

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046102	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/10/2026
NAME OF PROVIDER OR SUPPLIER ALTO		STREET ADDRESS, CITY, STATE, ZIP CODE 10300 INDIAN CREEK PARKWAY OVERLAND PARK, KS 66210		
(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 197852, 197412, 197310, 197207, 196415, 196418, and 196109 at the above named assisted living conducted on 02/04/26, 02/09/26, and 02/10/26.	S 000		
S3028 SS=D	26-41-101 (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 facility 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 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.	S3028		

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

TITLE

(X6) DATE

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S3028	Continued From page 1 This REQUIREMENT is not met as evidenced by: KAR 26-41-101(f)(3)(A)(C) The facility reported a census of 105 residents(R) with six residents included in the sample and three focused reviews. Based on interview and record review for R7 the administrator failed to ensure an allegation of neglect was reported to the department within 24 hours and failed to start an investigation when staff notified the administrator of the incident. The administrator failed to complete an investigation and submit it to the department within five working days of the same incident. Findings included: - Record review for Resident (R) 7 revealed an admission date of 07/29/24 with diagnoses of dementia and type two diabetes mellitus. The 01/01/26 "Functional Capacity Screen" (FCS) documented R7 was independent with transfers and walking/mobility, had short-term and long-term memory difficulties, and was at risk for falls. The 02/04/26 "Negotiated Service Agreement" (NSA) failed to describe services R7 received for cognitive difficulties and falls. The 12/27/25 at 12:26 PM "Progress Note" documented the nurse received report from the	S3028		

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S3028	Continued From page 2 night shift Certified Medication Aide (CMA) that R7 went to the hospital after she fell outside at approximately 05:00 AM. The nurse called the hospital for an update and was informed R7 was admitted because of a rib fracture. The 12/27/25 "Resident Incident Report" documented R7 suffered a fall with an injury outside the assisted living back patio entrance by the dining room. Staff were unable to find R7 at approximately 04:00 AM and found her on the ground outside appearing cold and confused. Facility staff called the Director of Nursing (DON) who instructed staff to provide R7 with a pillow and blankets and call emergency services. Vital signs were not obtained. The 12/27/25 "Witness Statement" by CMA E reported the nurse instructed her to ensure R7 received checks during the night. She checked R7 at approximately 11:30 PM and observed her lying in bed. At approximately 04:00 AM R7 was not in her room. CMA E notified the on-call nurse. Facility staff looked for R7 in the building and could not find her. They found her outside the back door on the ground. The 12/27/25 "Witness Statement" by CMA F reported she checked on R7 and observed she was not in her room. She notified CMA E that R7 was missing, and they began searching for R7 in the building. They found her outside near the dining room's back door. The 12/27/25 "Witness Statement" by Administrative Nurse C reported CMA E reported by phone at 04:53 AM R7 was not in her room. Administrative Nurse C instructed CMA E to	S3028		

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S3028	Continued From page 3 initiate the facility's elopement procedure. All staff looked in every room and outside. At 05:05 AM R7 was still missing. At 05:23 AM facility staff informed Administrative Nurse C they found R7 on the patio. The undated "Witness Statement" by Administrative Nurse B documented Administrative Nurse C notified her R7 was not in her room and facility staff searched the building and grounds for her. Administrative Staff B instructed facility staff to gather flashlights and look outside. Staff found R7 outside the dining room on the ground. Administrative Nurse B notified R7's daughter and requested the daughter review video footage from the in-room video camera. R7's daughter reported the last time R7 was seen in her room per video footage was at 02:20 AM. On 02/09/26 at approximately 01:50 PM Administrative Nurse B stated R7's daughter noticed on the in-room video camera R7 got out of bed around 11:00 PM to 01:00 AM each night. The daughter requested R7 be checked each night around 11:00 PM. Night shift staff checked R7 but did not document the checks. One night staff checked R7 and she was in bed at 11:00 PM. When they checked again she was not in her room. Staff found R7 outside on the ground on the patio. They were unable to determine how long R7 was outside before staff found her. On 02/09/26 at approximately 05:36 PM Administrative Staff A stated R7 was found outside one morning on the patio. They did not know how long R7 was outside. Administrative Staff A confirmed she did not report the incident	S3028		

