STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175078	A. Building B. Wing	06/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy at College Hill	5005 E 21st Street North Wichita, KS 67208

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to provide adequate supervision to prevent accidents for Resident (R) 71, who required assistance with bathing. On 04/27/2026 at 08:00 PM, R71 self-propelled himself into an unlocked shower room, then came out and waved down Certified Nurse Aide (CNA) M to request assistance with shaving. CNA M assisted R71 with shaving and then left the resident alone in the shower to complete his own shower. While staff were out of the shower room, R71 slipped and hit his chin on the shower bar. Approximately two hours later, R71 began to feel nauseous. He vomited, reported a headache, and requested to go to the hospital. R71 went to the emergency department, where he was diagnosed with a subdural hematoma (SDH-serious condition, typically caused by head injury, where blood collects between the skull and the surface of the brain) and was subsequently placed on a ventilator. The resident returned to the facility on [DATE] on hospice and died in the facility on 05/06/2026. This placed R71 in immediate jeopardy. The facility further failed to identify causative factors for falls and develop and implement interventions to prevent further falls for R68 and R6, and failed to ensure a safe, accident-free environment when staff propelled R8 in his wheelchair without the use of foot pedals. Findings Included:- R6's Electronic Health Record (EHR) documented diagnoses of difficulty in walking, weakness, abnormal posture, lack of coordination, and anxiety. R6's admission Minimum Data Set, dated 05/01/2026, documented a Brief Interview for Mental Status score of 15, which indicated intact cognition. R6's Falls Care Area Assessment (CAA), dated 05/01/2026, documented that he triggered for falls due to daily antianxiety medication use, therefore increasing his risk for falls. R6's Functional Ability CAA, dated 05/01/2026, documented that R6 required partial or moderate assistance with lower body dressing, donning, and doffing footwear. He required supervision or touching assistance with walking and setup, clean-up assistance for meals. He had recently admitted and was working with Physical Therapy, Occupational Therapy, and Speech Therapy for strengthening. The Nursing - Clinical admission Evaluation - V 4.0 - - V 6 dated 04/24/2026 documented R6 was a moderate risk for falls. The Nursing - Clinical admission Evaluation - V 4.0 - - V 6 dated 05/12/2026 documented R6 was a high risk for falls. R6's Care Plan dated 04/25/2026 addressed oxygen therapy to assist with ambulation as indicated. The care plan did not address a fall risk and lacked interventions related to fall prevention. (continued on next page)

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 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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R6's Fall Incident Report dated 05/11/2026 documented R6 had a fall as he was walking in the hall and felt himself going down and tried to use his right hand to prevent a fall that resulted in R6 going to the hospital for shoulder pain. There was no post fall intervention documented. On 06/01/2026 at 01:01 PM, observation revealed R6 ambulated with a walker and one staff assistance including a gait belt. During an interview on 06/03/2026 at 09:38 AM, Certification Medication Aide (CMA)S stated that R6 was not a fall risk as she had checked the care plan before her shift, but said he would call for assistance as he used a portable oxygen tank and a walker. During an interview on 06/03/2026 at 09:45 AM, Licensed Nurse (LN) J stated R6 was a fall risk, and it should be in his care plan as he had a recent fall. LN J was a standby assist due to being off balance and on oxygen. During an interview on 06/03/2026 at 01:45 PM, Administrative Nurse D stated that staff would know if a resident was a fall risk by looking at their care plan, huddle, or during rounds with staff. Administrative Nurse D stated that to ensure resident safety after a fall that it would be investigated as to why it happened, education would be provided, and it would be put in the care plan as a fall precaution. Administrative Nurse D stated that all resident falls should be updated in the resident care plan as a fall risk with an intervention. R6's Electronic Health Record (EHR) documented diagnoses of difficulty in walking, weakness, abnormal posture, lack of coordination, and anxiety. R6's admission Minimum Data Set, dated 05/01/2026, documented a Brief Interview for Mental Status score of 15, which indicated intact cognition. R6's Falls Care Area Assessment (CAA), dated 05/01/2026, documented that he triggered for falls due to daily antianxiety medication use, therefore increasing his risk for falls. R6's Functional Ability CAA, dated 05/01/2026, documented that R6 required partial or moderate assistance with lower body dressing, donning, and doffing footwear. He required supervision or touching assistance with walking and set-up, clean-up assistance for meals. He had recently admitted and was working with Physical Therapy, Occupational Therapy, and Speech Therapy for strengthening. The Nursing - Clinical admission Evaluation - V 4.0 - - V 6 dated 04/24/2026 documented R6 was a moderate risk for falls. The Nursing - Clinical admission Evaluation - V 4.0 - - V 6 dated 05/12/2026 documented R6 was a high risk for falls. R6's Care Plan dated 04/25/2026 addressed oxygen therapy to assist with ambulation as indicated. The care plan did not address a fall risk and lacked interventions related to fall prevention. R6's Fall Incident Report dated 05/11/2026 documented R6 had a fall as he was walking in the hall and felt himself going down and tried to use his right hand to prevent a fall that resulted in R6 going to the hospital for shoulder pain. There was no post fall intervention documented. