STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087210	A. BUILDING: _____ B. WING _____	05/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERALD SENIORS, LLC	1226 S BYRON ROAD WICHITA, KS 67209

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS The following citations represent the findings of the licensure resurvey with attached complaint number 198766, for the above named facility conducted on 05/06/26 and 05/07/26.	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: K.A.R. 26-39-103(h) (1)(a)	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 4 "Residents'"(R)'s. The sample included 3 residents and 1 focused review. Based on interview and record review the operator failed to ensure that the facility staff consulted with the resident's physician of an accident involving the resident that resulted in injury and has potential for requiring a physician's intervention. Findings Included: - Record review for R1 revealed an admission date of 02/20/26 with diagnoses of malignant neoplasm of the colon, malignant neoplasm of unspecified kidney, malignant neoplasm of connective and soft tissue unspecified, other frontotemporal neurocognitive disorder, type two diabetes, and unspecified convulsions. Review of R1's "Functional Capacity Screen" (FCS) dated 02/20/26 revealed R1 was unable to perform any part of the task of bathing, dressing, and toileting. R1 required physical assistance with transferring, walking/mobility and eating. R1 lacked the ability to manage her own medications and medical treatments. R1 was incontinent and had impaired short-term memory, long-term memory, memory/recall, and decision making. R1 was usually able to make herself understood and she sometimes understood others. R1 was at risk for falls and impaired decision making. R1 used a gait belt and walker assistive device. Review of R1's "Negotiated Service Agreement" (NSA) dated 05/06/26 identified the facility staff would provide R1 with physical assistance with bathing, toileting, dressing, walking/mobility,	S 135		

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S 135	Continued From page 2	S 135		

transferring, and eating. The facility CMA/ "Licensed Nurse" (LN) would administer R1's medications, and the local hospice agency would manage R1's treatments.

R1's record lacked a document titled "Health Service Plan" (HSP)

Review of R1's "electronic Medical Record" under the section titled "Observations" revealed the following entries:

On 02/20/26 at 02:30 AM Operator/LN A documented that R1 arrived to the facility accompanied by the local hospice agency. R1 ambulated with a one person assist, gait belt, and her walker.

On 02/21/26 at 11:45 AM Operator/LN A documented R1 was difficult to get out of bed. R1 was documented as "getting stiff and agitated". R1 "yells and hits or scratches staff", and a gait belt is used. R1 almost fell to the floor due to her being "difficult in cooperating". R1 refused her medications.

On 03/08/26 at 10:29 PM Operator/LN A documented R1 was noted to have her "head down, mouth open, drooling" and was not responsive. R1 was having a seizure.

On 03/15/26 at 12:00 PM Operator/LN A documented R1 had negative behaviors, yelling, being non cooperative, and spitting out her medications. R1's mood was "very agitated".

R1's "Observation Notes" lacked documentation of R1's bruises and skin tears.

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S 135	Continued From page 3 Record review of R1's hospice binder revealed a document titled "Hospice and Facility Coordinated Plan of Care" dated 05/05/26. Under the section titled "Care Plan Interventions" revealed the section for "Wound Care" was not marked. R1's hospice binder lacked documentation of a recent skin assessment for R1, and the binder further lacked wound care orders for R1. Observation on 05/07/26 at approximately 09:50 AM R1 sat in a wheelchair at the dining room table, staff was observed to propel R1's wheelchair to her room. Interview on 05/07/26 at approximately 09:55 AM with Operator/LN A confirmed R1 no longer ambulates and R1 is dependent on the wheelchair and staff to propel the wheelchair for mobility. Observation on 05/07/26 at approximately 10:00 AM of R1 revealed the following bruises: On R1's right anterior forearm approx. 3 inches from the antecubital space revealed a darkened area with yellowing edges that measured approximately 3 inches length and 1.5 inches in width. On R1's sternum an oblong bruise that measured approximately 4 inches in length and 3.5 inches in width and had dark purple in the middle of the bruise with areas of yellowing around the edge and center of the bruise.	S 135		

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S 135	Continued From page 4 On R1's Left arm a dressing that covered a healing skin tear. The edges were approximated. On R1's Left anterior wrist a purple bruise that measured approximately 0.5 inches in diameter, and on the lateral top of R1's left hand from the middle of the hand to the left lateral edge was a bruise that had a dark purple center with light purple edges. On R1's left shin a dressing dated 05/03/26 covered a purple area approximately 5 inches in length and 4 inches in width and in the center an opened skin tear that measured approximately 1.25 inches in length and the edges gapped approximately 0.5 inches. On R1's left lower back an oblong bruise with purple center and the edges yellowing that measured approximately 4 inches in length and approximately 1.5 inches in width. On R1's lower right shin a black scab that measured approximately 0.5 inches in length and less than 0.25 inches in width. R1's "Electronic Medical Record" lacked documentation that the physician was notified of R1 having bruising. - Record review for R2 revealed an admission date of 09/23/25 with diagnoses of acute and chronic respiratory failure with hypoxia, chronic obstructive pulmonary disease, endocarditis, rheumatic mitral valve disease, other pancytopenia, muscle weakness, and need for assistance with personal care.	S 135		

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S 135	Continued From page 5 Review of R2's FCS dated 09/29/25 revealed R2 required physical assistance with bathing, dressing, toileting, and transferring. R2 required supervision with walking/mobility and was independent with eating. R2 lacked the ability to manage her own medications and medical treatments. R2 was usually continent, and had impaired short-term memory, memory/recall, and decision making. R2 was able to make herself understood and she understood others. R2 was at risk for falls and impaired decision making. Review of R2's NSA dated 09/29/25 identified the facility staff would provide physical assistance with bathing, dressing, toileting, walking/mobility, and 1 staff assistance with transferring. The facility CMA or LN would manage R2's medications and medical treatments. R2 had an outside provider for therapy and home health. Review of R2's HSP instructed facility staff to administer R2's medications, provide physical assistance with bathing, dressing, and toileting. Facility staff were instructed to provide "stand by" assistance with mobility. Review of R2's "Resident Record" revealed a document titled "Visit Note" dated 10/08/25 that reveled R2 was seen by "Physical Therapy". Review of R2's "electronic Medical Record" under the "Observations" revealed the following entries: On 03/03/26 at 07:30 PM Operator/LN A documented the following: R2 was seen by the Nephrologist on 03/03/26. The nephrologist told R2 and R2's family member that her kidney	S 135		

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S 135	Continued From page 6	S 135		

functions was "only 17%". The decision was made by R2 to not do dialysis.

On 03/09/26 at 09:15 PM Operator/LN A documented R2's family came to see R2 and R2 and her family decided to call a local hospice agency.

On 04/28/26 at 09:00 PM Operator/LN A documented that R2 was showing signs of decline. R2 experienced increased weakness and sleeping more. It was "Difficult to get from her chair to the bathroom across the hall". Operator/LN A called the hospice company and asked for a bed side commode for R2.

On 05/02/26 at 10:30 PM Operator/LN A documented R2 experienced an increase in weakness and R2 was refusing the majority of meals.

On 05/03/26 at 09:00 PM Operator/LN A documented that R2 had breakfast and dinner.

R2's "Observation" notes lacked documentation of R2's bruises.

Observation on 05/07/26 at approximately 08:30 AM of R2 with local hospice nurse D revealed the following bruises:

On R2's sternum were 3 dark blue circular areas that were in a vertical line on the sternum. From the top of the most proximal bruise to the bottom of the most distal bruise measured approximately 6 inches in length and at the widest of the bruising it measured approximately 0.75 inches

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S 135	Continued From page 7 in width. On R2's right upper anterior arm a redden purple area that measured approximately 3 inches in length and approximately 0.5 inches in width. On the anterior/top side of R2's hand were 2 purple circular bruises that measured approximately 0.25 inches in diameter. On R2's left shin was an oblong bruise that had a dark purple center with dark green around the edge of the purple center. The bruise measured approximately 2 inches in length and 1 inch in width. On R2's left wrist were two dark purple circular bruises that measured approximately 0.5 inches in diameter. On R2's lower buttocks the coccyx appeared dark purple, in the shape of a butterfly, and on the left hip above the purple discoloration were two purple circular areas that measured approximately 0.5 inches in diameter. R2's "Electronic Medical Record" lacked documentation that the physician was notified of R2 having bruising. - Record review for R3 revealed an admission date of 07/30/25 with diagnoses of lymphedema, pain in the right leg, other forms of acute ischemic heart disease, dysphagia, vascular dementia, psychotic disturbance, mood disturbance, anxiety, transient cerebral ischemic attack, anemia, insomnia, and atrial fibrillation.	S 135		

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S 135	Continued From page 8 Review of R3's FCS dated 07/30/25 revealed R3 required physical assistance with bathing, dressing, toileting, and transferring. R3 lacked the ability to manage here own medications and medical treatments. R3 was occasionally incontinent, and had impaired short-term memory, long-term memory, memory/recall, and decision making. R3 was usually able to make herself understood and she understood others. R3 was marked at risk for impaired decision making. R2 required a walker mobility device. Review of R3's NSA dated 07/30/25 identified the facility staff would provide ace wrappings every morning, and sequential boots in the evenings or when R3 requested them. Physical assistance with bathing, dressing, and toileting. Facility staff were to provide standby assistance for R3's mobility with her walker. Review of R3'S HSP dated 07/30/25 instructed facility staff to supervise R3 at mealtimes and administer R3's medications and medical treatments. Facility staff were to provide physical assistance with bathing, dressing, toileting, and supervision with transferring. Review of R3's electronic "Medical Record" under the "Observations" tab revealed the following entries: On 03/12/26 at 08:45 PM Operator/LN A documented R3 admitted to a local hospice agency. R3's "Observation" notes lacked documentation	S 135		

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S 135	Continued From page 9 of R3's bruises. Observation on 05/07/26 at approximately 10:45 AM of R3 revealed the following bruises: On R3's right forearm a purple circular bruise that measured approximately 2 inches in diameter and next to that bruise a smaller circular purple bruise that measured approximately 1 inch in diameter. Interview on 05/07/26 at approximately 10:45 AM with R3 revealed that someone "squeezed her arm to tight", and the smaller of the two bruises was "where their thumb was". R3 accused CMA C of bruising her arm. On R3's left upper posterior arm were 2 circular purple bruises that together measured approximately 1.5 inches in length, and approximately 0.5 inches in width. Interview on 05/07/26 at approximately 02:00PM with Operator/LN A confirmed she did not investigate R3's allegation of CMA C squeezing her arm. Operator/LN A further confirmed that she did not open an investigation on the bruising of unknown origin on R1, R2, and R3. Operator/LN A confirmed the facility staff did not report to her the bruising of unknown origin. R3's "Electronic Medical Record" lacked documentation that the physician was notified of R3 having bruising. Interview on 05/07/26 at approximately 01:50PM with Operator/LN A confirmed that the "Medical Record" for R1, R2, and R3 lacked	S 135		

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S 135	Continued From page 10 documentation that the physician was notified of R1, R2, and R3 having bruising. The operator failed to ensure that the facility staff consulted with the resident's physician of an accident involving the resident that resulted in injury and has potential for requiring a physician's intervention.	S 135		
S5026 SS=H	26-42-101 (f) (1) Staff Treatment of residents ANE (f)The administrator or operator shall ensure that all of the following requirements are met: (1) No resident shall be subjected to any of the following: (A) Verbal, mental, sexual, or physical abuse, including corporal punishment and involuntary seclusion; (B) neglect; or (C) exploitation. This REQUIREMENT is not met as evidenced by: K.A.R. 26-42-101 (f) (1) (B) The facility reported a census of 4 residents. The sample included 3 "Residents'" (R)'s and 1 focused review. Based on observation, interview, and record review, the Operator/LN A (Licensed Nurse) failed to ensure R1, R2, and R3 were provided services which were reasonably necessary to ensure the safety and well-being and to avoid physical harm, when R1, R2, and R3 experienced multiple bruises from an unknown origin. The Operator/LN further failed to	S5026		

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S5026	Continued From page 11	S5026		

protect R1 from neglect when "Certified Medication Aide" (CMA) B confirmed during her interview that she did not provide care to R1 through the nighttime hours. CMA B continued to confirm she does not provide care for R1 unless there is another staff member in the home to assist.

