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	N087041	A. BUILDING: _____ B. WING _____	C 09/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNINGSTAR MEMORY CARE	1240 N BROADMOOR AVENUE WICHITA, KS 67206

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS The following citations represent the findings of a Health Licensure Resurvey and Complaint survey regarding allegations in the following complaints: 199639, 199648, 198519, 198430, 195081, and 194898, conducted on 08/31/26 and 09/01/26. The facility reported a census of 35 residents. The sample included 4 residents.	S 000		
S 100 SS=D	26-39-103 (a) RESIDENT RIGHTS a) Protection and promotion of resident rights. Each administrator or operator shall ensure the protection and promotion of the rights of each resident as set forth in this regulation. Each resident shall have a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the adult care home. This STANDARD is not met as evidenced by: K.A.R. 26-39-103 (a) Resident Rights Based on interview and record review the facility failed to ensure each resident had a dignified existence for one of four residents reviewed for resident rights, Resident (R)3. The failure resulted in staff escorting R5 into R3's room on 08/22/26 at 01:07 AM while R3 was in his bed. R5 walked over to R3 while he was in bed and started speaking to R3 while he remained in his bed with staff standing and observing the interaction. R5 was bent over R3 while he remained in his bed and appeared to be speaking to him. The interaction lasted for approximately 6 minutes while staff continued to observe the interaction. This action violated R3's right to a	S 100		

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

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S 100	Continued From page 1	S 100		

dignified existence.

R3 diagnoses included hypertension and dementia.

The 02/20/26 Functional Capacity Screen revealed R3 had impaired short-term, long-term, memory recall, and decision making. R3 was identified at risk for falls, wandering and impaired decision making. The comments section contained the following documentation: R3's sleeping pattern was not consistent and R3 was up a lot during the night. R3 would stand up and fall asleep. Staff were to monitor this and intervene.

The 02/20/26 Negotiated service agreement lacked services to be provided for R3 for wandering and the support of a consistent sleeping pattern. The document further lacked healthcare services to be provided to R3 when he was awake during the nighttime hours.

R3 admitted on 02/07/25 and required physical assistance with bathing and dressing, monitoring for falls, wandering, and impaired decision making.

The health service plan dated 02/20/26 instructed facility staff to offer resident appropriate activities based on R3's interest, and monitor R3 for sitting on the edge of his bed. Staff were instructed to check on R3 throughout the day to prevent him from sitting on the edge of the bed, and to encourage him to sit in his recliner or loveseat, or to lay flat on his bed. "Due to his insomnia, he will sit on the edge of the bed and doze off, putting him at risk for falls".

Review of the facility provided Ring Video footage

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provided to the facility by R3's Durable Power of Attorney revealed the following on 08/22/26:

At 01:07 AM R3's room lights are out and R3 appeared to be in bed. The apartment door opened and Certified Nurse Aide (CNA) C enters the room and allowed R5 to enter the room and walk to R3's side of the bed where she proceeds to be speaking to R3 while he is in bed. CNA C remained in the apartment kitchen and turned on the kitchen light at 01:08 AM and remained at the door to the apartment while R5 was at the bedside. CNA C walked over and observed the interaction between R3 and R5.

At 01:09 AM R5 bent over the bed and continued to speak to R3 and then stood straight and appeared to have a short conversation with CNA C while they remained at R3's bedside.

At 01:10 AM R5 continued to speak to R3 and shook her finger at R3 while he remained in his bed while R5 stood over him. Staff continued to observe the interaction.

At 01:11 AM CNA C went to R3's closet shut the door and reopened the closet door after R5 said something to her. CNA C went through the clothes hanging in R3's closet and pulled out a long sleeved gray shirt while R5 watched her. R5 then walked over to CNA C to look at the shirt that was pulled from R3's closet while he remained in bed.