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 06/01/2026 at 01:01 PM, observation revealed R6 ambulated with a walker and one staff assistance including a gait belt. During an interview on 06/03/2026 at 09:38 AM, Certification Medication Aide (CMA)S stated that R6 was not a fall risk as she had checked the care plan before her shift, but said he would call for assistance as he used a portable oxygen tank and a walker. During an interview on 06/03/2026 at 09:45 AM, Licensed Nurse (LN) J stated R6 was a fall risk, and it should be in his care plan as he had a recent fall. LN J was a standby assist due to being off balance and on oxygen. During an interview on 06/03/2026 at 01:45 PM, Administrative Nurse D stated that staff would know if a resident was a fall risk by looking at their care plan, huddle, or during rounds with staff. Administrative Nurse D stated that to ensure resident safety after a fall that it would be investigated as to why it happened, education would be provided, and it would be put in the care plan as a fall precaution. Administrative Nurse D stated that all resident falls should be updated in the resident care plan as a fall risk with an intervention. The facility policy Fall Prevention Program, dated 02/01/2026 date reviewed/revised 03/10/2026, documented that each resident would be assessed for fall risk and would receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls. - R8's Electronic Health Record (EHR) documented diagnoses of pneumonia (an infection in the lungs due to inhalation of food and vomit), sepsis (a life-threatening systemic reaction that develops due to infections that cause inflammation throughout the entire body), altered mental status (state of awareness that was different from the normal awareness of a person), neuropathy and neuralgia (weakness, numbness, and pain from nerve damage, usually in the hands and feet), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), and hypertension (HTN-elevated blood pressure). R8's Modification of admission Minimum Data Set (MDS), dated 12/22/25, documented a Brief Interview for Mental Status (BIMS) score of 15, which indicated no cognitive impairment. R8 required a wheelchair for mobility. The MDS documented that R8 required supervision or touching assistance with a walker and for most of his other activities of daily living (ADL). R8's 12/22/25 Falls Care Area Assessment (CAA) documented R8 is at risk of falls and has an increased risk of falling due to the neuropathy in his bilateral lower extremities. The CAA documented R8's internal risk factors are neuromuscular with neuropathy, perceptual with vision impairment, and cognitive impairment. R8's Quarterly MDS, dated 03/24/26, documented a BIMS score of 14, which indicated no cognitive impairment. R8 was independent with mobility in a wheelchair and independent to supervision or touching assistance for most of his other ADLs. The MDS also documented R8 had one non-injury fall. R8's Care Plan, dated 12/18/25, documented he was at risk for falls due to impaired balance, poor safety awareness, neuromuscular and functional impairment and/ or the use of medications that may increase fall risks related to a history of repeated falls and neuropathy. R8's Fall Risk Evaluation, dated 03/31/26, documented that he was a high fall risk. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R8's Rehab Post Fall Evaluation, dated 03/31/26, documented a fall on 03/30/26 at 10:45 PM and further documented R8 used a wheelchair as an assistive device. Observed on 06/01/26 at 08:45 AM, staff pushed R8 in a wheelchair without foot pedals, R8's legs were bent at the knee, and his feet were positioned just above the floor. Observed on 06/01/26/26 at 09:05 AM, R8 transferred himself into bed without assistance. On 06/01/26 at 08:45 AM, Certified Nurse Aide (CNA) QQ reported residents should not be pushed in a wheelchair without foot pedals on their wheelchairs. She knew she had been caught pushing [R8] in his wheelchair without his foot pedals and further reported she knows she is not supposed to do that. On 06/02/26 at 11:50 AM, Licensed Nurse (LN) I reported that staff should find the foot pedals for the wheelchair and use them any time they are pushing a resident in their wheelchair, and further reported that all residents that have wheelchairs also have foot pedals available for use on their wheelchairs. On 06/02/26 at 01:15 PM, Administrative Nurse D reported staff were to use foot pedals when pushing a resident in their wheelchair. The facility fall prevention policy dated 02/01/26, with date reviewed/revised 03/10/26, documents that each resident will be assessed for fall risk and will receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls.

