STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175565	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNPORCH OF SMITH COUNTY	**920 E KANSAS AVE , SMITH CENTER, Kansas, 66967**

(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) COMPLETION DATE
F0000	INITIAL COMMENTS The following citations represent the findings of a Health Recertification Survey. The census was 21. The sample included 12 residents.	F0000		
F0947 SS = F	Required In-Service Training for Nurse Aides CFR(s): 483.95(g)(1)-(4) §483.95(g) Required in-service training for nurse aides. In-service training must- §483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. §483.95(g)(2) Include dementia management training and resident abuse prevention training. §483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.71 and may address the special needs of residents as determined by the facility staff. §483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and record review the facility failed to ensure three of the five nurse aides reviewed had the required 12 hours of in-service. Findings included: - Review of the facility provided training logs revealed the following:	F0947		

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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F0947 SS = F	Continued from page 1 Certified Nurse Aide (CNA) M, with a hire date of 04/18/2020, lacked any hours of the 12 in-service hours required in 12 months. CNA N, with a hire date of 08/06/2018, lacked any hours of the 12 in-service hours required in 12 months. CNA O, with a hire date of 07/11/2024, lacked any hours of the 12 in-service hours required in 12 months. On 09/16/2026 at 11:15 AM, Administrative Nurse D verified the three CNAs worked as needed (PRN) at the facility approximately four hours a month and worked full time at the hospital and the facility lacked a system in place for the PRN aides to complete their yearly 12-hour in-services. Administrative Nurse D verified it should be completed yearly and stated she would get a Performance Improvement Plan (PIP) started on that right away. The facility “In-Service Training, All Staff” policy, undated. documented all staff must participate in initial orientation and annual in-service training. All staff are required to participate in regular in-service education. In-service education participation is considered at working times for which staff are paid their regular wages. The primary objective of the in-service training is to ensure that staff can interact in a manner that enhances the residents’ quality of life and quality of care and can demonstrate competency in the topic of the training. Training requirements are met prior to staff providing services to residents annually, and as necessary based on the facility assessment. Complete training is documented by the staff development coordinator, or his or her designee, and includes the date of the training, the topic of the training, the method used for training, a summary of the competency assessment; and the hours of training complet	F0947		
F0812 SS = E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved	F0812		

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F0812 SS = E	Continued from page 2 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 store, prepare, distribute, and serve food by professional standards for food service safety in one of two kitchens. Findings included: - On 09/15/2026 at 08:15 AM, during observation of one household kitchen, the refrigerator had a black plastic container with unrecognizable food in it that was not dated; and the gallon jug of milk was not dated. The cabinet that had spices had a lot of debris on the bottom of the cabinet. The cabinet that had foil and plastic wrap had a brown sticky substance had run down the door and pooled on the bottom of the cabinet. On 09/15/2026 at 09:00 AM, Dietary BB stated staff has a sheet that tells them what was to be cleaned on a daily basis and verified the above concerns in the kitchen. On 09/16/2026 at 11:30 AM, Certified Nurse Aide (CNA) P took the temperatures of the chicken fried steak, Brussel sprouts, and gravy, but forgot to take the temperature of the mashed potatoes and cauliflower. CNA P served two residents mashed potatoes and cauliflower. CNA P stated she should have taken the temperature of the food but she was nervous, as she was not the staff person that usually served meals. On 09/16/2026 at 03:00 PM, Dietary BB stated CNA	F0812		

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F0812 SS = E	Continued from page 3 P was nervous and should have remembered to take all of the food temperatures prior to serving. The facility's “Food Preparation and Service” undated policy documented that proper hot and cold temperatures are maintained during food distribution and service. Foods that are held in the temperature “danger zone” are discarded after four hours. The facility’s “Sanitation” policy, dated 11/22, documented all kitchens, kitchen areas, and dining areas are kept clean, free from garbage and debris, and protected from rodents and insects. All utensils, counters, shelves, and equipment are kept clean, maintained in good repair, and free from breaks, corrosion, open seams, cracks, and chipped areas that may affect their use or proper cleaning.	F0812		
F0605 SS = D	Right to be Free from Chemical Restraints CFR(s): 483.10(e)(1),483.12(a)(2),483.45(c)(3)(d)(e) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any . . . chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must-. . .	F0605		

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F0605 SS = D	Continued from page 4 §483.12(a)(2) Ensure that the resident is free from . . . chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. . . . . §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic. §483.45(d) Unnecessary drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. §483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;	F0605		

