STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175124	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEPOINT EL DORADO, LLC	**1313 S HIGH STREET , EL DORADO, Kansas, 67042**

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F0000	INITIAL COMMENTS The following citations represent the findings of a Health Recertification Survey and complaint survey regarding allegations in 3094088 and 3069688. The census was 53. The sample included 15 residents.	F0000		
F0725 SS = F	Sufficient Nursing Staff CFR(s): §483.35(a)(1)(2) §483.35 Nursing Services. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity, and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. §483.35(a) Sufficient Staff. §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.	F0725		

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

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

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F0725 SS = F	Continued from page 1 This REQUIREMENT is NOT MET as evidenced by: Based on the record review and interview, the facility failed to have sufficient nursing staff on the weekends to ensure adequate care as determined by the facility's resident census and acuity. Findings Included: - An inspection of the Centers for Medicare and Medicaid Services (CMS) Payroll-Based Journal (PBJ) staffing documentation confirmed low weekend staffing for the weekends of Fiscal Year (FY)2026 Quarter (Q) 1 (10/01/2025 to 12/31/2025) and FY 2026 Q2 (01/01/2026 to 03/31/2026). During an interview on 08/26/2026 at 10:00 AM, Administrative Staff A reported that she had a ratio for determining staffing levels. She stated she had never looked to see if the facility triggered for any staffing concerns, as their staffing had a four-star rating. After reviewing the staffing indicators, she acknowledged that the facility did trigger for low weekend staffing. During an interview on 08/26/2026 at 10:50 AM, Consultant KK stated that the census had increased at the facility and they would need to review the required staffing ratios. She reviewed the actual hours worked on some of the weekend staff sheets that the facility provided and compared that to the census and confirmed that the facility had low weekend actual hours recorded with the census that was reported. During an interview on 08/26/2026 at 10:52 AM, Consultant JJ stated that the facility could have had low weekend staffing, as he had just had a PBJ audit completed by CMS that was accurate. He stated that if they had a salaried staff member work a weekend, he could only count 40 hours for them even if they filled out a form. Consultant JJ did not specify what type of audit was performed. The facility did not provide a staffing policy.	F0725		
F0812 SS = F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must -	F0812		

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F0812 SS = F	Continued from page 2 §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to provide sanitary conditions for food storage to prevent the spread of food borne illness to the residents of the facility in the nourishment room. Findings included: On 08/24/2026 at 07:47 AM, during the initial tour of the nourishment room, located in the dining area, the drip tray on the cappuccino machine was visibly dirty with brown liquid and sugar like substance, the tea machine drip tray had brown liquid sitting in it, the floor was sticky and had brown and black residue under the baseboard, the stand-up refrigerator contained two open containers of nectar consistency, thickened water with no opened date, one container of nectar consistency thickened orange juice with no opened date, and one gallon of milk with no opened date. There was a juice dispensing machine on the counter that had a brown, oxidized appearance on half of the drip tray. The cabinet under the cappuccino machine contained a tray of clean plastic cups with brown liquid residue on the cups and the tray. On 08/25/2026 at 03:46 PM, Dietary CC stated that the dietary aides that were assigned to the dining area for that day were responsible for keeping the dining area and the nourishment area clean.	F0812		

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F0812 SS = F	Continued from page 3 On 08/25/2026 at 04:07 PM, Administrative Staff A stated that it was the responsibility of the dietary aides to clean the nourishment room and dining area, but there was no check-off sheet to verify it had been completed. They were also to check and date food items in the stand-up refrigerator and nourishment area. During an interview on 08/25/2026 at 04:11 PM, Dietary Staff DD stated that the dietary aides were responsible for the cleaning of the dining area and the nourishment area. On 08/26/2026 at 08:11 AM, Dietary BB stated that the dietary aides were the ones who were responsible for cleaning the nourishment room and dining area. They were to check expiration dates along with open dates on all food and drink products. Dietary BB said they had no verification that it had been completed, as there was no documentation in place to verify it had been completed. The “Food Prep and Handling” policy documented all food items and products served to elders that would be prepared or served from or in a central kitchen, neighborhood kitchen, or serving area would be according to the standardized recipes. The kitchen and equipment would be kept clean, neat, orderly and maintained.	F0812		
F0838 SS = F	Facility Assessment CFR(s): 483.71(a)(1)(3)(b)(1)(c)(1)-(5) §483.71 Facility assessment. The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations (including nights and weekends) and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. §483.71(a) The facility assessment must address or include the following: §483.71(a)(1) The facility's resident population, including, but not limited to:	F0838		