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. Based on review and interviews, the facility failed to facilitate and ensure the resident council was able to meet regularly. Findings included:- Record review of the Resident Council Meeting revealed the facility had no minutes or meetings for the months of May 2025 through May 2026.On 06/02/26 at 02:00 PM, Resident (R) 3 stated the Resident Council had not met on a regular basis since the new owners acquired the facility. R3 stated the Administrative Staff A conducted a meeting in 02/26. R3 stated she could not remember the actual day of the meeting. R3 stated the activities directors used to facilitate the Resident Council meeting but said the facility had several turnovers in the activity department, and a Resident Council meeting had not occurred.On 06/03/26 at 01:31 PM, Administrative Nurse D stated Administrative Staff A had held a meeting with the residents. She stated the facility had turnover in the activity department. She stated she was unsure if the meetings were happening.On 6/03/26 at 02:11 PM, Administration Staff A stated she had arranged and assisted the residents with one resident council meeting in the past three months. She stated she did not know where the minutes to that meeting could be found. She stated she had not had many grievances filed since she had become the administrator at the facility.The facility's Resident Council Meeting policy dated 02/01/26 documented the facility supports the rights of residents to organize and participate in resident groups, including a Resident Council. This policy provides guidance to promote structure, order, and productivity in these group meetings.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on interviews, record reviews, and observation, the facility failed to ensure a safe, clean, comfortable, home like environment. This deficient practice placed the residents at risk for tripping hazards, electrical accidents, respiratory hazards, and decreased comfort. Findings included:- On 06/01/2026 at 07:40 AM, observation revealed the 300 hall had a maintenance storage room unlocked with seven air conditioner units stacked in it.On 06/01/2026 at 07:45 AM, initial tour revealed the following:Observation revealed R8 had a black fuzzy substance on the windowsill on the corner of the right window. The walls had several areas without paint. R8 stated that he did not use the window air conditioner as he was afraid it would blow out dust or some other substance on him.Observation of the 200 hall revealed there was no cover on one ceiling light with two springs approximately ten inches hanging down. The cart with the red cooler on it, with two plastic scoops in a zip lock bag was dirty with pieces of popcorn on the second shelf. The bottoms of numerous doors in the hallway had black substance all over them. The walls above the trim in the hall had white spackle looking substance all over the wall above it. A second light fixture with cover was broken on the right end and was missing a light bulb, so it was dimly lit.Observation of the 500 hall revealed six holes in the wall above the baseboard, and the courtyard door to the outside was not shut. The handrails in the 500 hall had large areas of missing paint with visible dirt on brackets behind the handrails. The second courtyard door was unlocked to the outside. The storage room in the 500 hall had five tall boxes of supplies and one plastic wrapped mattress sitting directly on the floor.Observation of the 100 hall revealed the floor was stained and had brown dirt like substance along the middle of the hallway with a blue popped balloon on the hallway floor. The Hoyer lift was sitting in the hallway against the wall with food debris and other black substances on the foot part.Observation revealed the floor on the right side, next to the activity room and respiratory storage room, had a vent with a black organic-like substance on the wall. The same substance was present in the vent on the 100 hall.On 06/02/26 at 08:40 AM, observation of the dining room revealed a white floor vent towards the northeast wall was covered in dust, and a vent cover was knocked off the bottom of the wall and laid on the dining room floor.During an interview on 06/02/2026 at 08:21 AM, Housekeeping E stated that housekeeping cleans the vents every day in the hallways and in the rooms, along with cleaning the air conditioner units, but they do not change the air conditioner filters. During an interview on 06/02/2026 at 08:25 AM, Maintenance V stated that they do not ever change the air conditioner filters, but they do clean them once a week. He said he would ask if it is charted somewhere, as he does not chart it. He stated that he worked with housekeeping to make sure the cleaning got done, and that he would check with housekeepingOn 06/02/2026 at 08:53 AM, Maintenance V stated staff just implemented a checkoff sheet for housekeeping staff to document on when the cleaning was done.During an interview on 06/03/2026 at 10:15 AM, Maintenance V stated that he received an alert on his phone for issues that needed addressed and it would be addressed immediately. He stated the vents with black substance on them were to be cleaned and monitored every day to make sure it would be gone. He stated that staff have a meeting every two weeks for concerns. Maintenance V stated the vents were addressed by housekeeping.During an interview on 06/03/2026 at 01:40 PM, Administrative Nurse D stated that the expectation for staff to identify cleaning needs or broken equipment should be addressed immediately with See something, say something by informing maintenance when there is an issue or staff is to clean it themselves when they notice it.The facility policy The Safe and Homelike Environment dated 02/01/2026 documented that in accordance with residents' rights, the facility would provide a safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. That included ensuring that the resident would receive care and services safely and that the physical layout of the facility, both inside and outside, maximized resident independence and does not pose a safety risk.