Findings included:

- Record review for R1 revealed an admission date of 02/20/26 with diagnoses of malignant neoplasm of the colon, malignant neoplasm of unspecified kidney, malignant neoplasm of connective and soft tissue unspecified, other frontotemporal neurocognitive disorder, type two diabetes, and unspecified convulsions.

Review of R1's "Functional Capacity Screen" (FCS) dated 02/20/26 revealed R1 was unable to perform any part of the task of bathing, dressing, and toileting. R1 required physical assistance with transferring, walking/mobility and eating. R1 lacked the ability to manage her own medications and medical treatments. R1 was incontinent and had impaired short-term memory, long-term memory, memory/recall, and decision making. R1 was usually able to make herself understood and she sometimes understood others. R1 was at risk for falls and impaired decision making. R1 used a gait belt and walker assistive devices.

Review of R1's "Negotiated Service Agreement" (NSA) dated 05/06/26 identified the facility staff would provide R1 with physical assistance with bathing, toileting, dressing, walking/mobility, transferring, and eating. The facility CMA/

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S5026	Continued From page 12 "Licensed Nurse" (LN) would administer R1's medications, and the local hospice agency would manage R1's treatments. R1's record lacked a document titled "Health Service Plan" (HSP) Review of R1's "Electronic Medical Record" under the section titled "Observations" revealed the following entries: On 02/20/26 at 02:30 AM Operator/LN A documented that R1 arrived at the facility accompanied by the local hospice agency. R1 ambulated with a one person assist, gait belt, and her walker. On 02/21/26 at 11:45 AM Operator/LN A documented R1 was difficult to get out of bed. R1 was documented as "getting stiff and agitated". R1 "yells and hits or scratches staff", and a gait belt is used. R1 almost fell to the floor due to her being "difficult in cooperating". R1 refused her medications. On 03/08/26 at 10:29 PM Operator/LN A documented R1 was noted to have her "head down, mouth open, drooling" and was not responsive. R1 was having a seizure. On 03/15/26 at 12:00 PM Operator/LN A documented R1 had negative behaviors, yelling, being non-cooperative, and spitting out her medications. R1's mood was "very agitated". R1's "Observation Notes" lacked documentation of R1's bruises and skin tears.	S5026		

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S5026	Continued From page 13 Record review of R1's hospice binder revealed a document titled "Hospice and Facility Coordinated Plan of Care" dated 05/05/26. Under the section titled "Care Plan Interventions" revealed the section for "Wound Care" was not marked. R1's hospice binder lacked documentation of a recent skin assessment for R1, and the binder further lacked wound care orders for R1. Observation on 05/07/26 at approximately 09:50 AM R1 sat in a wheelchair at the dining room table, staff was observed to propel R1's wheelchair to her room. Interview on 05/07/26 at approximately 09:55 AM with Operator/LN A confirmed R1 no longer ambulated and was dependent on the wheelchair and staff to propel the wheelchair for mobility. Observation on 05/07/26 at approximately 10:00 AM of R1 revealed the following bruises: On R1's right anterior forearm approximately 3 inches from the antecubital space revealed a darkened area with yellowing edges that measured approximately 3 inches length and 1.5 inches in width. On R1's sternum an oblong bruise that measured approximately 4 inches in length and 3.5 inches in width and had dark purple spot in the middle of the bruise with areas of yellowing around the edge and center of the bruise. On R1's Left arm a dressing that covered a healing skin tear. The edges were approximated.	S5026		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5026	Continued From page 14 On R1's Left anterior wrist a purple bruise that measured approximately 0.5 inches in diameter, and on the lateral top of R1's left hand from the middle of the hand to the left lateral edge was a bruise that had a dark purple center with light purple edges. On R1's left shin a dressing dated 05/03/26 covered a purple area approximately 5 inches in length and 4 inches in width and in the center an opened skin tear that measured approximately 1.25 inches in length and the edges gapped approximately 0.5 inches. On R1's left lower back an oblong bruise with purple center and the edges yellowing that measured approximately 4 inches in length and approximately 1.5 inches in width. On R1's lower right shin a black scab that measured approximately 0.5 inches in length and less than 0.25 inches in width. - Record review for R2 revealed an admission date of 09/23/25 with diagnoses of acute and chronic respiratory failure with hypoxia, chronic obstructive pulmonary disease, endocarditis, rheumatic mitral valve disease, other pancytopenia, muscle weakness, and need for assistance with personal care. Review of R2's FCS dated 09/29/25 revealed R2 required physical assistance with bathing, dressing, toileting, and transferring. R2 required supervision with walking/mobility and was independent with eating. R2 lacked the ability to	S5026		

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manage her own medications and medical treatments. R2 was usually continent, and had impaired short-term memory, memory/recall, and decision making. R2 was able to make herself understood and she understood others. R2 was at risk for falls and impaired decision making.

Review of R2's NSA dated 09/29/25 identified the facility staff would provide physical assistance with bathing, dressing, toileting, walking/mobility, and 1 staff assistance with transferring. The facility CMA or LN would manage R2's medications and medical treatments. R2 had an outside provider for therapy and home health.

Review of R2's HSP instructed facility staff to administer R2's medications, provide physical assistance with bathing, dressing, and toileting. Facility staff were instructed to provide "stand by" assistance with mobility.

Review of R2's "Resident Record" revealed a document titled "Visit Note" dated 10/08/25 that reveled R2 was seen by "Physical Therapy".

Review of R2's "Electronic Medical Record" under the "Observations" revealed the following entries:

On 03/03/26 at 07:30 PM Operator/LN A documented the following: R2 was seen by the Nephrologist on 03/03/26. The nephrologist told R2 and R2's family member that her kidney functions was "only 17%". The decision was made by R2 to not do dialysis.

On 03/09/26 at 09:15 PM Operator/LN A documented R2's family came to see R2 and R2

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S5026	Continued From page 16	S5026		

and her family decided to call a local hospice agency.

On 04/28/26 at 09:00 PM Operator/LN A documented that R2 was showing signs of decline. R2 experienced increased weakness and sleeping more. It was "Difficult to get from her chair to the bathroom across the hall". Operator/LN A called the hospice company and asked for a bedside commode for R2.

On 05/02/26 at 10:30 PM Operator/LN A documented R2 experienced an increase in weakness and was refusing the majority of meals.

On 05/03/26 at 09:00 PM Operator/LN A documented that R2 had breakfast and dinner.

R2's "Observation" notes lacked documentation of R2's bruises.

Review of the facility provided documents from the local hospice company titled "Shower Body Check Program" revealed the following:

On 04/07/26 in the section titled "Bruises", "Skin Tears", and "Red Areas", "No" was marked next to "Bruises" and "Skin Tears", and "Yes" was marked next to red areas.

On 04/10/26 in the section titled "Bruises", "Skin Tears", and "Red Areas", "No" was marked next to "Bruises" and "Skin Tears", and "Yes" was marked.

On 04/14/26 in the section titled "Bruises", "Skin Tears", and "Red Areas", "No" was marked next

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S5026	Continued From page 17 to each concern. Observation on 05/07/26 at approximately 08:30 AM of R2 with local hospice nurse D revealed the following bruises: On R2's sternum were 3 dark blue circular areas that were in a vertical line on the sternum. From the top of the most proximal bruise to the bottom of the most distal bruise measured approximately 6 inches in length and at the widest of the bruises measured approximately 0.75 inches in width. On R2's right upper anterior arm a red/purple area that measured approximately 3 inches in length and approximately 0.5 inches in width. On the anterior/top side of R2's hand were 2 purple circular bruises that measured approximately 0.25 inches in diameter. On R2's left shin was an oblong bruise that had a dark purple center with dark green around the edge of the purple center. The bruise measured approximately 2 inches in length and 1 inch in width. On R2's left wrist were two dark purple circular bruises that measured approximately 0.5 inches in diameter. On R2's lower buttocks the coccyx appeared dark purple, in the shape of a butterfly, and on the left hip above the purple discoloration were two purple circular areas that measured approximately 0.5 inches in diameter.	S5026		

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S5026	Continued From page 18 Interview on 05/07/26 with local hospice nurse D confirmed the area on R2's buttocks were an expected finding for someone in the active dying process. Local hospice nurse D confirmed that R2 was in the active dying process. Hospice nurse D continued to confirm the hospice staff had noticed an increase in R1, R2, and R3 having bruising. - Record review for R3 revealed an admission date of 07/30/25 with diagnoses of lymphedema, pain in the right leg, other forms of acute ischemic heart disease, dysphagia, vascular dementia, psychotic disturbance, mood disturbance, anxiety, transient cerebral ischemic attack, anemia, insomnia, and atrial fibrillation. Review of R3's FCS dated 07/30/25 revealed R3 required physical assistance with bathing, dressing, toileting, and transferring. R3 lacked the ability to manage here own medications and medical treatments. R3 was occasionally incontinent, and had impaired short-term memory, long-term memory, memory/recall, and decision making. R3 was usually able to make herself understood and she understood others. R3 was marked at risk for impaired decision making. R3 required a walker mobility device. Review of R3's NSA dated 07/30/25 identified the facility staff would provide ace wrappings every morning, and sequential boots in the evenings or when R3 requested them. Physical assistance with bathing, dressing, and toileting. Facility staff were to provide standby assistance for R3's mobility with her walker.	S5026		

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S5026	Continued From page 19 R3's NSA lacked documentation of the local hospice provider. Review of R3'S HSP dated 07/30/25 instructed facility staff to supervise R3 at mealtimes and administer R3's medications and medical treatments. Facility staff were to provide physical assistance with bathing, dressing, toileting, and supervision with transferring. Review of R3's electronic "Medical Record" under the "Observations" tab revealed the following entries: On 03/12/26 at 08:45 PM Operator/LN A documented R3 admitted to a local hospice agency. R3's "Observation" notes lacked documentation of R3's bruises. Review of R3's medical record revealed a document titled "Hospice Interdisciplinary Group Assessment and Plan of Care Update Report" dated 03/18/26. The document revealed R3 began on hospice services on 03/12/26. Observation on 05/07/26 at approximately 10:45 AM of R3 revealed the following bruises: On R3's right forearm a purple circular bruise that measured approximately 2 inches in diameter and next to that bruise a smaller circular purple bruise that measured approximately 1 inch in diameter. Interview on 05/07/26 at approximately 10:45 AM revealed that someone "squeezed her arm to	S5026		

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tight", and the smaller of the two bruises was "where their thumb was". R3 accused CMA C of bruising her arm.