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S3028	Continued From page 4 to the department nor conduct an investigation and submit it to the department within five days of the incident. The administrator failed to ensure an allegation of neglect was reported to the department within 24 hours and failed to start an investigation when staff notified the administrator of the incident. The administrator failed to complete an investigation and submit it to the department within five working days of the same incident.	S3028		
S3082 SS=E	26-41-201 (d) Functional Capacity Screen Accurate d) Designated facility staff shall ensure that each resident ' s functional capacity at the time of screening is accurately reflected on that resident ' s screening form. This REQUIREMENT is not met as evidenced by: KAR 26-41-201(d) The facility reported a census of 45 residents with three residents included in the sample and three focused reviews. Based on interview and record review the administrator failed to ensure designated staff ensured the "Functional Capacity Screen" (FCS) for Residents (R) 3, R4, R6, and R9 accurately reflected their functional capacity. Findings included: - Record review for R3 revealed an admission	S3082		

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S3082	Continued From page 5 date of 07/27/23 with a diagnosis of dementia. The 10/21/25 "FCS" for R3 documented "3 - unable to perform" for short-term and long-term memory, memory/recall, and decision making. The 11/05/25 "NSA" failed to describe the services R3 received for cognitive difficulties. - Record review for R4 revealed an admission date of 09/23/24 with diagnoses of dementia and weakness. The 08/15/25 "FCS" for R4 documented "2 - Physical Assistance Needed" for short-term and long-term memory, and memory/recall. The 06/30/25 "NSA" failed to describe the services R4 received for cognitive difficulties. - Record review for R9 revealed an admission date of 05/16/25 with diagnoses of dementia and muscle weakness. The 02/04/26 "FCS" for R9 documented "2 - Physical Assistance Needed" for decision-making. The 02/04/26 "NSA" failed to describe the services R9 received for cognitive difficulties. On 02/09/2 at 10:18 AM Administrative Nurse B confirmed the cognition section was inaccurate for R3, R4, and R9. - Record review for R6 revealed an admission date of 02/17/25 with a diagnosis of Parkinson's disease with dyskinesia.	S3082		

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S3082	Continued From page 6 The 08/03/19/25 "FCS" failed to document R6 was at risk for falls and/or unsteadiness. On 02/09/26 at approximately 01:43 PM Administrative Nurse B confirmed the "FCS" for R6 should have been marked for falls and/or unsteadiness. She stated R6 fell a lot and emergency services were called twice in one night because R6 fell. On 02/10/26 at 01:21 PM A "Functional Capacity Screen" policy was requested which the facility did not provide. The administrator failed to ensure designated staff ensured the "Functional Capacity Screen" (FCS) for Residents (R) 3, R4, R6, and R9 accurately reflected their functional capacity.	S3082		
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	S3085		

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S3085	Continued From page 7 (3) identification of each party responsible for payment if outside resources provide a service. This REQUIREMENT is not met as evidenced by: KAR 26-41-202(a)(1)(2) The facility reported a census of 105 residents with six residents included in the sample and three focused reviews. Based on interview and record review the administrator failed to ensure the "Negotiated Service Agreements" (NSA) for Residents (R) 3, R4, R5, R6, R7 and R8 described the services they received based on their "Functional Capacity Screens" (FCS). Findings included: - Record review for R3 revealed an admission date of 07/27/23 with a diagnosis of dementia. The 10/21/25 "FCS" identified R3 required physical assistance with toileting and walking/mobility and was unable to perform management of treatments. He was incontinent of bladder. The "FCS" documented in the cognition section "3 - unable to perform" for short-term and long-term memory, memory/recall, and decision making. R3 was sometimes understandable and rarely or never understood during communication and was at risk for falls. The 11/05/25 "NSA" failed to describe the services R3 received for toileting,	S3085		