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F0605 SS = D	Continued from page 5 §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is NOT MET as evidenced by: Based on observations, interviews, and record review, the facility failed to ensure an appropriate indication, or a documented physician rationale which included the unsuccessful attempts for nonpharmacological symptom management and risk versus benefits for the continued use for Resident (R) 7 and R17's Seroquel (an antipsychotic). Findings included: - The Electronic Medical Record (EMR) for R7 documented diagnoses of dementia with behavioral disturbance (a progressive mental disorder characterized by failing memory and confusion), psychosis (any major mental disorder characterized by a gross impairment in reality perception), anxiety (a mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), and major depressive disorder (a major mood disorder that causes persistent feelings of sadness). The "Annual Minimum Data Set" (MDS), dated 11/20/2025, documented R7 had moderately	F0605		

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F0605 SS = D	Continued from page 6 impaired cognition. R7 required partial staff assistance for showers, dressing, personal hygiene, and ambulation. The MDS further documented R7 received antipsychotic (a class of medications used to treat major mental conditions), antianxiety (a class of medications used to calm and relax people), and antidepressant (a class of medications used to treat mood disorders) medications daily, and had no behaviors. The “Quarterly MDS,” dated 08/04/2026, documented moderately impaired cognition. R7 required substantial staff assistance with oral hygiene, dressing, and personal hygiene. The MDS further documented R7 received antipsychotic, antianxiety, and antidepressant medications daily and had no behaviors. The 07/01/2026 “Care Plan” documented the following interventions for R7: 07/03/2018- Pharmacy reviews monthly or per protocol. 01/13/2023- Behavior monitoring. 07/09/2024 – Administer medications as ordered; monitor for side effects and effectiveness every shift. 01/07/2025 - Ensure magnetic locks are locked on the door when R7 is wandering or wants to leave the facility. 02/06/026 – Psychotropic consent education provided to elder and responsible party. The “Physician’s Order,” dated 06/10/2024, directed staff to administer Seroquel, 25 milligrams (mg), by mouth, every day for behaviors. The medication was discontinued on 06/25/2024. The “Physician’s Order,” dated 06/25/2024, directed staff to administer Seroquel, 25 mg, by mouth, every day for major depressive disorder. The medication was discontinued on 07/10/2024. The “Physician’s Order,” dated 07/10/2024, directed staff to administer Seroquel, 12.5 mg, by mouth, every day, for psychosis. This medication was discontinued on 05/13/2026. The “Physician’s Order,” dated 05/13/2025, directed staff to administer Seroquel 25 mg, give 12.5 mg by mouth twice daily for psychosis. This medication was discontinued on 05/19/2026.	F0605		

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F0605 SS = D	Continued from page 7 The “Physician’s Order,” dated 05/19/2026, directed staff to administer Seroquel 25 mg, give 12.5 mg by mouth every day for psychosis. R5’s EMR lacked physician documentation of the unsuccessful attempts for nonpharmacological symptom management and a risk versus benefits statement. On 09/15/2026, R7 sat in the living room in a recliner; she had multiple times when she would get up from her chair and leave her walker. Staff would redirect her back to the recliner. On 09/16/2026 at 12:59 PM, Certified Nurse Aide (CNA) P stated that R7 exit seeked a lot, and they have to keep an eye on her. She will often be up for most of the night and then will be very tired a couple of days later. On 09/16/2026 at 03:00 PM, Licensed Nurse (LN) H stated R7 often went into another resident's room and could get bossy with staff. R7 used to be a CNA and wants to be in charge. LN H further stated that R7 does not get aggressive with other residents, just staff. They have to redirect her a lot and keep an eye on her. On 09/16/2026 at 03:15 PM, Administrative Nurse D stated that the pharmacist would send risk versus benefit to the physician, but he would just write that the benefit was greater than the risk and would not elaborate or provide an appropriate indication for the use of Seroquel. The facility’s “Psychotropic Medication Use” policy, dated 02/2025, documented that residents do not receive psychotropic medications that are not clinically indicated and necessary to treat a specific condition documented in the medical record. Psychotropic medication management is an interdisciplinary process that involves the resident, family, and/or the representative and includes determining adequate indications for use. Adequate indications for use refer to the identified, documented clinical rationale for administering medication. The clinical rationale for the use of psychotropic medication or a change from one type of psychotropic to another is documented in the medical record. Documentation must include that behavioral (nonpharmacological) interventions were attempted but not successful, and these interventions were deemed clinically contraindicated, and the rationale for this conclusion. Alternately, documentation from a physician must describe that alternative treatments are clinically contraindicated	F0605		

