STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087071	A. BUILDING: _____ B. WING _____	C 10/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHISHOLM PLACE	1859 N. WEBB ROAD WICHITA, KS 67206

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S 000	INITIAL COMMENTS The following citations represent the findings of a Complaint survey of the above named facility regarding allegations in the following complaints: 199989, 199867, 199859, and 199860 conducted on 10/15/26 and 10/19/26. The facility reported a census of 59 residents. The sample included 4 residents.	S 000		
S3026 SS=E	26-41-101 (f) (1) Staff Treatment of Residents ANE (f)The administrator or operator shall ensure that all of the following requirements are met: (1) No resident shall be subjected to any of the following: (A) Verbal, mental, sexual, or physical abuse, including corporal punishment and involuntary seclusion; (B) neglect; or (C) exploitation. This REQUIREMENT is not met as evidenced by: K.A.R. 26-41-101 (f) (1) (A) Administration Based on record review and interview the facility failed to ensure Certified Nurse Aide (CNA) D did not threaten or subject residents to menacing conduct that resulted or might reasonably be expected to result in fear or emotional or mental distress for two of four residents sampled, Resident's (R)'s 3 and 4. R3 admitted to the facility on 09/29/23, R3's diagnoses included anorexia, anxiety disorder, dementia, difficulty in walking, major depressive disorder, long term use of anticoagulants, and	S3026		

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

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S3026	Continued From page 1	S3026		

pain.

The 10/01/26 Functional Capacity Screen (FCS) revealed R3 was unable to perform bathing, dressing, toileting, and transferring. R3 required supervision with mobility and eating. R3 was incontinent, had impaired short-term memory, and impaired decision making. R3 was able to make herself understood and she understood others. R3 was identified at risk for falls, impaired vision, and impaired decision making. R3 used a wheelchair and mechanical sling lift mobility devices.

The 06/16/26 combined Negotiated Service Agreement (NSA)/Health Service Plan (HSP) revealed facility staff would provide two staff members for providing bed baths, total assistance with dressing, two staff members for toileting assistance every two hours, transferring resident required two staff members and a mechanical sling lift, provide safety checks four times a shift, and face to face check on residents status every two hours.

The surveyor reviewed the 09/17/26 "Facility Investigation" which revealed on 09/17/26 at 06:20 PM, CNA D responded to R3's room and found R3 sitting on the foot pedals of her wheelchair. CNA D called for assistance in getting R3 back into her wheelchair. CNA E went to R3's room to assist and overheard CNA D tell R3 "You don't know how bad I want to hit/punch you in the back of the head for being a dumb [expletive]."

Review of the notarized 09/17/26 "Witness Statement" signed by CNA E revealed as she approached R3's room she overheard CNA D tell R3 "You don't know how bad I want to hit/punch you in the back of the head for being a dumb

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S3026	Continued From page 2	S3026		

[expletive]."

R4 admitted to the facility on 05/01/25, R4's diagnoses included anorexia, mild dementia, chronic atrial fibrillation, chronic obstructive pulmonary disease, depression, gait instability, fracture and repair of the right femoral neck, heart failure, mixed anxiety and depressive disorder and paraplegia.

The 10/08/26 FCS revealed R4 required physical assistance with bathing, toileting, and dressing. R4 required supervision with transferring, walking and eating. R4 was occasionally incontinent of bowel and bladder. R4 had impaired short term memory and decision making. R4 was identified at risk for falls, socially inappropriate disruptive behavior, and impaired decision making. R4 used a walker and wheelchair mobility device.
The combined NSA/HSP revealed R4 required physical assistance with bathing, dressing, and toileting. R4 required two staff members for transferring. R4 required one staff member for wheelchair mobility. The facility would provide R4 three meals and three snacks daily. Staff were to provide safety checks four times per shift, and face to face check on R4 every two hours.