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure Resident (R)5's call light was within his reach to enable him to call for staff assistance. Findings Included:- R5's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of chronic obstructive pulmonary disease (COPD- a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), major depressive disorder (major mood disorder that causes persistent feelings of sadness), neuromuscular dysfunction of the bladder (the muscles that control the flow of urine out of the body do not relax and prevent the bladder from fully emptying), and diabetes mellitus (DM-when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin.R5's Significant Change Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. The MDS documented R5 had an impairment of the extremities on both sides of his lower body. The MDS documented that R5 needed setup or cleanup assistance with eating and oral hygiene and was dependent on staff for toileting, bathing, and dressing. The MDS documented R5 had no falls during the observation period.R5's Falls Care Area Assessment (CAA) dated 03/09/25 documented he had anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), antidepressant (a class of medications used to treat mood disorders) drug use, and assistance required for activities of daily living (ADLs), which placed R5 at risk for falls.R5's Care Plan documented:10/30/23-R5 was incontinent of bowels and was at risk for impairment of skin, rashes, and irritation of the peri-area. Staff were to keep R5's call light within his reach to use to notify nursing to use the toilet or an incontinence episode.04/21/26-R5 was at risk for falls related to impaired balance, poor safety awareness, and the use of medication that increases his fall risk. Staff were to keep R5's call light within his reach as he allows.On 06/01/26 at 08:10 AM, R5 laid in his bed with his eyes shut. R5's call light was at the bottom of his bed, on the left-hand side. R5's call light was out of his reach.On 06/03/26 at 09:46 AM, Certified Nurse Aide (CNA) Q stated call lights should be placed on the bed rail or on the person. He stated staff should let the residents know where they have placed the call light.On 06/03/26 at 09:39 AM, Licensed Nurse (LN) I stated call lights should always be within the resident's reach.On 06/03/26 at 01:31 PM, Administrative Nurse D stated call lights should be where the resident could reach and use the call light.The facility's Accommodation of Needs policy dated 02/02/26 documented facility would treat each resident with respect and dignity and would evaluate and make reasonable accommodations for the individual needs and preferences of a resident, except when the health and safety of the individual or other residents would be endangered.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on observation, record review, and interview, the facility failed to ensure staff secured and protected the privacy and confidentiality of Resident (R) 8's medical record. Findings included:- On 06/02/26 at 07:55 AM, Certified Medication Aide (CMA) R left her locked medication cart unattended with the laptop screen unlocked, and R8's personal medical information and medications were visible on the screen. On 06/02/26 at 07:57 AM, CMA R returned to her medication cart. CMA R confirmed she was assigned to that medication cart. CMA R then stated she was not positive if the screen needed to be locked or hidden when she was not at the cart. On 06/03/26 at 09:26 AM, Licensed Nurse (LN) I stated that medication carts and laptop screens should be locked at any time a medication aide or nurse walked away from the cart. On 06/03/26 at 01:32 PM, Administrative Nurse D confirmed that the cart and laptop screen should be locked when the staff member walked away from the cart. The facility's Confidentiality of Personal and Medical Records policy dated 02/01/26 documented this facility honors the resident's right to secure and confidential personal and medical records. This included the right to confidentiality of all information contained in a resident's records, regardless of the form of storage or location of the record.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. Based on interviews, observation, and record review the facility failed coordinate care for Resident (R) 22 following a Preadmission Screening and Resident Review (PASSAR-short series of questions designed to determine whether or not a more in-depth assessment for mental health or mental retardation services is required) which indicated a PASSAR II (an in-depth assessment for the purpose of determining whether the individual requires the level of services provided by a nursing facility or the level of services provided in a specialized program for persons with mental illness or developmental disabilities) was needed. Findings included:- R22's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), posttraumatic stress disorder (PTSD- a mental disorder characterized by an acute emotional response to a traumatic event or situation involving severe environmental stress), and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest).The