

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: B046091	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/26/2026
NAME OF PROVIDER OR SUPPLIER VILLA HEIGHTS LIVING LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 816 S MULBERRY STREET GARDNER, KS 66030		
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S 000	INITIAL COMMENTS The following represents the findings of a resurvey with attached complaints complaints 198251, 198256, and 198258 at the above named home plus conducted on 03/23/26, 03/24/26, 03/25/26, and 03/26/26.	S 000		
S 135 SS=E	26-39-103 (h) Resident Right Notification of Changes (h) Notification of changes. (1) The administrator or operator shall ensure that designated facility staff inform the resident, consult with the resident's physician, and notify the resident's legal representative or designated family member, if known, upon occurrence of any of the following: (A) An accident involving the resident that results in injury and has the potential for requiring a physician's intervention; (B) a significant change in the resident's physical, mental, or psychosocial status; (C) a need to alter treatment significantly; or (D) a decision to transfer or discharge the resident from the adult care home. (2) The administrator or operator shall ensure that a designated staff member informs the resident, the resident's legal representative, or authorized family members whenever the designated staff member learns that the resident will have a change in room or roommate assignment. This STANDARD is not met as evidenced by: KAR 26-39-103(h)(1)(A)(B)	S 135		

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

TITLE

(X6) DATE

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S 135	Continued From page 1 The facility reported a census of two residents which were included in the sample and two focused reviews for discharged residents. Based on interview and record review the operator failed to ensure designated staff notified Resident (R) 3's designated family member and physician upon two separate occurrences when she fell and suffered a bleeding head injury and when she suffered multiple bruises. Findings included: - Record review for R3 revealed an admission date of 10/11/24 with diagnoses of dementia and anxiety. The 06/05/25 "Functional Capacity Screen" (FCS) identified R3 required physical assistance with bathing, dressing, toileting and she was unable to perform management of medications and treatments. R3 was frequently incontinent of bladder, had short-term memory and decision-making cognitive difficulties, and was at risk for falls, impaired vision, and wandering. The 06/05/25 "Negotiated Service Agreement" (NSA) identified R3 received physical assistance from a hospice aide twice weekly with bathing. She received physical assistance from facility staff with dressing and toileting. R3 received checks and assistance to change soiled undergarments as needed for bladder incontinence. She received management of medications and treatments by facility staff. Staff used simple words, were concise, and articulated clearly for cognitive difficulties and encouraged R3 to remain in the common area for close	S 135		

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S 135	Continued From page 2 monitoring for wandering and falls. The "NSA" failed to describe services R3 received for impaired vision. The 02/19/26 at 03:00 AM "Employee Incident Report" by Certified Nurse Aide (CNA) J signed by Administrative Staff A reported CNA J arrived to work in the facility on 03/01/26 [sic]. During the night CNA J witnessed R3 fall onto her back and suffer an injury to the back of her head and he notified the nurse of the incident. The 02/19/26 at 09:12 late entry "Nurse Note" by Administrative Staff A documented R3 fell and bumped her head. There was no bleeding or swelling. The note lacked the date and time of the incident, actions taken and results of the actions. The 02/24/26 hospice "Skilled Nursing Visit Note" documented R3 complained of a headache and caregiver present reported R3 had a witnessed fall over the weekend. She walked back from the bathroom at 03:00 AM, lost her balance, fell backward and hit her head. R3 had a small laceration to the back of her head that was healed together and intact. Caregiver administered Tylenol with headache starting to resolve by the end of the visit. Caregivers were encouraged to call hospice with any falls or changes in condition. The 02/25/26 at 12:00 PM PCP (Primary Care Provider) "Progress Note" documented R3 "had a fall on Sunday and hit the back of her head." A small area was bleeding upon exam.	S 135		

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S 135	Continued From page 3 The 03/02/26 at 04:02 PM Hospice "Aide Regular Visit" note by Hospice Aide M documented R3 had yellow bruising on her chest and abdomen. The hospice aide notified the hospice nurse. The 03/05/26 nurse "Charting Note" by Administrative Staff A documented the hospice nurse called and reported a linear bruise on the resident's chest and small area of bruising noted on the abdomen. R3's unidentified family member took her to the hospital for examination. The 03/24/26 notarized "Witness Statement" by CNA J reported he arrived to work in the facility on 02/19/26 in the evening around 08:00 PM. Around 03:00 AM in the night, R3 tried to ambulate to the bathroom by herself. He approached her and she lost her balance and fell on her left [sic] side. R3 hit her head on the bed and said she was ok. CNA J assisted R3 up and to the bathroom. He noticed a "minor cut" on her scalp that measured 0.5 centimeters (cm) and covered it with an adhesive bandage. He assisted R3 back to bed. At the end of his shift, CNA J reported R3 fell during the night to the oncoming shift and informed them they should notify the nurse. The 03/26/26 notarized "Witness Statement" by CMA G reported on 03/03/26 at approximately 07:53 PM while assisting R3 with evening cares, CMA G observed "extensive bruising" on R3's breast, chest, arms, back and bottom that she had not previously seen. She had not worked since 02/24/26 and there was no facility documentation to explain how the bruising occurred. CMA G worked again on day shift on	S 135		

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S 135	Continued From page 4 03/05/26 from 07:00 AM to 03:30 PM. During her shift, R3's unidentified family member (legal representative) visited the facility. CMA G asked R3's family member if she was aware of the bruising to which she reported she was not aware. The 03/26/26 notarized "Witness Statement" by CMA G reported when she arrived to work at the facility on 02/08/26 at approximately 07:00 AM, CNA J was present and reported to CMA G R3 fell and hit her head sometime during the night. CMA G assisted R3 to get dressed for the day and noticed blood on R3's pillow. She observed a large wound on R3's head with dried blood on her scalp and hair, which appeared to be still bleeding. R3 expressed her head hurt. On 03/23/26 at 01:21 PM Administrative Staff A stated at 03:00 AM on 02/19/26 CNA J woke R3 up to assist her to the bathroom and she fell and hit her head. Administrative Staff A instructed staff to clean R3's head because there was a "stain of blood" on her head. Administrative Staff A confirmed did not report to R3's family her head was bleeding because "she had not set eyes on it yet." On 03/24/26 at approximately 08:01 AM R3's unidentified family member (legal representative) stated the following during a phone interview that on 03/05/26 she visited R3 at the facility. CMA G and Housekeeping Staff E were present. CMA G asked her if she was aware of R3's bruises and she was not aware. She observed R3's bruises herself in private in R3's room and became upset. She left the facility and returned later to pick up R3 and take her to the emergency room.	S 135		

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S 135	Continued From page 5 The undated facility's "Resident Rights Notification and Changes Policy" did not address informing the resident, consulting with the resident's physician, and notifying the resident's designated family member upon occurrences of accidents that resulted in injury and any significant changes in the resident's status. The operator failed to ensure designated staff notified Resident (R) 3's designated family member and physician upon two separate occurrences when she fell and suffered a bleeding head injury and when she suffered multiple bruises.	S 135		
S5026 SS=K	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: KAR 26-42-101(f)(1)(A)(B) The facility reported a census of two residents with two residents included in the sample and two focused reviews for discharged residents.	S5026		

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S5026	Continued From page 6 Based on interview and record review the operator failed to protect three cognitively impaired residents from potential abuse and neglect that resulted in Immediate Jeopardy when Resident (R) 3 suffered multiple bruises and rib fractures of unknown origin; R4 alleged sexual abuse and suffered bruises on her upper arms and lower legs (reported by the facility to be caused by a mechanical lift) and an additional bruise on her foot from unknown origin; and R2 who suffered bruises on her right hand and abdomen and a bruise on her upper outer thigh of unknown origin. Findings included: - Record review for R3 revealed an admission date of 10/11/24 with diagnoses of dementia and anxiety. The 06/05/25 "Functional Capacity Screen" (FCS) identified R3 required physical assistance with bathing, dressing, toileting and she was unable to perform management of medications and treatments. R3 was frequently incontinent of bladder, had short-term memory and decision-making cognitive difficulties, and was at risk for falls, impaired vision, and wandering. The 06/05/25 "Negotiated Service Agreement" (NSA) identified R3 received physical assistance from a hospice aide twice weekly with bathing. She received physical assistance from facility staff with dressing and toileting. R3 received checks and assistance to change soiled undergarments as needed for bladder incontinence. She received management of medications and treatments by facility staff. Staff	S5026		

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S5026	Continued From page 7 used simple words, were concise, and articulated clearly for cognitive difficulties and encouraged R3 to remain in the common area for close monitoring for wandering and falls. The "NSA" failed to describe services R3 received for impaired vision. Review of "Orders" by R3's primary care provider (PCP) revealed she did not take any blood thinning medication or any other medication that might cause increased bruising side effects. The 03/10/26 facility's "Intake Information" report to the department documented R3's family reported allegations of bruising on the resident. An investigation report was requested, which the facility failed to provide. The 03/02/26 at 04:02 PM Hospice "Aide Regular Visit" note by Hospice Aide M documented R3 had yellow bruising on her chest and abdomen. The hospice aide notified the hospice nurse. The 03/03/26 hospice "RN Comprehensive Visit" by hospice Licensed Nurse N revealed pain assessment and skin integrity sections that were blank. The note lacked evidence of any documentation of bruising. The 03/03/26 hospice "Patient Visit Summary" note by hospice Licensed Nurse N documented facility staff reported R3 had not experienced any recent falls. The 03/05/26 nurse "Charting Note" by Administrative Staff A documented the hospice	S5026		

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S5026	Continued From page 8 nurse called and reported a linear bruise on the resident's chest and small area of bruising noted on the abdomen. R3's unidentified family member took her to the hospital for examination. The 03/05/26 hospice "Communication" between hospice and an unidentified family member documented the family member called an unidentified hospice nurse and asked what she should do regarding R3's bruising. The hospice nurse advised the family member to take R3 to the emergency room for assessment. The emergency room stay was long and at 01:00 AM the family member called the hospice nurse and reported R3 had not been seen yet. She wanted to leave the emergency room but did not want to take R3 back to the facility. The 03/10/26 hospital "Visit Summary" listed the following diagnoses: multiple rib fractures on the left side, a rib fracture on the right side, and traumatic ecchymosis (bruising) of the abdominal wall. The "Visit Summary" included x-ray results of three views of R3's chest which revealed the following: 1) Right anterior (front) eighth rib subacute fracture suspected. 2) Left posterior (back) seventh rib presumably subacute fracture. 3) Left anterolateral (in front and to the side) sixth, seventh, eighth, and ninth rib presumably subacute fractures. The 03/10/26 hospital "Forensic Medical Report SANE [Sexual Assault Nurse Examiner] Program" documented the following observations:	S5026		

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S5026	Continued From page 9 On R3's chest: 1) 3.0 x 3.0 centimeters (cm) yellow/red bruise on her upper right chest 2) 3.5 x 8.0 cm yellow/red/purple bruise to her right breast 3) A grouping of yellow/red/purple bruises on her left breast On R3's arms 1) A grouping of yellow/red bruising on her upper left arm 2) A 2.0 x 2.0 cm yellow/purple bruising on the inside of her upper left arm On R3's skin: 1) A grouping of yellow/red/purple bruising on her left lower abdomen as follows: a) One 5.0 x 2.0 cm bruise b) An 8.0 x 8.0 cm grouping of bruises c) One 5.0 x 4.0 cm bruised are in abdominal fold on her left lower abdomen 2) A grouping of 4.5 x 4.0 cm yellow/red/purple bruising to her right lower abdomen 3) Scattered areas of erythema (redness) to her right knee 4) A 2.0 x 5.0 yellow/purple bruise to her upper left leg 5) A linear area of erythema on her left lower leg 6) A 4.5 x 2.0 cm grouping of yellow/red/purple bruising on the side of her right hip 7) A 2.0 x 1.5 cm yellow/red/purple bruise on her lower right flank 8) An 8.0 x 7.0 cm yellow/red/purple bruise on her right lower back The 03/24/26 notarized "Witness Statement" by CNA F reported she worked overnight on	S5026		

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S5026	Continued From page 10 03/01/26 until the morning of 03/02/26 and assisted R3 with morning cares to get ready for the day. R3 had a good night, and CNA F noticed nothing of concern. The 03/24/26 notarized "Witness Statement" by CMA C reported she worked at the facility on 03/04/26 and did not notice any bruises on R3 during morning cares or throughout her shift. The 03/24/26 notarized "Witness Statement" by CMA H reported she arrived to the facility to work a night shift on 03/03/26 at approximately 07:55 PM. CMA G was still present caring for the residents and CMA H followed CMA G and R3 to the bathroom in case CMA G needed assistance. CMA G showed CMA H R3's bruises. The 03/24/26 notarized "Witness Statement" by Administrative Staff A reported hospice staff called her on 03/05/26 at approximately 05:00 PM and reported R3 had bruises across her chest and in multiple areas on her abdomen. R3's unidentified family member (legal representative) was "very angry and agitated" and took R3 to the hospital. Administrative Staff A arrived at the facility and asked the housekeeper on duty if he had witnessed any falls and he reported he had not. Administrative Staff A called all facility staff via her phone asking if R3 had fallen. Facility staff did not report any falls. The 03/25/26 notarized "Witness Statement" by CMA I reported he worked at the facility off and on from 02/19/26 to 03/05/26 and did not notice any signs of pain or skin bruising except for "two minor bruises on the arm" for R3.	S5026		