On R3's left upper posterior arm were 2 circular purple bruises that together measured approximately 1.5 inches in length, and approximately 0.5 inches in width.

Interview on 05/07/26 at approximately 02:00PM with Operator/LN A confirmed she did not investigate R3's allegation of CMA C squeezing her arm. Operator/LN A further confirmed that she did not open an investigation on the bruising of unknown origin on R1, R2, and R3. Operator/LN A confirmed the facility staff did not report the bruising of unknown origin.

Interview on 05/07/26 at approximately 12:30 PM with CMA B revealed that she does not provide care for R1 if she is by herself at night, CMA B continued to confirm that she works in the home alone at night CMA B stated she will not wake R1 up to assist her to the bathroom. CMA B stated that when she sees a bruise on a resident she will call and report the bruising to Operator/LN A. CMA B continued to state she was unaware of the bruising to R1's sternum.

Interview on 05/07/26 at approximately 02:00 PM with Operator/LN A confirmed she staffs the home during the day shift with one CMA and a housekeeper. Operator/LN A continued that she staffs the home with one CMA during the night shift. Operator/LN A confirmed she did not open a full investigation on how R1, R2, and R3 obtained the bruising of unknown origin.

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S5026	Continued From page 21 The Operator/LN failed to ensure R1, R2, and R3 were provided services which were reasonably necessary to ensure the safety and well-being and to avoid physical harm, when R1, R2, and R3 experienced multiple bruises from an unknown origin. The Operator/LN further failed to protect R1 from neglect when CMA B confirmed during her interview that she does not provide care to R1 through the nighttime hours. CMA B continued to confirm she does not provide care for R1 unless there is another staff member in the home to assist.	S5026		
S5028 SS=E	26-42-101 (f) (3) Staff Treatment of Residents Reporting (f) (3) Each allegation of abuse, neglect, or exploitation shall be reported to the administrator or operator of the home as soon as staff is aware of the allegation and to the department within 24 hours. The administrator or operator shall ensure that all of the following requirements are met: (A) An investigation shall be started when the administrator or operator, or the designee, receives notification of an alleged violation. (B) Immediate measures shall be taken to prevent further potential abuse, neglect, or exploitation while the investigation is in progress. (C) Each alleged violation shall be thoroughly investigated within five working days of the initial report. Results of the investigation shall be 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	S5028		

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S5028	Continued From page 22 department within five working days of the initial report. (F) A written record shall be maintained of each investigation of reported abuse, neglect, or exploitation. This REQUIREMENT is not met as evidenced by: K.A.R. 26-42-101 (f) (3) (A) (B) (C) (D) (E) (F) The facility reported a census of 4 residents. The sample included 3 "Residents'" (R)'s and 1 focused review. Based on observation, interview, and record review, the Operator/"Licensed Nurse" (LN) failed to ensure an investigation was started when the Operator/LN was notified of bruising of unknown origin to R1, R2, and R3. The Operator/LN continued to fail to ensure immediate measures were taken to prevent further bruising to R1, R2, and R3. The Operator/LN failed to thoroughly investigate how R1, R2, and R3 received bruises and took appropriate action to prevent R1, R2, and R3 from bruises. The Operator/LN continued to fail to ensure that an investigation was completed and submitted to the department within 5 working days of the initial report of the bruises and maintain a written record of the investigation on how R1, R2, and R3 obtained the bruises. Findings included: - Record review for R1 revealed an admission date of 02/20/26 with diagnoses of malignant	S5028		

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neoplasm of the colon, malignant neoplasm of unspecified kidney, malignant neoplasm of connective and soft tissue unspecified, other frontotemporal neurocognitive disorder, type two diabetes, and unspecified convulsions.

Review of R1's "Functional Capacity Screen" (FCS) dated 02/20/26 revealed R1 was unable to perform any part of the task of bathing, dressing, and toileting. R1 required physical assistance with transferring, walking/mobility and eating. R1 lacked the ability to manage her own medications and medical treatments. R1 was incontinent and had impaired short-term memory, long-term memory, memory/recall, and decision making. R1 was usually able to make herself understood and she sometimes understood others. R1 was at risk for falls and impaired decision making. Rr1 used a gait belt and walker assistive device.

Review of R1's "Negotiated Service Agreement" (NSA) dated 05/06/26 identified the facility staff would provide R1 with physical assistance with bathing, toileting, dressing, walking/mobility, transferring, and eating. The facility CMA/ "Licensed Nurse" (LN) would administer R1's medications, and the local hospice agency would manage R1's treatments.

R1's record lacked a document titled "Health Service Plan" (HSP)

Review of R1's "electronic Medical Record" under the section titled "Observations" revealed the following entries:

On 02/20/26 at 02:30 AM Operator/LN A documented that R1 arrived to the facility

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accompanied by the local hospice agency. R1 ambulated with a one person assist, gait belt, and her walker.

On 02/21/26 at 11:45 AM Operator/LN A documented R1 was difficult to get out of bed. R1 was documented as "getting stiff and agitated". R1 "yells and hits or scratches staff", and a gait belt is used. R1 almost fell to the floor due to her being "difficult in cooperating". R1 refused her medications.

On 03/08/26 at 10:29 PM Operator/LN A documented R1 was noted to have her "head down, mouth open, drooling" and was not responsive. R1 was having a seizure.

On 03/15/26 at 12:00 PM Operator/LN A documented R1 had negative behaviors, yelling, being non cooperative, and spitting out her medications. R1's mood was "very agitated".

R1's "Observation Notes" lacked documentation of R1's bruises and skin tears.

Record review of R1's hospice binder revealed a document titled "Hospice and Facility Coordinated Plan of Care" dated 05/05/26. Under the section titled "Care Plan Interventions" revealed the section for "Wound Care" was not marked.

R1's hospice binder lacked documentation of a recent skin assessment for R1, and the binder further lacked wound care orders for R1.

Observation on 05/07/26 at approximately 09:50 AM R1 sat in a wheelchair at the dining room

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S5028	Continued From page 25 table, staff was observed to propel R1's wheelchair to her room. Interview on 05/07/26 at approximately 09:55 AM with Operator/LN A confirmed R1 no longer ambulates and R1 is dependent on the wheelchair and staff to propel the wheelchair for mobility. Observation on 05/07/26 at approximately 10:00 AM of R1 revealed the following bruises: On R1's right anterior forearm approx. 3 inches from the antecubital space revealed a darkened area with yellowing edges that measured approximately 3 inches length and 1.5 inches in width. On R1's sternum an oblong bruise that measured approximately 4 inches in length and 3.5 inches in width and had dark purple in the middle of the bruise with areas of yellowing around the edge and center of the bruise. On R1's Left arm a dressing that covered a healing skin tear. The edges were approximated. On R1's Left anterior wrist a purple bruise that measured approximately 0.5 inches in diameter, and on the lateral top of R1's left hand from the middle of the hand to the left lateral edge was a bruise that had a dark purple center with light purple edges. On R1's left shin a dressing dated 05/03/26 covered a purple area approximately 5 inches in length and 4 inches in width and in the center an opened skin tear that measured approximately 1.25 inches in length and the edges gapped	S5028		

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S5028	Continued From page 26 approximately 0.5 inches. On R1's left lower back an oblong bruise with purple center and the edges yellowing that measured approximately 4 inches in length and approximately 1.5 inches in width. On R1's lower right shin a black scab that measured approximately 0.5 inches in length and less than 0.25 inches in width. - Record review for R2 revealed an admission date of 09/23/25 with diagnoses of acute and chronic respiratory failure with hypoxia, chronic obstructive pulmonary disease, endocarditis, rheumatic mitral valve disease, other pancytopenia, muscle weakness, and need for assistance with personal care. Review of R2's FCS dated 09/29/25 revealed R2 required physical assistance with bathing, dressing, toileting, and transferring. R2 required supervision with walking/mobility and was independent with eating. R2 lacked the ability to manage her own medications and medical treatments. R2 was usually continent, and had impaired short-term memory, memory/recall, and decision making. R2 was able to make herself understood and she understood others. R2 was at risk for falls and impaired decision making. Review of R2's NSA dated 09/29/25 identified the facility staff would provide physical assistance with bathing, dressing, toileting, walking/mobility, and 1 staff assistance with transferring. The facility CMA or LN would manage R2's medications and medical treatments. R2 had an	S5028		

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outside provider for therapy and home health.

Review of R2's HSP instructed facility staff to administer R2's medications, provide physical assistance with bathing, dressing, and toileting. Facility staff were instructed to provide "stand by" assistance with mobility.

Review of R2's "Resident Record" revealed a document titled "Visit Note" dated 10/08/25 that reveled R2 was seen by "Physical Therapy".

Review of R2's "electronic Medical Record" under the "Observations" revealed the following entries:

On 03/03/26 at 07:30 PM Operator/LN A documented the following: R2 was seen by the Nephrologist on 03/03/26. The nephrologist told R2 and R2's family member that her kidney functions was "only 17%". The decision was made by R2 to not do dialysis.

On 03/09/26 at 09:15 PM Operator/LN A documented R2's family came to see R2 and R2 and her family decided to call a local hospice agency.

On 04/28/26 at 09:00 PM Operator/LN A documented that R2 was showing signs of decline. R2 experienced increased weakness and sleeping more. It was "Difficult to get from her chair to the bathroom across the hall". Operator/LN A called the hospice company and asked for a bedside commode for R2.