Quarterly Minimum Data Set (MDS) dated 04/15/26 documented a Brief Interview of Mental Status (BIMS) score of nine, which indicated moderately impaired cognition. The MDS documented R22 required staff assistance for setup and cleanup during bathing. R22's Cognitive Loss/Dementia Care Area Assessment (CAA), dated 10/16/25, documented she had a cognitive deficit and visual hallucinations. R22's Care Plan documented the following interventions: 02/04/26 - Staff would encourage ongoing family involvement.Staff would invite her family to attend special events, activities, and meals.Staff would invite and encourage her to attend activities, offer assistance for locomotion as indicated. Staff would invite her to all scheduled activities. Staff would provide her with in- room activities as needed and desired.Staff would provide her with social interaction opportunities. She enjoyed visits from her family and spending time with her dog. She enjoyed word games, trivia bingo, and ice cream socials. R22's EMR under the MISC tab revealed a PASSAR I, dated 09/11/24, which documented she was indicated for further evaluation. R22's clinical record lacked evidence further evaluation (PASSAR II) was provided.The facility was unable to provide evidence a PASSAR Level II was requested and provided as indicated for R22 as requested on 06/03/26 at 08:15 AM.On 06/02/26 at 08:42 AM, R22 sat in the dining room with a smoker apron on. She sat and watched TV. Her hair was oily and stringy.On 06/03/26 at 01:33 PM, Administrative Nurse D stated the social service department was unable to find any documentation that level two PASSAR assessment was completed as indicated. The facility's Resident Assessment - Coordination with PASARR Program policy dated 02/01/26 documented the facility coordinated assessments with the preadmission screening and resident review (PASARR) program under Medicaid to ensure that individuals with a mental disorder, intellectual disability, or a related condition receives care and services in the most integrated setting appropriate to their needs.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews, the facility failed to revise Resident (R) 5's Care Plan to include the care of his catheter (a flexible tube inserted through a narrow opening into a body cavity, particularly the bladder, for removing fluid). Findings Included:- R5's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of chronic obstructive pulmonary disease (COPD- a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), major depressive disorder (major mood disorder that causes persistent feelings of sadness), neuromuscular dysfunction of the bladder (the muscles that control the flow of urine out of the body do not relax and prevent the bladder from fully emptying), and diabetes mellitus (DM-when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin.R5's Quarterly Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of 15, which indicated intact cognition. The MDS documented R5 had an impairment of the extremities on both sides of his lower body. The MDS documented R5 needed setup or cleanup assistance with eating and oral hygiene, and dependent on staff for toileting, bathing, and dressing. The MDS documented R5 had a Foley catheter during the observation period.R5's Urinary Incontinence/Indwelling Catheter Care Area Assessment (CAA) dated 03/09/26 documented R5 triggered for alteration in elimination and the need for an indwelling catheter due to activities of daily living (ADLs). The CAA documented assistance was required with toileting, perineal care, use of a bed pan for bowel elimination needs, and indwelling catheter care, therefore placing him at risk for alterations in elimination needs.R5's Care Plan documented:02/04/26 - R5 was incontinent with bowels and risk for impaired skin, rashes, and irritation in the peri-area. Staff were to check R5 every two hours and assist him with toileting as needed. Staff were to keep R5's call light within his reach to use to notify nursing if R5 needed assistance with toileting or incontinence episodes. Staff to provide loose fitting, easy to remove clothing.R5's Care Plan lacked staff direction for the care of R5's urinary catheter.R5's EMR revealed the following physician orders:Indwelling urinary catheter irrigate with 60 milliliters (mls) of normal saline every shift for catheter care.Complete catheter care, hang catheter to dependent drainage, and keep inside a dignity bag, chart output every shift, every shift for urine retention.On 06/01/26 at 08:10 AM, R5 laid in his bed with his eyes shut. R5's urinary catheter bag was three fours full of yellow urine and hung from R5's bed, R5's catheter tubing was placed under his right leg, and the bag was not secured to the bed, it was dangling from the bed. R5's bag was just dangling. R5 did not have a dignity bag.On 06/03/26 at 09:51 AM, Certified Nurse Aide (CNA) Q stated he would know how to care for R5's urinary catheter by the ADL log located at the nurse's desk. He stated he was unsure of access to the resident's care plan, the CNA's used the logs at the nurse's desk.On 06/03/26 at 09:36 AM, Licensed Nurse (LN) I stated she was unsure of who placed the urinary catheters on the residents care planOn 06/03/26 at 01:31 PM, Administrative Nurse D stated the urinary catheter should be placed on the residents care plan.The facility's Care Plan Revisions Upon Status Change dated 02/01/26 documented It was the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs and all services that were identified in the resident's comprehensive assessment and meet professional standards of quality.

