STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175448	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABERDEEN VILLAGE	**17500 W 119TH STREET , OLATHE, Kansas, 66061**

(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 Risk-Based Survey Process was used to conduct a federal recertification survey. The Health Recertification Survey on the above-named facility resulted in the findings of the following citations. The census was 54. The sample included six residents.	F0000		
F0558 SS = D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is NOT MET as evidenced by: Based on interviews, observation, and record review, the facility failed to ensure reasonable accommodations were provided for Resident (R) 3 and R4 staff propelled the residents in their wheelchairs without providing foot pedals when pushed their wheelchair. The facility also failed to provide call lights for R13 and R14 to communicate their needs and wants to the staff. Findings included: - On 11/10/2026 at 08:01 AM, Certified Nurse Aide (CNA) M pushed R19 down the hall to breakfast. R19 did not have foot pedals. On 11/10/2026 at 08:02 AM, CNA M pushed R46 from the dining area to her room. CNA M asked R46 to pick her feet up. On 11/10/2026 at 08:22 AM, R13 sat in the recliner in the center of his room, his call light was on the floor under the bed out of his reach. On 11/10/2026 at 08:30 AM, R14 laid on the bed, and her call light lay on the floor between her bedside stand and the bed out of her reach.	F0558		

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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F0558 SS = D	Continued from page 1 On 11/10/2026 at 01:22 PM, CNA O stated call lights should be within the residents reach when in the room. The call light should be pinned to the bed or on the resident's chest when in bed. CNA O stated that residents being pushed by staff should have foot pedals on their wheelchairs to prevent injuries if their feet fell to the ground while being pushed. On 11/10/2026 at 01:39 PM, Licensed Nurse (LN) H stated call lights should always be placed within the reach of the resident. LN H stated not all residents require foot pedals on their wheelchairs. On 11/10/2026 at 02:27 PM, Administrative Nurse D stated she expected all call lights to be within the reach of every resident. She stated she expected staff to provide foot pedals for all residents being propelled by staff. The facility's "Resident Call System" policy dated 05/03/2019 documented the facility strived to provide an environment to promote resident safety, dignity, and sense of well-being. The facility would be equipped and maintained to protect the health and safety of the residents.	F0558		
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,	F0605		

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F0605 SS = D	Continued from page 2 involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must-. . . §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	F0605		

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F0605 SS = D	Continued from page 3 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; §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 observation, Interview and record Review, the facility failed to ensure Resident (R)2 was free from unnecessary psychotropic medication and potential chemical restraints, the facility failed to ensure R2's as-needed lorazepam (antianxiety medications that calm and relax people) had a stop date, or a specified duration with a physician's rationale for extended use. Findings Included: - R2's Electronic Medical Record (EMR) from the "Diagnosis" tab documented diagnoses of dementia (a progressive mental disorder characterized by	F0605		

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F0605 SS = D	Continued from page 4 failing memory and confusion), anxiety (mental or emotional reaction characterized by apprehension, uncertainty), muscle weakness, and encounter for palliative care. The “Quarterly Minimum Data Set (MDS)” dated 09/23/2026 documented a Brief Interview of Mental Status (BIMS) score of zero which indicated severely impaired cognition. The MDS documented R2 had received an opioid (a class of controlled drugs used to treat pain), and antianxiety (a class of medications that calm and relax people) medication during the observation period. R2's "Psychotropic Drug Use Care Area Assessment (CAA)”, dated 06/25/2026 documented R2 was at risk for potential injuries/complications related to the use of her medications, related to the potential signs and symptoms of side effects and adverse reactions, she may have more falls, increase in her cognitive loss, which may cause her to have more poor decisions, and skin breakdown due to increase in urinary and bowel incontinence. R2 's “Care Plan,” documented the following interventions: 11/18/2024-Pharmasict reviews R18’s medication monthly. R18 took medication that had a Black Box Warning (BBW- highest safety-related warning that medications can have assigned by the Food and Drug Administration). 07/07/2026- R18 took Lorazepam (antianxiety medication), staff were to monitor side effects. R2‘s EMR under the “Orders” tab revealed the following physician orders: Lorazepam oral tablet 0.5 milligram (mg) give 1 tablet by mouth every 4 hours as needed for agitation or restlessness dated 10/23/2026. R2’s as needed Lorazepam order lacked a stop date or a physician’s rationale for extended use. On 11/10/2026, R2 sat in her Broda chair (specialized wheelchair with the ability to tilt and recline) in the commons area rubbing her hands together. On 11/10/2026 at 01:32 PM, Licensed Nurse (LN) G stated all as needed Lorazepam should have a stop date. He stated the only time the order would not	F0605		

