

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046039	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/11/2026
NAME OF PROVIDER OR SUPPLIER THE HOMESTEAD OF LEAWOOD		STREET ADDRESS, CITY, STATE, ZIP CODE 12720 STATELINE RD LEAWOOD, KS 66209		
(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 197605, 197573, and 196951 at the above named assisted living conducted on 02/11/26.	S 000		
S3101 SS=E	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 representative. This REQUIREMENT is not met as evidenced by: KAR 26-41-202(h) The facility reported a census of 48 residents with three residents included in the sample and two focused reviews. Based on interview and record review the administrator failed to ensure designated staff ensured each individual involved in the development of the "Negotiated Service Agreement" (NSA) signed the agreement for Resident (R) 1, R2 and R3. Findings included: - Record review for R1 revealed an admission date of 11/07/23 with diagnoses of dementia and syncope and collapse.	S3101		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046039	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/11/2026
NAME OF PROVIDER OR SUPPLIER THE HOMESTEAD OF LEAWOOD		STREET ADDRESS, CITY, STATE, ZIP CODE 12720 STATELINE RD LEAWOOD, KS 66209		
(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
S3101	Continued From page 1 The 01/07/26 "Functional Capacity Screen" (FCS) identified R1 was unable to perform bathing, dressing, toileting, transfers, walking/mobility, and management of treatments. She required physical assistance with eating and management of medications. R1 was incontinent of bladder, had short-term memory, memory/recall, and decision-making cognitive difficulties. She was sometimes understandable and sometimes understood others during communication and was marked at risk for falls, impaired hearing, and impaired decision-making. The 01/07/26 "NSA" identified R1 received staff assistance with bathing, dressing, toileting, and eating. She received assistance of two staff with a mechanical lift for transfers and staff propelled her wheelchair for long distances for walking/mobility. R1 received administration of medications by a facility certified or licensed staff member. A hospice provider managed R1's skin wounds for treatments. R1 received assistance from facility staff every two hours to check, change, and provide peri care for bladder incontinence. Staff broke tasks into small steps and kept R1's routine as constant as possible for cognitive difficulties and allowed time to respond and stood in front of her when speaking for communication. Facility staff anticipated her needs and two staff transferred her with a mechanical lift to prevent injury from falls. R1 received assistance to apply hearing aids in the morning and remove them in the evening for impaired hearing and she had a DPOA for impaired decision-making. The 01/07/26 "NSA" lacked signatures of all individuals involved in its development.	S3101		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046039	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/11/2026
NAME OF PROVIDER OR SUPPLIER THE HOMESTEAD OF LEAWOOD		STREET ADDRESS, CITY, STATE, ZIP CODE 12720 STATELINE RD LEAWOOD, KS 66209		
(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
S3101	Continued From page 2 - Record review for R2 revealed an admission date of 05/02/24 with diagnoses of heart failure and chronic obstructive pulmonary disorder (COPD). The 11/12/25 "FCS" identified R2 required physical assistance with bathing, toileting, eating, and management of treatments. She was unable to perform management of medications and was frequently incontinent of bladder. R2 was sometimes understandable and sometimes understood others during communication and was marked at risk for falls, impaired vision, and impaired hearing. The 11/12/25 "NSA" identified R2 received assistance from hospice staff twice a week for bathing, facility staff assistance with toileting according to a schedule, and a mechanically altered diet for eating. She received administration of medications by a facility certified or licensed staff member and management of treatments for skin wounds by hospice. R2 wore incontinence products for incontinence of bladder and staff allowed time to respond and stood in front of her when speaking for communication. Facility staff notified the nurse before moving R3 after a fall. She was independent with glasses for impaired vision and independent with hearing aids for impaired hearing. The 11/12/25 "NSA" lacked signatures of all individuals involved in its development. - Record review for R3 revealed an admission date of 10/27/25 with diagnoses of pressure	S3101		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046039	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/11/2026
NAME OF PROVIDER OR SUPPLIER THE HOMESTEAD OF LEAWOOD		STREET ADDRESS, CITY, STATE, ZIP CODE 12720 STATELINE RD LEAWOOD, KS 66209		
(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
S3101	Continued From page 3 ulcer of unspecified thigh and chronic obstructive pulmonary disorder (COPD). The 11/26/25 "FCS" identified R3 required physical assistance with bathing, toileting, walking/mobility, and management of medications and treatments. She was unable to perform transfers and was frequently incontinent of bladder. She had long-term memory, memory/recall, and decision-making cognitive difficulties. R3 was sometimes understandable and sometimes understood others during communication and was marked at risk for falls and impaired decision-making. The 11/26/25 "NSA" identified R3 received assistance from facility staff twice a week for bathing, assistance with dressing, toileting, walking/mobility, and assistance with transfers from two facility staff and a mechanical lift. She received administration of medications by a facility certified or licensed staff member and management of treatments for skin wounds by a home health/hospice provider. R3 received checks every two hours from facility staff and assistance to change and complete peri care for bladder incontinence. R3 received all treatments, medications, and routine monitoring tasks by facility staff in a timely manner per physician's orders for cognitive difficulties. Facility staff allowed time to respond and stood in front of her when speaking for communication. Facility staff anticipated her needs to prevent injury from a fall and she had durable power of attorney (DPOA) for impaired decision-making. The 11/26/25 "NSA" lacked signatures of all individuals involved in its development.	S3101		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046039	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/11/2026
