STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046044	A. BUILDING: _____ B. WING _____	C 10/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRUSTWELL LIVING OF MISSION SPRINGS II	5350 WEST 61ST PLACE MISSION, KS 66205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS The following represents the findings of a resurvey with attached complaint 199941, 199710, 198934, 198127, 195171 and 194968 at the above named facility conducted on 10/14/26, 10/15/26 and 10/19/26. The facility reported a census of 43 residents. The sample included five residents.	S 000		
S3261 SS=E	26-41-105 (f) (11) Resident Record Documentation of Incidents (f) (11) documentation of all incidents, symptoms, and other indications of illness or injury including the date, time of occurrence, action taken, and results of the action This REQUIREMENT is not met as evidenced by: KAR 26-41-105(f)(11) Based on observation, interview, and record review the facility failed to ensure licensed staff documented all incidents, symptoms, indications of illness or injury including the dates, times, actions taken, and results of the actions for Resident (R)3. Findings included: - Record review for R3 revealed an admission date of 12/01/25 with diagnosis of traumatic brain injury. The 08/27/26 "Functional Capacity Screen" (FCS) identified R3 was unable to perform management	S3261		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046044	A. BUILDING: _____ B. WING _____	C 10/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRUSTWELL LIVING OF MISSION SPRINGS II	5350 WEST 61ST PLACE MISSION, KS 66205

(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
S3261	Continued From page 1	S3261		

of treatments and was at risk for falls.

The 08/27/26 "Negotiated Service Agreement" (NSA) identified R3 received staff notification to the Health Services Director (HSD) and/or clinical support if there were any changes in her skin for management of treatments. The "NSA" documented R3 was unsteady on her feet. Staff kept her apartment free from clutter and encouraged her and her husband to use their call pendant for assistance and R3 received frequent safety checks every shift and as needed for falls.

The 09/24/26 at 11:08 AM "Incident - Normal Entry" nursing note created on 09/24/26 at 09:18 PM AM documented a Certified Medication Aide (CMA) notified the nurse at 11:08 AM that R3 was observed on the floor of her apartment with an abrasion on her right upper arm.

The 09/24/26 at 11:57 AM "General - Normal Entry" nursing note created on 09/24/26 at 11:58 AM documented a CMA notified the nurse at 11:36 AM that R3 had an injury fall with a skin tear on her right upper arm.

The 10/09/26 at 07:30 PM "Observation" nursing note documented a CMA reported to the nurse R3 was on the floor of her apartment with a deep gash on her right arm. The nurse instructed the CMA to call Emergency Medical Services (EMS) to transport R3 to the hospital.

The 10/10/26 at 02:15 AM nursing "Observation" nursing note documented a CMA reported to the nurse R3 returned from the hospital to the facility with her husband.

The 10/14/26 "Skin Monitoring: Comprehensive CNA Shower Review" form for R3 was signed by

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046044	A. BUILDING: _____ B. WING _____	C 10/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRUSTWELL LIVING OF MISSION SPRINGS II	5350 WEST 61ST PLACE MISSION, KS 66205

(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
S3261	Continued From page 2	S3261		

Certified Nurse Aide (CNA) H. The form had handwritten markings near "bruising" and "rashes." The form included a body chart with markings on the back side of the left upper leg. The "Charge Nurse Signature" and "DON Signature" lines were blank.

Review of R3's record from 09/01/26 to 10/19/26 lacked follow-up documentation after a fall on 09/24/26 and skin tear. R3's nursing progress notes also lacked follow-up documentation after a fall on 10/09/26, visit to the emergency department, and a gash on her arm. R3's nursing progress notes lacked evidence of documentation of a bruise on her left side.

Observation on 10/15/26 at approximately 12:08 PM revealed R3 had a dark purple bruise that measured approximately 7.0 x 4.0 inches.

On 10/15/26 at approximately 12:08 PM an unidentified family member stated R3 fell "not more than two days ago" and he did not know if she hit her head. Sometimes he witnessed her fall and sometimes he heard her fall from another room.

On 10/19/26 at approximately 12:22 PM Administrative Nurse B confirmed R3's record lacked follow-up documentation after a fall on 09/24/26 with a skin tear and lacked follow-up documentation after a fall on 10/09/26 with a gash on her arm and a visit to the emergency department. Administrative Nurse B also confirmed R3's nursing progress notes lacked evidence of documentation of a bruise on her left side.

The facility's 04/01/26 "Assessments, Reviews, and Monitoring" policy documented residents

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046044	A. BUILDING: _____ B. WING _____	C 10/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRUSTWELL LIVING OF MISSION SPRINGS II	5350 WEST 61ST PLACE MISSION, KS 66205

(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
S3261	Continued From page 3 were monitored for changes in physical, cognitive, or functional status and documentation reflected the resident's condition. The operator failed to ensure licensed staff documented all incidents, symptoms, indications of illness or injury including the dates, times, actions taken, and results of the actions for R3.	S3261		
S3310 SS=F	26-41-207 (b) (5-6) (c) Infection Control Policies (b) (5) prohibiting any employee with a communicable disease or any infected skin lesions from coming in direct contact with any resident, any resident ' s food, or resident care equipment until the condition is no longer infectious; (6) providing orientation to new employees and employee in-service education at least annually on the control of infections in a health care setting; and (c) Each administrator or operator shall ensure the facility ' s compliance with the department ' s tuberculosis guidelines for adult care homes adopted by reference in K.A.R. 26-39-105 This REQUIREMENT is not met as evidenced by: KAR 26-41-207(c) Based on interview and record review the facility failed to remain in compliance with the department's tuberculosis (TB) guidelines for adult care homes adopted by reference in KAR 26-39-105 for three of five sampled staff.	S3310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046044	A. BUILDING: _____ B. WING _____	C 10/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRUSTWELL LIVING OF MISSION SPRINGS II	5350 WEST 61ST PLACE MISSION, KS 66205

(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
S3310	Continued From page 4 Findings included: - Review of Certified Medication Aide (CMA) E's employee record revealed a hire date of 03/11/26. Her record lacked evidence of documentation she received TB infection testing. Review of CMA F's employee record revealed a hire date of 05/11/26. Her record lacked evidence of documentation she received TB infection testing. On 10/14/26 at approximately 02:14 PM Administrative Staff C confirmed CMA's E, F and G records lacked evidence of documentation of TB infection testing. The 04/01/26 facility's "Tuberculosis Screening" policy documented staff completed baseline tuberculosis screening prior to hire as part of the onboarding process. The June 2013 department's "Tuberculosis (TB) Guidelines for Adult Care Homes" documented each new employee should receive a two-step TB skin test within seven days of employment. The facility failed to remain in compliance with the department's tuberculosis guidelines for adult care homes adopted by reference in KAR 26-39-105.	S3310		