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F0838 SS = F	Continued from page 4 (i) Both the number of residents and the facility's resident capacity; (ii) The care required by the resident population, using evidence-based, data-driven "methods" that considering the types of diseases, conditions, physical and behavioral health needs, cognitive disabilities, overall acuity, and other pertinent facts that are present within that population, consistent with and informed by individual resident assessments as required under § 483.20; (iii) The staff competencies and skill sets that are necessary to provide the level and types of care needed for the resident population; (iv)The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and (v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services. §483.71(a)(2) The facility's resources, including but not limited to the following: (i) All buildings and/or other physical structures and vehicles; (ii) Equipment (medical and non- medical); (iii) Services provided, such as physical therapy, pharmacy, behavioral health, and specific rehabilitation therapies; (iv) All personnel, including managers, nursing and other direct care staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care; (v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and (vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations. §483.71(a)(3) A facility-based and community-based	F0838		

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F0838 SS = F	Continued from page 5 risk assessment, utilizing an all-hazards approach as required in §483.73(a)(1). § 483.71(b) In conducting the facility assessment, the facility must ensure: § 483.71(b)(1) Active involvement of the following participants in the process: (i) Nursing home leadership and management, including but not limited to, a member of the governing body, the medical director, an administrator, and the director of nursing; and (ii) Direct care staff, including but not limited to, RNs, LPNs/LVNs, NAs, and representatives of the direct care staff, if applicable. (iii) The facility must also solicit and consider input received from residents, resident representatives, and family members. §483.71(c) The facility must use this facility assessment to: §483.71(c)(1) Inform staffing decisions to ensure that there are a sufficient number of staff with the appropriate competencies and skill sets necessary to care for its residents' needs as identified through resident assessments and plans of care as required in § 483.35(a)(3). §483.71(c)(2) Consider specific staffing needs for each resident unit in the facility and adjust as necessary based on changes to its resident population. §483.71(c)(3) Consider specific staffing needs for each shift, such as day, evening, night, and adjust as necessary based on any changes to its resident population. §483.71(c)(4) Develop and maintain a plan to maximize recruitment and retention of direct care staff. §483.71(c)(5) Inform contingency planning for events that do not require activation of the facility's emergency plan, but do have the potential to affect resident care, such as, but not limited to, the	F0838		

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F0838 SS = F	Continued from page 6 availability of direct care nurse staffing or other resources needed for resident care. This REQUIREMENT is NOT MET as evidenced by: Based on the record review and interview, the facility failed to conduct a thorough facility-wide assessment to determine the nursing staff resources necessary to care for residents competently during both day-to-day operations and emergencies. Findings Included: An inspection of the “Facility Long-Term Care Self-Assessment,” dated 08/03/2026, provided by the facility documented the following: The assessment failed to identify the specific staffing levels needed for each unit and identify the number of Registered Nurses (RN), Licensed Nurses (LPN/LVN), Certified Medication Aides (CMA), and Certified Nurse Aides (CNA) needed for each unit, patient acuity, and census. The assessment lacked the staffing levels required for each daily shift and weekends. On 08/26/2025 at 10:00 AM, Administrative Staff A stated that she was not aware that the facility assessment required the staffing ratios to be included. She reported that she had a ratio for that in her budget and would get that documentation. On 08/26/2025 at 10:50 AM, Consultant KK stated that the census had increased at that facility and they needed to review the required staffing ratios. The “Facility Long-Term Care Self-Assessment,” policy dated 08/03/2026, documented that they strive to meet the needs of all their residents and will provide the necessary competencies, resources, and training to do so.	F0838		
F0880 SS = F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:	F0880		

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F0880 SS = F	Continued from page 7 §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.	F0880		

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F0880 SS = F	Continued from page 8 §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on interviews, record reviews and observation, the facility staff failed to implement adequate infection control practices related to Enhanced Barrier Precautions (EBP-infection control interventions designed to reduce transmission of resistant organisms which employ targeted gown and glove use during high contact care) personal protective equipment (PPE-gowns, face shields and/or eyeglasses/goggles, and gloves) use, hand hygiene practices, and equipment cleaning after resident use. Findings included: - During a record review on 08/25/2026, the observation showed the infection control policy was undated, the COVID-19 policy was revised on 05/2024, the emergency water plan was revised on 05/2024, the antibiotic stewardship program was revised on 05/2024, the infection surveillance policy was revised on 05/2024, and the immunization policy was revised on 05/2024. Observed on 08/24/2026 at 07:56 AM, R5's oxygen cannula (a lightweight, flexible plastic device used to deliver supplemental oxygen directly into a patient's nostrils) laid across the floor in the resident's room. Observed on 08/24/2026 at 08:28 AM, R13 had an EBP sign on the wall outside the room that documented staff were to wear certain PPE when providing cares to R13 and there was a fall mat that was torn and laid on the floor in the bathroom. Observed on 08/24/2026 at 08:39 AM, Certified Medication Aid (CMA) R and Certified Nurses Aid (CNA) N transferred R8 with a Hoyer (total body mechanical lift) lift from a wheelchair to a reclining chair. CNA N did not clean the Hoyer lift after using it on R8. CNA N then placed the Hoyer lift outside of the resident's room, in the hallway. Observed on 08/24/2026 at 09:12 AM, R15 laid on a fall mat that was on the floor, and there was a fall mat attached to the wall at the left side of her bed; the mat on the wall had visible holes and rips to the outer surface of the mat.	F0880		