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F0605 SS = D	Continued from page 5 have a stop date was if hospice ordered the medication for a long period of time. LN G stated all other Lorazepam orders should have an initial 14 day stop date. On 11/10/2026 at 02:27 PM, Administrative Nurse D stated all as needed Lorazepam orders should have a stop date. She stated the nurse taking the order should ensure there was a stop date when taking the order. Administrative Nurse D stated in the weekly nursing meeting all orders were reviewed, and if nursing had missed the documentation for a stop date, the pharmacist would catch any abnormalities in a resident's medication. The facility's "Psychoactive Psychopharmacological Medication" policy dated 02/03/2025 documented Psychoactive medication would not be used for discipline or convenience and would not be used unless necessary to treat medical symptoms. Psychotropic medication was to be used only when a practitioner determines that the medication was appropriate to treat a residents specific diagnosed and documented condition and the medication was beneficial to the resident as demonstrated by monitoring and documentation of the resident's response to the medication.	F0605		
F0686 SS = D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is NOT MET as evidenced by: Based on observations, record review, and interviews, the facility failed to ensure pressure-reducing measures were implemented for	F0686		

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F0686 SS = D	Continued from page 6 Resident (R)18 when staff failed to apply R18's boots to both feet at all times, per her orders and plan of care. Findings included: - R18's Electronic Medical Record (EMR) from the "Diagnosis" tab documented diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), dementia (a progressive mental disorder characterized by failing memory and confusion), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), and major depressive disorder (major mood disorder that causes persistent feelings of sadness) The "Quarterly Minimum Data Set (MDS)" dated 07/17/2026 documented a Brief Interview of Mental Status (BIMS) score of three, which indicated severely impaired cognition. The MDS documented R18 was dependent on staff for toileting. The MDS documented R18 was at risk for pressure ulcer/injury, and no pressure ulcers during the observation period. R18's "Pressure Ulcer/Injury Care Area Assessment" (CAA) dated 12/22/2025 documented R18 was at risk for potential pressure related injuries/ulcers, bruising, skin tears, skin irritation, rashes, R18 did have very thin and fragile skin, she does have bowel and bladder incontinence, she does have dementia with poor decision making. R18 had poor appetite and had weight loss, she and her family have elected hospice services. The CAA documented staff would monitor skin and notify physicians of any changes. R18's "Care Plan" documented: 04/28/2025-R18 was at risk to pressure ulcer development due to her diagnosis. 09/03/2026-Staff were to always apply boots to both feet. Staff apply skin-prep (liquid skin protectant) to the area on right great toe daily. R18's EMR under "Orders" documented the following physicians' orders: Apply boots to both feet at all times. Offload heels with pillows while in bed every shift for protection to heels dated 06/01/2026.	F0686		

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F0686 SS = D	Continued from page 7 Apply skin prep to bilateral heels once a shift for prevention of skin breakdown every shift dated 09/28/2026. R18's EMR lacked documentation for the refusal of boots. On 11/10/2026 at 12:02 PM, R18 lay on her back on her bed. R18's green boots lay on the floor across from her bed. R18 did not have a pillow to offload her heels. R18's heels lay directly on her mattress. On 11/10/2026 at 01:32 PM, Licensed Nurse (LN) G stated if a resident needed to wear boots, or have their heels floated, that would be on the "Treatment Administration Record" (TAR). He stated the nurse could ask the Certified Nurse's Aide (CNA) to apply the residents' boots, but the nurse should go check before signing the TAR. On 11/10/2026 at 02:27 PM, Administrative Nurse D stated all nursing staff was responsible to apply boots on a resident if they were to have boots. She stated boots to be applied were on the TAR for the nurse to sign off. She stated if there was an order, the boots should have been on R18. The facility's "Pressure Ulcer/Injury Prevention, Nursing Intervention and Wound Treatment" policy dated 03/20/2026 documented all residents were considered to have a potential risk for the development of pressure ulcers. Nursing staff would evaluate skin integrity, implement preventative measures as indicated, and treat skin breakdown. The primary care provider admission orders would authorize approval before they were used for an established skin wound treatment guidelines. Dressing changes were performed by a licensed nurse. Licensed nursed may delegate minor skin tear treatments and preventative treatments on closed area to Certified Medication Aides (CMAs) who have received appropriate skin care training.	F0686		
F0689 SS = D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. 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	F0689		

