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| | B087184 | A. BUILDING: _____ B. WING _____ | C 05/28/2026 |

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| S 000 | INITIAL COMMENTS<br><br>The following citations represent the findings of the licensure resurvey for the above named facility conducted on 05/26/26 and 05/27/26. | S 000 | | |
| S5171 SS=D | 26-42-204 (i) Health Care Services Standards of Practice<br><br>(i) All health care services shall be provided to residents by qualified staff in accordance with acceptable standards of practice.<br><br>This REQUIREMENT is not met as evidenced by:<br>K.A.R. 26-42-204 (i)<br><br>The facility reported a census of 8 residents. The sample included 3 "Residents'" (R)'s and 1 focused review. Based on observation, interview, and record review, the Operator failed to provide healthcare services for R1 in accordance with professional standards of practice when the Operator 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. The Operator continued to fail to ensure the bed assist device for R1 was listed in the comment section of the "Functional Capacity Screen" (FCS), and the Operator 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).<br><br>Findings included:<br><br>- Record review for R1 revealed an admission | S5171 | | |

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

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| S5171 | Continued From page 1<br>date of 12/16/25 with a diagnosis of herpes viral vesicular dermatitis, abscess and granuloma, malnutrition.<br><br>Review of R1's FCS dated 12/16/25 revealed R1 required physical assistance with bathing, dressing, toileting, and transferring. R1 was independent with eating. R1 was unable to perform walking/mobility. R1 lacked the ability to manage her own medications, medical treatments and was incontinent. R1 was marked at risk for falls and had impaired decision making. R1 used a wheelchair mobility device.<br><br>R1's FCS Comment section lacked documentation of the bed assist device.<br><br>Review of R1's NSA dated 12/16/25 identified the facility staff would provide R1 with physical assistance of one staff member for transferring, toileting, dressing, bathing, and mobility. R1was independent with eating. Under the Section titled "Fall Prevention" facility staff were instructed to give R1 the call light, do hourly checks, and an audible monitor was placed in R1s room when R1 was alone in her room. Facility staff were instructed to administer and manage R1's medications and medical treatments.<br><br>R1's NSA lacked 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.<br><br>Observation on 05/27/26 at approximately 01:50 PM of R1's bed revealed, the bed sat against the northeast corner of the room, with the foot of the bed towards the west. The bed rail was attached to the south side of the bed. The bed rail was a rectangular-shaped bed assist device that was | S5171 | | |

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| S5171 | Continued From page 2 | S5171 | | |

attached to the bed frame and measured approximately 32 inches in length and 17.5 inches in width. There were 8 vertical bars in the open space of the rectangle that were spaced approximately 4.5 inches apart.

Interview on 05/27/26 at approximately 02:00 PM with Operator/Licensed Nurse A confirmed R1's FCS lacked documentation of the bed assist device in the comments section, R1's "Medical Record" lacked an assessment of R1's bed assist device to ensure the device posed no risk for entrapment, confirmed the devise was no a restraint, and R1's ability to safely use the bed assist device. Operator/Licensed Nurse A continued to confirm R1's NSA lacked 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 FDA (food and drug administration) "Bedrails in Assisted Living, Residential Health Care and Home Plus Facilities" recommended the following:

Complete an assessment of the resident to confirm that the device is not a restraint.

Complete an assessment of the resident to determine the purpose of the device and the resident's ability to safely use the device and document the findings in the resident's record.

Complete an assessment of the device using the recommendations in the FDA guidance to ensure the device is securely attached to the bed or bedframe and poses no risk for entrapment and document the findings in the resident record.

If the purpose of the device is to assist the

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| S5171 | Continued From page 3<br>resident with transfers, the FCS should document the resident's functional capacity based on the use of the device and should be listed in the comments section.<br><br>Include a description of the device, its purpose and special instructions on use and monitoring in the resident's NSA.<br><br>Document periodic reassessments of the resident's use of the device and their ability to use it safely and reassessment of the safety of the device in the resident's record.<br><br>The Operator failed to provide healthcare services for R1 in accordance with professional standards of practice when the Operator 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. The Operator continued to fail to ensure the bed assist device for R1 was listed in the comment section of the FCS and the Operator 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 | | |
| S5313 SS=F | 26-42-205 (g) (3) Over the counter medication<br><br>(g) (3) A licensed nurse or medication aide may accept over-the-counter medication only in its original, unbroken manufacturer ' s package. A licensed pharmacist or licensed nurse shall place the full name of the resident on the package. If the original manufacturer ' s package of an over-the-counter medication contains a medication in a container, bottle, or tube that can | S5313 | | |

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| S5313 | Continued From page 4<br>be removed from the original package, the licensed pharmacist or a licensed nurse shall place the full name of the resident on both the original manufacturer ' s medication package and the medication container.<br><br>This REQUIREMENT is not met as evidenced by:<br>K.A.R. 26-42-205 (g) (3)<br><br>The facility operator reported a census of 8 residents. The sample included 3 residents and 1 focused review. Based on observation and interview the operator failed to ensure a licensed pharmacist or the licensed nurse placed the full name of the resident on the "Over-The-Counter" (OTC) medication container.<br><br>Findings Included:<br><br>- Observation on 05/26/26 at approximately 01:15 PM of the home's medication cabinet located in the middle of the house in the common kitchen. "Certified Medication Aide" (CMA) B unlocked the medication cabinet and revealed the following OTC medications that lacked the full name of the resident:<br><br>1 bottle of Colace<br>1 bottle of Probiotic<br>1 bottle of Citracal<br>1 bottle of Aspirin<br>1 box of Dulcolax<br><br>Interview on 05/26/26 at approximately 01:30 PM with CMA B confirmed the OTC's lacked the full | S5313 | | |

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| S5313 | Continued From page 5<br>name of the resident.<br><br>The operator failed to ensure a licensed pharmacist or the licensed nurse placed the full name of the resident on the "Over-The-Counter" (OTC) medication container. | S5313 | | |
| S5315 SS=F | 26-42-205 (h) Medication Storage<br><br>(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.<br>(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.<br>(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.<br>(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.<br>(4) A licensed nurse or medication aide shall not administer medication beyond the manufacturer ' | S5315 | | |

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| S5315 | Continued From page 6<br>s or pharmacy provider ' s recommended date of expiration.<br><br>This REQUIREMENT is not met as evidenced by:<br>K.A.R. 26-42-205 (h)(1)<br><br>The facility reported a census of 8 residents. The sample included 3 residents and 1 focused review. Based on observation and interview the operator failed to ensure non-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)'s had access to.<br><br>Findings Included:<br><br>-Observation on 05/26/26 at approximately 01:35 PM of the facilities common bathroom located in the middle of the house on the west side revealed a white basket sitting on top of a three-drawer organizer the following medications were located inside the white basket:<br><br>1 tube of Calmoseptine<br>2 containers of medicated baby powder<br><br>Interview on 05/26/26 at approximately 04:00 PM with LN A and CMA B confirmed the calmoseptine and baby powder should have been stored behind a locked medication cart, cabinet or medication room.<br><br>The operator failed to ensure non-controlled | S5315 | | |

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| S5315 | Continued From page 7<br>managed by the home were in a locked medication room, cabinet, or medication cart that only LN or CMA had access to. | S5315 | | |