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S3085	Continued From page 8 walking/mobility, management of treatments, bladder incontinence, cognition, communication, and falls. On 02/09/26 at 01:23 PM Administrative Nurse B confirmed R3's "NSA" failed to describe the services he received based on his "FCS." - Record review for R4 revealed an admission date of 09/23/24 with diagnoses of dementia and weakness. The 08/15/25 "FCS" identified R4 was unable to perform management of treatments. The "FCS" documented in the cognition section "documented "2 - Physical Assistance Needed" for short-term and long-term memory, and memory/recall. The 06/30/2 "NSA" failed to describe the services R4 received for management of treatments and cognition. On 02/09/26 at approximately 01:2 PM Administrative Nurse B confirmed R4's "NSA" failed to describe the services he received based on his "FCS." - Record review for R5 revealed an admission date of 04/14/25 with a diagnoses of dementia and violent behavior. The 04/08/2 "FCS" identified R5 had short-term and long-term memory, memory/recall, and decision-making cognitive difficulties and was at risk for falls. The 04/08/25 "NSA" failed to describe the	S3085		

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S3085	Continued From page 9 services R5 received for cognition and falls. On 02/09/26 at approximately 01/25 PM Administrative Nurse B confirmed R5's "NSA" failed to describe the services he received based on his "FCS." - Record review for R6 revealed an admission date of 02/17/25 with a diagnosis of Parkinson's disease with dyskinesia. The 03/19/2 "FCS" identified R6 required physical assistance with management of medications and was unable to perform management of treatments. She had long-term memory, memory/recall, and decision-making cognitive difficulties. The 02/04/26 "NSA" failed to describe the services R6 received based on her "FCS." On 02/09/26 at 01:43 PM Administrative Nurse B confirmed R6's "NSA" failed to describe the services she received based on her "FCS." - Record review for R7 revealed an admission date of 07/29/24 with diagnoses of dementia and type two diabetes mellitus. The 01/01/26 "FCS" identified R7 required physical assistance with management of treatments, had short-term and long-term memory difficulties, and was at risk for falls. The 11/05/25 "NSA" failed to describe the services R7 received for management of treatments, cognition, and falls.	S3085		

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S3085	Continued From page 10 On 02/09/26 at approximately 01:50 PM Administrative Nurse B confirmed R7's "NSA" failed to describe the services she received based on her "FCS." - Record review for R8 revealed an admission date of 10/16/23 with a diagnoses of hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side and history of falling. The 11/06/25 "FCS" identified R8 required physical assistance with dressing, toileting, and transfers and was at risk for falls. The 11/0/25 "NSA" failed to describe the services R8 received for dressing, toileting, transfers, and falls. On 02/09/26 at 02:1 PM Administrative Nurse B confirmed R8's "NSA" failed to describe the services she received based on her "FCS." On 02/10/26 at 01:21 PM a "Negotiated Service Agreement" policy was requested which the facility did not provide. The administrator failed to ensure the "NSAs" for R3, R4, R5, R6, R7 and R8 described the services they received based on their "FCS."	S3085		
S3155 SS=G	26-41-204 (a) Health Care Services . (a) The administrator or operator in each assisted living facility or residential health care facility shall ensure that a licensed nurse provides or coordinates the provision of necessary health care services that meet the	S3155		

