

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: B046089	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/18/2026
NAME OF PROVIDER OR SUPPLIER GRACEHEALTH SENIOR HOMES LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 700 WEST ELM STREET OLATHE, KS 66061		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS The following represents the findings of an initial licensure survey for the above named home plus facility conducted on 05/18/26.	S 000		
S5029 SS=F	26-42-101 (g) Availability of policies and procedures (g) Availability of policies and procedures. Each administrator or operator shall ensure that policies and procedures related to resident services are available to staff at all times and are available to each resident, legal representatives of residents, case managers, and families during normal business hours. A notice of availability shall be posted in a place readily accessible to residents. This REQUIREMENT is not met as evidenced by: KAR 26-42-101(g) The facility reported a census of seven residents. Based on observation and interview the operator failed to ensure a notice of the availability of the facility's policies and procedures was posted in a place accessible to all residents. Findings included: - Observation on 05/18/26 at approximately 08:39 AM during the initial tour revealed a notice that the facility's policies and procedures were available was not posted. On 05/18/26 at 09:02 AM Administrative Staff A confirmed a notice of the facility's policies and procedures available was not posted. The operator failed to ensure a notice of the	S5029		

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

TITLE

(X6) DATE

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S5029	Continued From page 1 availability of the facility's policies and procedures was posted in a place accessible to all residents.	S5029		
S5085 SS=D	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: KAR 26-42-201(c)(1) The facility reported a census of seven residents with three included in the sample. Based on interview and record review the operator failed to complete a Functional Capacity Screen (FCS) for Resident (R) 1 at least once every 365 days. Finding included: - Record review for R1 revealed an admission date of 04/21/25 with a diagnosis of dementia. The 04/21/25 admission FCS identified R1 required physical assistance with bathing, dressing, toileting, transfers, and walking/mobility; was unable to perform management of medications and treatments; was incontinent of bladder, had short-term memory, long-term memory, memory recall, and decision-making	S5085		

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S5085	Continued From page 2 difficulties; was at risk of falls; and had impaired vision, hearing, and decision making. The 05/08/26 combined Negotiated Service Agreement/Healthcare Service Plan (NSA/HSP) identified facility staff would provide R1 assistance with one to two staff with bathing, dressing, toileting, transfers, and walking/mobility; staff managed medications and treatments; staff offered choices for cognition; and staff spoke clear and concise for hearing. R1's record lacked evidence of documentation of a completed annual FCS since admission which was 28 days late. On 05/18/26 at 12:22 PM Administrative Staff A confirmed R1's record lacked evidence of documentation of an FCS since admission. The operator failed to ensure an FCS was completed for R1 every 365 days.	S5085		
S5171 SS=E	26-42-204 (i) Health Care Services Standards of Practice (i) All health care services shall be provided to residents by qualified staff in accordance with acceptable standards of practice. This REQUIREMENT is not met as evidenced by: KAR 26-42-204(i) The facility reported a census of seven residents with three included in the sample. Based on observation, interview, and record review, the operator failed to ensure a licensed nurse completed an assessment for the ability to use	S5171		

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S5171	Continued From page 3 bed rails safely without risk of entrapment and to confirm the bed rails were not a restraint for Residents (R) 1 and R3. Findings included: - Record review for R1 revealed an admission date of 04/21/25 with a diagnosis of dementia. The 04/21/25 admission Functional Capacity Screen (FCS) identified R1 required physical assistance with bathing, dressing, toileting, transfers, and walking/mobility; was unable to perform management of medications and treatments; was incontinent of bladder, had short-term memory, long-term memory, memory recall, and decision-making difficulties; was at risk of falls; and had impaired vision, hearing, and decision making. The 05/08/26 combined Negotiated Service Agreement/Healthcare Service Plan (NSA/HSP) identified facility staff would provide R1 assistance with one to two staff with bathing, dressing, toileting, transfers, and walking/mobility; staff managed medications and treatments; staff offered choices for cognition; and staff spoke clear and concise for hearing. The NSA/HSP indicated R1 had two side rails for bed mobility. Review of "Resident Roster" provided by facility on entrance revealed R1 had a bed assistive device. R1's record lacked documentation of a bedrail assessment. - Record review for R3 revealed an admission date of 05/21/25 with a diagnosis of chronic kidney disease.	S5171		