At 01:12 AM R5 walked over to R3's closet where CNA C was continuing to go through the hanging clothes in R3's closet. R3 remained in bed. CNA C with the long sleeved shirt on the hanger in her hand and R5 walk back over to R3's bed and speak to him. CNA C then walked to the

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S 100	Continued From page 3 apartment door with the shirt shaking her head back and forth in a no gesture, while R5 remained talking to R3 at his bed side. At 01:13 AM CNA C turns the light off in R3's kitchen apartment and R5 went to the apartment door where they exited R3's apartment. R3 remained in bed. CNA C and R5 were in R3's apartment uninvited for 6 minutes. The surveyor reviewed CNA C's "Employee Disciplinary Form" dated 08/27/26 which showed CNA C showed poor judgement by allowing another resident to into another resident room without consent. CNA C continued to utilize poor judgement by allowing R5 to attempt to correct R3. On 09/02/26 at 04:21 PM Operator A and Licensed Practical Nurse B confirmed R3's family provided camera footage during a meeting which showed CNA C and R5 in R3's room. Operator A and LPN B confirmed an investigation was opened on the incident with the finding of CNA C using poor judgement which was a violation of R3's rights. As a result R3 had his right to a dignified existence violated.	S 100		
S 190 SS=D	26-39-102 (e) Admission, Transfer, Discharge (e) Before a resident is transferred or discharged involuntarily, the administrator or operator, or the designee, shall perform the following: (1) Notify the resident, the resident ' s legal representative, and if known, a designated family	S 190		

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member of the transfer or discharge and the reasons; and
(2) record the reason for the transfer or discharge under any of the circumstances specified in paragraphs (d) (1) through (4) in the resident ' s clinical record, which shall be substantiated as follows:
(A) The resident's physician shall document the rationale for transfer or discharge in the resident ' s clinical record if the transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met by the adult care home;
(B) the resident's physician shall document the rationale for transfer or discharge in the resident ' s clinical record if the transfer or discharge is appropriate because the resident's health has improved sufficiently so that the resident no longer needs the services provided by the adult care home; and
(C) a physician shall document the rationale for transfer or discharge in the resident ' s clinical record if the transfer or discharge is necessary because the health or safety of other individuals in the adult care home is endangered.

This REQUIREMENT is not met as evidenced by:
K.A.R. 26-39-102 (e) (2) (A) (C) Admission, Transfer, Discharge

Based on interview and record review, the facility failed to record the reason for the transfer or discharge in the resident record. The facility failed to substantiate the reason for the transfer or discharge with documentation from the physician which documented the rationality that included the resident welfare, and needs could not be met

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by the adult care home. The facility continued to fail to substantiate the rationality for the resident discharge because the health or safety of other individuals in the adult care home was endangered for one of four residents reviewed for admission, transfer, and discharge, Resident (R)1.

R1 diagnoses included Parkinson's disease, muscle weakness, and need for assistance with personal care.

The 03/02/26 Functional Capacity Screen (FCS) revealed R1 required physical assistance with bathing, dressing, toileting, transferring, and eating. R1 required a walker and wheelchair mobility device and was identified to be at risk for falls and unsteadiness. R1 was identified to have intact cognition, and R 1 was able to make himself understood and he understood others.

The 03/02/26 Negotiated Service Agreement (NSA) revealed qualified personnel would provide assistance for bathing, toileting, mobility, transferring, dressing, and incontinence needs.

The 03/02/26 NSA lacked health services for falls and unsteadiness.

The 04/02/26 FCS for significant change of condition revealed R 1 now required assistance with all tasks related to toileting and transferring and required a wheelchair. R1 had impaired short-term memory, memory recall, and decision making. R1 was identified to have difficulty making decisions and/or made decisions which were harmful or potentially harmful to the resident.

The 04/02/26 NSA revealed the addition of the

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following health care services:

Psychiatric services. R1 displayed verbal aggression towards staff. Staff were to explain the task prior to the task being performed for reassurance.

Special Personal Care Needs. R1 may need total assistance with transfers, may not be able to stand at times, not able to walk, and there were times R1 was not able to get out of a chair or bed.

The 04/02/26 NSA lacked services for impaired cognition and impaired decision making.

R1 admitted on 03/03/26 and required physical assistance with bathing, dressing, toileting, transferring, walking/mobility, and eating.