On 05/02/26 at 10:30 PM Operator/LN A documented R2 experienced an increase in

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EMERALD SENIORS, LLC	1226 S BYRON ROAD WICHITA, KS 67209

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S5028	Continued From page 28 weakness and R2 was refusing the majority of meals. On 05/03/26 at 09:00 PM Operator/LN A documented that R2 had breakfast and dinner. R2's "Observation" notes lacked documentation of R2's bruises. Review of the facility provided documents from the local hospice company titled "Shower Body Check Program" revealed the following: On 04/07/26 in the section titled "Bruises", "Skin Tears", and "Red Areas", "No" was marked next to "Bruises" and "Skin Tears", and "Yes" was marked. On 04/10/26 in the section titled "Bruises", "Skin Tears", and "Red Areas", "No" was marked next to "Bruises" and "Skin Tears", and "Yes" was marked next to red areas. On 04/14/26 in the section titled "Bruises", "Skin Tears", and "Red Areas", "No" was marked next to each concern. Observation on 05/07/26 at approximately 08:30 AM of R2 with local hospice nurse D revealed the following bruises: On R2's sternum were 3 dark blue circular areas that were in a vertical line on the sternum. From the top of the most proximal bruise to the bottom of the most distal bruise measured approximately 6 inches in length and at the widest of the bruising it measured approximately 0.75 inches in width.	S5028		

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S5028	Continued From page 29 On R2's right upper anterior arm a redden purple area that measured approximately 3 inches in length and approximately 0.5 inches in width. On the anterior/top side of R2's hand were 2 purple circular bruises that measured approximately 0.25 inches in diameter. On R2's left shin was an oblong bruise that had a dark purple center with dark green around the edge of the purple center. The bruise measured approximately 2 inches in length and 1 inch in width. On R2's left wrist were two dark purple circular bruises that measured approximately 0.5 inches in diameter. On R2's lower buttocks the coccyx appeared dark purple, in the shape of a butterfly, and on the left hip above the purple discoloration were two purple circular areas that measured approximately 0.5 inches in diameter. Interview on 05/07/26 with local hospice nurse D confirmed the area on R2's buttocks was an expected finding for someone in the active dying process. Local hospice nurse D confirmed that R2 was in the active dying process. - Record review for R3 revealed an admission date of 07/30/25 with diagnoses of lymphedema, pain in the right leg, other forms of acute ischemic heart disease, dysphagia, vascular dementia, psychotic disturbance, mood disturbance, anxiety, transient cerebral ischemic	S5028		

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S5028	Continued From page 30	S5028		

attack, anemia, insomnia, and atrial fibrillation.

Review of R3's FCS dated 07/30/25 revealed R3 required physical assistance with bathing, dressing, toileting, and transferring. R3 lacked the ability to manage here own medications and medical treatments. R3 was occasionally incontinent, and had impaired short-term memory, long-term memory, memory/recall, and decision making. R3 was usually able to make herself understood and she understood others. R3 was marked at risk for impaired decision making. R2 required a walker mobility device.

Review of R3's NSA dated 07/30/25 identified the facility staff would provide ace wrappings every morning, and sequential boots in the evenings or when R3 requested them. Physical assistance with bathing, dressing, and toileting. Facility staff were to provide standby assistance for R3's mobility with her walker.

R3's NSA lacked documentation of the local hospice provider.

Review of R3'S HSP dated 07/30/25 instructed facility staff to supervise R3 at mealtimes and administer R3's medications and medical treatments. Facility staff were to provide physical assistance with bathing, dressing, toileting, and supervision with transferring.

Review of R3's electronic "Medical Record" under the "Observations" tab revealed the following entries:

On 03/12/26 at 08:45 PM Operator/LN A documented R3 admitted to a local hospice

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S5028	Continued From page 31 agency. R3's "Observation" notes lacked documentation of R3's bruises. Review of R3's medical record revealed a document titled "Hospice Interdisciplinary Group Assessment and Plan of Care Update Report" dated 03/18/26. The document revealed R3 began on hospice services on 03/12/26. Observation on 05/07/26 at approximately 10:45 AM of R3 revealed the following bruises: On R3's right forearm a purple circular bruise that measured approximately 2 inches in diameter and next to that bruise a smaller circular purple bruise that measured approximately 1 inch in diameter. Interview on 05/07/26 at approximately 10:45 AM with R3 revealed that someone "squeezed her arm to tight", and the smaller of the two bruises was "where their thumb was". R3 accused CMA C of bruising her arm. On R3's left upper posterior arm were 2 circular purple bruises that together measured approximately 1.5 inches in length, and approximately 0.5 inches in width. Interview on 05/07/26 at approximately 02:00PM with Operator/LN A confirmed she did not investigate R3's allegation of CMA C squeezing her arm. Operator/LN A further confirmed that she did not open an investigation on the bruising of unknown origin on R1, R2, and R3. Operator/LN A confirmed the facility staff did not	S5028		

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S5028	Continued From page 32 report to her the bruising of unknown origin. Interview on 05/07/26 at approximately 12:30 PM with CMA B revealed that she does not provide care for R1 if she is by herself at night. CMA B stated she will not wake R1 up to assist her to the bathroom. CMA B stated that when she sees a bruise on a resident she will call and report the bruising to Operator/LN A. CMA B continued to state she was unaware of the bruising to R1's sternum. Interview with Operator/LN A confirmed she did not open an investigation on the bruising of unknow origin for R1, R2, and R3. Operator/LN A continued to confirm she did not report the bruising of unknown origin on R's1, 2, and 3, to the department. Operator/LN A confirmed the records for R1, R2, and R3 lacked documentation of the bruises on unknown origin. The Operator/"Licensed Nurse" (LN) failed to ensure an investigation was started when the Operator/LN was notified of bruising of unknown origin to R1, R2, and R3. The Operator/LN continued to fail to ensure immediate measures were taken to prevent further bruising to R1, R2, and R3. The Operator/LN failed to thoroughly investigate how R1, R2, and R3 received bruises and took appropriate action to prevent R1, R2, and R3 from bruises. The Operator/LN continued to fail to ensure that an investigation was completed and submitted to the department within 5 working days of the initial report of the bruises and maintain a written record of the investigation on how R1, R2, and R3 obtained the bruises.	S5028		

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S5040	Continued From page 33	S5040		
S5040 SS=F	26-42-101 (j) Emergency Telephone (j) Emergency telephone. Each administrator or operator shall ensure that the residents and employees have access to a telephone for emergency use at no cost. Each administrator or operator shall ensure that the names and telephone numbers of persons or places commonly required in emergencies are posted adjacent to this telephone. This REQUIREMENT is not met as evidenced by: K.A.R. 26-42-101(j) The facility reported a census of 4 residents. The sample included 3 residents and 1 focused review. Based on interview the operator failed to ensure employees and residents had access to a telephone for emergency use with the names and telephone numbers of persons or places commonly required in emergencies were posted adjacent to the phone. Findings Included: -Interview on 05/07/26 at approximately 01:49 PM Operator/Licensed Nurse A confirmed the home lacked a phone in the common area with the numbers most commonly used in an emergency posted adjacent to the phone. The operator failed to ensure employees and residents had access to a telephone for emergency use with the names and telephone numbers of persons or places commonly required in emergencies were posted adjacent to	S5040		

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S5040	Continued From page 34 the phone.	S5040		
S5085 SS=E	26-42-201 (c) Functional Capacity Screen Reassessment (c) Designated staff shall conduct a screening to determine each resident ' s functional capacity according to the following requirements: (1) At least once every 365 days; (2) following any significant change in condition as defined in K.A.R. 26-39-100; and (3) at least quarterly if the resident receives assistance with eating from a paid nutrition assistant. This REQUIREMENT is not met as evidenced by: K.A.R. 26-42-201 (c) (2) The facility reported a census of 4 residents. The sample included 3 "Residents'" (R)'s and 1 focused review. Based on record review and interview the Operator/"Licensed Nurse" (LN) failed to ensure a screening was conducted following a change of condition for R1 and R2. Findings included: - Record review for R1 revealed an admission date of 02/20/26 with diagnoses of malignant neoplasm of the colon, malignant neoplasm of unspecified kidney, malignant neoplasm of connective and soft tissue unspecified, other frontotemporal neurocognitive disorder, type two diabetes, and unspecified convulsions.	S5085		

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S5085	Continued From page 35 Review of R1's "Functional Capacity Screen" (FCS) dated 02/20/26 revealed R1 was unable to perform any part of the task of bathing, dressing, and toileting. R1 required physical assistance with transferring, walking/mobility and eating. R1 lacked the ability to manage her own medications and medical treatments. R1 was incontinent and had impaired short-term memory, long-term memory, memory/recall, and decision making. R1 was usually able to make herself understood and she sometimes understood others. R1 was at risk for falls and impaired decision making. R1 used a gait belt and walker assistive devices. Review of R1's "Negotiated Service Agreement" (NSA) dated 05/06/26 identified the facility staff would provide R1 with physical assistance with bathing, toileting, dressing, walking/mobility, transferring, and eating. The facility CMA/ "Licensed Nurse" (LN) would administer R1's medications, and the local hospice agency would manage R1's treatments. R1's record lacked a document titled "Health Service Plan" (HSP) Observation on 05/07/26 at approximately 09:50 AM R1 sat in a wheelchair at the dining room table, staff was observed to propel R1's wheelchair to her room. Interview on 05/07/26 at approximately 09:55 AM with Operator/LN A confirmed R1 no longer ambulates and R1 is dependent on the wheelchair and staff to propel the wheelchair for mobility.	S5085		

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S5085	Continued From page 36 - Record review for R2 revealed an admission date of 09/23/25 with diagnoses of acute and chronic respiratory failure with hypoxia, chronic obstructive pulmonary disease, endocarditis, rheumatic mitral valve disease, other pancytopenia, muscle weakness, and need for assistance with personal care. Review of R2's FCS dated 09/29/25 revealed R2 required physical assistance with bathing, dressing, toileting, and transferring. R2 required supervision with walking/mobility and was independent with eating. R2 lacked the ability to manage her own medications and medical treatments. R2 was usually continent, and had impaired short-term memory, memory/recall, and decision making. R2 was able to make herself understood and she understood others. R2 was at risk for falls and impaired decision making. Review of R2's NSA dated 09/29/25 identified the facility staff would provide physical assistance with bathing, dressing, toileting, walking/mobility, and 1 staff assistance with transferring. The facility CMA or LN would manage R2's medications and medical treatments. R2 had an outside provider for therapy and home health. Review of R2's HSP instructed facility staff to administer R2's medications, provide physical assistance with bathing, dressing, and toileting. Facility staff were instructed to provide "stand by" assistance with mobility. On 04/28/26 at 09:00 PM Operator/LN A documented that R2 was showing signs of decline. R2 experienced increased weakness and sleeping more. It was "Difficult to get from	S5085		

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S5085	Continued From page 37 her chair to the bathroom across the hall". Operator/LN A called the hospice company and asked for a bed side commode for R2. On 05/02/26 at 10:30 PM Operator/LN A documented R2 experienced an increase in weakness and R2 was refusing the majority of meals. On R2's lower buttocks the coccyx appeared dark purple, in the shape of a butterfly, and on the left hip above the purple discoloration were two purple circular areas that measured approximately 0.5 inches in diameter. Interview on 05/07/26 with local hospice nurse D confirmed the area on R2's buttocks was an expected finding for someone in the active dying process. Local hospice nurse D confirmed that R2 was in the active dying process. Interview on 05/06/27 at approximately 02:00 PM with Operator/LN A confirmed the medical records lacked documentation of a screening done that determined R1 and R2's functional capacity when they experienced a change of condition. The Operator/LN failed to ensure a screening was conducted following a change of condition for R1 and R2.	S5085		
S5116 SS=E	26-42-202 (d) NSA revisions (d) Each administrator or operator shall ensure the review and, if necessary, revision of each negotiated service agreement according to the following requirements:	S5116		