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S5026	Continued From page 11 The 03/26/26 notarized "Witness Statement" by CMA G reported the following: On 02/08/26 she arrived to work at the facility at approximately 07:00 AM. R3 was confined in her room by a medication cart placed across the doorway with the wheels locked. On 03/03/26 at approximately 07:53 PM while assisting R3 with evening cares, CMA G observed "extensive bruising" on R3's breast, chest, arms, back and bottom that she had not previously seen. She had not worked since 02/24/26 and there was no facility documentation to explain how the bruising occurred. CMA G worked again on day shift on 03/05/26 from 07:00 AM to 03:30 PM. During her shift, R3's unidentified family member (legal representative) visited the facility. CMA G asked R3's family member if she was aware of the bruising to which she reported she was not aware. On 03/23/26 at approximately 12:56 PM Administrative Staff A stated CMA G took photos of R3's bruises and notified R3's legal representative about the bruises. On 03/23/26 at 01:12 PM Administrative Staff A stated CNA's and CMA's did not document any incidents, symptoms, or other indications of illness or injury including the date, time of occurrence, actions taken, and results of the actions. They reported to her what happened, and she documented it in resident records later. On 03/23/26 at approximately 04:46 PM during a phone interview, a hospice provider for R3	S5026		

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S5026	Continued From page 12 Licensed Nurse D stated Administrative Staff A did not report all incidents and falls regarding R3 to them. Hospice requested Administrative Staff A report all incidents and falls to them and Administrative Staff A told them she would do better. On 03/24/26 at approximately 08:01 AM R3's unidentified family member (legal representative) stated the following during a phone interview: On 03/05/26 she visited R3 at the facility. CMA G and Housekeeping Staff E were present. CMA G asked her if she was aware of R3's bruises and she was not aware. She observed R3's bruises herself in private in R3's room and became upset. She left the facility and returned later to pick up R3 and take her to the emergency room. When she returned to the facility to pick up R3, she overheard Housekeeping Staff E on the phone with Administrative Staff A. Administrative Staff A told Housekeeping Staff E to lift R3's shirt and take photos of the bruises, which he attempted to do. The family member did not allow Housekeeping Staff E to lift R3's shirt or take photos. On 03/24/26 at approximately 10:59 AM CMA C stated she received abuse, neglect, and exploitation training and fall policy training at a previous job and after R3 had bruises at this job. If she observed bruises on a resident, she would report them to Administrative Staff A. On 03/24/26 at approximately 12:25 PM CNA F stated she had seen an occasional bruise on a resident that seemed "normal" and did not raise	S5026		

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S5026	Continued From page 13 concerns. She last had abuse, neglect, and exploitation training and fall policy training within the last month. If R3 fell, she would report the fall to Administrative Staff A. She did not believe R3 could get up by herself if no staff knew she fell. On 03/24/26 at approximately 03:34 PM CMA H stated she worked night shift on 03/03/26. When she arrived at work in the evening, CMA G already had R3 dressed in a night dress for the night. She went into the bathroom with CMA G and saw R3's bruises. She did not report the bruises to Administrative Staff A because she assumed CMA G had already reported them. On 03/25/26 at 12:03 PM Administrative Staff A stated she did not know what caused R3's bruises and rib fractures. She could not confirm abuse was ruled out. Administrative Staff A confirmed she did not submit an investigation to the state agency. On 03/25/26 at approximately 01:23 PM CNA K stated he could not remember the last time he received abuse, neglect, and exploitation training and fall policy training. If he noticed anything wrong like a bruise he would "alert the authorities." He would also tell Administrative Staff A. On 03/25/26 at approximately 02:14 PM CMA I stated if he saw a resident had a bruise, he reported it to the nurse. On 03/26/26 at approximately 10:08 AM CMA G stated she first noticed R3 had bruises in the evening on 03/03/26. She did not notify Administrative Staff A. CMA G informed R3's	S5026		

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S5026	Continued From page 14 family member about the bruises. The operator failed to protect R3 from potential abuse and neglect when she suffered multiple bruises and rib fractures of unknown origin and abuse could not be ruled out and failed to conduct an investigation and take immediate measures to prevent further potential abuse, neglect, or exploitation while the investigation was in progress. - Record review for R4 revealed an admission date of 11/08/25 with a diagnosis of dementia. The 11/08/25 "FCS" identified R4 required physical assistance with bathing, dressing, toileting, transfers, and eating. She was unable to perform management of medications and treatments and was incontinent of bladder. She had short-term and long-term memory, memory/recall and decision-making cognitive difficulties and was sometimes understandable and sometimes understood others during communication. R4 was at risk for falls. The 11/08/25 "NSA" identified R4 received physical assistance from facility staff twice weekly with bathing. She received physical assistance from facility staff with dressing and toileting and assistance with a mechanical lift for transfers or was independent of transfers (depending on the day). R4 received assistance from facility staff to cut food up in small pieces for eating and checks and assistance to change soiled undergarments every two hours for bladder incontinence. She received management of medications and treatments by facility staff and encouragement to take her time when	S5026		

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S5026	Continued From page 15 expressing herself for communication. Staff used simple sentences and were concise for cognitive difficulties. R4 received close monitoring and was offered toileting every two to three hours and as needed for falls. Review of "Orders" by R4's PCP revealed she did not take any blood thinning medication or any other medication that might cause increased bruising side effects. The 03/10/26 "Nurse Note" documented staff reported R4 had multiple bruises to both arms and her left lower foot that was caused by the mechanical lift. The 03/10/26 hospice "Service Note" documented the following bruises for R4 that facility staff reported were caused by the mechanical lift: 1) 4.0 x 4.0 cm bruise on left outer bicep 2) 3.0 x 2.0 cm bruise on top left wrist 3) 5.0 x 3.0 cm bruise on top outer left hand 4) 3.5 x 2.0 cm bruise on hanging skin of left bicep 5) 3.0 x 2.0 cm bruise on right bicep 6) 6.0 x 3.0 cm bruise on right antecubital area 7) Several small, scattered bruises on right outer bicep area 8) Faint bruises on right and left lower legs. The 03/11/26 PCP "Progress Note" documented facility staff reported R4 had bruises to her hands, upper arms, and left lower leg with no reports of recent falls or injuries. The PCP noted a green bruise to R4's left lower leg, purple bruising to both hands, purple bruising to the left inner wrist, and yellow/green bruising on both	S5026		

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S5026	Continued From page 16 upper arms. On 03/24/26 at approximately 08:42 AM R4's unidentified family member stated during a phone interview on 12/15/25 R4 reported Housekeeping Staff E went into her room while she changed into her pajamas and pinched and poked her backside. R4 reported it did not hurt but she got really mad and asked Housekeeping Staff E to stop. She hoped he would not do it anymore. R4's family reported the allegation to Administrative Staff A who said she "would take care of it." Administrative Staff A assessed R4 and did not find any bruising and she talked to Housekeeping Staff E who denied the allegations. During visits to the facility R4's family member observed several times Housekeeping Staff E worked in the facility by himself and assumed if R4 required assistance he would be the one doing it. She was not aware Housekeeping Staff E reportedly did not perform care for the residents. On 03/24/26 at 10:25 AM Administrative Staff A confirmed R4's family reported to her R4 had complained that Housekeeping Staff E pinched and poked her backside. She did not find any bruises upon nursing assessment of R4 and she talked to Housekeeping Staff E who denied the allegations. She confirmed she failed to report the allegations to the State Agency within 24 hours, failed to take immediate measures to prevent further potential abuse pending an investigation, and failed to submit an investigation to the department within five days of the initial report. On 03/24/26 at approximately 10:27 AM CMA B	S5026		

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S5026	Continued From page 17 stated R4 required a mechanical lift for transfers a few weeks before the same week she suffered bruises. Facility staff always used the lift with two staff. One time, CMA C and she assisted R4 with the mechanical lift to the toilet. After R4 was seated, CMA C left to do something else. While R4 sat on the toilet she tried to stand up and hit her arms on the bars of the mechanical lift. On 03/24/26 at approximately 10:59 AM, CMA C stated R4 required a mechanical lift for transfers within the last two weeks. She saw a bruise on R4's leg recently that happened when she was out of the facility with family and fell. If she saw bruises, she would report them to Administrative Staff A. CMA C last received abuse, neglect, and exploitation training at her previous job. On 03/24/26 at 11:24 AM Housekeeping Staff E stated he worked at the facility for over a year and never assisted the residents with bathing, dressing, toileting, or changing their briefs. On 03/24/26 at approximately 12:25 PM CNA F stated R4 started to require a mechanical lift for transfers within the month prior. She did not use the mechanical lift to transfer R4 because she only worked at night and R4 was already in bed when she arrived for her shift. She received abuse, neglect, and exploitation training within the last month. On 03/24/26 at 02:11 PM CMA B stated she did not know how R4 got bruises on her foot. The bruises on her arms showed up a few days after R4 hit her arms on the mechanical lift. CMA B wrote an incident report on 03/08/26 and backdated it to the date of the incident on	S5026		

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S5026	Continued From page 18 03/06/26. On 03/24/26 at 02:05 PM Administrative Staff A stated she "did not know what she was thinking" when she documented R4 had bruise on her foot. She did not have a bruise on her foot, it was on her calf. On 03/24/26 at approximately 02:19 PM Administrative Staff A stated she notified R4's family of her bruises including the bruise on her foot by sending photos of bruises to R4's family. She could not find the photo of the bruise on R4's foot. On 03/25/26 at approximately 01:23 PM CNA K stated R4 required a mechanical lift with two staff for all transfers. He did not know how long ago there was a change when she required more assistance during transfers but it had been for a couple of months. He worked night shift and never used the mechanical lift for R4 because she slept all night. CNA K could not recall when he last received abuse, neglect, and exploitation training. If he noticed anything wrong, like a bruise, he would alert the authorities and would also tell Administrative Staff A. On 03/26/26 at approximately 10:08 AM CMA G stated R4 required two-person assistance with transfers. On 03/26/26 at 05:19 PM Administrative Staff A stated R4 was ok to have male caregivers CNA J and CMA I assist with cares. She just didn't want housekeeping staff E's help. The operator failed to protect R4 from potential	S5026		

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S5026	Continued From page 19 abuse and neglect when she alleged sexual abuse by housekeeping staff E and suffered bruises on her upper arms and lower legs reportedly from a mechanical lift and a bruise on her foot from unknown origin - Record review for R2 revealed an admission date of 09/24/24 with a diagnosis of dementia. The 01/10/26 "FCS" identified R2 required physical assistance with bathing, dressing, toileting, transfers, and eating. She was unable to perform management of medications and treatments and was incontinent of bladder. R2 had short-term and long-term memory, memory/recall, and decision-making cognitive difficulties. She was sometimes understandable and sometimes understood others during communications. R2 was at risk for falls and wandering. The 01/10/26 "NSA" identified R2 received physical assistance from facility staff for bathing and dressing. She received checks and assistance to change soiled briefs every two hours for toileting and bladder incontinence. R2 received assistance from staff with a gait belt for transfers and staff cut up her food into smaller pieces and she fed herself for eating. She received management of medications and treatments by facility staff used simple words, articulated clearly and were concise for cognitive difficulties. Staff followed visual cues for communication. R2 received close monitoring and staff rounding every two hours and as needed while sleeping for falls and distraction from staff for wandering.	S5026		

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S5026	Continued From page 20 Review of "Orders" by R2's PCP revealed she received Eliquis 5 milligrams (mg) twice daily which was a blood thinning medication and could cause increased bruising side effects. The 08/24/25 at 07:25 PM "Nurse Note" by Administrative Staff A documented R4 had multiple bruises on her right arm from an unknown cause. R2's PCP and legal representative were notified of the bruising. The 08/27/25 at 12:00 PM PCP "Progress Note" documented R2 had bruising on her abdomen, right hand and right forearm. There had been no recent falls but R2 was on twice daily anticoagulant therapy. R2 did not use her hand per her usual. She was unable to express level of pain due to dementia. The 08/27/25 at 02:40 PM "Nurse Note" by Licensed Nurse O documented R2 had multiple bruises on her right hand and on the upper left quadrant of her abdomen. The nurse notified R2's PCP who was in the facility and received new orders to obtain a hand x-ray and blood tests related to bruising with no probable cause. The 03/11/26 PCP "Progress Note" documented facility staff reported on 03/11/26 R2 had a bruise on her right upper thigh. R2 was on long-term anticoagulation therapy. She had a light purple/green bruise on her right upper outer thigh. No new orders were written. On 03/26/26 at 03:19 PM Administrative Nurse A stated R2 had an x-ray of her hand in August 2025 because of a contracture. She never had a bruise. She did not need to report an injury of	S5026		

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S5026	Continued From page 21 unknown origin to the State Department or investigate the cause. The nurse who documented R2's hand and abdomen had bruises no longer worked at the facility. The operator failed to protect R2 from potential abuse and neglect when she suffered bruises on her hands, forearm, abdomen, and outer thigh from unknown origin. Review of current staff CMA C, Housekeeping Staff E, CNA F, CMA G, and CNA I's records lacked evidence of supporting documentation for criminal background checks. The facility's undated "Incident Abuse and Neglect Reporting, Prevention, and Investigation" policy documented the following: The purpose of the policy was to ensure the facility's "Standard of Zero Tolerance" of resident abuse and neglect in the home. The operator or designee would immediately notify the resident's decision maker of any alleged, suspected, or witnessed abuse or neglect within 12 hours of becoming aware of any alleged incident. Each allegation would be reported to the operator as soon as staff were aware and to the department within 24 hours. An investigation would be started when the operator or designee received notification of an alleged violation. Immediate measures would be taken to prevent further potential abuse, neglect, or exploitation while the investigation was in progress. The	S5026		