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S5171	Continued From page 4 The 05/21/25 FCS identified R3 required physical assistance with bathing, dressing, toileting, transfers, and walking/mobility; was unable to perform management of medications and treatments; had no cognitive difficulties; and was at risk of falls. The 05/21/25 combined NSA/HSP identified facility staff would provide R3 assistance with one to two staff with bathing, dressing, toileting, transfers, and walking/mobility; staff managed medications and treatments; staff offered choices for cognition; and staff encouraged R3 to call for assistance to prevent falls. R3's record lacked documentation of a bedrail assessment. On 05/18/26 at 12:34 PM Administrative Staff A confirmed there was no bed rail assessment in R1 or R3's records. The operator failed to ensure a licensed nurse completed an assessment of bed assistive devices for R1 and R3.	S5171		
S5215 SS=F	26-42-104 (d) Disaster and Emergency Preparedness Education (d) Each administrator or operator shall ensure disaster and emergency preparedness by ensuring the performance of the following: (1) Orientation of new employees at the time of employment to the home 's emergency management plan; (2) education of each resident upon admission to the home regarding emergency procedures;	S5215		

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S5215	Continued From page 5 (3) quarterly review of the home ' s emergency management plan with employees and residents; and (4) an emergency drill, which shall be conducted at least annually with staff and residents. This drill shall include evacuation of the residents to a secure location. This REQUIREMENT is not met as evidenced by: KAR 26-42-104(d)(3) The facility reported a census of seven residents. Based on interview and record review the operator failed to provide quarterly reviews of the facility's emergency management plan with staff and residents. Findings included: - On 05/18/26 at 09:35 AM quarterly reviews of the facility's emergency management plan with residents and staff were requested which the facility failed to provide. On 05/18/26 at 10:05 AM Administrative Staff A stated reviews of the facility's emergency management plan with staff and residents were conducted. She confirmed she did not have documentation to support it. The operator failed to provide quarterly reviews of the facility's emergency management plan with staff and residents.	S5215		
S5245 SS=F	26-42-105 (b) Resident Records Confidential (b) Each administrator or operator shall ensure	S5245		

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S5245	Continued From page 6 that all information in each resident's record, regardless of the form or storage method for the record, is kept confidential, unless release is required by any of the following: (1) Transfer of the resident to another health care facility; (2) law; (3) third-party payment contract; or (4) the resident or legal representative of the resident. This REQUIREMENT is not met as evidenced by: KAR 26-42-105(b) The facility reported a census of seven residents. Based on interview and record review the operator failed to ensure all information in each resident's record was kept confidential. Findings included: - Observation on 05/18/26 at 12:58 PM revealed a cabinet with no doors, in the common living area where all visitors and residents had access, which stored all resident records. On 05/18/26 at 12:58 PM AM Certified Medication Aide C confirmed the residents records are kept on the shelf, which was unsecured. On 05/18/26 at 02:23 PM Administrative Staff A confirmed the charts were unsecured. The operator failed to ensure all information in each resident's record was kept confidential.	S5245		

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S5315	Continued From page 7	S5315		
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 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:	S5315		