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S5116	Continued From page 38 (1) At least once every 365 days;(2) following any significant change in condition, as defined in K.A.R. 26-39-100; (3) at least quarterly if the resident receives assistance with eating from a paid nutrition assistant; and (4) if requested by the resident or the resident ' s legal representative, staff, the case manager, or, if agreed to by the resident or the resident ' s legal representative, the resident ' s family. This REQUIREMENT is not met as evidenced by: K.A.R. 26-42-202 (d) (2) The facility reported a census of 4 residents. The sample included 3 "Residents'" (R)'s and 1 focused review. Based on record review and interview the Operator/"Licensed Nurse" (LN) failed to ensure the review and if necessary revision of the "Negotiated Service Agreements'" (NSA)'s for R1 and R2 when they experienced a change of condition. Findings included: - Record review for R1 revealed an admission date of 02/20/26 with diagnoses of malignant neoplasm of the colon, malignant neoplasm of unspecified kidney, malignant neoplasm of connective and soft tissue unspecified, other frontotemporal neurocognitive disorder, type two diabetes, and unspecified convulsions. Review of R1's "Functional Capacity Screen"	S5116		

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S5116	Continued From page 39	S5116		

(FCS) dated 02/20/26 revealed R1 was unable to perform any part of the task of bathing, dressing, and toileting. R1 required physical assistance with transferring, walking/mobility and eating. R1 lacked the ability to manage her own medications and medical treatments. R1 was incontinent and had impaired short-term memory, long-term memory, memory/recall, and decision making. R1 was usually able to make herself understood and she sometimes understood others. R1 was at risk for falls and impaired decision making. R1 used a gait belt and walker assistive devices.

Review of R1's "Negotiated Service Agreement" (NSA) dated 05/06/26 identified the facility staff would provide R1 with physical assistance with bathing, toileting, dressing, walking/mobility, transferring, and eating. The facility CMA/ "Licensed Nurse" (LN) would administer R1's medications, and the local hospice agency would manage R1's treatments.

R1's record lacked a document titled "Health Service Plan" (HSP)

Observation on 05/07/26 at approximately 09:50 AM R1 sat in a wheelchair at the dining room table, staff was observed to propel R1's wheelchair to her room.

Interview on 05/07/26 at approximately 09:55 AM with Operator/LN A confirmed R1 no longer ambulates and R1 is dependent on the wheelchair and staff to propel the wheelchair for mobility.

- Record review for R2 revealed an admission

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S5116	Continued From page 40	S5116		

date of 09/23/25 with diagnoses of acute and chronic respiratory failure with hypoxia, chronic obstructive pulmonary disease, endocarditis, rheumatic mitral valve disease, other pancytopenia, muscle weakness, and need for assistance with personal care.

Review of R2's FCS dated 09/29/25 revealed R2 required physical assistance with bathing, dressing, toileting, and transferring. R2 required supervision with walking/mobility and was independent with eating. R2 lacked the ability to manage her own medications and medical treatments. R2 was usually continent, and had impaired short-term memory, memory/recall, and decision making. R2 was able to make herself understood and she understood others. R2 was at risk for falls and impaired decision making.

Review of R2's NSA dated 09/29/25 identified the facility staff would provide physical assistance with bathing, dressing, toileting, walking/mobility, and 1 staff assistance with transferring. The facility CMA or LN would manage R2's medications and medical treatments. R2 had an outside provider for therapy and home health.

Review of R2's HSP instructed facility staff to administer R2's medications, provide physical assistance with bathing, dressing, and toileting. Facility staff were instructed to provide "stand by" assistance with mobility.

On 04/28/26 at 09:00 PM Operator/LN A documented that R2 was showing signs of decline. R2 experienced increased weakness and sleeping more. It was "Difficult to get from her chair to the bathroom across the hall".

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S5116	Continued From page 41 Operator/LN A called the hospice company and asked for a bed side commode for R2. On 05/02/26 at 10:30 PM Operator/LN A documented R2 experienced an increase in weakness and R2 was refusing the majority of meals. On R2's lower buttocks the coccyx appeared dark purple, in the shape of a butterfly, and on the left hip above the purple discoloration were two purple circular areas that measured approximately 0.5 inches in diameter. Interview on 05/07/26 with local hospice nurse D confirmed the area on R2's buttocks was an expected finding for someone in the active dying process. Local hospice nurse D confirmed that R2 was in the active dying process. Interview on 05/06/27 at approximately 02:00 PM with Operator/LN A confirmed the medical records lacked documentation of the review of the NSA's for R1 and R2 when they experienced a change of condition. The Operator/"Licensed Nurse" (LN) failed to ensure the review and if necessary revision of the "Negotiated Service Agreements'" (NSA)'s for R1 and R2 when they experienced a change of condition.	S5116		
S5171 SS=D	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.	S5171		

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S5171	Continued From page 42 This REQUIREMENT is not met as evidenced by: K.A.R. 26-42-204 (i) The facility reported a census of 4 residents. The sample included 3 "Residents'"(R)'s and 1 focused review. Based on observation, record review and interview, the Operator/"Licensed Nurse" (LN) failed to provide healthcare services for R1in accordance with professional standards of practice when Operator/LN A failed to conduct an assessment of R1's bed assist device to ensure the device posed no risk for entrapment, confirmed the device was not a restraint, and R1's ability to safely use the bed assist device. Operator/LN continued to fail to ensure the bed assist devices for R1 was listed in the comment section of the "Functional Capacity Screen" (FCS) and the Operator/LN further failed to include a description of the bed assist device, the purpose of the device, and any special instructions on use and monitoring of the bed assist device in R1's "Negotiated Service Agreement'" (NSA). Findings included: - Record review for R1 revealed an admission date of 02/20/26 with diagnoses of malignant neoplasm of the colon, malignant neoplasm of unspecified kidney, malignant neoplasm of connective and soft tissue unspecified, other frontotemporal neurocognitive disorder, type two diabetes, and unspecified convulsions.	S5171		

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S5171	Continued From page 43 Review of R1's FCS dated 02/20/26 revealed R1 was unable to perform any part of the task of bathing, dressing, and toileting. R1 required physical assistance with transferring, walking/mobility and eating. R1 lacked the ability to manage her own medications and medical treatments. R1 was incontinent and had impaired short-term memory, long-term memory, memory/recall, and decision making. R1 was usually able to make herself understood and she sometimes understood others. R1 was at risk for falls and impaired decision making. R1 used a gait belt and walker assistive device. R1's FCS lacked documentation of the bed assist devices in the comment section of the screen. Review of R1's NSA dated 05/06/26 identified the facility staff would provide R1 with physical assistance with bathing, toileting, dressing, walking/mobility, transferring, and eating. The facility CMA/LN would administer R1's medications, and the local hospice agency would manage R1's treatments. R1's NSA lacked documentation of a description of the bed assist devices, the purpose of the devices, and any special instructions on use and monitoring of the bed assist devices. R1's record lacked a document titled "Health Service Plan" (HSP) Observation on 05/06/26 at approximately 03:45 PM of R1's bed revealed the head of R1's bed sat against the northwest corner of the wall with the right side of the bed against the west wall. The foot of the bed faced the southwest corner of	S5171		

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S5171	Continued From page 44 the room, and the left side of the bed faced the east side of the room. On each side of the bed attached to the bed frame was a rectangular bed assist device that measured approximately 34.5 inches in width, and 13 inches from the top of the rail to the mattress. There were 7 horizontal bars within the open area. Interview on 05/07/26 at approximately 02:00 PM with Operator/LN A confirmed R1's medical record lacked an assessment of R1's bed assist device to ensure the device posed no risk for entrapment, confirmed the device was not a restraint, and R1's ability to safely use the bed assist device. Operator/LN continued to confirm the bed assist devices for R1 was listed in the comment section of the FCS, and the Operator/LN further confirmed R1's NSA included a description of the bed assist device, the purpose of the device, and any special instructions on use and monitoring of the bed assist device. The Operator/LN failed to provide healthcare services for R1in accordance with professional standards of practice when Operator/LN A failed to conduct an assessment of R1's bed assist device to ensure the device posed no risk for entrapment, confirmed the device was not a restraint, and R1's ability to safely use the bed assist device. Operator/LN continued to fail to ensure the bed assist devices for R1 was listed in the comment section of the FCS and the Operator/LN further failed to include a description of the bed assist device, the purpose of the device, and any special instructions on use and monitoring of the bed assist device in R1's NSA.	S5171		

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S5195 SS=F	26-42-206 (f) (g) Facility Food Storage (f) Staff shall store all food under safe and sanitary conditions. Containers of poisonous compounds and cleaning supplies shall not be stored in the areas used for food storage, preparation, or serving. (g) Each home shall maintain at least a three-day supply of food to meet the requirements of the planned menus. This REQUIREMENT is not met as evidenced by: K.A.R. 26-42-206 (f) The facility reported a census of 4 residents. The sample included 3 residents and 1 focused review. Based on observation and interview, the operator failed to ensure all food was stored under safe and sanitary conditions. Findings Included: Observation on 05/06/26 at approximately 11:23 AM revealed an area located in the laundry room on the northwest wall, with shelves that faced the southwest wall of the room. The shelves contained stored household chemicals. On the third shelf down, in front of 4 bottles of laundry detergent was a pumpkin pie. Interview on 05/07/26 at approximately 01:48PM with Operator/Licensed Nurse A confirmed that the pumpkin pie was not stored under safe and sanitary conditions. The operator failed to ensure all food would be	S5195		

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S5195	Continued From page 46 stored under safe and sanitary conditions.	S5195		
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: K.A.R. 26-42-104 (d)(1)(2)(3)(4) The facility reported a census of 4 residents. The sample included 3 residents and 1 focused review. Based on interview the operator failed to ensure the homes disaster and emergency preparedness for all employees and residents by failing to provide an orientation of the emergency management plan at time of hire and admission. The operator continued to fail to provide a quarterly review of the homes emergency management plan to all staff and residents, and the Operator further failed to preform an	S5215		

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S5215	Continued From page 47 emergency drill that evacuated the residents to a secure location at least annually. Findings Included: -Interview on 05/07/26 at approximately 01:47PM with Operator /Licensed Nurse A confirmed that she did not have documentation of having provided disaster and emergency preparedness for all staff and residents at time of hire or admission. Operator/Licensed Nurse A continued to confirm that she did not provide quarterly reviews of the home's emergency management plan with all staff and residents. Operator/Licensed Nurse A further confirmed she did not have documentation of an emergency drill that evacuated the residents to a secure location at least annually. The operator failed to ensure disaster and emergency preparedness for all employees and residents by failing to provide orientation of the emergency management plan at time of hire and admission. The operator continued to fail to provide a quarterly review of the homes emergency management plan to all staff and residents, and the Operator further failed to perform an emergency drill that evacuated the residents to a secure location at least annually.	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 resident, any resident ' s food, or resident care equipment until the condition is no longer	S5230		