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S5026	Continued From page 22 resident would be separated from the alleged individual immediately. Any facility team member involved in actual, suspected, or alleged abuse or neglect would be placed on administrative leave immediately. The facility's 03/06/26 "Skin Integrity and Injury Incident Report Policy" documented a list of incidents that would be reported immediately to the nurse which included bruises and witnessed or unwitnessed falls. The operator failed to protect three cognitively impaired residents from potential abuse and neglect when Resident (R) 3 suffered multiple bruises and rib fractures of unknown origin; R4 alleged sexual abuse and suffered bruises on her upper arms and lower legs reportedly from a mechanical lift and a bruise on her foot from unknown origin; and R2 suffered bruises on her right hand and abdomen and a bruise on her upper outer thigh of unknown origin. The Immediate Jeopardy was removed when the following actions were documented by the facility in the "Removal Plan" and accepted by the department on 04/02/26. 1) Immediate re-education provided to all facility staff to report any change in condition including falls, bruising, or other injury to the licensed nurse immediately. 2) Immediate notification and instruction provided to all contracted/outside providers to report any change in condition including falls, bruising, or other injury to facility staff immediately and to the licensed nurse before	S5026		

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S5026	Continued From page 23 leaving the building. 3) Re-education provided to facility staff and contracted/outside providers on abuse, neglect, and exploitation (ANE) reporting requirements which included reporting to the operator/designee and the licensed nurse, and reporting to the department within 24 hours. 4) A licensed nurse would be required to assess a resident upon any reported or observed change in condition. 5) The resident's designated family member/legal representative and PCP would be notified immediately following any change in conditions which included falls or injury. 6) An investigation would be initiated upon any reported incident which included same-day review, staff interviews, and documentation. 7) 24-hour enhanced monitoring would be initiated for all residents identified at high-risk. 8) Shift-to-shift communication was implemented to ensure all changes in residents condition were communicated and followed up on without delay. 9) The operator/designee initiated real-time oversight to verify immediate reporting, timely nursing assessment, required notifications, and investigation. 10) The operator/designee would conduct daily audits of incident reporting, timeliness of nursing assessments, notification to resident's designated family member/legal representative and PCP, and staff and outside provider's compliance with reporting requirements.	S5026		
S5028 SS=F	26-42-101 (f) (3) Staff Treatment of Residents Reporting (f) (3) Each allegation of abuse, neglect, or	S5028		

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S5028	Continued From page 24 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 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: KAR 26-42-101(f)(3)(A)(B)(C)(E) The facility reported a census of two residents included in the sample and two focused reviews for discharged resident. Based on interview and record review the operator failed to ensure allegations of neglect and an allegation of sexual	S5028		

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S5028	Continued From page 25 abuse was reported to the department within 24 hours and failed to start, complete, and submit investigations to the department within five working days. The operator failed to take immediate measures to prevent further potential abuse and/or neglect. Findings included: - Record review for Resident (R)3 revealed an admission date of 10/11/24 with diagnoses of dementia and anxiety. The 06/05/25 "Functional Capacity Screen" (FCS) identified R3 required physical assistance with bathing, dressing, toileting and she was unable to perform management of medications and treatments. R3 was frequently incontinent of bladder, had short-term memory and decision-making cognitive difficulties, and was at risk for falls, impaired vision, and wandering. The 06/05/25 "Negotiated Service Agreement" (NSA) identified R3 received physical assistance from a hospice aide twice weekly with bathing. She received physical assistance from facility staff with dressing and toileting. R3 received checks and assistance to change soiled undergarments as needed for bladder incontinence. She received management of medications and treatments by facility staff. Staff used simple words, were concise, and articulated clearly for cognitive difficulties and encouraged R3 to remain in the common area for close monitoring for wandering and falls. The "NSA" failed to describe services R3 received for impaired vision.	S5028		

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S5028	Continued From page 26 The 03/10/26 facility's "Intake Information" report to the department documented R3's family reported allegations of bruising on the resident. An investigation report was requested, which the facility failed to provide. The 03/05/26 nurse "Charting Note" by Administrative Staff A documented the hospice nurse called and reported a linear bruise on the resident's chest and small area of bruising noted on the abdomen. On 03/03/26 at approximately 07:53 PM while assisting R3 with evening cares, CMA G observed "extensive bruising" on R3's breast, chest, arms, back and bottom that she had not previously seen. On 03/24/26 at approximately 03:34 PM CMA H stated she worked night shift on 03/03/26. When she arrived at work in the evening, CMA G already had R3 dressed in a night dress for the night. She went into the bathroom with CMA G and saw R3's bruises. She did not report the bruises to Administrative Staff A because she assumed CMA G had already reported them. On 03/25/26 at 12:03 PM Administrative Staff A stated she did not know what caused The operator failed to ensure an allegation of abuse/neglect was reported to the department within 24 hours and failed to start, complete, and submit an investigation to the department within five working days. The operator failed to take immediate measures to prevent further potential abuse and/or neglect when R3 suffered multiple bruises.	S5028		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: B046091	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/26/2026
NAME OF PROVIDER OR SUPPLIER VILLA HEIGHTS LIVING LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 816 S MULBERRY STREET GARDNER, KS 66030		
(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
S5028	Continued From page 27 R3's bruises and rib fractures. She could not confirm abuse was ruled out. Administrative Staff A confirmed she did not submit an investigation to the state agency, complete and investigation, or take immediate measures to prevent further potential abuse or neglect. The 11/08/25 "FCS" identified R4 required physical assistance with bathing, dressing, toileting, transfers, and eating. She was unable to perform management of medications and treatments and was incontinent of bladder. She had short-term and long-term memory, memory/recall and decision-making cognitive difficulties and was sometimes understandable and sometimes understood others during communication. R4 was at risk for falls. The 11/08/25 "NSA" identified R4 received physical assistance from facility staff twice weekly with bathing. She received physical assistance from facility staff with dressing and toileting and assistance with a mechanical lift for transfers or was independent of transfers (depending on the day). R4 received assistance from facility staff to cut food up in small pieces for eating and checks and assistance to change soiled undergarments every two hours for bladder incontinence. She received management of medications and treatments by facility staff and encouragement to take her time when expressing herself for communication. Staff used simple sentences and were concise for cognitive difficulties. R4 received close monitoring and was offered toileting every two to three hours and as needed for falls.	S5028		

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S5028	Continued From page 28 On 03/24/26 at approximately 08:42 AM R4's unidentified family member stated during a phone interview on 12/15/25 R4 reported Housekeeping Staff E went into her room while she changed into her pajamas and pinched and poked her backside. R4 reported it did not hurt but she got really mad and asked Housekeeping Staff E to stop. She hoped he would not do it anymore. R4's family reported the allegation to Administrative Staff A who said she "would take care of it." On 03/24/26 at 10:25 AM Administrative Staff A confirmed R4's family reported to her R4 had complained that Housekeeping Staff E pinched and poked her backside. She did not find any bruises upon nursing assessment of R4 and she talked to Housekeeping Staff E who denied the allegations. She confirmed she failed to report the allegations to the State Agency within 24 hours, failed to take immediate measures to prevent further potential abuse pending an investigation, and failed to submit an investigation to the department within five days of the initial report. The operator failed to ensure an allegation of abuse/neglect was reported to the department within 24 hours and failed to start, complete, and submit an investigation to the department within five working days. The operator failed to take immediate measures to prevent further potential abuse and/or neglect when R4 and her family reported an allegation of sexual abuse. - Record review for R2 revealed an admission date of 09/24/24 with a diagnosis of dementia.	S5028		

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S5028	Continued From page 29 The 01/10/26 "FCS" identified R2 required physical assistance with bathing, dressing, toileting, transfers, and eating. She was unable to perform management of medications and treatments and was incontinent of bladder. R2 had short-term and long-term memory, memory/recall, and decision-making cognitive difficulties. She was sometimes understandable and sometimes understood others during communications. R2 was at risk for falls and wandering. The 01/10/26 "NSA" identified R2 received physical assistance from facility staff for bathing and dressing. She received checks and assistance to change soiled briefs every two hours for toileting and bladder incontinence. R2 received assistance from staff with a gait belt for transfers and staff cut up her food into smaller pieces and she fed herself for eating. She received management of medications and treatments by facility staff used simple words, articulated clearly and were concise for cognitive difficulties. Staff followed visual cues for communication. R2 received close monitoring and staff rounding every two hours and as needed while sleeping for falls and distraction from staff for wandering. The 08/24/25 at 07:25 PM "Nurse Note" by Administrative Staff A documented R2 had multiple bruises on her right arm from an unknown cause. R2's PCP and legal representative were notified of the bruising. The 08/27/25 at 12:00 PM PCP "Progress Note" documented R2 had bruising on her abdomen, right hand and right forearm. There had been no	S5028		

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S5028	Continued From page 30 recent falls but R2 was on twice daily anticoagulant therapy. R2 did not use her hand per her usual. She was unable to express level of pain due to dementia. The 08/27/25 at 02:40 PM "Nurse Note" by Licensed Nurse O documented R2 had multiple bruises on her right hand and on the upper left quadrant of her abdomen. The nurse notified R2's PCP who was in the facility and received new orders to obtain a hand x-ray and blood tests related to bruising with no probable cause. The 03/11/26 PCP "Progress Note" documented facility staff reported on 03/11/26 R2 had a bruise on her right upper thigh. R2 was on long-term anticoagulation therapy. She had a light purple/green bruise on her right upper outer thigh. No new orders were written. The operator failed to ensure each allegation of abuse/neglect was reported to the department within 24 hours and failed to start, complete, and submit an investigations to the department within five working days when R2 had bruises of unknown origin on 08/24/25, 08/27/25, and 03/11/26 . The operator failed to take immediate measures to prevent further potential abuse and/or neglect for R2. The facility's undated "Incident Abuse and Neglect Reporting, Prevention, and Investigation" policy documented the following: The purpose of the policy was to ensure the facility's "Standard of Zero Tolerance" of resident abuse and neglect in the home.	S5028		

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S5028	Continued From page 31 The operator or designee would immediately notify the resident's decision maker of any alleged, suspected, or witnessed abuse or neglect within 12 hours of becoming aware of any alleged incident. Each allegation would be reported to the operator as soon as staff were aware and to the department within 24 hours. An investigation would be started when the operator or designee received notification of an alleged violation. Immediate measures would be taken to prevent further potential abuse, neglect, or exploitation while the investigation was in progress. The resident would be separated from the alleged individual immediately. Any facility team member involved in actual, suspected, or alleged abuse or neglect would be placed on administrative leave immediately. The facility's 03/06/26 "Skin Integrity and Injury Incident Report Policy" documented a list of incidents that would be reported immediately to the nurse which included bruises and witnessed or unwitnessed falls. The operator failed to ensure allegations of neglect and an allegation of sexual abuse was reported to the department within 24 hours and failed to start, complete, and submit investigations to the department within five working days. The operator failed to take immediate measures to prevent further potential abuse and/or neglect.	S5028		

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S5105	Continued From page 32	S5105		
S5105 SS=D	26-42-202 (a) Negotiated Service Agreement a) The administrator or operator of each home plus shall ensure the development of a written negotiated service agreement for each resident, based on the resident ' s functional capacity screening, service needs, and preferences, in collaboration with the resident or the resident ' s legal representative, the case manager, and, if agreed to by the resident or the resident ' s legal representative, the resident ' s family. The negotiated service agreement shall provide the following information: (1) A description of the services the resident will receive; (2) identification of the provider of each service; and (3) identification of each party responsible for payment if outside resources provide a service. This REQUIREMENT is not met as evidenced by: KAR 26-42-202(a)(1) The facility reported a census of two residents. Based on interview and record review the operator failed to ensure the "Negotiated Service Agreement" (NSA) for Residents (R) 2 described the services she received based on her "Functional Capacity Screens" (FCS), needs, and preferences. Findings included: - Record review for R2 revealed an admission date of 09/24/24 with a diagnosis of dementia.	S5105		

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S5105	Continued From page 33 The 01/10/26 "FCS" identified R2 required physical assistance with eating. The 01/10/26 "NSA" identified R2 received assistance from facility staff to cut her food into smaller pieces and she fed herself for eating. The "NSA" failed to describe services R4 received for Percutaneous Endoscopic Gastrostomy (PEG) tube feeding. The 10/10/25 at 04:20 PM late entry nursing "Charting Note" by Administrative Staff A documented R2 returned to the facility with patent PEG tube. The 11/05/25 physician's order documented to administer 250 milliliters (ml) isosource per PEG tube with 150 ml of water four times daily. Observation on 03/23/26 at approximately 01:33 PM revealed Administrative Staff A administered midday meal and medications to R2 through a PEG tube. On 03/26/26 at approximately 04:58 PM Administrative Staff A confirmed the "NSA" for R2 failed to describe the services she received for PEG tube feeding for eating. The operator failed to ensure the "NSA" for R2 described the services she received based on her "FCS," needs, and preferences.	S5105		
S5127 SS=F	26-42-202 (i) NSA Services Received (i) Each administrator or operator shall ensure that each resident receives services according to	S5127		

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S5127	Continued From page 34 the provisions of that resident ' s negotiated service agreement. This REQUIREMENT is not met as evidenced by: KAR 26-42-202(i) The facility reported a census of two residents which were included in the sample and two focused reviews for discharged residents. Based on interview and record review the operator failed to ensure Residents (R) 2 received the services described in her "Negotiated Service Agreement" (NSA) for toileting and bladder incontinence and R4 received the services described in her "NSA" for toileting, bladder incontinence, and falls. The operator failed to ensure all residents received the services described in their "NSA" for bathing. Findings included: - Record review for R2 revealed an admission date of 09/24/24 with a diagnosis of dementia. The 01/10/26 "Functional Capacity Screen" identified R2 required physical assistance with bathing and toileting and was incontinent of bladder. The 01/10/26 "NSA" identified R2 received physical assistance from designated staff for bathing and toileting and received checks and assistance to change soiled briefs every two hours for bladder incontinence.	S5127		