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S5315	Continued From page 8 KAR 26-42-205(h)(1)(4) The facility reported a census of seven residents. Based on observation and interview, the operator failed to ensure that all medications and biological's were stored in accordance with pharmacy recommendations or those of federal and state laws and regulations; all non-controlled medications and biological's managed by the home were stored in a locked medication room, cabinet, or cart; and medications beyond manufacturer or pharmacy provider's recommended date of expiration were not administered. Findings included: - Observation on 05/18/26 upon entering facility at 08:25 AM revealed a medication cart which stored all residents' medications was unlocked. - Observation on 05/18/26 at 09:08 AM Administrative Staff A put key in medication cart lock and turned the key. The lock was already in the "up" position indicating lock was already in unlocked position. The following medications were found in the cart: One container polyethylene glycol 3350 17.9 ounces with expiration date 03/11/26 One zippered bag bisacodyl 10 milligram (mg), five suppositories with expiration date 04/21/26 One zippered bag acetaminophen 650 mg, ten suppositories with expiration date 04/21/26 One tube diclofenac sodium 1% gel 100 grams, expiration date 05/05/26 One box ondansetron 8 mg, 30 tablets with expiration date 02/22/26 One tube mupirocin ointment 22 grams with no legible expiration date	S5315		

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S5315	Continued From page 9 On 05/18/26 at 09:31 AM Administrative Staff A stated she expected the medication cart to be locked and not have expired medications inside. She confirmed the medications either were past date of use or were not able to read expiration date. - Observation on 05/18/26 at 11:55 AM revealed Resident (R) 2's room door was open. Neither R2 nor any staff member were located in the apartment. The following medications were located on a cabinet in his room: One tube Nystatin cream 100,000 units per gram, 30 grams One tube Clotrimazole 1% cream, 30 grams One bottle Nystatin topical powder 100,000 units per gram 15 grams One bottle allergy nasal mist 0.05% 15 milliliters On 05/18/26 at 01:43 PM Certified Medication Aide C stated R2's medicated creams were kept in his room even though staff administer them. The operator failed to ensure all medications and biological's were stored in accordance with pharmacy recommendations or those of federal and state laws and regulations; all non-controlled medications and biological's managed by the home were stored in a locked medication room, cabinet, or cart; and medications beyond manufacturer or pharmacy provider's recommended date of expiration were not administered.	S5315		
S5316 SS=E	26-42-205 (i) Disposition of Medication (i) Accountability and disposition of medications.	S5316		

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S5316	Continued From page 10 Licensed nurses and medication aides shall maintain records of the receipt and disposition of all medications managed by the home in sufficient detail for an accurate reconciliation. (1) Records shall be maintained documenting the destruction of any deteriorated, outdated, or discontinued controlled medications and biologicals according to acceptable standards of practice by one of the following combinations: (A) Two licensed nurses; or (B) a licensed nurse and a licensed pharmacist. (2) Records shall be maintained documenting the destruction of any deteriorated, outdated, or discontinued non-controlled medications and biologicals according to acceptable standards of practice by any of the following combinations: (A) Two licensed nurses; (B) a licensed nurse and a medication aide; (C) a licensed nurse and a licensed pharmacist; or (D) a medication aide and a licensed pharmacist. This REQUIREMENT is not met as evidenced by: KAR 26-42-205(i) The facility reported a census of seven residents. Based on interview and record review the operator failed to ensure a licensed nurse and medication aides maintained records of medications managed by the home for an accurate reconciliation. Findings included:	S5316		

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S5316	Continued From page 11 - Observations and record review of facility's controlled medications and count reconciliation book on 05/18/26 at approximately 09:20 AM revealed the following: 1) Two cassettes for Resident (R) 1 held lorazepam 0.5 milligram (mg) tablets, the "1600" cassette held nine tablets and the "AM" cassette had ten tablets. The count reconciliation book failed to include pages for either cassette. 2) A "PRN" cassette for R1 held 14 tablets of lorazepam 0.5 mg with the "Controlled Substance Log" indicating 15 tablets remained. 3) The count reconciliation book held three pages for R4 with one page indicating two doses of lorazepam 0.5 mg remained and two pages indicated 14 tablets of lorazepam 0.5 mg remained. The controlled substance compartment contained one cassette with 14 tablets. 4) A cassette for R5 held 15 tablets of lorazepam 0.5 mg without a corresponding log in the book. On 05/18/26 at 09:31 AM Administrative Staff A confirmed the controlled medications failed to be accurately reflected in the controlled substance logbook. On 05/18/26 at 10:24 AM Administrative Staff A confirmed she did not have a policy regarding controlled medication reconciliation. The operator failed to ensure a licensed nurse and medication aides maintained records of medications managed by the home for an accurate reconciliation.	S5316		