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S5230	Continued From page 48 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: K.A.R. 26-42-207 (c) The facility reported a census of 4 "Residents'"(R)'s. The sample included 3 residents and 1 focused review. Based on interview and record review the operator failed to ensure the homes compliance with the department's "Tuberculosis" (TB) guidelines for adult care homes adopted by reference in K.A.R. 26-39-105 for R's 1, 2 and 3, and newly hired "Certified Medication Aide"(CMA) C. Findings Included: - Record review for R1 revealed an admission date of 02/20/26 with diagnoses of malignant neoplasm of the colon, malignant neoplasm of unspecified kidney, malignant neoplasm of connective and soft tissue unspecified, other frontotemporal neurocognitive disorder, type two diabetes, and unspecified convulsions. Review of R1's "Medical Record" revealed a TB	S5230		

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S5230	Continued From page 49 screening questionnaire that was completed on 02/25/26. R1's "Medical Record" lacked documentation of the required two step TB skin test being administered within seven days of admission to the facility. - Record review for R2 revealed an admission date of 09/23/25 with diagnoses of acute and chronic respiratory failure with hypoxia, chronic obstructive pulmonary disease, endocarditis, rheumatic mitral valve disease, other pancytopenia, muscle weakness, and need for assistance with personal care. Review of R2's "Medical Record" revealed a TB screening questionnaire that was completed on 09/29/25. R2 's "Medical Record" lacked documentation of the required two step TB skin test being administered within seven days of admission to the facility. - Record review for R3 revealed an admission date of 07/30/25 with diagnoses of lymphedema, pain in the right leg, other forms of acute ischemic heart disease, dysphagia, vascular dementia, psychotic disturbance, mood disturbance, anxiety, transient cerebral ischemic attack, anemia, insomnia, and atrial fibrillation. R3 's "Medical Record" lacked documentation of the required two step TB skin test being administered within seven days of admission to	S5230		

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S5230	Continued From page 50 the facility. Interview on 05/07/26 at approximately 01:50PM with Operator /Licensed Nurse A confirmed the "Medical Record" for R1, R2, and R3 lacked the documentation of the required two step TB skin test being administered within the seven days of admission The operator failed to ensure the home's compliance with the department's TB guidelines for adult care homes adapted by reference in K.A.R. 26-39-105 for R1, R2, and R3. Record review for newly hired CMA C revealed she began employment on 01/12/26. CMA C's employee record lacked documentation of the required TB symptom screen and two step TB skin test being preformed within 7 days of employment Interview on 05/07/26 at approximately 01:55 PM with Operator/Licensed Nurse A confirmed CMA C personal record lacked documentation of the required TB screen and two step TB being preformed within 7 days of employment. The operator failed to ensure the home's compliance with the department's TB guidelines for adult care homes adapted by reference in K.A.R. 26-39-105 for newly hired CMA C.	S5230		
S5251 SS=E	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	S5251		

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S5251	Continued From page 51 the date, time of occurrence, action taken, and results of the action. This REQUIREMENT is not met as evidenced by: K.A.R. 26-42-105 (f)(11) The facility reported a census of 4 "Residents'"(R)'s. The sample included 3 residents and 1 focused review. Based on interview and record review the operator failed to ensure documentation of all incidents, symptoms, and other indications of illness or injury including the date, time occurrence, action taken and results of the action for R1, R2, and R3. Findings Included: - Record review for R1 revealed an admission date of 02/20/26 with diagnoses of malignant neoplasm of the colon, malignant neoplasm of unspecified kidney, malignant neoplasm of connective and soft tissue unspecified, other frontotemporal neurocognitive disorder, type two diabetes, and unspecified convulsions. Review of R1's "Functional Capacity Screen" (FCS) dated 02/20/26 revealed R1 was unable to perform any part of the task of bathing, dressing, and toileting. R1 required physical assistance with transferring, walking/mobility and eating. R1 lacked the ability to manage her own medications and medical treatments. R1 was incontinent and	S5251		

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had impaired short-term memory, long-term memory, memory/recall, and decision making. R1 was usually able to make herself understood and she sometimes understood others. R1 was at risk for falls and impaired decision making. Rr1 used a gait belt and walker assistive device.

Review of R1's "Negotiated Service Agreement" (NSA) dated 05/06/26 identified the facility staff would provide R1 with physical assistance with bathing, toileting, dressing, walking/mobility, transferring, and eating. The facility CMA/ "Licensed Nurse" (LN) would administer R1's medications, and the local hospice agency would manage R1's treatments.

R1's record lacked a document titled "Health Service Plan" (HSP)

Review of R1's "electronic Medical Record" under the section titled "Observations" revealed the following entries:

On 02/20/26 at 02:30 AM Operator/LN A documented that R1 arrived to the facility accompanied by the local hospice agency. R1 ambulated with a one person assist, gait belt, and her walker.

On 02/21/26 at 11:45 AM Operator/LN A documented R1 was difficult to get out of bed. R1 was documented as "getting stiff and agitated". R1 "yells and hits or scratches staff", and a gait belt is used. R1 almost fell to the floor due to her being "difficult in cooperating". R1 refused her medications.

On 03/08/26 at 10:29 PM Operator/LN A

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documented R1 was noted to have her "head down, mouth open, drooling" and was not responsive. R1 was having a seizure.

On 03/15/26 at 12:00 PM Operator/LN A documented R1 had negative behaviors, yelling, being non cooperative, and spitting out her medications. R1's mood was "very agitated".

R1's "Observation Notes" lacked documentation of R1's bruises and skin tears.

Record review of R1's hospice binder revealed a document titled "Hospice and Facility Coordinated Plan of Care" dated 05/05/26. Under the section titled "Care Plan Interventions" revealed the section for "Wound Care" was not marked.

R1's hospice binder lacked documentation of a recent skin assessment for R1, and the binder further lacked wound care orders for R1.

Observation on 05/07/26 at approximately 09:50 AM R1 sat in a wheelchair at the dining room table, staff was observed to propel R1's wheelchair to her room.

Interview on 05/07/26 at approximately 09:55 AM with Operator/LN A confirmed R1 no longer ambulates and R1 is dependent on the wheelchair and staff to propel the wheelchair for mobility.

Observation on 05/07/26 at approximately 10:00 AM of R1 revealed the following bruises:

On R1's right anterior forearm approx. 3 inches

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from the antecubital space revealed a darkened area with yellowing edges that measured approximately 3 inches length and 1.5 inches in width.

On R1's sternum an oblong bruise that measured approximately 4 inches in length and 3.5 inches in width and had dark purple in the middle of the bruise with areas of yellowing around the edge and center of the bruise.

On R1's Left arm a dressing that covered a healing skin tear. The edges were approximated. On R1's Left anterior wrist a purple bruise that measured approximately 0.5 inches in diameter, and on the lateral top of R1's left hand from the middle of the hand to the left lateral edge was a bruise that had a dark purple center with light purple edges.

On R1's left shin a dressing dated 05/03/26 covered a purple area approximately 5 inches in length and 4 inches in width and in the center an opened skin tear that measured approximately 1.25 inches in length and the edges gapped approximately 0.5 inches.

On R1's left lower back an oblong bruise with purple center and the edges yellowing that measured approximately 4 inches in length and approximately 1.5 inches in width.

On R1's lower right shin a black scab that measured approximately 0.5 inches in length and less than 0.25 inches in width.
R1's "Electronic Medical Record" lacked documentation of all incidents, symptoms, and other indications of illness or injury including the

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S5251	Continued From page 55 date, time of occurrence, action taken, and results of actions taken. - Record review for R2 revealed an admission date of 09/23/25 with diagnoses of acute and chronic respiratory failure with hypoxia, chronic obstructive pulmonary disease, endocarditis, rheumatic mitral valve disease, other pancytopenia, muscle weakness, and need for assistance with personal care. Review of R2's FCS dated 09/29/25 revealed R2 required physical assistance with bathing, dressing, toileting, and transferring. R2 required supervision with walking/mobility and was independent with eating. R2 lacked the ability to manage her own medications and medical treatments. R2 was usually continent, and had impaired short-term memory, memory/recall, and decision making. R2 was able to make herself understood and she understood others. R2 was at risk for falls and impaired decision making. Review of R2's NSA dated 09/29/25 identified the facility staff would provide physical assistance with bathing, dressing, toileting, walking/mobility, and 1 staff assistance with transferring. The facility CMA or LN would manage R2's medications and medical treatments. R2 had an outside provider for therapy and home health. Review of R2's HSP instructed facility staff to administer R2's medications, provide physical assistance with bathing, dressing, and toileting. Facility staff were instructed to provide "stand by" assistance with mobility.	S5251		

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S5251	Continued From page 56 Review of R2's "Resident Record" revealed a document titled "Visit Note" dated 10/08/25 that reveled R2 was seen by "Physical Therapy". Review of R2's "electronic Medical Record" under the "Observations" revealed the following entries: On 03/03/26 at 07:30 PM Operator/LN A documented the following: R2 was seen by the Nephrologist on 03/03/26. The nephrologist told R2 and R2's family member that her kidney functions was "only 17%". The decision was made by R2 to not do dialysis. On 03/09/26 at 09:15 PM Operator/LN A documented R2's family came to see R2 and R2 and her family decided to call a local hospice agency. On 04/28/26 at 09:00 PM Operator/LN A documented that R2 was showing signs of decline. R2 experienced increased weakness and sleeping more. It was "Difficult to get from her chair to the bathroom across the hall". Operator/LN A called the hospice company and asked for a bed side commode for R2. On 05/02/26 at 10:30 PM Operator/LN A documented R2 experienced an increase in weakness and R2 was refusing the majority of meals. On 05/03/26 at 09:00 PM Operator/LN A documented that R2 had breakfast and dinner. R2's "Observation" notes lacked documentation of R2's bruises.	S5251		

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S5251	Continued From page 57 Review of the facility provided documents from the local hospice company titled "Shower Body Check Program" revealed the following: On 04/07/26 in the section titled "Bruises", "Skin Tears", and "Red Areas", "No" was marked next to "Bruises" and "Skin Tears", and "Yes" was marked. On 04/10/26 in the section titled "Bruises", "Skin Tears", and "Red Areas", "No" was marked next to "Bruises" and "Skin Tears", and "Yes" was marked. On 04/14/26 in the section titled "Bruises", "Skin Tears", and "Red Areas", "No" was marked next to each concern. Observation on 05/07/26 at approximately 08:30 AM of R2 with local hospice nurse D revealed the following bruises: On R2's sternum were 3 dark blue circular areas that were in a vertical line on the sternum. From the top of the most proximal bruise to the bottom of the most distal bruise measured approximately 6 inches in length and at the widest of the bruising it measured approximately 0.75 inches in width. On R2's right upper anterior arm a redden purple area that measured approximately 3 inches in length and approximately 0.5 inches in width. On the anterior/top side of R2's hand were 2 purple circular bruises that measured approximately 0.25 inches in diameter.	S5251		