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F0880 SS = F	Continued from page 9 Observed on 08/24/2026 at 04:12 PM, R13 had folded blankets that sat on the floor at the end of the bed, and there was a fall mat on the bathroom floor that had holes in its corners. Observed on 08/24/2026 at 04:18 PM, R13, who had EBP, received care from CMA T. CMA T only wore gloves to clean R13's perineum (the area between the anus and genitalia) and wore the same gloves to clean R13's hands. Observed on 08/26/2026 at 08:49 AM, R5's oxygen cannula laid on the floor next to the oxygen concentrator (a medical device that pulls in room air, removes nitrogen, and delivers purified, concentrated oxygen to people who have trouble breathing). Observed on 08/25/2026 at 09:06 AM, R2's oxygen cannula was not in use and was draped over the back of the wheelchair seat. R2's continuous positive airway pressure (CPAP-ventilation device that blows a gentle stream of air into the nose to keep the airway open during sleep) mask laid directly on the bedside table with no protective bag over. Observed on 08/25/2026 at 08:43 AM, CNA N and CNA O provided cares to R13, who had EBP in place. Neither CNA wore a gown. On 08/24/2026 at 08:50 AM, CNA N stated that a Hoyer lift did not need to be cleaned after it was used to transfer a resident. On 08/24/2026 at 08:51 AM, CMA R stated the Hoyer lift did not need to be cleaned after it was used on a resident unless it was visibly soiled or was utilized on a resident that had EBP precautions. On 08/24/2026 at 04:26 PM, CMA T reported that a gown should have been worn while she provided cares to a resident on EBP, and she should have removed her gloves, performed hand hygiene, and then washed R13's hands. On 08/25/2026 at 08:47 AM, CNA N and CNA O stated they were not aware that R13 had EBP in place and they did not see the EBP sign that was posted on the wall next to the door of R13's room. On 08/26/2026 at 09:12 AM, CNA P stated oxygen tubbing should never have been left on the floor, and if it was on the floor, it should have been discarded and replaced.	F0880		

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F0880 SS = F	Continued from page 10 On 08/26/2026 at 09:50 AM, CMA S stated that oxygen tubing and CPAP masks should have been placed in a bag when it was not in use. On 08/26/2026 at 09:32 AM, Licensed Nurse (LN) F stated that she expected staff to wear the correct PPE for EBP and that it was not appropriate for staff to have performed cares with soiled gloves; it was expected that staff remove soiled gloves, perform hand hygiene, then apply clean gloves before they continued cares. LN F expected oxygen tubing or respiratory supplies to have been kept in a bag when not in use and expected staff to have cleaned the Hoyer lift after each use. The facility's undated "Infection Control Policy" documented the infection prevention and control program will follow accepted national standards and is based on facility assessment and includes prevention, identification, reporting, investigation, and controlling infections and communicable disease for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement. The infection control program includes surveillance, investigation, controlling and preventing infections in the facility including appropriate immunizations; appropriate reporting of infectious incidents; standard and transmission-based precautions to prevent spread of infections; development of procedures such as isolation to be applied to an individual resident; circumstances to prohibit employees with communicable disease or other infectious state from direct contact with residents or food; hand hygiene for staff involved in direct resident contact; and maintaining a record of incidents and corrective actions related to infections.	F0880		
F0552 SS = E	Right to be Informed/Make Treatment Decisions CFR(s): 483.10(c)(1)(4)(5) §483.10(c) Planning and Implementing Care. The resident has the right to be informed of, and participate in, his or her treatment, including: §483.10(c)(1) The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. §483.10(c)(4) The right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care.	F0552		