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S5127	Continued From page 35 Review of bath sheets for R2 revealed they were blank. The 03/26/26 notarized "Witness Statement" by Certified Medication Aide (CMA) G reported on multiple mornings when she arrived to work her shift, R2 was still in bed with bedding, clothing, and hair soaked in urine from head to toe. She reported her concerns to Administrative Staff A but issue continued. On 03/23/26 at approximately 01:12 PM Administrative Staff A confirmed R2's record lacked evidence of documentation she received assistance from designated staff for bathing and toileting and received checks and assistance to change soiled briefs every two hours for bladder incontinence. On 03/25/26 at 12:44 PM Administrative Staff A stated the bathing sheets for R2 "were not utilized." She confirmed R2's record lacked evidence of documentation R2 received assistance from designated staff for bathing. On 03/25/26 at approximately 01:23 PM Certified Nurse Aide (CNA) K stated when he worked night shift, R2 slept all night and did not get up to go to the toilet. She never soiled herself that he knew of. He checked her twice during the night and she was always dry. CNA K confirmed R2 did not receive every two hour, checks and assistance to change briefs if soiled. - Record review for R4 revealed an admission date of 11/08/25 with a diagnosis of dementia. The 11/08/25 "FCS" identified R4 required	S5127		

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S5127	Continued From page 36 physical assistance with bathing and toileting, was incontinent of bladder, and was at risk for falls. The 11/08/25 "NSA" identified R4 received physical assistance from facility staff with bathing as needed and assistance with bathing from hospice staff on Tuesday and Friday. She received assistance from facility staff with toileting and checks and assistance to change soiled undergarments every two hours for bladder incontinence. R4 received close monitoring and was offered toileting every two to three hours and as needed to prevent injury from falls. Review of bath sheets for R2 revealed they were blank. On 03/23/26 at approximately 01:12 PM Administrative Staff A confirmed R4's record lacked evidence of documentation she received assistance for toileting and received checks and assistance to change soiled briefs every two hours for bladder incontinence. Administrative Staff A confirmed R4's record lacked evidence of documentation she was offered toileting every two to three hours and as needed for falls. On 03/24/26 at approximately 12:25 PM CNA F stated she checked R4 throughout her shift. One time R4 had wet briefs for about two hours while she waited for the day shift staff to arrive around 07:00 to assist in changing R4's wet briefs. On 03/25/26 at 12:44 PM Administrative Staff A stated the bathing sheets for R4 "were not utilized." She confirmed R4's record lacked	S5127		

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S5127	Continued From page 37 evidence of documentation R2 received assistance from facility staff as needed and from a hospice aid on Tuesday and Friday for bathing. On 03/25/26 at approximately 01:23 PM CNA K stated when he worked night shift, R4 slept all night and did not get up to go to the bathroom. He checked her "sometimes" during the night and she was always dry. CNA K confirmed R4 did not receive checks and assistance to change briefs if soiled every two hours and offers to toilet every two to three hours. - Record review for R3 revealed an admission date of 10/11/24 with diagnoses of dementia and anxiety. The 06/05/25 "FCS" identified R3 required physical assistance with bathing. The 06/05/25 "NSA" identified R3 received physical assistance from staff or a hospice aid for bathing. On 03/25/26 at 12:44 PM Administrative Staff A stated the bathing sheets for R3 "were not utilized." She confirmed R3's record lacked evidence of documentation R3 received assistance from staff or a hospice aid for bathing. - Record review for R1 revealed an admission date of 02/24/26 with diagnoses of dementia, cerebral infarction, and repeated falls. The 02/24/26 "FCS" identified R1 required physical assistance with bathing. The 02/24/26 "NSA" identified R1 received	S5127		

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S5127	Continued From page 38 physical assistance from staff two times a week for bathing. On 03/25/26 at 12:44 PM Administrative Staff A stated the bathing sheets for R1 "were not utilized." She confirmed R1's record lacked evidence of documentation R1 received assistance from staff for bathing. The undated facility's "Skin Monitoring: Comprehensive CNA Shower Training Form/Policy" documented staff performed a visual observation of the resident's skin during a shower and reported any abnormal looking skin to the charge nurse immediately. The operator failed to ensure R2 received the services described in her "NSA" for toileting and bladder incontinence and R4 received the services described in her "NSA" for toileting, bladder incontinence, and falls. The operator failed to ensure all residents, R2, R4, R3, and R1 received the services described in their "NSA" for bathing.	S5127		
S5171 SS=J	26-42-204 (i) Health Care Services Standards of Practice (i) All health care services shall be provided to residents by qualified staff in accordance with acceptable standards of practice. This REQUIREMENT is not met as evidenced by: KAR 26-42-204(i) The facility reported a census of two residents with two residents included in the sample and	S5171		

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S5171	Continued From page 39 two focused reviews for discharged residents. Based on interview and record review the operator failed to ensure facility staff notified the licensed nurse when Resident (R) 3 fell and suffered a head injury. This failure place the resident in Immediate Jeopardy when facility staff failed to notify the licensed nurse and did not complete a post fall assessment on R3 for six hours following a fall with head injury. Findings included: - Record review for R3 revealed an admission date of 10/11/24 with diagnoses of dementia and anxiety. The 06/05/25 "Functional Capacity Screen" (FCS) identified R3 required physical assistance with bathing, dressing, toileting and she was unable to perform management of medications and treatments. R3 was frequently incontinent of bladder, had short-term memory and decision-making cognitive difficulties, and was at risk for falls, impaired vision, and wandering. The 06/05/25 "Negotiated Service Agreement" (NSA) identified R3 received physical assistance from a hospice aide twice weekly with bathing. She received physical assistance from facility staff with dressing and toileting. R3 received checks and assistance to change soiled undergarments as needed for bladder incontinence. She received management of medications and treatments by facility staff. Staff used simple words, were concise, and articulated clearly for cognitive difficulties and encouraged R3 to remain in the common area for close monitoring for wandering and falls. The "NSA"	S5171		

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S5171	Continued From page 40 failed to describe services R3 received for impaired vision. The 02/19/26 at 03:00 AM "Employee Incident Report" by Certified Nurse Aide (CNA) J signed by Administrative Staff A reported CNA J arrived to work in the facility on 03/01/26 [sic]. During the night CNA J witnessed R3 fall onto her back and suffer an injury to the back of her head and he notified the nurse of the incident. The 02/19/26 at 09:12 AM late entry "Nurse Note" by Administrative Staff A documented R3 fell and bumped her head. There was no bleeding or swelling. The note lacked the date and time of the incident, actions taken, and results of the actions. The 02/24/26 hospice "Skilled Nursing Visit Note" documented R3 complained of a headache and the caregiver present at the facility reported R3 had a witnessed fall over the weekend. She walked back from the bathroom at 03:00 AM, lost her balance, fell backward and hit her head. R3 had a small laceration to the back of her head that was healed together and intact. The caregiver administered Tylenol and noted the resident's headache started to resolve by the end of the visit. Caregivers were encouraged to call hospice with any falls or changes in condition. The 02/25/26 at 12:00 PM PCP (Primary Care Provider) "Progress Note" documented R3 "had a fall on Sunday and hit the back of her head." A small area was bleeding upon exam. The 03/24/26 notarized "Witness Statement" by	S5171		

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S5171	Continued From page 41 CNA J reported he arrived to work in the facility on 02/19/26 in the evening around 08:00 PM. Around 03:00 AM in the night, R3 tried to ambulate to the bathroom by herself. He approached her and she lost her balance and fell on her left [sic] side. R3 hit her head on the bed and said she was ok. CNA J assisted R3 up and to the bathroom. He noticed a "minor cut" on her scalp that measured 0.5 centimeters (cm) and covered it with an adhesive bandage. He assisted R3 back to bed. At the end of his shift, CNA J reported R3 fell during the night to the oncoming shift and informed them they should notify the nurse. The 03/26/26 notarized "Witness Statement" by CMA G reported the following: CMA G arrived to work at the facility on 02/08/26 at approximately 07:00 AM. At that time R3 was confined in her room with a medication cart placed across the doorway with the wheels locked. CNA J was present and reported to CMA G R3 fell and hit her head sometime during the night while he was the only staff in the facility at the time. CMA G assisted R3 to get dressed for the day and noticed blood on R3's pillow. She observed a large wound on R3's head with dried blood on her scalp and hair. It appeared there had been no attempt to clean the wound. There was a bandage stuck in R3's hair rather than covering the wound itself. CMA G cleaned the wound, which appeared to be still bleeding. R3 expressed her head hurt. CMA G communicated to the other staff present	S5171		

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S5171	Continued From page 42 in the facility with her, Housekeeping Staff E about the wound and asked if the nurse or hospice had been notified about a fall or a head injury. Housekeeping Staff E stated he did not know and called Administrative Staff A on speakerphone. Administrative Staff A stated she was unaware of any falls or head injury and instructed Housekeeping Staff E to take photos and send them to her. After Housekeeping Staff E sent photos of R3's head wound to Administrative Staff A, Administrative Staff A called Housekeeping Staff E back and instructed him to "comb her hair over the wound so (R3's DPOA) no one would see it." CMA G told Housekeeping Staff E she heard Administrative Staff A's instruction to him and said she would not participate in hiding the injury because it was unethical and not legally appropriate. Shortly after CMA G's conversation with Housekeeping Staff E, Administrative Staff A called her directly and angrily told CMA G that she need not concern herself with how Administrative Staff A handled these situations and assured CMA G she would report the incident and inform R3's DPOA. Administrative Staff A instructed CMA G not to speak with family members about anything that happened at the facility and not to question how Administrative Staff A ran her business. On 03/23/26 at 01:21 PM Administrative Staff A stated at 03:00 AM on 02/19/26 CNA J woke R3 up to assist her to the bathroom and she fell and hit her head. Administrative Staff A instructed	S5171		

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S5171	Continued From page 43 staff to clean R3's head because there was a "stain of blood" on her head. Administrative Staff A reported to R3's Durable Power of Attorney (DPOA) R3 fell but did not report R3 suffered a laceration or bleeding because "she had not set eyes on it yet." On 03/23/26 at approximately 04:46 PM during a phone interview, a hospice provider for R3, Licensed Nurse D stated Administrative Staff A did not report all incidents and falls regarding R3 to them. Hospice requested Administrative Staff A reported all incidents and falls to them and Administrative Staff A told them she would do better. On 03/24/26 at approximately 10:59 AM CMA C stated she received fall policy training at her previous job. On 03/24/26 at approximately 12:25 PM CNA F stated she had witnessed an occasional bruise on a resident that seemed "normal" and did not raise concerns. She last received fall policy training within the last month. If R3 fell she would report the fall to Administrative Staff A. She did not believe R3 could get up by herself without staff knowing. On 03/24/26 at 03:03 PM Administrative Staff A stated day shift staff notified her R3 had blood on her pillow and the back of her head. She arrived to the facility about 09:00 AM to assess R3 and wrote a note about it in R3's record. Administrative Staff A confirmed it was six hours from the time R3 hit the back of her head until she received an assessment by a licensed nurse.	S5171		

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S5171	Continued From page 44 On 03/24/26 at 04:17 PM Administrative Staff A stated Housekeeping Staff E called her by phone and reported R3 had blood on her head. Administrative Staff directed Certified Medication Aide (CMA) G to "clean it up and she would be on her way to see it." Then she called night shift CNA J to ask if R3 had fallen. CNA J answered, yes, she fell at 3:00 AM. On 03/24/26 at approximately 05:06 PM CNA J stated R3 was already out of bed walking across the floor to go out the door of her room when he witnessed her fall to the right (not the left as reported in his witness statement above) and hit her head on the "metal part" of her bed. There was a little bit of blood on her head, and he put an adhesive bandage over it. The adhesive bandage did not stick well because of R3's hair. CNA J did not report the fall to the nurse. He reported the fall to the day shift staff when they arrived so they could notify the nurse. The fall policy was to report falls to the nurse. He had not received fall policy training at this facility. On 03/25/26 at approximately 01:23 PM CNA K stated he could not remember the last time he received fall policy training. If he noticed anything wrong like a bruise he would "alert the authorities." He would also tell Administrative Staff A. On 03/26/26 at approximately 10:08 AM CMA G stated she had begun keeping her own documentation of what happened at the facility. She brought it up to Administrative Staff A several times, stating there needed to be more documentation. Administrative Staff A had the wrong date when R3 fell and hit head. She fell on	S5171		

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S5171	Continued From page 45 Sunday 02/08/26 not on 02/19/26. On 04/01/26 at 03:44 PM Medical Provider P stated during a phone interview she received a text from Administrative Staff A on 02/19/26 that R3 had fallen and bumped her head with no loss of consciousness or dizziness. On 02/24/26 Medical Provider P received another text from Administrative Staff A reminding her to follow up with R3 during her next visit on Wednesday 02/25/26 regarding R3's Sunday fall. The facility's 03/06/26 "Skin Integrity and Injury Incident Report Policy" documented the following incidents would be reported to the nurse immediately: bruises, wounds or open areas, abrasions or scrapes, skin tears, redness, swelling, or signs of skin breakdown, any unexplained marks or injuries on a resident's body, witnessed and unwitnessed falls, any changes including disorientation, increase confusion, decreased appetite, fluid intake and output, and constipation. The nurse would assess the resident and complete any required documentation or treatment. The operator failed to ensure facility staff notified the licensed nurse when R3 fell and suffered a head injury. This failure placed the resident in Immediate Jeopardy when staff failed to notify the licensed nurse of R3's fall and further failed to complete an assessment for R3 for six hours following a fall with head injury. The Immediate Jeopardy was removed when the following actions were documented by the facility in the "Removal Plan" and accepted by the department on 04/02/26.	S5171		