NAME OF PROVIDER OR SUPPLIER THE HOMESTEAD OF LEAWOOD		STREET ADDRESS, CITY, STATE, ZIP CODE 12720 STATELINE RD LEAWOOD, KS 66209		
(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
S3101	Continued From page 4 On 02/11/26 at 02:37 PM Administrative Nurse C confirmed R3's "NSAs" lacked signatures of all individuals involved in their development. The administrator failed to ensure designated staff ensured each individual involved in the development of the "NSA" signed the agreement for R1, R2, and R3.	S3101		
S3215 SS=F	26-41-205 (h) Medication Storage (h) Storage. Licensed nurses and medication aides shall ensure that all medications and biologicals are securely and properly stored in accordance with each manufacturer ' s recommendations or those of the pharmacy provider and with federal and state laws and regulations. (1) Licensed nurses or medication aides shall store non-controlled medications and biologicals managed by the facility in a locked medication room, cabinet, or medication cart. Licensed nurses and medication aides shall store controlled medications managed by the facility in separately locked compartments within a locked medication room, cabinet, or medication cart. Only licensed nurses and medication aides shall have access to the stored medications and biologicals. (2) Each resident managing and self-administering medication shall store medications in a place that is accessible only to the resident, licensed nurses, and medication aides. (3) Any resident who self-administers medication and is unable to provide proper storage as recommended by the manufacturer or pharmacy	S3215		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046039	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/11/2026
NAME OF PROVIDER OR SUPPLIER THE HOMESTEAD OF LEAWOOD		STREET ADDRESS, CITY, STATE, ZIP CODE 12720 STATELINE RD LEAWOOD, KS 66209		
(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
S3215	Continued From page 5 provider may request that the medication be stored by the facility. (4) A licensed nurse or medication aide shall not administer medication beyond the manufacturer 's or pharmacy provider 's recommended date of expiration. This REQUIREMENT is not met as evidenced by: KAR 26-41-205(h)(1) The facility reported a census of 48 residents. Based on observation and interview, the administrator failed to ensure designated staff stored controlled medications in separately locked compartments within a locked medication room. Findings included: - Observation on 01/11/26 at 09:47 AM revealed a small, unlocked refrigerator in a locked medication room. Two boxes of liquid lorazepam inside the refrigerator were not stored in a locked compartment. On 01/11/26 at approximately 09:47 AM Certified Administrative Nurse B confirmed two boxes of controlled medications were not double-locked. The administrator failed to ensure designated staff stored controlled medications in separately locked compartments within a locked medication room.	S3215		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046039	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/11/2026
NAME OF PROVIDER OR SUPPLIER THE HOMESTEAD OF LEAWOOD		STREET ADDRESS, CITY, STATE, ZIP CODE 12720 STATELINE RD LEAWOOD, KS 66209		
(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		
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) The facility reported a census of 48 residents with three residents included in the sample and two focused reviews. Based on interview and record review the administrator failed to ensure licensed staff documented when Resident (R) 1 suffered a femur fracture, follow-up wound healing for a skin tear, and when she passed away; and when R2 passed away. Findings included: - Record review for R1 revealed an admission date of 11/07/23 with diagnoses of dementia and syncope and collapse. The 01/07/26 "Functional Capacity Screen" (FCS) identified R1 was unable to perform bathing, dressing, toileting, transfers, walking/mobility, and management of treatments. She required physical assistance with eating and management of medications. R1 was incontinent of bladder, had short-term memory, memory/recall, and decision-making cognitive	S3261		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046039	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/11/2026
NAME OF PROVIDER OR SUPPLIER THE HOMESTEAD OF LEAWOOD		STREET ADDRESS, CITY, STATE, ZIP CODE 12720 STATELINE RD LEAWOOD, KS 66209		
(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 difficulties. She was sometimes understandable and sometimes understood others during communication and was marked at risk for falls, impaired hearing, and impaired decision-making. The 01/07/26 "NSA" identified R1 received staff assistance with bathing, dressing, toileting, and eating. She received assistance of two staff with a mechanical lift for transfers and staff propelled her wheelchair for long distances for walking/mobility. R1 received administration of medications by a facility certified or licensed staff member. A hospice provider managed R1's skin wounds for treatments. R1 received assistance from facility staff every two hours to check, change, and provide peri care for bladder incontinence. Staff broke tasks into small steps and kept R1's routine as constant as possible for cognitive difficulties and allowed time to respond and stood in front of her when speaking for communication. Facility staff anticipated her needs and two staff transferred her with a mechanical lift to prevent injury from falls. R1 received assistance to apply hearing aids in the morning and remove them in the evening for impaired hearing and she had a DPOA for impaired decision-making. The 12/04/25 at 11:45 late entry "Nurses Note" documented R1 went to the emergency department for a femur fracture diagnosed by an x-ray. R1's record lacked evidence of documentation of signs or symptoms and other indications of injury including the date and time of occurrence of femur fracture.	S3261		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046039	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/11/2026
