of the facility. CMA A further confirmed that R2 returned to the home and R1 continued to be out of the home, that he never returned from the outing with R2. Interview on 02/05/26 at approximately 12:00 PM LN B confirmed she did not report to the department either occasion of R1 leaving the facility without letting staff know where he was going because he took care of all of his own business, and the parole officer had sent a letter stating he could leave. The Operator failed to report to the department an allegation of neglect when cognitively impaired R1 left the facility without returning to the facility.	S5028		