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S5171	Continued From page 46 1) Immediate re-education provided to all facility staff to report any change in condition including falls, bruising, or other injury to the licensed nurse immediately. 2) Immediate notification and instruction provided to all contracted/outside providers to report any change in condition including falls, bruising, or other injury to facility staff immediately and to the licensed nurse before leaving the building. 3) Re-education provided to facility staff and contracted/outside providers on abuse, neglect, and exploitation (ANE) reporting requirements which included reporting to the operator/designee and the licensed nurse, and reporting to the department within 24 hours. 4) A licensed nurse would be required to assess a resident upon any reported or observed change in condition. 5) The resident's designated family member/legal representative and PCP would be notified immediately following any change in conditions which included falls or injury. 6) An investigation would be initiated upon any reported incident which included same-day review, staff interviews, and documentation. 7) 24-hour enhanced monitoring would be initiated for all residents identified at high-risk. 8) Shift-to-shift communication was implemented to ensure all changes in residents condition were communicated and followed up on without delay. 9) The operator/designee initiated real-time oversight to verify immediate reporting, timely nursing assessment, required notifications, and investigation. 10) The operator/designee would conduct daily	S5171		

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S5171	Continued From page 47 audits of incident reporting, timeliness of nursing assessments, notification to resident's designated family member/legal representative and PCP, and staff and outside provider's compliance with reporting requirements.	S5171		
S5215 SS=F	26-42-104 (d) Disaster and Emergency Preparedness Education (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 home ' s emergency management plan; (2) education of each resident upon admission to the home regarding emergency procedures; (3) quarterly review of the home ' 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 by: KAR 26-42-104(d)(1)(2)(3) The facility reported a census of two residents. Based on interview and record review the operator failed to orient new staff at hire and educate residents upon admission to the facility's emergency plan. The operator failed to provide quarterly reviews of the facility's emergency management plan with the residents and staff.	S5215		

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S5215	Continued From page 48 Findings included: - Review of the facility's emergency management plan revealed a quarterly review with staff and residents was provided on 07/30/25. The plan lacked evidence of documentation reviews were provided to residents and staff every quarter. Facility records lacked evidence of documentation the emergency management plan was provided to staff at hire and to residents upon admission. On 12/03/25 at 09:50 AM Administrative Staff A confirmed the emergency management plan lacked evidence of documentation the staff and residents received quarterly reviews of the plan and that staff were oriented at hire and residents were educated at admission to the emergency management plan. The facility's undated "Emergency Management Plan - Quarterly Review Policy" documented the facility conducted formal quarterly reviews of the emergency management plan. The operator failed to orient new staff at hire and educate residents upon admission to the facility's emergency plan. The operator failed to provide quarterly reviews of the facility's emergency management plan with the residents and staff.	S5215		
S5230 SS=F	26-42-207 (b)(5)(6) (c) Infection Control Policies (b)(5) prohibiting any employee with a communicable disease or any infected skin lesions from coming in direct contact with any	S5230		

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S5230	Continued From page 49 resident, any resident ' s food, or resident care equipment until the condition is no longer infectious; (6) providing orientation to new employees and employee in-service education at least annually on the control of infections in a health care setting; (c) Each administrator or operator shall ensure the home ' s compliance with the department ' s tuberculosis guidelines for adult care homes adopted by reference in K.A.R. 26-39-105. This REQUIREMENT is not met as evidenced by: KAR 26-42-207(c) The facility reported a census of two residents. Based on interview and record review the operator failed to ensure the facility remained in compliance with the department's tuberculosis (TB) guidelines for adult care homes adopted by reference in KAR 26-39-105 for four of five sampled staff. Findings included: - Record review for Certified Medication Aide (CMA) G revealed a hire date of 09/03/25. Her record lacked evidence documentation of a two-step TB skin test and a symptom screen questionnaire. Record review for Housekeeping Staff E revealed a hire date of 01/01/25. His record lacked evidence documentation of a two-step TB skin test and a symptom screen questionnaire.	S5230		

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S5230	Continued From page 50 Record review for CMA C revealed a hire date of 03/09/26. The 03/08/26 first step and 03/15/26 second step TB skin tests were administered with expired tuberculin. Record review for Certified Nurse Aide (CNA) J revealed a hire date of 03/09/26. The 03/08/26 first step and 03/15/26 second step TB skin tests were administered with expired tuberculin. Observation on 03/25/26 at 11:34 AM revealed an unsealed vial of tuberculin by itself with no box. The vial lacked a label with an open date. On 02/25/26 at approximately 11:34 AM Administrative Staff A confirmed the vial of tuberculin lacked a label with an open date. She stated it was opened on 08/25/25 and was not discarded 30 days after opening. Four staff and one resident had TB tests administered after the vial should have been discarded 30 days after opening. Administrative Staff A stated confirmed CMA G and Housekeeping Staff E's records lacked TB skin test results and symptom screen questionnaires. The undated facility's "TB Skin Test Upon Hire Policy" documented all staff completed a TB skin test or approved TB screening before beginning work. No staff may have resident contact until TB clearance was documented. The operator failed to ensure the facility remained in compliance with the department's tuberculosis guidelines for adult care homes	S5230		

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S5230	Continued From page 51 adopted by reference in KAR 26-39-105.	S5230		
S5245 SS=F	26-42-105 (b) Resident Records Confidential (b) Each administrator or operator shall ensure that all information in each resident's record, regardless of the form or storage method for the record, is kept confidential, unless release is required by any of the following: (1) Transfer of the resident to another health care facility; (2) law; (3) third-party payment contract; or (4) the resident or legal representative of the resident. This REQUIREMENT is not met as evidenced by: KAR 26-42-105(b) The facility reported a census of two residents which were included in the sample and two focused reviews for discharged residents. Based on observation, interview, and record review the operator failed to ensure residents' information for Resident (R) 1, R2, R3, and R4 were kept confidential. Findings included: - Observation on 03/23/26 at 11:53 AM revealed the following: Tall shelves near the kitchen in a public accessible location had three-ring binders with	S5245		

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S5245	Continued From page 52 R1, R2, R3, and R4's first and last names printed in large letters. Two signs were taped to the wall above the med cart in the kitchen area in view of residents and visitors. The first sign read "Shower Days Scheduled and PRN" and listed the first names of R1, R2, and R4 with bathing dates and times. The second sign read "[R2's] Tube Feeding Schedule" and listed times of 08:00 AM, 12:00 PM, 04:00 PM, and 08:00 PM. On 03/24/26 at 10:15 AM Administrative Staff A confirmed resident information was kept in public view and not in secured location. She stated she would "do better" and move them to a locked area. Observation 03/26/26 at 12:06 PM revealed signs on the wall in the kitchen were removed with no resident information visible. R1, R2, R3, and R4's three-ring binder charts remained on the shelves near the kitchen in a public accessible area. On 03/26/26 at 04:50 PM Administrative Staff A confirmed resident's information was still in a public accessible area. The undated facility's "Resident Records Storage and Confidentiality Policy" documented paper files must be kept in locked filing cabinets or secure record rooms accessible only to authorized staff. Resident information must not be discussed in public areas or with unauthorized individuals. The operator failed to ensure residents'	S5245		

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S5245	Continued From page 53 information for R1, R2, R3, and R4 were kept confidential.	S5245		
S5250 SS=D	26-42-105 (f) (1 - 10) Resident Records Content (f) Each resident record shall contain at least the following: (1) The resident's name; (2) the dates of admission and discharge; (3) the admission agreement and any amendments; (4) the functional capacity screenings; (5) the health care service plan, if applicable; (6) the negotiated service agreement and any revisions; (7) the name, address, and telephone number of the physician and the dentist to be notified in an emergency; (8) the name, address, and telephone number of the legal representative or the individual of the resident's choice to be notified in the event of a significant change in condition; (9) the name, address, and telephone number of the case manager, if applicable; (10) records of medications, biologicals, and treatments administered and each medical care provider 's order if the facility is managing the resident's medications and medical treatments; and This REQUIREMENT is not met as evidenced by: KAR 26-42-105(f)(3) The facility reported a census of two residents which were included in the sample and two	S5250		

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S5250	Continued From page 54 focused reviews for discharged residents. Based on interview and record review the operator failed to ensure Resident (R) 4's record contained an admission agreement and any amendments upon admission and prior to her discharge from the facility. Findings included: - Record review for R4 revealed an admission date of 11/08/25 with a diagnosis of dementia. The 11/08/25 "Functional Capacity Screen" (FCS) identified R4 required physical assistance with bathing, dressing, toileting, transfers, and eating. She was unable to perform management of medications and treatments and was incontinent of bladder. She had short-term and long-term memory, memory/recall and decision-making cognitive difficulties and was sometimes understandable and sometimes understood others during communication. R4 was at risk for falls. The 11/08/25 "Negotiated Service Agreement" (NSA) identified R4 received physical assistance from facility staff twice weekly with bathing. She received physical assistance from facility staff with dressing and toileting and assistance with a mechanical lift for transfers or was independent of transfers (depending on the day). R4 received assistance from facility staff to cut food up in small pieces for eating and checks and assistance to change soiled undergarments every two hours for bladder incontinence. She received management of medications and treatments by facility staff and encouragement to take her time when expressing herself for	S5250		

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S5250	Continued From page 55 communication. Staff used simple sentences and were concise for cognitive difficulties. R4 received close monitoring and was offered toileting every two to three hours and as needed for falls. Review of R4's "Admission Agreement" revealed R4's durable power of attorney (DPOA) signed the agreement and dated it 11/08/25. Review of the undated video statement by R4's DPOA revealed he stated Administrative Staff A called him several times on 03/09/26 and 03/10/26 requesting he come to the facility to sign paperwork. When he got to the facility, Administrative Staff A requested he sign the "Admission Agreement" and back date it R4's admission date which was 11/08/25. On 03/24/26 at 01:50 PM Administrative Staff A stated R4's DPOA signed her "NSA" at admission but did not sign the "Admission Agreement" because she did not have a copy of the "Admission Agreement" for R4 when she admitted. Administrative Staff A stated she went over the "Admission Agreement" with R4's DPOA when he came to pick up R4 and move her out of the facility. She confirmed she requested he back date the "Admission Agreement" to R4's admission date on 11/08/25. The undated facility's "Admission Agreement Signing Policy" documented the "Admission Agreement must be signed before any services were provided. The operator failed to ensure R4's record contained an admission agreement and any	S5250		

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NAME OF PROVIDER OR SUPPLIER VILLA HEIGHTS LIVING LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 816 S MULBERRY STREET GARDNER, KS 66030		
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S5250	Continued From page 56 amendments upon admission and prior to her discharge from the facility.	S5250		
S5251 SS=F	26-42-105 (f) (11) Resident Records 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 26-42-105(f)(11) The facility reported a census of two residents which were included in the sample and two focused reviews for discharged residents. Based interview and record review the operator failed to ensure a licensed nurse documented all incidents, symptoms, and other indications of illness or injury including the time of occurrences, actions taken, and results of the actions for all four sampled residents. Findings included: - Record review for R1 revealed an admission date of 02/24/26 with diagnoses of dementia, cerebral infarction, and repeated falls. The 02/24/25 "Functional Capacity Screen" (FCS) identified R1 required physical assistance with bathing, dressing, toileting, transfers, and eating. She was unable to perform management	S5251		

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S5251	Continued From page 57 of medications and treatments and was incontinent of bladder. R1 had short-term and long-term memory, memory/recall, and decision-making cognitive difficulties. She was sometimes understandable and sometimes understood others during communication and was at risk for falls. The 02/24/25 "Negotiated Service Agreement" (NSA) identified R1 received assistance by facility staff with bathing twice a week. She received staff assistance with dressing and checks and changes every two hours and as needed for toileting and bladder incontinence. R1 received assistance from facility staff with transfers and cueing and staff cut food in small pieces for eating. R1 received management of medications and treatments by facility staff and close monitoring and offering to toilet every two to three hours to prevent injury from falls. Staff used simple sentences and were concise for cognitive difficulties and staff spoke slowly for communication. The 02/24/26 at 03:41 PM nurse "Charting Note" by Administrative Staff A documented R1 admitted to the facility with fungal infection in coccyx, sacral area, and left great toe. She had a skin tear on her right forearm and a shingle skin rash over her right ribs and under her right breast. R1 had multiple falls from her previous home with some resulting injuries. Will continue to monitor. The 03/18/26 at 04:48 PM nurse "Charting Note" by Administrative Staff A documented R1 was well adjusted to the facility. Will continue to monitor.	S5251		

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S5251	Continued From page 58 R1's nursing notes lacked evidence of documentation of actions taken, besides monitoring, and results of the actions for fungal infections, shingles rash, and skin tear including results of continued monitoring. - Record review for R2 revealed an admission date of 09/24/24 with a diagnosis of dementia. The 01/10/26 "FCS" identified R2 required physical assistance with bathing, dressing, toileting, transfers, and eating. She was unable to perform management of medications and treatments and was incontinent of bladder. R2 had short-term and long-term memory, memory/recall, and decision-making cognitive difficulties. She was sometimes understandable and sometimes understood others during communications. R2 was at risk for falls and wandering. The 01/10/26 "NSA" identified R2 received physical assistance from facility staff for bathing and dressing. She received checks and assistance to change soiled briefs every two hours for toileting and bladder incontinence. R2 received assistance from staff with a gait belt for transfers and staff cut up her food into smaller pieces and she fed herself for eating. She received management of medications and treatments by facility staff used simple words, articulated clearly and were concise for cognitive difficulties. Staff followed visual cues for communication. R2 received close monitoring and staff rounding every two hours and as needed while sleeping for falls and distraction from staff for wandering.	S5251		