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S3155	Continued From page 11 needs of each resident and are in accordance with the functional capacity screening and the negotiated service agreement. This REQUIREMENT is not met as evidenced by: KAR 26-41-204(a) The facility reported a census of 105 residents with six included in the sample and three closed record reviews. Based on observation, interview, and record review the administrator failed to ensure a licensed nurse provided the necessary health care services to keep cognitively impaired Resident (R) 7 safe from elopement and to prevent injury from falls. This failure resulted in harm when R7 exited the building without staff knowledge and suffered a fall with injury. Findings included: - Record review for R7 revealed an admission date of 07/29/24 with diagnoses of dementia and type two diabetes. The 01/01/26 "Functional Capacity Screen" (FCS) identified R7 was independent with transfers, and walking/mobility, had short-term and long-term memory difficulties, and was at risk for falls. The 11/05/25 "Negotiated Service Agreement" (NSA) identified R7 was independent with	S3155		

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S3155	Continued From page 12 transfers and walking/mobility. The "NSA" failed to describe the services R7 received for cognition and falls. The 06/15/25 "Elopement Risk Evaluation Form" documented R7 had a diagnosis of dementia and had cognitively impaired poor decision-making skills with no previous elopement or exit-seeking behaviors. The evaluation tool summarized R7 was not at risk for elopement. The 06/09/25 at 05:33 PM nursing "Progress Note" documented R7's daughter reported to the nurse practitioner she saw on their personal video camera footage R7 did odd things around midnight because of insomnia. New orders were received to adjust medications. The 10/14/25 at 07:36 AM nursing "Progress Note" documented night shift staff reported R7 fell during the night. Her family reported they viewed video footage and saw R7 was on the floor for an hour before she called family members. They arrived to the facility to assist R7 off the floor. Facility staff reminded R7 to use her call pendant when she required help. The 10/29/25 at 05:20 PM nursing "Progress Note" documented R7's daughter requested staff to peek in R7's room around 02:00 AM each night to ensure she had not fallen. The 11/27/25 nursing "Progress Note" documented R7 used her call pendant at 08:40 AM. Upon arrival, the nurse found R7 sitting on the ground. The nurse re-educated R7 to use her roller walker for safety. R7 stated "I understand but might not remember."	S3155		

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S3155	Continued From page 13 Review of nursing "Progress Notes" from 10/14/25 to 12/27/25 revealed nursing staff documented R7 fell three times on 10/14/25, 11/27/25, and 12/24/25 before she exited the building without staff knowledge and fell a fourth time on 12/27/25. The 12/27/25 at 12:26 PM nursing "Progress Note" documented the night Certified Medication Aide (CMA) reported R7 was at the hospital after a fall outside of the building around 05:00 AM. The hospital updated the facility that R7 was admitted due to a fractured rib. The 12/27/25 "Resident Incident Report" documented R7 suffered a fall with an injury outside the assisted living back patio entrance by the dining room. Staff discovered R7 was not in her room at approximately 04:00 AM and found her on the ground outside appearing cold and confused around 05:00 AM. Facility staff called the Director of Nursing (DON) who instructed staff to provide R7 with a pillow and blankets and call emergency services. The 12/27/25 "Witness Statement" by CMA E reported the nurse instructed her to ensure R7 received checks during the night. She checked R7 at approximately 11:30 PM and observed her lying in bed. At approximately 04:00 AM R7 was not in her room. CMA E notified the on-call nurse. Facility staff looked for R7 in the building and could not find her. They found her outside the back door on the ground. The 12/27/25 "Witness Statement" by CMA F reported she checked on R7 and observed she	S3155		