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F0552 SS = E	Continued from page 11 §483.10(c)(5) The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, the facility failed to inform Resident (R) 10, R23, R28, R48, and R50 and/or their representatives regarding the risks related to psychotropic (alters mood or thoughts) medications. Findings included: 1. R10's Electronic Medical Record (EMR) listed a physician's order for lorazepam (antianxiety), 1 milligram (mg) tablet, give one tablet by mouth two times a day and every four hours as needed for anxiety disorder, date ordered 08/18/2026. R10's EMR lacked documentation that R10, or his representative, received education or gave informed consent for the use of lorazepam. 2. R23's EMR listed a physician's order for fluoxetine (antidepressant) 10 mg tablet, give one tablet by mouth one time a day for depression, date ordered 07/24/2026. R23's EMR lacked documentation that R23, or his representative, received education or gave informed consent for the use of fluoxetine. 3. R28's EMR listed the following physician's orders: Mirtazapine (antidepressant) 15 mg, give one tablet by mouth at bedtime for major depressive disorder, date ordered 03/26/2024. Duloxetine (antidepressant) 60 mg delayed release, give one capsule by mouth daily for major depressive disorder, date ordered 04/29/2025. Trazodone (antidepressant) 50 mg, give one tablet by mouth at bedtime for insomnia, date ordered 11/08/2025. Lexapro (antidepressant) 20mg, give one tablet by mouth daily for major depressive disorder, date ordered 06/23/2026.	F0552		

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F0552 SS = E	Continued from page 12 R28's EMR lacked documentation that R28, or his representative, received education or gave informed consent for the use of mirtazapine, duloxetine, trazodone, and Lexapro. 4. R48's EMR listed a physician's order for Lexapro 20 mg, give one tablet by mouth in the morning for major depressive disorder, date ordered 11/25/2025. R48's EMR lacked documentation that R48, or his representative, received education or gave informed consent for the use of Lexapro. 5. R50's EMR listed the following physician's orders: Duloxetine 60 mg delayed release, give one capsule by mouth daily for major depressive disorder, give with 30 mg capsule for a total of 90 mg, date ordered 11/24/2025. Duloxetine 30 mg delayed release, give one capsule by mouth daily for major depressive disorder; give with 60 mg capsule for a total of 90 mg, date ordered 11/24/2025. Wellbutrin (antidepressant), give one tablet by mouth one time a day for major depressive disorder, date ordered 01/19/2026. R50's EMR lacked documentation that R50, or his representative, received education or gave informed consent for the use of duloxetine and Wellbutrin. On 08/26/2026 at 09:05 AM, Licensed Nurse (LN) J reported that consent for any antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality) medications was obtained before a resident could start that medication. On 08/26/2026 at 11:09 AM, Administrative Nurse D reported that the facility had only been obtaining informed consent for the use of antipsychotic medications and not for the other psychoactive medications. Administrative Nurse D reported that Administrative Nurse E had just been educated last week at a conference that informed consent was required for all the psychotropic medications and had started a list to obtain consents for those psychotropic medications that did not have one. The facility's policy "Psychotropic Medication Monitoring," not dated, documented that the facility will use and administer psychotropic medications	F0552		

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F0552 SS = E	Continued from page 13 appropriately, working with the interdisciplinary team to ensure the appropriate use, evaluation, and monitoring. Document the discussion with the resident and/or responsible party regarding the risk versus benefit of the use of these medications.	F0552		
F0677 SS = D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, and interview, the facility failed to ensure Resident (R) 4 received necessary activities of daily living (ADL) care for bathing. Findings included: … - R4's Electronic Medical Record (EMR) revealed a diagnosis of tracheostomy (opening through the neck into the trachea through which an indwelling tube may be inserted) and diabetes mellitus with a foot ulcer. R4's 07/23/2026 "Admission Change Minimum Data Set" (MDS) documented a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. R4’s MDS documented that she required set up and cleanup for personal hygiene and required supervision for bathing. R4’s 07/29/2026 "Functional Abilities (Self-Care and Mobility) Care Area Assessment" (CAA) documented R4 required assistance in ADLs, she had impaired balance and transition during transfers, and functional impairment in activity. Contributing factors included bilateral foot ulcers with cellulitis (skin infection caused by bacteria), generalized weakness, and decreased safety awareness. R4’s 07/20/2026 "Care Plan" instructed staff that R4 bathed during their preferred time scheduled in tasks. Staff was instructed to allow R4 to bathe independently for as long as she was able to do so safely. R4’s "Progress Notes," reviewed from 07/17/2026	F0677		