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S5328	Continued From page 12	S5328		
S5328 SS=F	26-42-205 (I) (3) Medication Regimen Review Documentation (3) The administrator or operator, or the designee, shall ensure that the medication regimen review is kept in each resident 's clinical record. This REQUIREMENT is not met as evidenced by: KAR 26-42-205(I)(3) The facility reported a census of seven residents with three residents included in the sample. Based on interview and record review the operator failed to ensure quarterly medication regimen reviews were kept in all residents' clinical records. Findings included: - Review of Resident (R) 1's record revealed an admission date of 04/21/25 with the following diagnoses: dementia, gout, hyperlipidemia, and hypertension. The 04/21/25 Functional Capacity Screen (FCS) identified R1 was unable to perform management of medications. The 05/08/26 Negotiated Service Agreement (NSA) for R1 identified facility staff would administer medications. R1's record lacked documentation of quarterly medication regimen reviews. - Review of R2's record revealed an admission date of 11/13/24 with the following diagnoses:	S5328		

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S5328	Continued From page 13 Alzheimer's disease, arthritis, and congestive heart failure. The 11/13/24 FCS identified R2 was unable to perform management of medications. The 11/13/24 NSA for R2 identified facility staff would administer medications. R2's record lacked documentation of quarterly medication regimen reviews. - Review of R3's record revealed an admission date of 05/21/25 with the following diagnoses: diabetes mellitus type two, depression, chronic kidney disease, and arthritis. The 05/21/25 FCS identified R3 was unable to perform management of medications. The 05/23/25 NSA for R3 identified facility staff would administer medications. R3's record lacked documentation of quarterly medication regimen reviews. On 05/18/26 at 11:22 AM Administrative Staff A confirmed quarterly medication regimen reviews were not in any of the residents' records. The operator failed to ensure quarterly medication regimen reviews were kept in the residents' clinical records.	S5328		
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	S5335		

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S5335	Continued From page 14 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: KAR 28-39-437(a) The facility reported a census of seven residents. Based on observation and interview the operator failed to ensure the building was maintained to protect the health and safety of the residents by ensuring all chemicals were stored within locked areas. Findings included: - Observation on 05/18/26 at 08:44 AM revealed the staff's bathroom door was not lockable. One 8.8 ounce spray bottle of febreze was on the decorative wall shelf with label that read "Keep out of reach of children:" - Observation on 05/18/26 at 08:50 AM revealed the laundry room door was open with cabinets inside the room. One cabinet had a latch with an unsecured lock and another cabinet had a latch with no lock present. The following chemicals were in the cabinets labeled "Keep out of reach of children" Five 6.2-ounce aerosol cans air freshener spray refill One 32 fluid ounce container OdoBan One gallon container OdoBan Two 8.8 ounce cans Febreze	S5335		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: B046089	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/18/2026
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S5335	Continued From page 15 One 15-ounce aerosol can insect killer Five 24 fluid ounce containers toilet bowl cleaner One 32 fluid ounce mold and mildew remover One 81 fluid ounce container bleach One 121 fluid ounce container of bleach Four 213 fluid ounce containers of detergent On 05/18/26 at 08:56 AM Certified Medication Aide D stated the cabinets would have been last accessed by night shift and confirmed they were not secured. - Observation on 05/18/26 at approximately 10:55 AM revealed a cabinet with a lock that was unsecured below the kitchen sink. The following chemicals had labels that read "Keep out of reach of children:" One 24 fluid ounce spray bottle of multi-surface cleaner Two 115 pack containers dishwasher detergent On 05/18/26 at approximately 10:59 AM Administrative Staff A confirmed chemicals were not secured by a locked padlock. The operator failed to ensure the building was maintained to protect the health and safety of the residents by ensuring all chemicals were stored within locked areas.	S5335		