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S3155	Continued From page 14 was not in her room. She notified CMA E that R7 was missing, and they began searching for R7 in the building. They found her outside near the dining room's back door. The 12/27/25 "Witness Statement" by Administrative Nurse C reported CMA E reported by phone at 04:53 AM (approximately 53 minutes after staff discovered she was missing from her room) R7 was not in her room. Administrative Nurse C instructed CMA E to initiate the facility's elopement procedure. All staff looked in every room and outside. At 05:05 AM R7 was still missing. At 05:23 AM facility staff informed Administrative Nurse C they found R7 on the patio. The undated "Witness Statement" by Administrative Nurse B documented Administrative Nurse C notified her R7 was not in her room and facility staff searched the building and grounds for her. Administrative Staff B instructed facility staff to gather flashlights and look outside. Staff found R7 outside the dining room on the ground. Administrative Nurse B notified R7's daughter and requested the daughter review video footage from the in-room video camera. R7's daughter reported the last time R7 was seen in her room per video footage was at 02:20 AM. The 01/01/26 "Elopement Risk Evaluation Form" documented R7 had a pertinent diagnosis, was confused, hard of hearing, and had left the community without appropriate supervision one time. The evaluation tool summarized R7 was not at risk for elopement in the memory care unit but would be at risk if she still lived in the assisted living.	S3155		

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S3155	Continued From page 15 Observation and interview on 02/09/26 at 03:55 PM revealed R7 sat in a chair in her room watching TV. Her rolling walker was behind the chair out of R7's reach. R7 stated she seldom used her walker, only if she was going to walk a long way. On 02/04/26 at approximately 09:45 AM Administrative Staff A stated the exit doors were kept unlocked at all times for residents to leave if they wanted. The front door, west patio door, and dining room patio door were locked to enter each evening at 08:00 PM. All other doors were emergency exit doors and required a key to enter. The doors were not alarmed in the assisted living portions of the building. On 02/09/26 at approximately 01:50 PM Administrative Nurse B stated R7's daughter noticed on the in-room personal video camera R7 got out of bed around 11:00 PM to 01:00 AM each night. The daughter requested R7 be checked each night around 11:00 PM. Night shift staff checked R7 but did not document the checks. One night staff checked R7 and she was in bed at 11:00 PM. When they checked again she was not in room. Staff found R7 outside on the ground on the patio. They were unable to determine how long R7 was outside before staff found her. On 02/09/26 at approximately 05:36 PM Administrative Staff A stated R7 was found outside one morning on the patio. They did not know how long R7 was outside. On 02/10/26 at 12:21 PM an unidentified family	S3155		

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S3155	Continued From page 16 member stated R7 had a camera in her room that went to family's devices. The family reviewed the video footage per facility's request the morning after R7 was found outside. The family saw it took R7 15 minutes to tie her shoes and walked out her room door at 02:30 AM. Facility staff called the family at 05:00 AM and informed them R7 was found outside on the patio by the dining room. She was cold and wet. The doctor at the hospital reported to the family R7's temperature was 92.0 degrees Fahrenheit (F) or 93.0 F, she could not remember which. But it took until at least noon for R7's body temperature to return to normal under a warming air blanket. She fractured a rib and cut her left third finger. The weather on 12/27/25 at 04:53 AM according to www.Wunderground.com was 46 degrees F with a wind speed of five miles per hour (mph) and no precipitation. It was dark with sunrise time at 07:37 AM The 04/04/18 "Elopement/Missing Resident Policy" documented some communities may not be designed to accommodate residents who were likely to wander away or who have a substantial risk of elopement. Prospective residents would be evaluated for elopement risk and current residents would be evaluated if there was a change in their condition or if they attempt to elope. In the event a resident could not be accounted for a review of the sign in/sign out sheet log and resident's record to ensure there was not an anticipated absence. Staff would notify the nurse and the executive director when a resident was determined to be missing. The administrator failed to ensure a licensed	S3155		

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S3155	Continued From page 17 nurse provided the necessary health care services to keep cognitively impaired R7 safe from elopement and to prevent injury from falls. This failure resulted in harm when R7 exited the building in the middle of the night, without staff knowledge and suffered a fall with injury.	S3155		
S3215 SS=E	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 provider may request that the medication be stored by the facility. (4) A licensed nurse or medication aide shall not	S3215		