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F0677 SS = D	Continued from page 14 through 08/25/2026, lacked any documented refusals from R4 for her showers or bathing. R4's "Bathing Tasks Completed," reviewed from 07/17/2026 through 08/25/2026, documented that R4 would receive a shower on Monday and Friday evening. R4 had four of the 12 showers that should have been provided documented as showers on 07/17/2026 and 08/24/2026. It was documented on 08/17/2026 that R4 refused a shower, and on 08/21/26 it was documented as other. On 08/24/2026 at 12:44 PM, R4 reported she had been offered one shower since she was admitted. On 08/26/2026 at 12:32 PM, Certified Medication Aide Q reported that there was a schedule for baths, and it was to be documented in the EMR under tasks. CMA Q reported that R4 was not a day shower, and if a resident refused a shower, it was to be documented in the EMR, and a refusal sheet was filled out. CMA Q said that staff were to report to the nurse when a resident refused a shower, and the nurse was to speak with the resident and completed the refusal sheet. On 08/26/2026 at 12:45 PM, Licensed Nurse (LN) I reported that if a resident refused a shower, the CNAs were to complete a refusal sheet and let the nurse know, and then they talked to the resident; she said that R4 was scheduled for a shower on the evening shift on Monday and Friday. LN I reported that she expected the CNAs to document the EMR task when they offered a shower, gave a shower, and if the resident refused on the days they were scheduled for bathing. On 08/26/2026 at 01:35PM, Administrative Nurse D said she expected the staff to offer showers and document if the resident refused. She reported that she expected the nurse to speak to the resident and document it on a refusal form. Administrative Nurse D reported that Administrative Nurse F would have any documented refusal forms for bathing. On 08/26/2026 at 01:40 PM, Administrative Nurse F reported that she did not have any bathing refusal forms for R4. The facility's policy "Activities of Daily Living (ADLs), Supporting" dated 03/2018, documented that appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with bathing.	F0677		

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F0684 SS = D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review the facility failed to ensure hospice staff and facility staff collaborated and communicated regarding Resident (R) 2’s pain management regimen resulting in unavailable pain medication and unmitigated pain for R2. Findings included: - R2’s Electronic Medical Record (EMR) revealed diagnoses of chronic pain and anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear). R2’s 08/04/2026 "Significant Change Minimum Data Set" (MDS) documented a Brief Interview for Mental Status (BIMS) score of 10, which indicated moderately impaired cognition. R2’s MDS documented that she required moderate assistance with transfers. R2’s MDS revealed she had scheduled and as-needed pain medications that included an opioid (a class of controlled drugs used to treat pain). Additionally, the MDS noted R2 was frequently in pain that affected her sleep and day-to-day activities; she received hospice care. R2’s 08/16/2026 "Pain Care Area Assessment" (CAA) documented the pain CAA triggered secondary to resident complaints of pain during the pain interview. Each resident was carefully monitored throughout the day and night by a licensed nurse and evaluated for pain. The physician was to be immediately notified if there was no pain relief from the current regimen. Contributing factors included chronic medical, end-of-life process, and/or chronic pain. Risk factors included ineffective pain relief. R2’s "Care Plan" dated 10/16/2025 instructed staff to allow R2 rest breaks between tasks as needed.	F0684		

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F0684 SS = D	Continued from page 16 R2's "Care Plan" dated 12/23/2025 revealed R2 required staff assistance with pain management. R2's "Care Plan" dated 01/13/2026 instructed staff to administer analgesics as ordered by the resident's physician. Staff was instructed to monitor and document for side effects and effectiveness. R2's "Care Plan" dated 07/28/2026 instructed staff that hospice would be involved in medication management, orders, and treatments. R2's "Physician Orders" documented lidocaine (topical adhesive medications that numb specific areas of the body to provide temporary relief from minor pain) external patch five percent, apply to affected area topically every 12 hours as needed for pain, date ordered 09/22/2025. R2's "Electronic Medications Administration Record" (EMAR) indicated that the lidocaine was never administered during the months of 07/2026 and 08/2026. R2's "Physician Orders" documented acetaminophen 500 milligrams (mg), give two tablets by mouth three times a day for pain, date ordered 10/17/2025. R2's "Physician Orders" documented acetaminophen extended release 650 mg, give one tablet by mouth every six hours as needed for pain, date ordered 11/02/2025. R2's EMAR documented that R2 received the as-needed acetaminophen extended release on 08/25/2026 at 07:45 AM for a pain scale of 10, which was documented as ineffective. R2's "Physician Orders" documented meloxicam (anti-inflammatory medication for pain) 7.5 mg, give one tablet by mouth one time a day for chronic pain, date ordered 01/21/2026. R2's "Physician Orders" documented oxycodone (opioid for pain) 5 mg, give one tablet three times a day for pain, date ordered 08/15/2026 and discontinued on 08/24/2026. R2's EMAR documented that R2 received her last scheduled dose of oxycodone on 08/24/2026 at 05:00 AM. R2's "Physician Orders" documented oxycodone 5 mg, give one tablet every two hours as needed for	F0684		

