STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175383	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESLEY TOWERS INC	700 MONTEREY PL , HUTCHINSON, Kansas, 67502

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F0000	INITIAL COMMENTS The following citations represent the findings of a health resurvey.	F0000		
F0605 SS = D	Right to be Free from Chemical Restraints CFR(s): 483.10(e)(1),483.12(a)(2),483.45(c)(3)(d)(e) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any . . . chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must-. . . §483.12(a)(2) Ensure that the resident is free from . . . chemical restraints imposed for purposes of discipline or convenience and	F0605		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F0605 SS = D	Continued from page 1 that are not required to treat the resident's medical symptoms. . . . . §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic. §483.45(d) Unnecessary drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. §483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;	F0605		

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F0605 SS = D	Continued from page 2 §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is NOT MET as evidenced by: The facility had a census of 45 residents. The sample included 13 residents, of which five residents were reviewed for unnecessary medications. Based on observation, record review, and interview, the facility failed to ensure Resident (R) 2 received as-needed (PRN) Clonazepam (an antianxiety medication that would calm and relax people with excessive restlessness, nervousness and tension) without a 14 day stop date or definitive end date for use. Findings included: - Resident 2's diagnoses included anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), gastroparesis (a chronic condition where stomach muscles work poorly, causing delayed emptying of food into the small intestines without a physical blockage), and gastroesophageal reflux disease (GERD-backflow of stomach contents to the esophagus) and nausea. The quarterly Minimum Data Set (MDS), dated 12/17/25, recorded the R2 had a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The	F0605		

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F0605 SS = D	Continued from page 3 MDS recorded R2 received antianxiety (class of medications that calm and relax people) and antidepressant (class of medications used to treat mood disorders) medications. The "Psychotropic Drug Use Care Area Assessment" (CAA), dated 10/04/25, documented R2 received psychotropic medications, and staff would monitor R2 every shift for side effects and the physician would be notified of abnormal findings. The CAA documented that a pharmacist consultant would review R2's medications monthly and the primary care physician would review R2's medication with each visit. R2 received the medication due to a history of insomnia and anxiety. The "Care Plan," dated 02/17/26, recorded R2 received Clonazepam (antianxiety medication) for anxiety including restlessness, worrying, frequent repetitive health concerns and questions, sleep disturbance, and refusal of care. The care plan documented staff would monitor R2 for adverse reactions, which included drowsiness, lack of energy, clumsiness, slurred speech, confusion, and impaired thinking and judgement. The "Physician Order," dated 03/04/26, directed staff to administer Clonazepam, 0.5 milligrams, one tablet, every 12 hours as needed for anxiety. The resident's medical record lacked documentation the PRN Clonazepam had a 14 day stop date or specific date to stop the medication. On 03/10/26 at 07:50 AM, an observation revealed R2 in her recliner, dressed in pajamas. Licensed Nurse (LN) H administered the resident's morning medications. On 03/11/26 at 07:50 AM, Administrative Nurse D verified the resident PRN order for Clonazepam, one tablet every 12 hours as needed. Administrative Nurse D also stated R2 routinely used the medication twice daily and verified the order did not have a 14 day stop date and lacked an end date for use. The facility's "Psychotropic Medication" policy, dated December 2022, recorded residents were not administered psychotropic medications unless the medication was necessary to treat a specify condition as diagnosed and	F0605		

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F0605 SS = D	Continued from page 4 documented in the clinical record, and the medication is beneficial to the resident, as demonstrated by monitoring and documentation of the resident's response to the medication. The policy documented PRN orders for all psychotropic medications would be used only when the medication was necessary to treat a diagnosed specific condition that is documented in the clinical record, and for a limited duration-such as 14 days. If the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she shall document their rationale in the resident's medical record and indicate the duration for the PRN order.	F0605		
F0657 SS = D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is NOT MET as evidenced by:	F0657		

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F0657 SS = D	Continued from page 5 The facility had a census of 45 residents. The sample included 13 residents, with one reviewed for nutrition/hydration status. Based on observation, record review, and interview, the facility failed to update Resident (R) 11's care plan, who was at risk for elopement with a section with instructions to staff on interventions to prevent R11 from eloping. Findings included: - R11's Electronic Medical Record (EMR) documented diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion), anxiety disorder (a progressive mental disorder characterized by failing memory and confusion), and psychotic disturbance (any major mental disorder characterized by a gross impairment in reality perception). R11's "Quarterly Minimum Data Set" (MDS), dated 12/23/24, documented she had a Brief Interview for Mental Status (BIMS) score of one, which indicated severely impaired cognition. The MDS documented R11 required supervision with ambulation and used a walker or wheelchair for mobility. The MDS documented R11 had no upper or lower extremity impairment. The MDS documented R11 had no falls since the prior assessment. The “Elopement Assessment,” dated 12/20/25, documented the resident had a score of five, which indicated R11 was at risk for elopement. R11's "Care Plan," revised 12/23/25, documented R11 required supervision to substantial staff assistance with activities of daily living (ADLs). The care plan lacked a section regarding elopement with instructions to staff for interventions to prevent elopement. On 03/11/26 at 11:00 AM, observation revealed R11 sat in a chair by the dining room window in the front entrance hallway, eating a snack with her walker in front of her. On 03/11/26 at 08:30 AM, Administrative Nurse D verified R11's care plan lacked a section regarding elopement, and the 12/20/25 elopement assessment placed her at risk for elopement. Administrative Nurse D stated residents are assessed for elopement risk on admission, quarterly, with significant change, and	F0657		