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S5251	Continued From page 58 On R2's left shin was an oblong bruise that had a dark purple center with dark green around the edge of the purple center. The bruise measured approximately 2 inches in length and 1 inch in width. On R2's left wrist were two dark purple circular bruises that measured approximately 0.5 inches in diameter. On R2's lower buttocks the coccyx appeared dark purple, in the shape of a butterfly, and on the left hip above the purple discoloration were two purple circular areas that measured approximately 0.5 inches in diameter. R2's "Electronic Medical Record" lacked documentation of all incidents, symptoms, and other indications of illness or injury including the date, time of occurrence, action taken, and results of actions taken. - Record review for R3 revealed an admission date of 07/30/25 with diagnoses of lymphedema, pain in the right leg, other forms of acute ischemic heart disease, dysphagia, vascular dementia, psychotic disturbance, mood disturbance, anxiety, transient cerebral ischemic attack, anemia, insomnia, and atrial fibrillation. Review of R3's FCS dated 07/30/25 revealed R3 required physical assistance with bathing, dressing, toileting, and transferring. R3 lacked the ability to manage here own medications and medical treatments. R3 was occasionally incontinent, and had impaired short-term	S5251		

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S5251	Continued From page 59	S5251		

memory, long-term memory, memory/recall, and decision making. R3 was usually able to make herself understood and she understood others. R3 was marked at risk for impaired decision making. R2 required a walker mobility device.

Review of R3's NSA dated 07/30/25 identified the facility staff would provide ace wrappings every morning, and sequential boots in the evenings or when R3 requested them. Physical assistance with bathing, dressing, and toileting. Facility staff were to provide standby assistance for R3's mobility with her walker.

R3's NSA lacked documentation of the local hospice provider.

Review of R3'S HSP dated 07/30/25 instructed facility staff to supervise R3 at mealtimes and administer R3's medications and medical treatments. Facility staff were to provide physical assistance with bathing, dressing, toileting, and supervision with transferring.

Review of R3's electronic "Medical Record" under the "Observations" tab revealed the following entries:

On 03/12/26 at 08:45 PM Operator/LN A documented R3 admitted to a local hospice agency.

R3's "Observation" notes lacked documentation of R3's bruises.

Review of R3's medical record revealed a document titled "Hospice Interdisciplinary Group Assessment and Plan of Care Update Report"

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S5251	Continued From page 60 dated 03/18/26. The document revealed R3 began on hospice services on 03/12/26. Observation on 05/07/26 at approximately 10:45 AM of R3 revealed the following bruises: On R3's right forearm a purple circular bruise that measured approximately 2 inches in diameter and next to that bruise a smaller circular purple bruise that measured approximately 1 inch in diameter. Interview on 05/07/26 at approximately 10:45 AM with R3 revealed that someone "squeezed her arm to tight", and the smaller of the two bruises was "where their thumb was". R3 accused CMA C of bruising her arm. On R3's left upper posterior arm were 2 circular purple bruises that together measured approximately 1.5 inches in length, and approximately 0.5 inches in width. Interview on 05/07/26 at approximately 02:00PM with Operator/LN A confirmed she did not investigate R3's allegation of CMA C squeezing her arm. Operator/LN A further confirmed that she did not open an investigation on the bruising of unknown origin on R1, R2, and R3. Operator/LN A confirmed the facility staff did not report to her the bruising of unknown origin. R3's "Electronic Medical Record" lacked documentation of all incidents, symptoms, and other indications of illness or injury including the date, time of occurrence, action taken, and results of actions taken.	S5251		

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S5251	Continued From page 61 Interview on 05/07/26 at approximately 01:50PM wtih Operator/LN A confirmed that the "Medical Record" for R1,R2 and R3 lacked documentation of all incidents, symptoms, and other indications of illness and injury including the date, time of occurrence, action taken, and results of the action. The operator failed to ensure documentation of all incidents, symptoms, and other indications of illness or injury including the date, time occurrence, action taken and results of the action for R1, R2, and R3.	S5251		
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 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	S5315		

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S5315	Continued From page 62 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: K.A.R. 26-42-205 (h)(1) The facility reported a census of 4 residents. The sample included 3 residents and 1 focused review. Based on observation and interview the operator failed to ensure non-controlled and controlled medications managed by the home were in a locked medication room, cabinet, or medication cart that only "Licensed Nurse's (LN)'s or "Certified Medication Aides'" (CMA)'shad access to. Findings Included: - Observation on 05/06/26 at approximately 11:00 AM of the facility common dining room, revealed in the northwest corner of the room sat the unlocked medication cart with the keys on top of the cart. The drawers opened to the southwest. The second drawer was opened and the following medications were on top of a metal box inside the drawer that was closed and had a	S5315		

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S5315	Continued From page 63 lock on it. Housekeeping staff E was walking around while talking on her cellular phone, there were two hospice aides providing cares in the home, and the CMA was in a resident room. 1 bottle of Morphine 100milligram/5 milliliters 1 tube of Triamcinolone 0.1% ointment 1 bubble pack card of Vitamin C 500 milligrams Interview on 05/07/26 at approximately 01:47PM with Operator/Licensed Nurse A confirmed the Morphine should have been stored in a separately locked compartment within a locked medication cart, cabinet or medication room. The operator further confirmed the triamcinolone ointment and vitamin c should have been stored behind a locked medication cart, cabinet or medication room. The operator failed to ensure non-controlled and controlled medications managed by the home were in a locked medication room, cabinet, or medication cart that only LN or CMA had access to.	S5315		
S5325 SS=F	26-42-205 (l) Medication Regimen Review Frequency (l) Medication regimen review. A licensed pharmacist or licensed nurse shall conduct a medication regimen review at least quarterly for each resident whose medication is managed by the home and each time the resident experiences any significant change in condition.	S5325		

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S5325	Continued From page 64 This REQUIREMENT is not met as evidenced by: K.A.R. 26-42-205 (l) The facility reported a census of 4 residents. The sample included 3 "Residents'" (R)'s and 1 focused review. Based on interview and record review, the Operator/"Licensed Nurse" (LN) failed to ensure a licensed pharmacist or a licensed nurse performed a medication review quarterly, and when the resident experienced a change of condition for the residents whom the home managed the medications. This affected R1, R2, R3, and R4. Findings included: - Record review for R1 revealed an admission date of 02/20/26 with diagnoses of malignant neoplasm of the colon, malignant neoplasm of unspecified kidney, malignant neoplasm of connective and soft tissue unspecified, other frontotemporal neurocognitive disorder, type two diabetes, and unspecified convulsions. Review of R1's "Functional Capacity Screen" (FCS) dated 02/20/26 revealed R1 was unable to perform any part of the task of bathing, dressing, and toileting. R1 required physical assistance with transferring, walking/mobility and eating. R1 lacked the ability to manage her own medications and medical treatments. R1 was incontinent and had impaired short-term memory, long-term memory, memory/recall, and decision making. R1 was usually able to make herself understood and she sometimes understood others. R1 was at risk	S5325		

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for falls and impaired decision making. Rr1 used a gait belt and walker assistive device.

Review of R1's "Negotiated Service Agreement" (NSA) dated 05/06/26 identified the facility staff would provide R1 with physical assistance with bathing, toileting, dressing, walking/mobility, transferring, and eating. The facility CMA/ "Licensed Nurse" (LN) would administer R1's medications, and the local hospice agency would manage R1's treatments.

- Record review for R2 revealed an admission date of 09/23/25 with diagnoses of acute and chronic respiratory failure with hypoxia, chronic obstructive pulmonary disease, endocarditis, rheumatic mitral valve disease, other pancytopenia, muscle weakness, and need for assistance with personal care.

Review of R2's FCS dated 09/29/25 revealed R2 required physical assistance with bathing, dressing, toileting, and transferring. R2 required supervision with walking/mobility and was independent with eating. R2 lacked the ability to manage her own medications and medical treatments. R2 was usually continent, and had impaired short-term memory, memory/recall, and decision making. R2 was able to make herself understood and she understood others. R2 was at risk for falls and impaired decision making.

Review of R2's NSA dated 09/29/25 identified the facility staff would provide physical assistance with bathing, dressing, toileting, walking/mobility, and 1 staff assistance with transferring. The facility CMA or LN would manage R2's

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S5325	Continued From page 66 medications and medical treatments. R2 had an outside provider for therapy and home health. Review of R2's HSP instructed facility staff to administer R2's medications, provide physical assistance with bathing, dressing, and toileting. Facility staff were instructed to provide "stand by" assistance with mobility. - Record review for R3 revealed an admission date of 07/30/25 with diagnoses of lymphedema, pain in the right leg, other forms of acute ischemic heart disease, dysphagia, vascular dementia, psychotic disturbance, mood disturbance, anxiety, transient cerebral ischemic attack, anemia, insomnia, and atrial fibrillation. Review of R3's FCS dated 07/30/25 revealed R3 required physical assistance with bathing, dressing, toileting, and transferring. R3 lacked the ability to manage here own medications and medical treatments. R3 was occasionally incontinent, and had impaired short-term memory, long-term memory, memory/recall, and decision making. R3 was usually able to make herself understood and she understood others. R3 was marked at risk for impaired decision making. R2 required a walker mobility device. Review of R3's NSA dated 07/30/25 identified the facility staff would provide ace wrappings every morning, and sequential boots in the evenings or when R3 requested them. Physical assistance with bathing, dressing, and toileting. Facility staff were to provide standby assistance for R3's mobility with her walker.	S5325		

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S5325	Continued From page 67 Review of R3'S HSP dated 07/30/25 instructed facility staff to supervise R3 at mealtimes and administer R3's medications and medical treatments. Facility staff were to provide physical assistance with bathing, dressing, toileting, and supervision with transferring. - Record review for R4 revealed an admission date of 01/24/25 with diagnoses of anemia, chronic diastolic congestive heart failure, atherosclerosis of native arteries of right leg with ulceration of ankle, chronic obstructive pulmonary disease, long term use of anticoagulants, and supraventricular tachycardia. Review of R4's FCS dated 01/24/26 revealed R4 required physical assistance with bathing, toileting, transferring, and walking/mobility. R4 was independent with eating. R4 required physical assistance with his medications. Handwritten on the R4's FCS was the resident was able to give himself his inhalers and he could apply some ointments on his skin. R4 was occasionally incontinent, and he had impaired short-term memory. R4 was able to make himself understood and he understood others. R4 was identified at risk for falls, impaired vision, and impaired hearing. R4 used a walker and wheelchair mobility device. Review of R4's NSA dated 01/24/26 identified the facility staff would administer R4's medications and R4 would self-administer his "Inhalers and creams". Facility staff were to provide physical assistance with bathing and dressing, and toileting. Facility staff were to provide standby assistance when R4 ambulated. R4 had a local	S5325		