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F0684 SS = D	Continued from page 17 pain, date ordered 08/21/2026 and discontinued on 08/24/2026. R2's EMAR documented that R2 received the as-needed oxycodone 5 mg tablet last on 08/24/2026 at 02:30 PM. R2's "Physician Orders" documented oxycodone oral solution 5mg/5 milliliters (mL), give 5 mL by mouth every eight hours for severe pain, date ordered 08/24/2026. R2's EMAR documented on 08/25/2026 at 07:40 AM: oxycodone oral solution 5mg/5 mL, give 5 mL by mouth every eight hours for severe pain not available. R2's "Progress Note" on 08/21/2026 at 06:00 PM documented R2 had increased inconsolable anxiety throughout this shift while she was awake. R2 crawled out of her low bed onto her fall mat. Once she was assisted up and into her wheelchair, she requested to lay back down. R2 was assisted into a recliner in the east lobby where she continued to holler out in a loud sobbing cry. R2 complained of pain in her shoulders. As needed, Ativan (antianxiety medication) and oxycodone were administered per orders throughout the shift. R2's son was notified; he voiced agreement that use of as-needed medications should be utilized for R2's comfort. R2's "Progress Note" on 08/23/2026 at 09:55 AM documented R2 was hollering out loud upon arrival to her room. Staff observed her lying on the fall mat next to her low bed. R2 reported she had to use the bathroom. As needed, Ativan and oxycodone were administered per orders; she was able to swallow the meds crushed and in water without difficulty. Resident then consumed her breakfast with meal set up without difficulty. R2 sat in the east lobby after breakfast and began tearfully hollering out again. Staff administered as-needed Ativan per orders, again crushed and in water. R2's untimed "Hospice Note" dated 08/24/2026 documented the facility called because R2 was having difficulty swallowing. The facility requested a new order to crush medications or give liquids. R2 appeared unwilling to open her mouth to take her medications. She was spoken to in a calm manner to open her mouth as a Certified Medication Aide (CMA) administered crushed oxycodone, and a report was given to Licensed Nurse (LN) H. T Observation on 08/24/2026 at 07:55 AM revealed R2 was in her room hollering out loud help she was	F0684		

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F0684 SS = D	Continued from page 18 laying on her mattress that was on the floor next to her low bed. Observation on 08/24/2026 at 11:40 AM revealed R2 was lying in her low bed with the fall mattress next to the bed. Her eyes were closed; she declined the interview, stating she was tired. Observation on 08/24/2026 at 01:43 PM revealed R2 was calling out and from in her room as she lay in her low bed. There were two unknown staff members in her room from dietary, she called out that she hurt. Observation on 08/24/2026 at 04:16 PM revealed R2 was in her low bed, making loud noises of moaning and moving around in the low bed. Observation on 08/25/2026 at 07:55 AM revealed R2 lay in her low bed. She was moaning and very difficult to understand. Observation on 08/25/2026 at 08:41 AM revealed R2 lay in her low bed with the fall mattress next to her bed. She was moaning and moving around in her bed using the side rails, crying and moaning, "I hurt". Observation on 08/25/2026 at 9:06 AM revealed R2 was on her mattress on the floor. LN I, Certified Nurse Aide (CNA) O, and CNA N were in the room. R2 moaned as she lay on the mattress on the floor and cried out, “I'm hurting.” The staff positioned R2 on a blanket on the mattress as they rolled her over side to side and slid her over to the lifting device and positioned her legs. CNA O talked to R2 and asked her a few times if she was ok and if she had pain as R2 continued to moan. The staff was able to have R2 stand to assist her in her wheelchair. Observation on 08/25/2026 at 09:25 AM revealed R2 was moaning and had a facial grimace as CNA O and CNA N transferred R2 with the mechanical lift into her bed. R2 said out loud, “It hurts too much.” Once R2 was in bed and lying flat, R2 stopped moaning and relaxed. CNA O and CNA N provided incontinent care. R2 grimaced and moaned when they rolled her in her bed. Observation on 08/25/2026 at 09:30 AM revealed Consultant Staff HH (Hospice CNA) entered R2’s room after she knocked, and she told CNA N and CNA O that she was going to give R2 a shower. Observation on 08/25/2026 at 09:32 AM revealed CNA O and CNA N transferred R2 back into her	F0684		