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F0689 SS = D	Continued from page 8 supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, and interviews, the facility failed to assess Resident (R) 18's ability to safely operate a lift chair recliner prior to the use of the recliner. Findings included: - R18's Electronic Medical Record (EMR) from the "Diagnosis" tab documented diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), dementia (a progressive mental disorder characterized by failing memory and confusion), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), and major depressive disorder (major mood disorder that causes persistent feelings of sadness) The "Quarterly Minimum Data Set (MDS)" dated 07/17/2026 documented a Brief Interview of Mental Status (BIMS) score of three which indicated severely impaired cognition. The MDS documented R18 was dependent on staff for toileting and had no falls since admission or re-entry during the observation period. R18's "Falls Care Area Assessment (CAA)", dated 12/22/2025 documented R18 was at risk for falls and injuries associated with falls, R18 had very thin and fragile skin that could tear during a fall, she was at risk for other injuries as well, she is very unsteady, she has had two non-injury falls this look back. The CAA documented that R18 had dementia with poor decision making, her and her family have elected hospice services, R18 could have more frequent falls as she gets closer to end of life. Staff monitored for falls and had put interventions in place. R18's "Care Plan," documented the following interventions: 04/28/2025-R18 was a high risk for falls due to her diagnosis. 05/21/2026- A noninjury fall, staff were to be aware of any unusual activity near R18's room R18 would attempt to get up without her walker. Staff put a stop sign across R18's door to prevent other residents from entering her room.	F0689		

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F0689 SS = D	Continued from page 9 R18's EMR, under the "Progress Notes" under "Incident Note" tab revealed the following "Nursing Note" dated 10/31/2026 at 02:12 AM staff responded to R18 calling for help. Upon arrival the Licensed Nurse (LN) and Certified Nurses Aide (CNA) found R18 sitting on the floor in front of her recliner. R18's back was leaning on the recliner, and her legs were under the bedside table. R18 had raised the recliner all the way up and it appeared she had slid off the recliner. R18 did not hit her head. Staff assessed range of motion, which was active all extremities. Staff assisted R18 into her wheelchair. R18's EMR under Assessment documented a "Root Cause" dated 10/31/2026 that recorded the resident sometimes would use any remote for different things such as TV remote to call for help or the recliner remote for the TV. R18's EMR under "Assessments" recorded a Lift chair Evaluation dated 11/02/2026 documented R18 was unable to manage assistive devices. Review of R18's EMR lacked an initial lift chair assessment prior to R18 receiving a lift recliner chair. On 11/10/2026 at 01:32 PM, Licensed Nurse (LN) G stated the nurse on duty was responsible for ensuring a device assessment was performed prior to the resident getting a recliner or a lift chair. He stated families check with the nurse to ensure the resident is getting a chair the resident could use. On 11/10/2026 at 02:27 PM, Administrative Nurse D stated the facility failed to do an initial lift chair assessment. She stated an assessment should have been performed or the remote for the chair shouldn't have been in R18's room. The facility's "Falls" policy dated 08/10/2026 documented residents would be identified for risk of falls and interventions implemented to reduce the risk.	F0689		
F0880 SS = D	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	F0880		

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F0880 SS = D	Continued from page 10 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: §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.	F0880		

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F0880 SS = D	Continued from page 11 §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. §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 record review, observations, and interviews, the facility failed to establish and maintain an effective infection prevention and control program to prevent the potential spread of infection when staff failed to perform hand hygiene after carrying a clear trash bag to the soiled utility room and then assisting residents. Findings Included: - On 11/110/2026 at 08:01 AM, Certified Nurse Aide (CNA) M pushed R19 to the dining room, carrying a dirty gown and a clear white trash bag with a soiled brief and a green paper chuck. CNA M threw the trash bag in the bin in the soiled utility room, removed his gloves, and pushed R46 into her room, CNA M then went into R34's room to help him dress. CNA M did not perform hand hygiene between tasks, removing dirty gloves or between residents. On 11/10/2026 at 01:28 PM, CNA M stated hand hygiene should be performed when gloves were removed, before and after cares with a resident, or when hands were soiled. On 11/10/2026 at 01:32 PM, Licensed Nurse (LN) G stated hand hygiene should be performed after and before cares with residents, and while serving food. He stated hand washing should be done when your hands were soiled. On 11/10/2026 at 02:27 PM, Administrative Nurse D stated there were numerous times a day hand hygiene should be performed, touching anything soiled, between residents, serving food, and hand washing should be performed when hands were	F0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175448	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F0880 SS = D	Continued from page 12 visibly dirty. The facility's "Hand Hygiene" policy dated 02/03/2025 documented all staff members would comply with current Centers for Disease Control and Prevention (CDC) hand hygiene guidelines, as effective hand hygiene reduces the incidence of healthcare associated infections.	F0880		