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S5325	Continued From page 68 home health agency for skilled nursing services. Review of the facility binder titled "Pharmacy" revealed a document titled "Medication Regimen Review" and was dated 03/27/25. Interview on 05/07/26 at approximately 02:00 PM with Operator/ LN A confirmed she lacked documentation of the quarterly pharmacy reviews for all residents. Operator/LN A continued to state that she had placed a call to the local pharmacy to have the reviews sent to her electronic mail again. The Operator/"Licensed Nurse" (LN) failed to ensure a licensed pharmacist or a licensed nurse performed a medication review quarterly, and when the resident experienced a change of condition for the residents whom the home managed the medications. This affected R1, R2, R3, and R4.	S5325		
S5335 SS=F	28-39-437 Construction (a) Each home-plus facility shall be designed, constructed, equipped, and maintained to protect the health and safety of residents, personnel, and the public. (b) All new construction, renovation, remodeling, and changes in building use in existing buildings shall comply with building and fire codes, ordinances, and regulations enforced by city, county, and state jurisdictions, including the state fire marshal. This REQUIREMENT is not met as evidenced by:	S5335		

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S5335	Continued From page 69 K.A.R 28-39-437 (a) The facility reported a census of 4 residents. The sample included 3 residents and 1 focused review. Based on observation and interview, the operator failed to ensure the home was maintained to protect the health and safety of the residents, personnel, and the public. Findings Included: - Observation on 05/06/26 at approximately 11:23 AM revealed a door on the northeast wall that opened to the southeast wall with the key in the doorknob. The door freely opened, and on the north wall in the laundry room were the following unsecured chemicals: 1 can of Disinfectant Spray 1 can of Unidentified aerosol spray with a black lid 1 Unidentified jug of purple cleaner 1 jug of Top Job Bleach 1 bottle of Natural Care Itch relief dog shampoo 8 jugs of Ajax laundry detergent Interview on 05/07/26 at approximately 01:49PM with Operator/Licensed Nurse A confirmed that the laundry room key was kept in the door and door remained unlocked. The operator failed to ensure the home was maintained to protect the health and safety of the residents, personnel, and the public.	S5335		
S9999	Final Observations	S9999		

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S9999	Continued From page 70 K.S.A. 39-928 Upon receipt of an application for license, the licensing agency with the approval of the state fire marshal shall issue a license if the applicant is fit and qualified and if the adult care home facilities meet the requirements established under this law. A license, unless sooner suspended or revoked, shall remain in effect upon filing by the licensee, and approval by the licensing agency and the state fire marshal or their duly authorized agents, of an annual report upon such uniform dates and containing such information in such form as the licensing agency prescribes and payment of an annual fee. S/S level F Findings included: - Department records revealed the facility failed to file and pay the2023, 2024, and 2025 annual renewal licensing fees. Interview on 04/07/26 at approximately 01:45 PM with Operator/LN A confirmed the facility's failure to pay the renewal fee to the department for 2020, 2021, 2022, 2023, 2024 and 2025. The facility failed to file and pay the 2020, 2021, 2022, 2023, 2024 and 2025 annual renewal licensing fee to the department as required by KSA 39- 928. The Operator further failed to comply with;	S9999		

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	B087210	A. BUILDING: _____ B. WING _____	05/07/2026

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S9999	Continued From page 71 K.S.A. 39-938 Adult care homes shall comply with all the lawfully established requirements and rules and regulations of the secretary of aging and the state fire marshal and any other agency of government so far as pertinent and applicable to adult care homes, their building, operators, staff, facilities, maintenance, operation, conduct and the care and treatment of residents. S/S level F This requirement is not met as evidenced by: The facility reported a census of 4. The sample included 3 residents and 1 focused review. Based on observation and interviews for all residents, the facility failed to post a conspicuous notice at the entrance to the adult care home and each resident's room stating that the rooms of some residents may be monitored electronically by or on behalf of the room's resident or residents. Findings included: - Record review for R1 revealed an admission date of 02/20/26 with diagnoses of malignant neoplasm of the colon, malignant neoplasm of unspecified kidney, malignant neoplasm of connective and soft tissue unspecified, other frontotemporal neurocognitive disorder, type two diabetes, and unspecified convulsions.	S9999		

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Review of R1's "Functional Capacity Screen" (FCS) dated 02/20/26 revealed R1 was unable to perform any part of the task of bathing, dressing, and toileting. R1 required physical assistance with transferring, walking/mobility and eating. R1 lacked the ability to manage her own medications and medical treatments. R1 was incontinent and had impaired short-term memory, long-term memory, memory/recall, and decision making. R1 was usually able to make herself understood and she sometimes understood others. R1 was at risk for falls and impaired decision making. Rr1 used a gait belt and walker assistive device.

Review of R1's "Negotiated Service Agreement" (NSA) dated 05/06/26 identified the facility staff would provide R1 with physical assistance with bathing, toileting, dressing, walking/mobility, transferring, and eating. The facility CMA/ "Licensed Nurse" (LN) would administer R1's medications, and the local hospice agency would manage R1's treatments.

Observation on 05/07/26 at approximately 09:50 AM of R1's of the outside of R1's bedroom door revealed it lacked a posting stating that the rooms of some residents may be monitored electronically by or on behalf of the room's resident or residents.

Interview on 05/07/26 at approximately 09:50 AM with Operator/"Licensed Nurse" (LN) A confirmed R1 had a camera in her room that was placed by R1's "Durable Power of Attorney" (DPOA), and Operator/LN A further confirmed the entrance to R1's room lacked a posting stating that the rooms of some residents may be monitored electronically by or on behalf of the room's

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resident or residents.

- Record review for R2 revealed an admission date of 09/23/25 with diagnoses of acute and chronic respiratory failure with hypoxia, chronic obstructive pulmonary disease, endocarditis, rheumatic mitral valve disease, other pancytopenia, muscle weakness, and need for assistance with personal care.

Review of R2's FCS dated 09/29/25 revealed R2 required physical assistance with bathing, dressing, toileting, and transferring. R2 required supervision with walking/mobility and was independent with eating. R2 lacked the ability to manage her own medications and medical treatments. R2 was usually continent, and had impaired short-term memory, memory/recall, and decision making. R2 was able to make herself understood and she understood others. R2 was at risk for falls and impaired decision making.

Review of R2's NSA dated 09/29/25 identified the facility staff would provide physical assistance with bathing, dressing, toileting, walking/mobility, and 1 staff assistance with transferring. The facility CMA or LN would manage R2's medications and medical treatments. R2 had an outside provider for therapy and home health.

Review of R2's HSP instructed facility staff to administer R2's medications, provide physical assistance with bathing, dressing, and toileting. Facility staff were instructed to provide "stand by" assistance with mobility.

Observation on 05/07/26 at approximately 08:00

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AM revealed the entrance to R2's room lacked a posting that the rooms of some residents may be monitored electronically by or on behalf of the room's resident or residents.

Interview on 05/07/26 at approximately 08:00 AM with Operator/LN A confirmed R2 had a family placed camera in her room, Operator/LN A further confirmed the entrance to R1's room lacked a posting stating that the rooms of some residents may be monitored electronically by or on behalf of the room's resident or residents.

- Record review for R3 revealed an admission date of 07/30/25 with diagnoses of lymphedema, pain in the right leg, other forms of acute ischemic heart disease, dysphagia, vascular dementia, psychotic disturbance, mood disturbance, anxiety, transient cerebral ischemic attack, anemia, insomnia, and atrial fibrillation.

Review of R3's FCS dated 07/30/25 revealed R3 required physical assistance with bathing, dressing, toileting, and transferring. R3 lacked the ability to manage here own medications and medical treatments. R3 was occasionally incontinent, and had impaired short-term memory, long-term memory, memory/recall, and decision making. R3 was usually able to make herself understood and she understood others. R3 was marked at risk for impaired decision making. R2 required a walker mobility device.

Review of R3's NSA dated 07/30/25 identified the facility staff would provide ace wrappings every morning, and sequential boots in the evenings or when R3 requested them. Physical assistance

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with bathing, dressing, and toileting. Facility staff were to provide standby assistance for R3's mobility with her walker.

Review of R3'S HSP dated 07/30/25 instructed facility staff to supervise R3 at mealtimes and administer R3's medications and medical treatments. Facility staff were to provide physical assistance with bathing, dressing, toileting, and supervision with transferring.

Observation on 05/07/26 at approximately 10:45 AM of R3's entrance to her room revealed it lacked a posting that the rooms of some residents may be monitored electronically by or on behalf of the room's resident or residents.

- Record review for R4 revealed an admission date of 01/24/25 with diagnoses of anemia, chronic diastolic congestive heart failure, atherosclerosis of native arteries of right leg with ulceration of ankle, chronic obstructive pulmonary disease, long term use of anticoagulants, and supraventricular tachycardia.

Review of R4's FCS dated 01/24/26 revealed R4 required physical assistance with bathing, toileting, transferring, and walking/mobility. R4 was independent with eating. R4 required physical assistance with his medications. Handwritten on the R4's FCS was the resident was able to give himself his inhalers and he could apply some ointments on his skin. R4 was occasionally incontinent, and he had impaired short-term memory. R4 was able to make himself understood and he understood others. R4 was identified at risk for falls, impaired vision, and

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impaired hearing. R4 used a walker and wheelchair mobility device.

Review of R4's NSA dated 01/24/26 identified the facility staff would administer R4's medications and R4 would self-administer his "Inhalers and creams". Facility staff were to provide physical assistance with bathing and dressing, and toileting. Facility staff were to provide standby assistance when R4 ambulated. R4 had a local home health agency for skilled nursing services.

Observation on 05/06/24 at approximately 03:45 PM of the entrance to R4's room revealed it lacked a posting that the rooms of some residents may be monitored electronically by or on behalf of the room's resident or residents.

Interview on 05/07/24 at approximately 01:45 PM with Operator/LN A confirmed she did not have a posting on the entrance to each resident room that stated the rooms of some residents may be monitored electronically by or on behalf of the room's resident or residents. Operator/LN A further confirmed there were cameras in two resident rooms at this time. Operator/LN A further confirmed the posting at the entrance to the home revealed there was video monitoring in progress and the home did not have any active/live video cameras in the common areas of the home at this time. Operator/LN A confirmed the outside of the home lacked a posting that the rooms of some residents may be monitored electronically by or on behalf of the room's resident or residents.

The facility failed to post a conspicuous notice at the entrance to the adult care home and each

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S9999	Continued From page 77 resident's room stating that the rooms of some residents may be monitored electronically by or on behalf of the room's resident or residents.	S9999		