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S5251	Continued From page 59 The 10/10/25 at 04:20 PM late entry nursing "Charting Note" by Administrative Staff documented R2 returned to the facility with patent Percutaneous Endoscopic Gastrostomy (PEG) tube. The 10/13/25 at 03:15 PM nursing "Charting Note" by Administrative Staff A documented R2 continued to tolerate feeding well and was still weak. Will continue to monitor. The 01/14/26 at 03:34 PM (93 days after previous nursing note) nursing "Charting Note" by Administrative Staff A documented PEG tube was patent. Will continue to monitor. R2's nursing notes lacked evidence of documentation of actions, besides monitoring, and results of the actions for weakness including results of continued monitoring. - Record review for R3 revealed an admission date of 10/11/24 with diagnoses of dementia and anxiety. The 06/05/25 "Functional Capacity Screen" (FCS) identified R3 required physical assistance with bathing, dressing, toileting and she was unable to perform management of medications and treatments. R3 was frequently incontinent of bladder, had short-term memory and decision-making cognitive difficulties, and was at risk for falls, impaired vision, and wandering. The 06/05/25 "Negotiated Service Agreement" (NSA) identified R3 received physical assistance from a hospice aide twice weekly with bathing.	S5251		

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S5251	Continued From page 60 She received physical assistance from facility staff with dressing and toileting. R3 received checks and assistance to change soiled undergarments as needed for bladder incontinence. She received management of medications and treatments by facility staff. Staff used simple words, were concise, and articulated clearly for cognitive difficulties and encouraged R3 to remain in the common area for close monitoring for wandering and falls. The "NSA" failed to describe services R3 received for impaired vision. The 02/19/26 at 09:12 AM nurse "Charting Note" by Administrative Staff A documented R3 fell and hit head. The nurse practitioner was notified with recommendations to continue monitoring. The note lacked documentation of the date and time of the fall, assessment of other potential areas of injury, actions taken to prevent further falls with injury, and results of the actions. Review of R3's nursing notes revealed lack of evidence of documentation of continued monitoring and fall follow-up neurological assessments by a licensed nurse, actions taken to prevent further falls with injury, and results of the actions. - Record review for R4 revealed an admission date of 11/08/25 with a diagnosis of dementia. The 11/08/25 "FCS" identified R4 required physical assistance with bathing, dressing, toileting, transfers, and eating. She was unable to perform management of medications and treatments and was incontinent of bladder. She had short-term and long-term memory,	S5251		

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S5251	Continued From page 61 memory/recall and decision-making cognitive difficulties and was sometimes understandable and sometimes understood others during communication. R4 was at risk for falls. The 11/08/25 "NSA" identified R4 received physical assistance from facility staff twice weekly with bathing. She received physical assistance from facility staff with dressing and toileting and assistance with a mechanical lift for transfers or was independent of transfers (depending on the day). R4 received assistance from facility staff to cut food up in small pieces for eating and checks and assistance to change soiled undergarments every two hours for bladder incontinence. She received management of medications and treatments by facility staff and encouragement to take her time when expressing herself for communication. Staff used simple sentences and were concise for cognitive difficulties. R4 received close monitoring and was offered toileting every two to three hours and as needed for falls. Review of "Charting Notes" for R4 from 11/26/25 to 03/23/26 revealed the following: The 11/26/25 Primary Care Provider (PCP) "Progress Note" documented R4 "was lethargic and unable to ambulate with the previous treatment plan. Her medications were adjusted with a decrease in Zyprexa and trazodone." R4's "Charting Notes" lacked nursing documentation of any lethargy and inability to ambulate including dates, time of occurrences, actions taken, and results of the actions.	S5251		

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S5251	Continued From page 62 R4's "Charting Notes" lacked nursing documentation of R4's 12/15/25 report of allegation of sexual abuse by Housekeeping Staff E including date and time of occurrence, actions taken, and results of the actions. The 03/10/25 nursing "Charting Note" documented staff reported R4 had multiple bruises to both arms and her left lower foot that was caused by the mechanical lift. The 03/11/26 PCP "Progress Note" documented facility staff reported R4 had bruises with no reports of recent falls or injury. R4's "Charting Notes" lacked documentation of staff reporting an incident involving a mechanical lift including the date, time of occurrence, actions taken, and results of the actions. On 03/24/26 at approximately 08:42 AM R4's unidentified family member stated during a phone interview on 12/15/25 R4 reported Housekeeping Staff E went into her room while she changed into her pajamas and pinched and poked her backside. R4 reported it did not hurt but she got really mad and asked Housekeeping Staff E to stop. She hoped he would not do it anymore. R4's family reported the allegation to Administrative Staff A who said she "would take care of it." On 03/24/26 at 10:25 AM Administrative Staff A confirmed R4's family reported to her R4 had reported that Housekeeping Staff E pinched and poked her backside. She did not find any bruises upon nursing assessment.	S5251		

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S5251	Continued From page 63 On 03/24/26 at 02:11 PM CMA B stated she did not know how R4 got bruises on her foot. The bruises on her arms showed up a few days after R4 hit her arms on the mechanical lift. CMA B wrote an incident report on 03/08/26 and backdated it to the date of the incident on 03/06/26. On 03/26/26 at approximately 05:29 PM during findings meeting Administrative Staff A confirmed all sampled residents' records lacked documentation of all incidents, symptoms, and other indications of illness or injury including the date, time of occurrence, actions taken, and results of the actions. The undated facility's "Nursing Documentation Policy" documented the following: All entries must reflect actual observations, interventions, and resident responses. Documentation must be complete during the shift in which care occurred. Assessments must be fully documented. Care tasks must be fully documented. Required documentation included shift notes with summary of resident status, changes, and significant events; routine and as needed assessments; incident reporting of any falls, injuries or unusual occurrences; and communication notifications to physicians, families, or leadership. The operator failed to ensure a licensed nurse documented all incidents, symptoms, and other indications of illness or injury including the time of occurrences, actions taken, and results of the actions for all four sampled residents.	S5251		

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S5255 SS=F	26-42-102 (a) Staff Qualifications Sufficient Staff (a) The administrator or operator of each home plus shall ensure the provision of a sufficient number of qualified personnel to provide each resident with services and care in accordance with that resident 's functional capacity screening, health care service plan, and negotiated service agreement. This REQUIREMENT is not met as evidenced by: KAR 26-42-102(a) The facility reported a census of two residents with two included in the sample and two focused reviews for discharged residents. Based on observation, interview, and record review the operator failed to provide enough qualified staff to provide each resident with the services and care in accordance with their "Functional Capacity Screens" (FCS) and "Negotiated Service Agreements (NSA)" Findings included: - Record review for Resident (R) 3 revealed an admission date of 10/11/24 with diagnoses of dementia and anxiety. The 06/05/25 "Functional Capacity Screen" (FCS) identified R3 required physical assistance with bathing, dressing, toileting and she was unable to perform management of medications and treatments. R3 was frequently incontinent of bladder, had short-term memory and decision-making cognitive difficulties, and was at	S5255		

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S5255	Continued From page 65 risk for falls, impaired vision, and wandering. The 06/05/25 "Negotiated Service Agreement" (NSA) identified R3 received physical assistance from a hospice aide twice weekly with bathing. She received physical assistance from facility staff with dressing and toileting. R3 received checks and assistance to change soiled undergarments as needed for bladder incontinence. She received management of medications and treatments by facility staff. Staff used simple words, were concise, and articulated clearly for cognitive difficulties and encouraged R3 to remain in the common area for close monitoring for wandering and falls. The "NSA" failed to describe services R3 received for impaired vision. Review of R3's Medication Administration Record (MAR) from 01/01/26 to 03/05/26 revealed levothyroxine 75 micrograms (mcg) one tablet by mouth daily before meals on an empty stomach for hypothyroid between 05:00 to 06:00 AM. The medication was documented as administered daily by Administrative Staff A except for the following dates: 01/11/26 - blank, none administered 01/14/26 - Certified Medication Aide (CMA) H administered 01/25/26 - blank, none administered 02/08/26 - blank, none administered 02/19/26 - blank, none administered 02/22/26 - blank, none administered The 03/24/26 notarized "Witness Statement" by Housekeeping Staff E reported he worked in the facility on 03/05/26 performing his "normal duties like cleaning and laundry, etc." At around 02:00	S5255		

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S5255	Continued From page 66 PM hospice staff arrived to assist R3 with a shower. R3 refused and housekeeping staff E "convinced" R3 to accept a shower. The 03/26/26 notarized "Witness Statement" by CMA G reported she arrived to work at the facility on 02/08/26 at approximately 07:00 AM. R3 was confined in her room by a medication cart placed across the doorway with the wheels locked with one night shift staff present in the facility. On 03/24/26 at approximately 08:01 AM R3's unidentified family member (legal representative) stated the following during a phone interview: She visited the facility almost every day. She rarely saw Administrative Staff A at the facility but saw Housekeeping Staff E there "all the time." Sometimes he was there "all weekend long" and was often "alone with no other staff." She witnessed Housekeeping Staff E assist the residents with activities of daily living (ADL's). He crushed medications and mixed them with some kind of liquid or a bite of applesauce or pudding and administered them to the residents in a spoon. On 03/24/26 at approximately 05:06 PM CNA J stated he worked night shift by himself. R3 did not need any medication early in the morning around 5:00 or 06:00 AM. On 03/24/26 at approximately 12:25 PM CNA F stated R3 had a medication that was scheduled to be administered by 06:00 AM. She could not recall the name of the medication. Sometimes she documented the medication was administered and when day shift arrived around	S5255		

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S5255	Continued From page 67 07:00 AM they administered the medication to R3. Administrative Staff A instructed her within the last six months to administer the 06:00 AM medication to R3 and document it under Administrative Staff A's name on the facility computer. The operator failed to provide R3 enough qualified staff to administer a morning medication before meals on an empty stomach between 05:00 and 06:00 AM each day. The operator further failed to provide enough qualified staff to assist R3 with ADL's. - Record review for R4 revealed an admission date of 11/08/25 with a diagnosis of dementia. The 11/08/25 "FCS" identified R4 required physical assistance with bathing, dressing, toileting, transfers, and eating. She was unable to perform management of medications and treatments and was incontinent of bladder. She had short-term and long-term memory, memory/recall and decision-making cognitive difficulties and was sometimes understandable and sometimes understood others during communication. R4 was at risk for falls. The 11/08/25 "NSA" identified R4 received physical assistance from facility staff twice weekly with bathing. She received physical assistance from facility staff with dressing and toileting and assistance with a mechanical lift for transfers or was independent of transfers (depending on the day). R4 received assistance from facility staff to cut food up in small pieces for eating and checks and assistance to change soiled undergarments every two hours for	S5255		

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S5255	Continued From page 68 bladder incontinence. She received management of medications and treatments by facility staff and encouragement to take her time when expressing herself for communication. Staff used simple sentences and were concise for cognitive difficulties. R4 received close monitoring and was offered toileting every two to three hours and as needed for falls. The 02/12/26 hospice "Service Note" at 05:30 PM by Licensed Nurse R was electronically signed by Housekeeping Staff E and named Housekeeping Staff E as the facility CNA. The note documented the facility CNA reported R4 slept well the night before with no anxiety or agitation. R4 became anxious at times with pacing and exit seeking which had not happened during the last week to his knowledge. The hospice nurse reminded the facility CNA to call hospice with any needs or concerns. The 02/26/26 hospice "Service Note" at 02:25 PM by Licensed Nurse R was electronically signed by Housekeeping Staff E and named Housekeeping Staff E as the facility CNA. The note documented the facility CNA reported R4 had not been exit seeking as much, was less anxious, and denied any needs for R4. On 03/24/26 at approximately 08:42 AM R4's unidentified family member stated the following: She and other family members took turns staying at the facility with R4 for 48 hours before R4 moved out and were able to observe what happened at the facility. There were "plenty of times" only one staff member was at the facility during the day. Housekeeping Staff E was often	S5255		

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S5255	Continued From page 69 there by himself. R4 had a significant decline the last month and recently could not stand by herself. She observed staff used a mechanical lift for the first time on 03/12/26 to assist R4 to transfer. Prior to that, two staff used a gait belt to help R4 to stand. She did not witness staff assisted R4 to transfer when there was only one there by themselves. On 03/24/26 at approximately 11:24 AM Housekeeping Staff E stated he sometimes helped other staff with a mechanical lift to transfer R4. On 03/25/26 at approximately 01:23 PM CNA K stated R4 required assistance of two staff for transfers starting about two months ago. He worked by himself at night and never had to get her up by himself because "she slept all night." Sometimes he checked her briefs and they were always dry. On 03/26/26 at approximately 10:08 AM CMA G stated R4 required assistance of two staff with transfers. On 03/30/26 at 02:07 PM Licensed Nurse Q stated during a phone interview she worked for hospice and provided care to R4. When she was in the facility there were always at least two staff present. Sometimes one of the two staff was Housekeeping Staff E. She guessed he was an aide or med tech but was not sure of his position at the facility. A few weeks ago, she witnessed Housekeeping Staff E assist the hospice bath aide transfer R4 to the shower and then stepped	S5255		