The service plan dated 04/09/26 instructed facility staff R1 was unable to ambulate and used a high back wheelchair. R1 required the assistance of two staff members and a gait belt for safe transferring. R1 required moderate assistance with dressing, bathing, and two staff members for toileting. Staff were to provide night checks throughout the sleeping hours by qualified personnel.
The 04/09/26 service plan lacked instructions to staff for R1's impaired cognition and impaired decision making.

Review of the 02/10/26 at 11:42 AM provider "Progress Note" revealed R1 was combative at times and required restraints during the acute stay at the local hospital. R1 would intermittently refuse medications and cares. R1 could be impulsive, combative, and confused with exit seeking behaviors. The provider documented unable to obtain an accurate review of symptoms

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due to dementia.

Review of the "Progress Notes" dated 03/03/26 to 04/09/26 revealed the following entries:

On 03/03/26 at 02:19 PM an admission to the facility note.

The note lacked documentation of R1 having a history of being resistant to cares or having inappropriate behaviors.

On 03/04/26 at 09:08 PM a nursing note revealed R1 had no behaviors observed on shift, and R1 was calm and cooperative with cares.

On 03/09/26 at 01:33 PM R1 refused the gait belt for transferring. Staff reported R1 would not bear weight and was a two-person assist at times.

On 03/11/26 at 02:49 PM a behavior note revealed R1 had been verbally aggressive with staff and exhibited anxious behavior. The primary care provider was notified of R1's anxious behavior.

On 03/14/26 at 11:15 AM a fall note revealed R1 was found at 04:20 AM on the floor of his room. R1 stated he needed to use the restroom and staff assisted R1 off of the floor and to the toilet.

On 03/14/26 at 12:09 PM R1 was sent by ambulance to the local hospital at approximately 09:20 AM for an unresponsive episode.

On 03/14/26 at 03:47 PM a clinical note revealed R1 was admitted to the local hospital for sepsis.

On 03/16/26 at 04:39 PM R1 re-admitted to the facility. R1 arrived in a wheelchair and was a two

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person assist for transfers.

On 03/19/26 at 04:09 PM a clinical note revealed there were times when R1 was unable to stand and assist with transfers, and R1 needed a higher level of care.

On 03/19/26 at 04:21 PM a clinical note revealed R1 participated in physical therapy with an outside provider.

On 03/22/26 at 01:06 PM a clinical note revealed ambulance was called for R1 on 03/21/26 at 10:02 PM to transport R1 the local hospital for treatment of chest pain. Upon the ambulance arrival R1 refused to be transported to the local hospital for treatment.

On 03/29/26 at 02:44 PM a clinical note revealed R1 refused to stand up and assist with activities of daily living for most of the weekend prior. When staff would attempt to assist R1 to stand up with a gait belt, R1 would throw himself back or try to dangle his legs. Interventions attempted prior to standing did not resolve R1's refusal.

On 03/30/26 at 01:37 PM R1 was able to stand with a two-person assistance and a gait belt, and he was able to transfer from the wheelchair to the toilet with two-person assistance.

On 04/01/26 at 03:57 PM a clinical note revealed the facility Executive Director called and spoke with R1's Durable Power of Attorney to obtain a date of when they would be moving R1 out of the facility which could better care for him.

On 04/03/26 at 09:04 PM a clinical note revealed R1 was demanding towards staff and did not want to help stand himself, and he wanted to do

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things his way. R1 was a two-person assist for bedtime activities of daily living and proper use of a gait belt.

On 04/04/26 at 10:58 PM a clinical note revealed R1 was up during first and second shift self-propelling his wheelchair throughout the facility and asking for assistance when needed. R1 remained a two-person assist for transferring and toileting. Staff reported R1 did attempt to try and help by using the grab bars to hold himself up in a standing position.

On 04/07/26 at 05:00 PM a clinical note revealed a local skilled facility agreed to an emergency admission on 04/09/26.

Review of the 03/30/36 "30 Day Involuntary Discharge Notice" revealed the facility was issuing a 30-day involuntary discharge effective on 04/01/26. The reason for the discharge was identified R1's current care needs exceeded the scope of services that the facility was licensed and able to provide within a assisted living/memory care setting. "Specifically, the facility is no longer able to safely meet his medical and/or behavioral care needs without exceeding regulatory limitations". The health and safety of R1 and/or other residents may be at risk, and/or R1's care required a higher level of clinical support and supervision that permitted in an assisted living memory care environment. Transfer and discharge of the resident agreement, a resident may be involuntarily discharged for the following reasons, including, but not limited to the safety of individuals in the facility would be endangered and the health of individuals in the facility would be endangered.