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F0684 SS = D	Continued from page 19 wheelchair using the mechanical lift. R2 continued to moan and state, “I’m hurting.” CNA O stated, “I am going to check with the nurse to see the last time she had something for pain.” On 08/25/2026 at 09:40 AM, Consultant Staff HH propelled R2 out of the room towards the shower room. CNA O reported that she thought R2 had been in pain and that is why she asked her if she was ok. CNA O said she believed R2 had pain medication that morning and would be reporting R2’s pain to the nurse. CNA N reported that she thought R2 was in pain during the cares provided and would let the nurse know. Observation on 08/26/2026 at 08:46 AM revealed R2 was out of bed in her wheelchair; CNA reported that R2 appeared comfortable when she got her up. CMA S entered R2's room with her medications, and R2 swallowed the liquid medications. CMA S reported that R2 was much more comfortable than she was the previous day. On 08/25/2026 at 09:56 AM, CMA S reported that she could not give R2 her oxycodone pain medication as it was a liquid and they did not have it available this morning. CMA S reported that R2 had not been taking any of her medications by mouth, but she was able to give her the as-needed acetaminophen tablet this morning. CMA S reported she was preparing an oxycodone 5mg tablet now, as soon as LN H entered that order in the computer. On 08/25/2026 at 09:59 AM, LN H reported she expected the staff to let the nurse know if a resident was having pain before they provided care, and if the resident was safe. LN H reported the tablet form of the oxycodone was discontinued yesterday, and the facility was waiting for the pharmacy to deliver the liquid oxycodone. On 08/25/2026 at 10:05 AM, LN I reported that she did assess R2 for pain before the staff assisted her up from the mattress on the floor. LN I reported that she thought the medication aide had given her pain medication already this morning and did confirm that R2 was in pain while she lay on the mattress on the floor. On 08/25/2026 at 09:46 AM, Administrative Nurse D reported that she spoke to the Pharmacy just a few minutes prior about R2's liquid medications to request they be delivered to the facility. Administrative Nurse D verified hospice had ordered the medications the previous day. She went on to say that she had been required to contact the	F0684		

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F0684 SS = D	Continued from page 20 hospice provider as they had not sent the prescriptions to the pharmacy to fill for the new orders, and that is the cause of the liquid medications not being available. Administrative Nurse D reported that the CMA must have crushed R2's acetaminophen that morning and placed it in pudding for administration. Administrative Nurse D did not know why the staff had not provided R2's oxycodone since the previous day at 02:30 PM. On 08/25/2026 at 01:17 PM, Consultant Staff II (Hospice Registered Nurse) reported that typically the pharmacy would provide the medications that were ordered the same day, but with R2's liquid oxycodone, she had other medications that could not be crushed, and hospice had to take care of that. Consultant Staff II reported that the hospice nurse was in the facility to evaluate R2 the previous day and stated that the hospice nurse had educated LN H that R2's Ativan and oxycodone could be crushed until the liquid form came to the facility. She expected the facility to give pain medications. Consultant II stated if there was a concern with R2's pain management or orders, the facility could have called the hospice provider at any time day or night. The facility's "Hospice Policy," dated 07/2017, documented in general, it is the responsibility of the facility to meet the resident's personal care and nursing needs in coordination with the hospice representative and ensure that the level of care provided is appropriately based on the individual resident's needs. These responsibilities include the following, but not limited to: Communicating with the hospice provider (and documenting such communication) to ensure that the needs of the resident are addressed and met 24 hours per day. Providing medical supplies, durable medical equipment, and medications necessary for the palliation of pain and symptoms. The facility's policy "Pain Management," undated, documented that effective pain management can remove the adverse psychological and physiological effects of unrelieved pain. Optimal management of the elders experiencing pain enhances healing and promotes both physical and psychological wellness. Management of the elder's pain is an interdisciplinary process.	F0684		
F0689 SS = D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents.	F0689		