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S5255	Continued From page 70 away during the shower. The operator failed to provide R4 enough qualified staff to administer medications and to assist R4 with ADL's including check and changing of soiled undergarments every two hours for bladder incontinence and to prevent falls. - Record review for R2 revealed an admission date of 09/24/24 with a diagnosis of dementia. The 01/10/26 "FCS" identified R2 required physical assistance with bathing, dressing, toileting, transfers, and eating. She was unable to perform management of medications and treatments and was incontinent of bladder. R2 had short-term and long-term memory, memory/recall, and decision-making cognitive difficulties. She was sometimes understandable and sometimes understood others during communications. R2 was at risk for falls and wandering. The 01/10/26 "NSA" identified R2 received physical assistance from facility staff for bathing and dressing. She received checks and assistance to change soiled briefs every two hours for toileting and bladder incontinence. R2 received assistance from staff with a gait belt for transfers and staff cut up her food into smaller pieces and she fed herself for eating. She received management of medications and treatments by facility staff used simple words, articulated clearly and were concise for cognitive difficulties. Staff followed visual cues for communication. R2 received close monitoring and staff rounding every two hours and as	S5255		

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S5255	Continued From page 71 needed while sleeping for falls and distraction from staff for wandering. The 03/26/26 notarized "Witness Statement" by CMA G reported R2 was routinely fed through a Percutaneous Endoscopic Gastrostomy (PEG) tube by non-certified staff and/or staff who were not trained to perform the task. CMA G observed on multiple mornings when she arrived for her shift, R2 was still in bed soaked in urine from head to toe including her clothing and hair. She reported her concern to Administrative Staff A on 11/18/25 but the issue remained unresolved. On 03/23/26 at 11:55 AM CMA C stated Administrative Staff A would be at the facility soon to administer PEG tube feeding for R2. Observation on 03/23/26 at 12:40 PM revealed Administrative Staff A arrived at the facility. R2 had not received a PEG tube feeding for lunch. Observation on 03/23/26 at 01:33 PM revealed Administrative Staff A provided R2 PEG tube feeding. Observation on 03/24/26 at 09:55 AM revealed a sign was taped the wall above the medication cart that read "[R2] Tube Feeding Schedule" with times listed at 08:00 AM, 12:00 PM, 04:00 PM, and 08:00 PM. On 03/24/26 at approximately 08:01 AM R3's unidentified family member (legal representative) stated she visited the facility almost every day. She witnessed Housekeeping Staff E feed R2 through her feeding tube. All the staff fed her.	S5255		

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S5255	Continued From page 72 On 03/24/26 at 09:50 AM Administrative Staff A stated R2 received placement of a PEG tube due to difficulty swallowing. On 03/24/26 at approximately 12:25 PM CNA F stated the following: She worked with Housekeeping Staff E for brief periods of time. When he arrived at 07:00 AM he administered medications and fed R2 through a PEG tube. Housekeeping Staff E showed her how to do the PEG tube feeding but she never administered a feeding by herself. Sometimes Administrative Staff A had to leave quickly after R2 received a PEG tube feeding. Administrative Staff A instructed CNA F to log into the facility computer using Administrative Staff A's password to document the feeding was provided. On 03/25/26 at approximately 01:23 PM CNA K stated R2 required assistance of two staff for transfers. She did not get up during the night to go to the bathroom. She never soiled herself that he knew of. He checked her twice during the night and she was always dry. On 03/26/26 at approximately 10:08 AM CMA G stated when she arrived in the morning a medication cart was in the way of the facility's front entrance/exit door because night shift staff put the cart in front of R2's door. R2's bedroom door was next to the facility's front entrance/exit door. The operator failed to provide R2 enough qualified staff to administer medications and to	S5255		

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S5255	Continued From page 73 providing feeding through a PEG tube. The operator further failed to provide enough qualified staff to assist with R2 with ADL's including check and changing of soiled undergarments every two hours for bladder incontinence. The 03/24/26 notarized "Witness Statement" by Housekeeping Staff E reported he worked in the facility on 03/05/26 performing his "normal duties like cleaning and laundry, etc." CMA G clocked out of the facility at 03:20 PM and CMA B arrived at approximately 03:40 PM. Housekeeping Staff E's witness statement revealed he was the only staff in the facility for approximately 20 minutes alone with four cognitively impaired residents who required physical assistance with activities of daily living (ADL's). The 03/26/26 notarized "Witness Statement" by CMA G reported the following: She observed individuals were permitted to provide resident care without proper certification. CNA's and non-certified staff administered medications including controlled medications. If staff member administering medication was not certified to do so, Administrative Staff A instructed them not to sign the controlled medications book. When Administrative Staff A visited the facility, she filled in the blank entries and signed her name. CMA G observed staff locking residents in or out of their rooms. Night shift staff were supposed to remain awake and available frequently placed the medication cart in front of a resident's door	S5255		

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S5255	Continued From page 74 and locked the wheels so the resident could not leave their room or access the bathroom. During those times, staff members slept while on duty. Review of five current staff records revealed five staff (CMA C, CNA F, CMA G, CNA J, and Housekeeping Staff E) lacked evidence of documentation criminal background checks were completed. CMA G and Housekeeping Staff E lacked evidence of documentation of certification of successful completion of a training course to perform functions that required specialized training. Review of the facility's schedule from 02/15/26 to 03/26/25 revealed one to two staff were scheduled daily for day shift. One staff was scheduled daily for night shift except on 02/21/26, 03/18/26, and 03/21/26. Housekeeping Staff E was not on the schedule. Review of the facility's penciled staff clock-in times from 02/15/26 to 03/26/25 revealed the following: Two staff clocked in daily for day shift except on 02/15/26, 02/16/26, 02/26/26, 02/28/26, 03/01/26, 03/05/26, 03/07/26, 03/08/26, 03/14/26, 03/15/26, 03/20/26, 03/21/26, and 03/22/26. The penciled clock-in times lacked evidence of documentation at least two staff worked during day for 13 shifts. One staff clocked in daily for night shift except on 02/21/26, 03/09/26, and 03/03/26. The penciled clock-in times lacked evidence of documentation at least one staff worked during the night for three shifts.	S5255		

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S5255	Continued From page 75 The penciled clock-in times lacked the times Housekeeping Staff E was in the facility. Observation on 03/23/26 at 11:50 AM revealed CMA B and CMA C were present supervising the residents and assisting with ADL's as needed. Observation on 03/24/26 at 05:06 PM revealed there were two current residents at the facility. R1 and R2 sat in the common area with no staff nearby. At 05:22 PM Administrative Staff A entered the front door of the facility and called for CMA B because she was not visible in the facility. R1 and R2 were alone with no staff supervision for 16 minutes. On 03/25/26 at 11:39 AM CMA B stated she was in the bathroom the previous day when the residents were left alone for 16 minutes. On 03/23/26 at 11:54 AM CMA C stated R2 required assistance of two persons for transfers and Administrative Staff A would arrive soon to provide a PEG tube feeding for R2. On 03/23/26 at 12:53 PM Administrative Staff A stated she did not clock-in or keep a log of dates and times she was present at the facility. On 03/24/26 at approximately 10:37 AM CMA B stated she worked day shift on Monday, Wednesday, and Friday. She also picked up extra shifts if needed. She had never worked alone at the facility. There were always two staff working. She rarely worked with Housekeeping Staff E and did not know when he worked.	S5255		

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S5255	Continued From page 76 On 03/24/26 at approximately 10:59 AM CMA C stated she worked day shift on Monday, Wednesday, and Friday. Housekeeping Staff E worked on Thursday, and she rarely worked with him. She worked with him once and he did the dishes, laundry, and sat and talked with the residents. On 03/24/26 at approximately 11:24 AM Housekeeping Staff E stated he wrote down the time he worked on a paper sheet. He worked Thursday and Saturday and was never alone. He vacuumed, mopped, cleaned, mowed the yard, shoveled the snow, did the laundry, and sometimes played games with the residents. He never assisted residents with ADL's or administered medications. On 03/24/26 at approximately 12:25 PM CNA F stated the following: She worked night shift and worked by herself until day shift staff arrived in the morning around 07:00 AM. She worked with Housekeeping Staff E for brief periods of time. When he arrived at 07:00 AM the tasks were not designated between the two of them. If CNA F was busy assisting one residents, Housekeeping Staff E helped another resident with ADL's to get ready for the day and administered medications. She did not know if Housekeeping Staff E was a CMA. On 03/24/26 at approximately 03:34 PM CMA H stated she worked by herself on night shift until day shift staff arrived around 07:00 AM. CMA H administered the morning medications before the	S5255		

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S5255	Continued From page 77 end of her shift. On 03/24/26 at approximately 05:06 PM CNA J stated Housekeeping Staff E was at the facility "most of the time cleaning and stuff." On 03/25/26 at 11:37 AM Administrative Staff A stated Housekeeping Staff E worked as an unpaid volunteer. He was legal but did not have a green card yet. He was not paid to work because his immigration status prevented her from completing a background check on him. Administrative Staff confirmed staff records lacked evidence of documentation of criminal background checks for five staff and evidence of certification for two staff. On 03/25/26 at approximately 02:14 PM CMA I stated Housekeeping Staff E was a "volunteer." He "helped with everything around this place." He did not pay attention if Housekeeping Staff E went into residents' rooms. On 04/01/26 at approximately 03:44 PM Medical Provider P stated during a phone interview she was sure of Housekeeping Staff E's role at the facility, but she thought he was a CNA. She witnessed him assist a resident to transfer from a recliner to a wheelchair but did not witness him providing any other ADL's. The operator failed to provide enough qualified staff to provide each resident with the services and care in accordance with their "FCS" and "NSA."	S5255		
S5258 SS=F	26-42-102 (d) Staff Qualifications Employee Records	S5258		

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S5258	Continued From page 78 (d) The employee records and agency staff records shall contain the following information: (1) Evidence of licensure, registration, certification, or a certificate of successful completion of a training course for each employee performing a function that requires specialized education or training; (2) supporting documentation for criminal background checks of facility staff and contract staff, excluding any staff licensed or registered by a state agency, pursuant to K.S.A. 39-970 and amendments thereto; (3) supporting documentation from the Kansas nurse aide registry that the individual does not have a finding of having abused, neglected, or exploited a resident in an adult carehome; and (4) supporting documentation that the individual does not have a finding of having abused, neglected, or exploited any resident in an adult care home, from the nurse aide registry in each state in which the individual has been known to work as a certified nurse aide. This REQUIREMENT is not met as evidenced by: KAR 26-42-102(d)(1)(2) The facility reported a census of two residents. Based on interview and record review the operator failed to ensure evidence of certification for one of five sampled staff and supporting documentation for criminal background checks for five of five sampled staff were contained in the staff records.	S5258		

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S5258	Continued From page 79 Findings included: - Record review for Certified Medication Aide (CMA) G revealed a hire date of 09/03/25. The record lacked evidence of documentation of certification and completion of a criminal background check. - Record review for CMA C revealed a hire date of 03/09/26. The record lacked evidence of documentation of completion of a criminal background check. - Record review for Certified Nurse Aide (CNA) F revealed a hire date of 08/25/25. The record lacked evidence of documentation of completion of a criminal background check. - Record review for CNA J revealed a hire date of 03/09/26. The record lacked evidence of documentation of completion of a criminal background check. - Record review for Housekeeping Staff E revealed a hire date of 01/01/25. The record lacked evidence of documentation of completion of a criminal background check. - The facility's "Staff Background Check and Registry Check Policy" documented background checks and registry screenings must be completed and verified before an employee's first day of independent work. - The operator failed to ensure evidence of certification for one of five sampled staff and supporting documentation for criminal background checks for five of five sampled staff	S5258		

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S5258	Continued From page 80 were contained in the staff records.	S5258		
S5300 SS=F	26-42-205 (d) (1-2) Facility Administration of Medications (d) Home administration of resident ' s medications. If a home is responsible for the administration of a resident ' s medications, the administrator or operator shall ensure that all medications and biologicals are administered to that resident in accordance with a medical care provider ' s written order, professional standards of practice, and each manufacturer ' s recommendations. The administrator or operator shall ensure that all of the following are met: (1) Only licensed nurses and medication aides shall administer and manage medications for which the home has responsibility. (2) Medication aides shall not administer medication through the parenteral route. This REQUIREMENT is not met as evidenced by: KAR 26-42-205(d)(1) The facility reported a census of two residents which were included in the sample and two focused reviews for discharged residents. Based on observation, interview, and record review the operator failed to ensure medications for Resident (R) 2 were administered on time per physician's order and percutaneous endoscopic gastrostomy (PEG) tube feedings for R2 were administered in accordance with professional standards of practice. The operator failed to	S5300		

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S5300	Continued From page 81 ensure a medication for R3 was administered daily per physician's orders. The operator failed to ensure a PRN (as needed) medication for constipation was administered to R4 per physician's order which resulted in R4 being subjected to manual digital removal of hardened stool. The operator further failed to ensure only licensed nurses or Certified Medication Aides (CMA) administered medications to the residents by allowing Certified Nurse Aides (CNA) and housekeeping staff to administer medications. Findings included: - Record review for R2 revealed an admission date of 09/24/24 with a diagnosis of dementia. The 01/10/26 "Functional Capacity Screen" (FCS) identified R2 was unable to perform management of medications and treatments. The 01/10/26 "Negotiated Service Agreement" (NSA) identified R2 received management of medications and treatments by facility staff. The 11/05/25 physician's order for 250 milliliters (ml) isosource per PEG tube with 150 ml of water four times daily. Review of R2's electronic "Medication Administration Record" (eMAR) from 01/01/26 to 03/23/26 revealed the following orders: Quetiapine 25 milligrams (mg) tablet one tablet three times daily with midday administration at 11:00 AM to 01:00 PM. Risperidone 1.0 mg/1.0 ml 1.0 ml via feeding	S5300		