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F0657 SS = D	Continued from page 6 annually. The facility's "Comprehensive Care Plans Policy," revised 10/25, documented the comprehensive care plan would be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly MDS assessment, and significant change assessment.	F0657		
F0677 SS = D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is NOT MET as evidenced by: The facility had a census of 45 residents. The sample included 13 residents, with one reviewed for activities of daily living (ADL). Based on observation, record review and interview, the facility failed to provide care and services for Resident (R)29 regarding personal hygiene and grooming. Findings included: - R29's" Quarterly Minimum Data Set" (MDS), dated 01/08/26, indicated the resident had a Brief Interview for Mental Status (BIMS) score of 15 indicating resident was cognitively intact. The MDS documented R29 was independent with staff oversight for personal hygiene; The MDS noted that a shower or bath was not attempted due to medical condition or safety concerns. R29's "Care Plan," dated 01/31/26, indicated R29 had ADL self-care performance deficits and staff would check her nail length and trim and clean on bath days and as necessary and report any changes to the nurse. The care plan lacked further documentation on bathing needs. On 03/09/26 at 03:30 PM, observation revealed R29 sat in a recliner in her room, dressed in street clothes. Her hair was uncombed, and she had white hair visible on her chin. On 03/10/26 at 08:00 AM, observation revealed R29 sat	F0677		

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F0677 SS = D	Continued from page 7 at the dining room table with other residents eating lunch. Her hair was uncombed, and she had white hair visible on her chin. On 03/10/26 at 12:30 PM, Administrative Nurse D verified R29 had white hair stubble on her chin and said staff should shave R29's face on shower days. Administrative Nurse D stated the shower/bath sheets were for staff to documents if they shaved the residents and verified R29 had a shower on 03/06/26 and staff did not shave her face. The facility "ADL" policy, dated November 2023, documented all residents are bathed as often as necessary to maintain cleanliness, refresh, and stimulate circulation. Tub baths and showers are provided by all nursing staff two times a week, as tolerated, and/or as needed. Residents skin conditions are monitored with each bath. The policy documented that staff would assist the residents with bathing as needed and to dress and shave.	F0677		
F0692 SS = D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is NOT MET as evidenced by:	F0692		

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F0692 SS = D	Continued from page 8 The facility had a census of 45 residents. The sample included 13 residents, with one reviewed for hydration. Based on observation, record review, and interview, the facility staff failed to consistently monitor Resident (R) 20's fluid intake related to a physician-ordered fluid restriction. Findings included: - R20's Electronic Medical Record (EMR) documented diagnoses of chronic respiratory failure and ascites (an abnormal buildup of fluid in the abdomen that may cause swelling). R20's "Quarterly Minimum Data Set" (MDS), dated 02/06/26, documented a Brief Interview of Mental Status (BIMS) score of 13, which indicated intact cognition. The MDS documented R20 required supervision with upper body dressing and rolling left to right in bed; partial to moderate assist with toileting hygiene, showering, putting on and taking off footwear, personal hygiene, and transfers; substantial to maximal assist with lower body dressing. She was dependent on staff for mobility in a manual wheelchair. R20's "Care Plan," revised on 01/18/26, documented she had a 1500 milliliter (ml) fluid restriction per day. The "Physician Order,“ dated 03/05/26, instructed staff to provide R20 with a 1500 ml fluid restriction daily (650 ml 06:00 AM-02:00 PM, 650 ml 02:00 PM-10:00 PM, and 200ml 10:00 PM-06:00 AM) R20’s March 2026 “Medication Administration Record” (MAR) lacked amounts of fluid intake on each shift. The Jana (computer documentation system) used by the nurse aides had documentation of fluid intake for one shift on two days. On 03/11/26 at 08:00 PM, observation revealed R20's bedside table had a pitcher on it with 600 ml of water. On 03/11/26 at 07:55 AM, Certified Nurse Aide (CNA) M stated the facility had one resident on a fluid	F0692		