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S3215	Continued From page 18 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 105 residents with 27 living in the memory care unit. Based on observation and interview, the administrator failed to ensure designated staff stored controlled medications in the memory care unit in separately locked compartments within a locked medication room. Findings included: - Observation on 02/04/26 at approximately 10:46 AM in the memory care unit revealed a small, unlocked refrigerator in a locked medication room. Nine boxes of liquid lorazepam inside the refrigerator were not stored in a locked compartment. On 02/04/26 at approximately 10:46 AM Certified Medication Aide (CMA) D stated the lock on the refrigerator had been unlocked since shift change that morning because she did not know the code to the lock. On 02/04/26 at approximately 10:46 AM Administrative Nurse C confirmed the refrigerator contained controlled medications and was not locked.	S3215		

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S3215	Continued From page 19 On 02/10/26 at 01:21 PM a medication storage policy was requested which the facility failed to provide. The administrator failed to ensure designated staff stored controlled medications in separately locked compartments within a locked medication room.	S3215		
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 105 residents with six residents included in the sample and three focused reviews. Based on interview and record review the administrator failed to ensure licensed staff documented all incidents, symptoms, indications of illness or injury including the dates, times, actions taken, and results of the actions for Residents (R) 7 and R9. Findings included: - Record review for R7 revealed an admission date of 07/29/24 with diagnoses of dementia and	S3261		

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S3261	Continued From page 20 type two diabetes mellitus. The 01/01/26 "Functional Capacity Screen" (FCS) identified R7 was independent with transfers, and walking/mobility, had short-term and long-term memory difficulties, and was at risk for falls. The 11/05/25 "Negotiated Service Agreement" (NSA) identified R7 was independent with transfers and walking/mobility. The "NSA" failed to describe the services R7 received for cognition and falls. The 12/27/25 at 12:26 PM nursing "Progress Note" documented the night Certified Medication Aide (CMA) reported R7 was at the hospital after a fall outside of the building around 05:00 AM. The hospital updated the facility that R7 was admitted due to fractured rib. R7's record lacked evidence of documentation of a fall incident outside of the facility including indications of injury, the date, time of occurrence, action taken, and results of the action. On 02/09/26 at approximately 01:50 PM Administrative Nurse B confirmed R7's record lacked evidence of documentation of a fall incident outside of the facility including indications of injury, the date, time of occurrence, action taken, and results of the action. - Record review for R9 revealed an admission date of 05/16/25 with diagnoses of dementia and muscle weakness. The 02/04/26 "FCS" identified R9 required	S3261		

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S3261	Continued From page 21 physical assistance with transfers, walking/mobility. He had short-term memory, memory/recall, and decision-making cognitive difficulties and was at risk for falls. The 02/04/26 "NSA" identified facility staff provided R9 stand by assistance with cueing and prompting for transfers. The "NSA" failed to describe the services R9 received for walking/mobility, cognition, and falls. The 02/03/26 at 09:05 AM nursing "Progress Note" documented night shift reported R9 fell in the middle of the night and an x-ray was ordered by his hospice provider. R9 was unable to walk in the morning, was in a lot of pain, and stated he wanted to sleep. R9's record lacked evidence of documentation of a fall incident during the night including indications of injury, the date, time of occurrence, action taken, and results of the action. On 02/09/26 at approximately 02:36 PM Administrative Nurse B confirmed R9's record lacked evidence of documentation of a fall incident during the night including indications of injury, the date, time of occurrence, action taken, and results of the action. She stated the night shift CNA found R9 on the floor in his bathroom and was unsure how long R9 was on the floor. The reviewed 12/06/23 facility's "Documentation" policy documented "complete documentation as soon as possible after an event or observation. . . describe signs and symptoms." Ensure each entry was complete with all significant information related to an event, resident's	S3261		

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S3261	Continued From page 22 condition, care given, and response to the care." The administrator failed to ensure licensed staff documented all incidents, symptoms, indications of illness or injury including the dates, times, actions taken, and results of the actions for R7 and R9.	S3261		