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S5300	Continued From page 82 tube three times daily with midday administration at 11:00 AM to 01:00 PM. Review of a sign taped to the wall above the medication cart read "[R2's] Tube Feeding Schedule" with scheduled times at 08:00 AM, 12:00 PM, 04:00 PM, and 08:00 PM. On 03/23/26 at 11:54 AM CMA C stated Administrative Staff A would be at the facility soon for a tube feeding. Observation on 03/23/26 at 01:33 PM revealed Administrative Staff A administered R2 a midday (12:00 PM) tube feeding and medications which were one and one-half hours late. The operator failed to ensure medications for R2 were administered on time per physician's order and PEG tube feedings were administered timely in accordance with professional standards of practice. - Record review for R3 revealed an admission date of 10/11/24 with diagnoses of dementia and anxiety. The 06/05/25 "FCS" identified R3 was unable to perform management of medications and treatments. The 06/05/25 "NSA" identified R3 received management of medications and treatments by facility staff. Review of R3's "eMAR" from 01/01/26 to 03/23/26 revealed the following:	S5300		

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S5300	Continued From page 83 Levothyroxine 75 micrograms (mcg) take one tablet daily before meals on an empty stomach. The medication was not administered to R3 on 2 days in January on 01/11/26 and 01/25/26, and three days in February on 02/08/26, 02/19/26, and 02/22/26. The operator failed to ensure levothyroxine for R3 was administered daily per physician's orders. - Record review for R4 revealed an admission date of 11/08/25 with a diagnosis of dementia. The 11/08/25 "FCS" identified R4 was unable to perform management of medications and treatments. The 11/08/25 "NSA" identified R4 received management of medications and treatments by facility staff. Review of by R4's "eMAR" from 01/01/26 to 03/23/26 revealed an order for bisacodyl 10 mg suppository daily as needed for constipation and an order for docusate-senna tablet by mouth daily in the morning for constipation. The 03/06/26 at 01:00 PM hospice "Service Note" by Licensed Nurse Q documented Administrative Staff A requested a hospice visit for constipation. Administrative Staff A reported they had to digitally disimpact hard stool for R4 and requested an order for a laxative. The hospice nurse asked Administrative Staff A if the facility had utilized any of R4's as needed senna (oral medication for constipation) or suppositories. Administrative Staff A stated she	S5300		

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S5300	Continued From page 84 was "unsure and did not realize there were PRN orders." The hospice nurse provided Administration Staff A education regarding PRN medications for constipation. The operator failed to ensure a PRN (as needed) medication for constipation was administered to R4 per physician's order which resulted in R4 being subjected to manual digital removal of hardened stool. - Review of staff hired dates (reported by the facility) compared to dates staff accounts were created in facility's "eMAR" system (reported by the pharmacy provider) revealed the following: Administrative Staff A hire date: 09/24/24. eMAR account: 09/19/24. Five days before hire. CMA B hire date: 12/12/24. eMAR account: 05/20/25. 159 days after hire. CMA H hire date: 03/22/25. eMAR account: 05/20/25. 59 days after hire. CMA I hire date: 06/06/25. eMAR account: 07/03/25. 27 days after hire. CMA C hire date: 09/02/25. eMAR account: 09/30/25. 28 days after hire. CMA G hire date: 09/03/25. eMAR account: 09/09/25. Six days after hire. The accounts list did not name any CNA's or housekeeping staff that had accounts to access the eMAR system. The notarized "Witness Statement" by CMA G reported she witnessed CNAs and other uncertified staff administering medications including controlled medications. When Administrative Staff A visited the facility, usually	S5300		

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S5300	Continued From page 85 once per week, she completed and signed blank medication entries that were administered by non-CMA's. Staff members were not required to document medication administration in eMAR. On 03/24/26 at approximately 08:01 R3's unidentified family member stated during a phone interview she was in the facility almost every day and witnessed Housekeeping Staff E in the facility "all the time." Sometimes he was there all weekend long and slept overnight. Sometimes he was in the facility by himself with no other staff. Housekeeping Staff E fed R2 through a feeding tube and dispensed medicine. He crushed medications and mixed them into liquid or a bite of applesauce or pudding and fed it the residents on a spoon. On 03/24/26 at approximately 08:42 R4's unidentified family member stated during a phone interview the family did not want R4 left alone in the facility until they moved her out. Family members took turns staying with R4. She witnessed Housekeeping Staff E was often in the facility by himself. She was not aware he was housekeeping staff only and was not to assist with cares or administer medication. On 03/24/26 at approximately 12:25 PM CNA F stated she worked night shift by herself until day shift staff arrived at the facility around 07:00 AM. When Housekeeping Staff E was the staff that arrived to work at 07:00 AM, he administered medications and fed R2 through her feeding tube. Administrative Staff A requested CNA F to administer a 06:00 AM medication to R3 and document the medication was administered using Administrative Staff A's username and password.	S5300		

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S5300	Continued From page 86 Sometimes CNA F documented the medication was administered by 06:00 AM per physician's orders but the medication was not administered until later when day shift staff arrived. On 03/24/26 at approximately 03:34 PM CMA H stated she worked night shift and administered morning medications to the residents before the end of her shift. The computer was always on with Administrative Staff A logged in even though Administrative Staff A was not present in the facility. CMA H marked the medications were administered under Administrative Staff A's name. For a long time, staff did not have their own usernames and passwords to log into the eMAR system. She now had her own username and password, but if Administrative Staff A was logged in CMA H continued to document medications were administered under Administrative Staff A's name. On 03/26/26/ at approximately 05:24 PM Administrative Staff A confirmed there were periods of time facility staff did not have their own usernames and passwords to log into facility's eMAR system. Administrative Staff A stated she "would do better" and make sure to log out of the computer so staff could not document under her name. The undated facility's "Nursing Documentation Policy" documented "Staff must use their own credentials and log out when leaving a workstation." The undated facility's "Resident Records Storage and Confidentiality Policy" documented resident records were accurately maintained. Staff must	S5300		

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S5300	Continued From page 87 not share or write down passwords in accessible areas. The January 2022 Kansas Board of Nursing "Nurse Practice Act Statutes and Administrative Regulations" documented that inaccurately recording, falsifying, or altering any record of a patient was "unprofessional conduct" and may be grounds for disciplinary action. The operator failed to ensure medications for R2 were administered on time per physician's order and PEG tube feedings for R2 were administered in accordance with professional standards of practice. The operator failed to ensure a medication for R3 was administered daily per physician's orders. The operator failed to ensure a PRN (as needed) medication for constipation was administered to R4 per physician's order which resulted in R4 being subjected to manual digital removal of hardened stool. The operator failed to ensure only licensed nurses or CMAs administered medications to the residents by allowing CNAs and housekeeping staff to administer medications.	S5300		
S5302 SS=D	26-42-205 (d) (4) Delegation of Medication Administration (4) Any licensed nurse may delegate nursing procedures not included in the medication aide curriculum to medication aides under the Kansas nurse practice act, K.S.A. 65-1124 and amendments thereto. This REQUIREMENT is not met as evidenced	S5302		

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S5302	Continued From page 88 by: KAR 26-42-205(d)(4) The facility reported a census of two residents with Resident (R) 2 marked for percutaneous endoscopic gastrostomy (PEG) tube feedings on the "Resident Roster." Based on interview and record review the operator failed to ensure Certified Medication Aides (CMAs) received training and completed competencies for delegated PEG tube feedings and medication administration. Findings included: - Record review for R2 revealed an admission date of 09/24/24 with a diagnosis of dementia. The 01/10/26 "Functional Capacity Screen" (FCS) identified R2 required physical assistance with eating and was unable to perform management of medications. The 01/10/26 "Negotiated Service Agreement" (NSA) identified R2 received assistance from facility staff to cut her food into smaller pieces and she fed herself for eating. She received management of medications by facility staff. The "NSA" failed to describe services R4 received for PEG tube feeding and medication administration. The 10/10/25 at 04:20 PM late entry nursing "Charting Note" by Administrative Staff A documented R2 returned to the facility with patent Percutaneous Endoscopic Gastrostomy (PEG) tube. The 11/05/25 physician's order documented to	S5302		

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S5302	Continued From page 89 administer 250 milliliters (ml) isosource per PEG tube with 150 ml of water four times daily. The 03/26/26 notarized "Witness Statement" by CMA G reported R2 was routinely fed through a PEG tube by staff who were not trained to perform the task. - Record review for CMA C revealed a hire date of 03/09/26. Her record lacked evidence of documentation a licensed nurse completed competencies with her to administer tube feedings medication administration. Record review for CMA G revealed a hire date of 09/03/25. Her record lacked evidence of documentation a licensed nurse completed competencies with her to administer tube feedings and medication administration. On 03/24/26 at approximately 08:01 AM R3's unidentified family member (legal representative) stated she visited the facility almost every day. She witnessed Housekeeping Staff E feed R2 through her feeding tube. All the staff fed her. On 03/24/26 at 09:50 AM Administrative Staff A stated R2 received placement of a PEG tube due to difficulty swallowing. On 03/24/26 at approximately 12:25 PM CNA F stated she worked with Housekeeping Staff E for brief periods of time. When he arrived at 07:00 AM he administered medications and fed R2 through a PEG tube. Housekeeping Staff E showed her how to do the PEG tube feeding but she never administered a feeding by herself.	S5302		

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S5302	Continued From page 90 On 03/24/26 at 04:14 PM Administrative Staff A confirmed records for all staff lacked evidence of documentation a licensed nurse completed competencies with each one to administer tube feedings. The undated facility's "Nursing Delegated Task Policy" documented facility staff must demonstrate competency before performing any delegated task. Tasks would be documented by nurses in the resident's care plan and provide on-going supervision appropriate to the task and the resident's condition. Competency reviews would be conducted at hire and annually. The operator failed to ensure CMAs received training and completed competencies for delegated PEG tube feedings and medication administration.	S5302		
S5315 SS=F	26-42-205 (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 home in a locked medication room, cabinet, or medication cart. Licensed nurses and medication aides shall store controlled medications managed by the home in separately locked compartments within a locked medication room, cabinet, or medication cart. Only licensed nurses and medication aides shall	S5315		

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S5315	Continued From page 91 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 home. (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 26-42-205(h) The facility reported a census of two residents. Based on observation and interview, the operator failed to store a vial of injectable medication in accordance with the pharmacist's and manufacturer's recommendations. Findings included: - Observation on 03/25/26 at 11:34 AM revealed an unsealed vial of tuberculin by itself with no box. The vial lacked a label with an open date. The vial of tuberculin contained instructions that a vial of which had been opened and in use for 30 days should be discarded.	S5315		

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S5315	Continued From page 92 On 02/25/26 at approximately 11:34 AM Administrative Staff A confirmed the vial of tuberculin lacked a label with an open date and stated it was opened on 08/25/25. On 02/25/26 at 11:43 AM Administrative Staff A confirmed the vial of tuberculin had to be discarded 30 days after opening. The undated facility's "Medication Storage Policy" documented expired medications must be removed immediately, labeled, and stored in a designated area for proper disposal. The operator failed to store a vial of tuberculin in accordance with the pharmacist's and manufacturer's recommendations.	S5315		
S9999	Final Observations KAR 26-42-103(a)(b)(c) scope and severity level F (a) The administrator or operator of each home plus shall ensure the provision of orientation to new employees and regular in-service education for all employees to ensure that the services provided assist residents to attain and maintain their individuality, autonomy, dignity, independence, and ability to make choices in a home environment. (b) The topics for orientation and in-service education shall include the following: (1) Fire prevention and safety;	S9999		

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S9999	Continued From page 93 (2) disaster procedures; (3) accident prevention; (4) resident rights; (5) infection control; and (6) prevention of abuse, neglect, and exploitation of residents. (c) If the home plus admits residents with dementia, the administrator or operator shall ensure the provision of staff education, at orientation and at least annually thereafter, on the treatment and appropriate response to persons who exhibit behaviors associated with dementia. This requirement is not met as evidenced by: The facility reported a census of two residents with both having a diagnosis of dementia or cognitive impairment. Based on interview and record review the operator failed to provide orientation to new staff for all six required topics and dementia training upon hire for five out of five sampled staff. Findings included: - Record review for Certified Medication Aide (CMA) C revealed a hire date of 03/09/26. The record lacked evidence of documentation the six required orientation topics and dementia training was completed upon hire. Record review for CMA G revealed a hire date of 09/03/25. The record lacked evidence of documentation the six required orientation topics and dementia training was completed upon hire.	S9999		

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S9999	Continued From page 94 Record review for Certified Nurse Aide (CNA) F revealed a hire date of 08/25/25. The record lacked evidence of documentation the six required orientation topics and dementia training was completed upon hire. Record review for CNA J revealed a hire date of 03/09/26. The record lacked evidence of documentation the six required orientation topics and dementia training was completed upon hire. Record review for Housekeeping Staff E revealed a hire date of 01/01/25. The record lacked evidence of documentation the six required orientation topics and dementia training was completed upon hire. On 03/25/26 at 11:32 AM Administrative Staff A confirmed the six required orientation topics and dementia training for staff had not been completed upon hire. The operator failed to provide the six required orientation topics and dementia training to new staff upon hire for five out of five sampled staff.	S9999		