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F0692 SS = D	Continued from page 9 restriction. CNA M stated that at the end of her shift, she gave the nurse a piece of paper with the amount of fluid R20 drank during that shift. On 03/11/26 at 08:00 AM, Licensed Nurse (LN) G verified R20's MAR lacked documentation regarding the amount of fluid R20 consumed on each shift and stated the CNAs should document the amounts intake. On 03/11/26 at 08:22 AM, Dietary Staff CC stated she did not record fluid intake for the residents at meals. Dietary Staff CC stated she was told to give R20 a 12-ounce glass of whatever fluid she requested. On 03/11/26 at 08:11 AM, Administrative Nurse D verified staff were not consistently documenting R20's fluid intake in the Jana system and stated they should be. The facility's " Fluid Restriction Policy," revised 11/23, documented that fluid restrictions would be documented in the EMR records by CNA/CMA with a check mark noting that the CNA/CMA is aware of the fluid restriction. The CNA/CMA would document the fluid intake on the meal percentage sheet each meal, and at the end of the shift would give the total intake to the LN/CMA to document in the vital stats tab in the EMR.	F0692		
F0804 SS = D	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is NOT MET as evidenced by: The facility reported a census of 45 residents and two kitchens. Based on observation, interview, and record review, the facility failed to ensure staff served meals at safe and appetizing temperatures. This was	F0804		

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F0804 SS = D	Continued from page 10 evident by the low temperature of food items on the last meal tray (test tray) from the kitchen on 03/11/26. Findings included: - During an observation on 03/11/26 at 11:35 AM, Dietary Staff (DS) DD prepared six servings of cooked roast beef with a temperature of 171 degrees Fahrenheit (F), cooked mashed potatoes and brown gravy with a temperature of 152 degrees F, and cooked peas with a temperature of 158 degrees F. Dietary Staff DD placed the cooked food onto covered heated plates which were then placed onto an open serving cart. On 03/11/26 at 11:50 AM, upon delivering the last meal tray (test tray) from the kitchen to the surveyor, DS DD took the temperature of the food items upon the tray and reported: cooked roast beef temperature of 122 degrees F, and cooked peas temperature of 132 degrees F. During an interview on 03/11/26 at 11:50 AM, Dietary Staff DD stated he expected the temperature of all hot cooked food items served to residents to be around 145 degrees F. During an interview on 03/11/26 at 11:40 AM, Staff CC stated hot food should have a temperature of at least 145 degrees, before it is served to residents. During an interview on 03/11/26 at 11:50 AM, Dietary Staff BB stated she expected the dietary staff to serve hot food to residents at the appropriate temperatures, over 140 degrees F. Staff BB said she expected staff to not serve hot food to residents that was not at least 140 degrees F. During an interview on 03/10/26 at 2:00 PM, R40 stated the food was cold most of the time. During record review on 03/10/26, Summary of Resident Council Meeting Minutes for the year 2026 revealed resident complaints of cold food from 19 residents in attendance at the meeting.	F0804		

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F0804 SS = D	Continued from page 11 The facility's policy "Food Preparation and Handling," dated 03/25/21, documented all food items and products served to elders that will be prepared or served from/in a central kitchen and/or neighborhood kitchen/serving area will be according to standardized recipes. Food items would be prepared using methods and techniques designed to preserve maximum nutritive value, enhance flavor and be free of injurious organisms and substances. The facility's policy lacked the holding temperature of food.	F0804		
F0880 SS = E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be	F0880		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0880 SS = E	Continued from page 12 followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: The facility reported a census of 45 residents, including 13 residents in the sample. Based on observation, interview and record review the facility failed to Ensure adequate infection control practices related to clean Hoyer lift slings. Findings included: - On 03/10/26 at 09:30 AM, an observation of the clean linen room revealed wall pegs to hold the Hoyer lift (mechanical device used to transfer individuals between surfaces) slings, 14 slings were placed on the pegs in the clean linen room these pegs did not keep the slings	F0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175383	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/11/2026

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F0880 SS = E	Continued from page 13 or the straps from lying on the floor. On 03/10/26 at 11:30 AM, an interview with Housekeeping Staff V revealed the slings touching the floor in the clean laundry room were like this since Housekeeping Staff V started working at the facility. 03/10/26 at 11:40 AM, an interview with Housekeeping Staff U during the observation of the clean linen room storage room revealed the slings have always hung on the pegs attached to the wall and the slings have always touched the floor since starting here one and half years ago. 03/10/26 at 2:40 PM, during the second observation of the clean linen room, the slings were placed correctly on the pegs which prevented the slings and straps from touching the floor. On 03/10/26 at 2:45 PM, an interview with Administrative Staff D revealed she expected the staff to keep the slings off the floor. The facilities policy “Infection Prevention and Control Policy,” revised on 10/25, revealed the facility has established and maintains an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment to help prevent the development and transmission of communicable diseases and infection as pre accepted national stands and guidelines. Per Equipment Protocol, all reusable items and equipment requiring special cleaning, disinfection, or sterilization shall be cleaned in accordance with our current procedure governing the cleaning and sterilization of soiled or contaminated equipment.	F0880		