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F0689 SS = D	Continued from page 21 The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, and interview, the facility failed to provide an environment free from accident for Resident (R) 8, and R48 when the residents were transferred by Hoyer (total body mechanical lift) lift and staff removed their hands from the lift sheet while the residents were suspended in the air. Findings included: 1. R8's Electronic Medical Record (EMR) documented diagnoses of multiple sclerosis (MS-progressive disease of the nerve fibers of the brain and spinal cord), muscle weakness, and a history of falling. R8's "Significant Change Minimum Data Set" (MDS), dated 05/11/2026, documented a Brief Interview for Mental Status (BIMS) score of 10, which indicated moderately impaired cognition. R8's "Falls Care Area Assessment" (CAA), dated 05/11/2026, documented that R8 had falls triggered secondary to impaired gait and mobility and level of assistance required with transfers. Contributing factors included history of falls prior to admission, acute illness, weakness and physical performance limitations that affected balance, gait, strength, and muscle endurance. R8's "Care Plan", dated 03/23/2026 and revised on 03/27/2026, documented she required staff assistance with activities of daily living (ADL) and was transfer dependent with use of the Hoyer lift. Observed on 08/24/2026 at 08:39 AM, Certified Medication Aide (CMA) R and Certified Nurse Aide (CNA) N transferred R8 from her wheelchair to her recliner with the Hoyer lift. CMA R moved the wheelchair over by the bed once R8 was lifted into the air with the Hoyer while CNA N transferred R8 with the Hoyer lift by pushing it and no staff had contact with R8 while she was transferred. CMA R	F0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175124	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEPOINT EL DORADO, LLC	**1313 S HIGH STREET , EL DORADO, Kansas, 67042**

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F0689 SS = D	Continued from page 22 walked behind the recliner, and when R8 was positioned over the recliner, she then grabbed the strap on the lift sheet and guided her down into the recliner. 2. R48's EMR documented diagnoses of radiculopathy (a pinched or damaged nerve root in the spine), diabetes mellitus (DM), major depressive disorder, anxiety, and obesity. R48's "Admission MDS," dated 02/05/2026, documented a BIMS score of 15, which indicated no cognitive impairment. The MDS documented R48 was dependent on part of his hygiene & dressing activities of daily living (ADLs). The MDS documented that R48 used a wheelchair for mobility and was dependent on staff when in his wheelchair. R48 was coded as not attempted due to medical condition or safety concerns with regard to transfers and mobility. R48's "Care Plan", dated 06/05/2025, documented R48 was at risk for injuries related to falls due to unsteady gait, poor balance, poor safety awareness, impulsiveness, behaviors, and neurological back problems that caused his legs to give out. The care plan further documented that R48 was able to transfer with stand-by to minimal assistance related to weakness and impaired safety awareness. Staff was instructed to assist R48 with getting up from the floor, and they could use the mechanical lift. A care plan intervention dated 05/03/2026 instructed staff to use a large transfer sling, and an intervention dated 08/27/2026 instructed that R48 was to be transferred with two staff and they were to use a Hoyer lift. Observed on 08/25/2026 at 10:32 AM, CMA R stood one foot behind R48 while he was suspended in the air and transferred with the Hoyer lift into his wheelchair. Staff did not place their hands on R48 during the transfer. On 08/24/2026 at 08:50 AM, CNA N stated that a resident transfer with the Hoyer lift required two staff members for the safety of the resident. On 08/25/2026 at 10:46 AM, Licensed Nurse G reported that she expected staff to place their hands on the resident and guide them with the lift sling any time the resident was transferred with the Hoyer lift. 08/25/2026 at 4:04 PM, Administrative Nurse D reported that all CNAs were to always maintain contact and to keep their hands on the resident	F0689		

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F0689 SS = D	Continued from page 23 when they were transferred with the Hoyer lift. The facility policy “Mechanical Lift Transfer,” dated 01/03/2019, documented that residents of this community who are unable to transfer themselves independently or with maximal assistance or who are unable to bear any weight will be transferred safely with the mechanical lift device, which has been assessed to be the right lift for the needs of each resident. At least two nursing personnel are required to transfer a resident when using a mechanical Hoyer (total) lift.	F0689		
F0700 SS = D	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is NOT MET as evidenced by: Based on interview, observation, and record review, the facility failed to obtain informed consent from the residents or the resident’s legal representative for installation of bedrails for Resident (R) 48. Findings include: - R48’s Electronic Medical Record (EMR) documented diagnoses of radiculopathy (a pinched or damaged nerve root in the spine), diabetes	F0700		

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F0700 SS = D	Continued from page 24 mellitus (DM), major depressive disorder, anxiety, and obesity. The “LPE Enabler Bar Assessment-V3,” dated 08/07/2026, documented that enabler bars were not in use for this resident. R48’s EMR lacked informed consent for bed rails. R48’s Care Plan dated 06/05/2025 lacked documentation that R48 had bed rails attached to his bed. Observed on 08/25/2026 at 10:11 AM, R48 had upper side rails on each side of his bed. On 08/25/2026 at 03:35 PM, Licensed Nurse G reported the enabler bar assessment dated 08/07/2026 did not contain the information that enabler bars were used. On 08/25/2026 at 03:59 PM, Administrative Nurse D reported that she expected the charge nurse to have performed the enabler bar assessment on the 08/07/2026 resident review assessment. The facility did not provide a policy for the use of bed rails.	F0700		