Review on 08/31/26 of the "Resident Roster"

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S 190	Continued From page 10 revealed the facility had a census of 35 residents. The roster revealed the following: 22 out of 35 residents required physical assistance with activities of daily living. 01 out of 35 residents required the physical assistance of two people. Interview on 09/01/26 at 04:21 PM with Operator A and Licensed Practical Nurse (LPN) B confirmed R1 posed no safety threat to other residents. LPN B continued to confirm the safety threat was to staff when R1 would dangle his feet and not assist with transferring. LPN B confirmed the admission FCS and NSA did not identify or plan for R1's history of behaviors or resistance to cares. LPN B confirmed R1's record lacked substantiation from the primary care provider identifying R1's needs could not be met by the facility, and R1 was a danger to others. As a result, R1 received an involuntary discharge from the facility and moved out of the facility on 04/09/26. R1 was admitted to the facility for 33 days.	S 190		
S3171 SS=D	26-41-204 (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: K.A.R. 26-41-204 (i) Health Care Services	S3171		

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S3171	Continued From page 11 Based on observation, interview, and record review the facility failed to ensure health care services were provided within professional standards of practice when an assessment was not performed every 365 days for bed assist devices that ensured the devices posed no risk for entrapment, confirmed the devices were not a restraint, and the residents ability to safely use the devices for one of four residents sampled, Resident (R)2. R2 diagnoses included dementia, major depressive disorder, muscle weakness, and pain in the right knee. The 02/24/26 Functional Capacity Screen revealed R2 required a two person staff assist for transferring and a wheelchair for mobility. R2 was identified at risk for falls. The 02/24/26 Negotiated Service Agreement identified the facility would provide R2 two-person physical assistance to get into and out of the bed and chair. R2 would be encouraged to stay in the facility television room all day/evening and sleeping hours. R2 had a safety bed assist device in place on her bed for mobility. R2 admitted on 06/29/25 and required physical assistance with all activities of daily living, eating, and mobility. R2 required supervision for safety. The health service plan dated 02/24/26 directed staff to provide a two-person assistance for transferring. R2 was unable to get in and out of bed or chair without total physical assistance of two staff members. Observation on 09/01/26 at approximately 03:00	S3171		

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S3171	Continued From page 12 PM, R2's bed sat against the northeast corner of the room. There appeared to be a specialized mattress in the bed. On the left and the right sides of the upper section of the bed were bed assist devices that were a circular on top with a straight bar which protruded from the bottom of the device. The circle measured approximately thirteen inches in diameter with six small bars within the diameter of the circle to prevent entrapment. The circle was secured to the bed frame by the straight bar. Review of the 06/04/25 "Assistive Device Safety Evaluation" revealed the device was to promote independence, safely assist with bed mobility or transfer, resident was ambulatory, resident had a history of falling, and resident had difficulty with balance or poor trunk control. The reason for the device was documented as the resident had been falling out of bed; history of falls near bed. R2 was documented as able to safely and appropriately utilize the device for mobility purposes, and there were no cognitive limitations noted in the use of the device. The device was identified to be on the left side of the bed. Interview on 09/01/26 at 04:21 PM with Operator A and Licensed Practical Nurse (LPN) B confirmed the assessment for R1's bed assist device was greater than 365 days old, and LPN B continued to confirm R1's bed had two bed assist devices. 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.	S3171		

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MORNINGSTAR MEMORY CARE	1240 N BROADMOOR AVENUE WICHITA, KS 67206

(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
S3171	Continued From page 13 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 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. Include a description of the device, its purpose and special instructions on use and monitoring in the resident's NSA. 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. The failure placed R2 at risk for injury and restraint when she was not reassessed to show her ability to safely use the devices and confirm the devices did not limit her ability to freely move in the bed.	S3171		