The surveyor reviewed the 09/25/26 "Facility Investigation" which revealed on 09/16/26 CNA D was overheard telling R4 she would not give him his snack or a drink due to R4 refusing his medications. CNA D continued to tell R4 she should drink R4's juice in front of him.

Review of the notarized 09/17/26 "Witness Statement" signed by CNA E revealed R4 had refused to take his medications and CNA D told R4 since he did not take his medications R4 was not allowed to have anything to eat or drink and

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S3026	Continued From page 3 CNA D should sit and drink his juice "in front of his face". Interview on 10/09/26 with Administrator A confirmed CNA D had immediately been suspended pending the facility investigation and terminated. Administrator A continued to confirm both allegations of abuse were reported to local law enforcement. As a result R3 and R4 were subjected to menacing conduct might reasonably be expected to result in fear or emotional or mental distress.	S3026		
S3028 SS=D	26-41-101 (f) (3) Staff Treatment of Residents Reporting (f) (3) Each allegation of abuse, neglect, or exploitation shall be reported to the administrator or operator of the facility as soon as staff is aware of the allegation and to the department within 24 hours. The administrator or operator shall ensure that all of the following requirements are met: (A) An investigation shall be started when the administrator or operator, or the designee, receives notification of an alleged violation. (B) Immediate measures shall be taken to prevent further potential abuse, neglect, or exploitation while the investigation is in progress. (C) Each alleged violation shall be thoroughly investigated within five working days of the initial report. Results of the investigation shall be reported to the administrator or operator. (D) Appropriate corrective action shall be taken if the alleged violation is verified. (E) The department ' s complaint investigation report shall be completed and submitted to the department within five working days of the initial report.	S3028		

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S3028	Continued From page 4 (F) A written record shall be maintained of each investigation of reported abuse, neglect, or exploitation. This REQUIREMENT is not met as evidenced by: K.A.R. 26-41-101 (f) (3) Administration Based on record review and interview the facility failed to ensure each allegation of abuse was reported to the Administrator of the facility as soon as staff were aware of the allegation for one of four residents sampled, Resident (R) 4. R4 admitted to the facility on 05/01/25, R4's diagnoses included anorexia, mild dementia, chronic atrial fibrillation, chronic obstructive pulmonary disease, depression, gait instability, fracture and repair of the right femoral neck, heart failure, mixed anxiety and depressive disorder and paraplegia. The 10/08/26 FCS revealed R4 required physical assistance with bathing, toileting, and dressing. R4 required supervision with transferring, walking and eating. R4 was occasionally incontinent of bowel and bladder. R4 had impaired short term memory and decision making. R4 was identified at risk for falls, socially inappropriate disruptive behavior, and impaired decision making. R4 used a walker and wheelchair mobility device. The combined NSA/HSP revealed R4 required physical assistance with bathing, dressing, and toileting. R4 required two staff members for	S3028		

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S3028	Continued From page 5	S3028		

transferring. R4 required one staff member for wheelchair mobility. The facility would provide R4 three meals and three snacks daily. Staff were to provide safety checks four times per shift, and face to face check on R4 every two hours.

The surveyor reviewed the 09/25/26 "Facility Investigation" which revealed on 09/16/26 CNA D was overheard telling R4 she would not give him his snack or a drink due to R4 refusing his medications. CNA D continued to tell R4 she should drink R4's juice in front of him. "The alleged interaction occurred on 09/16/26 and reported to the evening shift nurse and clinical service director on 09/17/26.

Review of the notarized 09/17/26 "Witness Statement" signed by CNA E revealed R4 had refused to take his medications and CNA D told R4 since he did not take his medications R4 was not allowed to have anything to eat or drink and CNA D should sit and drink his juice "in front of his face".

Interview on 10/09/26 with Administrator A confirmed CNA D had immediately been CNA E failed to immediately report an allegation of abuse as soon as she was aware to the Administrator.

As a result R4's allegation of abuse was not immediately investigated.