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F0605 SS = D	Continued from page 8 and the rationale for this conclusion. - The EMR for R17 documented diagnoses of dementia with behavioral disturbance (a progressive mental disorder characterized by failing memory and confusion) and psychosis (any major mental disorder characterized by a gross impairment perception). The “Admission MDS” dated 05/31/2026, documented R17 had severely impaired cognition. R17 required substantial staff assistance with toileting, ambulation, and supervision with dressing and transfers. The MDS further documented R17 received antipsychotic and antianxiety medications daily and had no behaviors. The “Quarterly MDS,” dated 08/25/2026, documented R17 had severely impaired cognition. R17 required substantial staff assistance with lower body dressing, showers, and partial staff assistance with upper body dressing, transfers, and supervision. The MDS further documented that R17 received antipsychotic and antianxiety medication daily and had no behaviors. The 09/09/2026 “Care Plan” documented the following interventions for R17: 05/27/2026 – Medications would be reviewed by the pharmacist consultant monthly, by a physician every 60 days, and by both as needed. 06/12/26- Monitor and record occurrence of target behaviors and document per facility protocol. Administer psychotropic medications as ordered by the physician and monitor for side effects. 09/12/2026 – R17 has become increasingly difficult to redirect and often refuses care. When R17 refuses care, tell her that “Mom says so,” as this tactic was effective when family cared for her at home. The “Physician’s Order,” dated 06/01/2026, directed staff to administer quetiapine fumarate (antipsychotic medication), 150 milligrams (mg), one tablet daily for psychosis. On 09/15/2026 at 01:49 PM, R17 independently ambulated out of her room without her walker. Staff offered her a cup of coffee and had her sit in the dining room. R17 had been up and out of her room multiple times without her walker. On 09/16/2026 at 01:01 PM, Certified Nurse Aide (CNA) P stated that in the evenings, R17 would exit	F0605		

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F0605 SS = D	Continued from page 9 seek, and they provided her with reminders. CNA P stated she does not usually go into other residents' rooms and was easily redirectable. On 09/16/2026 at 03:00 PM, Licensed Nurse H stated staff does not know how she will be day to day. R17 required medication last night because she was exit-seeking and not redirectable. On 09/16/2026 at 03:15 PM, Administrative Nurse D stated that the pharmacist would send risk versus benefit to the physician, but he would just write that the benefit was greater than the risk and would not elaborate or provide an appropriate indication for the use of Seroquel. The facility's "Psychotropic Medication Use" policy, dated 02/2025, documented that residents do not receive psychotropic medications that are not clinically indicated and necessary to treat a specific condition documented in the medical record. Psychotropic medication management is an interdisciplinary process that involves the resident, family, and/or the representative and includes determining adequate indications for use. Adequate indications for use refer to the identified, documented clinical rationale for administering medication. The clinical rationale for the use of psychotropic medication or a change from one type of psychotropic to another is documented in the medical record. Documentation must include that behavioral (nonpharmacological) interventions were attempted but not successful, that these interventions were deemed clinically contraindicated, and the rationale for this conclusion. Alternately, documentation from a physician must describe that alternative treatments are clinically contraindicated and the rationale for this conclusion.	F0605		
F0761 SS = D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal	F0761		

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F0761 SS = D	Continued from page 10 laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to label Resident (R) 5 insulin flex pen when opened for use and when outdated. Findings included: - On 09/15/2026 at 12:30 PM, observation of the medication room revealed the R 5's Lantus (long-acting insulin) flex pen was not labeled with an opened date or an expired date. On 09/15/2026 at 12:35 PM, Licensed Nurse G verified the nurses should label and date the insulin flex pens and insulin vials with the date opened and date expired. On 09/16/26 at 09:15 AM, Administrative Nurse D verified the nurses should label and date the insulin flex pens and insulin vials with the date opened. Medlineplus.gov directs open, unrefrigerated Lantus can be used within 28 days; after that time, they must be discarded. The facility's "Storage of Medication" policy, undated, documented, the facility would store all biologicals in a safe, secure, and orderly manner. The nursing staff would be responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner. The facility shall not use discontinued, outdated, or deteriorated drugs or biologicals and all such drugs shall be returned to the pharmacy or destroyed.	F0761		