NAME OF PROVIDER OR SUPPLIER THE HOMESTEAD OF LEAWOOD		STREET ADDRESS, CITY, STATE, ZIP CODE 12720 STATELINE RD LEAWOOD, KS 66209		
(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 8 The 01/12/26 at 01:23 PM "Nurses Note" documented R1 had a skin tear on her right shin. A nurse cleansed the wound and applied steri-stips. R1's record lacked evidence of documentation of follow up results of the actions including wound monitoring for signs of infection or wound worsening and or wound healing. The 01/19/26 at 05:27 PM (last note in record) "Nurses Notes" documented R1's oxygen saturation was 87% on room air with "wheezing and gargling" sounds in her chest. R1's physician and the hospice provider were notified and new orders were received. The certified medication aide (CMA) on duty would administer the medication upon delivery. R1's record lacked evidence of documentation of follow-up results of medications and any notes of her condition following. On 02/11/26 at 12:17 PM Administrative Nurse C stated R1's had passed away and confirmed R1's record lacked evidence of results of medications when she had low oxygen saturation with wheezing and gurgling sounds in her chest and when she passed. On 02/11/26 at approximately 12:20 PM Administrative Nurse B stated the cause of R1's shin skin tear on 01/12/26 was never found but it had healed which R1's record lacked documentation of. Administrative Nurse B further confirmed R1's record lacked evidence of documentation when she suffered a femur fracture when two staff transferred her using a	S3261		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046039	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/11/2026
NAME OF PROVIDER OR SUPPLIER THE HOMESTEAD OF LEAWOOD		STREET ADDRESS, CITY, STATE, ZIP CODE 12720 STATELINE RD LEAWOOD, KS 66209		
(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 9 mechanical lift and bumped her knee against the wall. - Record review for R2 revealed an admission date of 05/02/24 with diagnoses of heart failure and chronic obstructive pulmonary disorder (COPD). The 11/12/25 "FCS" identified R2 required physical assistance with bathing, toileting, eating, and management of treatments. She was unable to perform management of medications and was frequently incontinent of bladder. R2 was sometimes understandable and sometimes understood others during communication and was marked at risk for falls, impaired vision, and impaired hearing. The 11/12/25 "NSA" identified R2 received assistance from hospice staff twice a week for bathing, facility staff assistance with toileting according to a schedule, and a mechanically altered diet for eating. She received administration of medications by a facility certified or licensed staff member and management of treatments for skin wounds by hospice. R2 wore incontinence products for incontinence of bladder and staff allowed time to respond and stood in front of her when speaking for communication. Facility staff notified the nurse before moving R3 after a fall. She was independent with glasses for impaired vision and independent with hearing aids for impaired hearing. The 10/24/25 at 02:58 PM "Nurses Note" (last nursing note in record) documented R2 continued on fall follow-up charting. She had no	S3261		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046039	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/11/2026
NAME OF PROVIDER OR SUPPLIER THE HOMESTEAD OF LEAWOOD		STREET ADDRESS, CITY, STATE, ZIP CODE 12720 STATELINE RD LEAWOOD, KS 66209		
(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 10 noted injuries or pain. On 02/11/2 at approximately 12:22 PM Administrative Nurse B confirmed R2's record lacked evidence of documentation of nursing notes after 10/24/25 including when she passed away. The administrator failed to ensure licensed staff documented when Resident (R) 1 suffered a femur fracture, follow-up wound healing for a skin tear, and when she passed away; and when R2 passed away.	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; (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	S3280		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046039	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/11/2026
NAME OF PROVIDER OR SUPPLIER THE HOMESTEAD OF LEAWOOD		STREET ADDRESS, CITY, STATE, ZIP CODE 12720 STATELINE RD LEAWOOD, KS 66209		
(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
S3280	Continued From page 11 by: KAR 26-41-104(d)(3) The facility reported a census of 48 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 every quarter. Findings included: - Documentation of quarterly reviews with residents of the facility's emergency management plan were requested which the facility failed to provide. On 02/11/26 at 043:22 PM Administrative Staff A confirmed facility lacked records documenting designated staff provided reviews of the facility's emergency management plan with residents every quarter. The 10/25/23 facility's "Emergency Preparedness" policy documented each administrator would ensure disaster preparedness by providing quarterly reviews of the emergency management plan with residents. The administrator failed to provide evidence of documentation designated staff provided reviews of the facility's emergency management plan with residents every quarter.	S3280		