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	175078	A. Building B. Wing	06/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy at College Hill	5005 E 21st Street North Wichita, KS 67208

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews, the facility failed to ensure staff assisted Residents (R)5 with bathing, and hygiene as needed. Findings Included:- R5's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of chronic obstructive pulmonary disease (COPD- a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), major depressive disorder (major mood disorder that causes persistent feelings of sadness), neuromuscular dysfunction of the bladder (the muscles that control the flow of urine out of the body do not relax and prevent the bladder from fully emptying), and diabetes mellitus (DM-when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin. The Quarterly Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of 15, which indicated intact cognition. The MDS documented R5 had an impairment of the extremities on both sides of his lower body. The MDS documented R5 needed set up or clean up assistance with eating and oral hygiene, and dependent on staff for toileting, bathing, and dressing. R5's Functional Abilities (Self-Care Mobility) Care Area Assessment (CAA) dated 03/09/26 documented R5 triggered for alterations in functional abilities and self-care/mobility due to requiring assistance with activities of daily living (ADLs), set-up assistance for meals, oral care, and total care for self-care needs, such as bathing, toileting, turning, and mobility needs. R5's Care Plan documented:04/21/26-R5 had a self-care deficit and required assistance with ADLs and was incontinent.R5 was a two-person assistance with bathing and showing. Staff would inspect skin during showers, alert nurses to any skin issues, and encourage two baths a week. Staff were to check R5's nails and trim and clean his nails during baths. R5's EMR under Care Report documented R5 preferred days for showers were Monday and Thursday, the Care Report documented a bath on 04/02/26, 04/04/26, and 04/17/26, and no bathing in the month of 05/26. R5's Bath Sheets revealed no bath sheets from 04/01/26 through 05/31/26. R5's EMR lacked any documentation of bathing refusals. On 06/01/26 at 12:05 AM, R5's right hand land on his electric wheelchair. R5's fingernails were long and had a dark brown substance under his fingernails. On 06/02/26 at 08:24 AM, R5's right hand laid on his right side on his abdomen. R5's fingernails were long and had a dark brown substance under his fingernails. On 06/01/26 at 12:05 PM, R5 stated he had only one shower since he had been here in the last two years. He stated staff had told him he was too big for the shower chair. He stated he had received a few bed baths. R5 stated he was unsure when he should get his baths or showers as he doesn't get a shower or a bath. He stated he would wash his hands and try to get his fingernails clean, but he was unable to use his sink. He stated his sink was not cleaned and staff dumped his urine from his catheter bag down his sink, and no one cleaned the sink. On 06/03/26 at 09:46 AM, Certified Medication Aide (CMA)R stated she was hired a couple months ago as the bath aide. Stated she did not chart bathing in the EMR and that she just found out yesterday that she was supposed to chart in TASK for bathing. She stated the facility's process for bathing was that she used a bathing sheet. She stated she asked the residents if they would like a shower. If the resident refused, the refusal was documented on the bath sheet. If there had been several refusals, the bath sheets would be taken to Administrative Nurse D. She stated she did not know what happened after she turned the refusals in to Administrative Nurse D. CMA R stated fingernails were cleaned in the shower. She stated if she was able to trim nails, she would during the residents shower. On 06/03/26 at 09:39 AM, LN I stated she didn't do anything with showers; she stated the facility had a bath aide, and she did showers. LNI stated if a resident refused their shower, the aide takes the sheets to the nurse, the nurse was to talk to the resident and ask again if the resident would like a shower at a different time. LN I stated the shower sheets go to Administrative Nurse D, and she takes care of the refusals. LN I stated all nursing staff could clean a residents fingernails. On 06/03/26 at 01:31 PM, Administrative Nurse D stated in a perfect world, all showers would be given when the resident would like a shower. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	She stated the facility had a lot of turnover in staffing in the last few months. Administrative Nurse D stated the previous owners had used bath sheets, and the current facility continued with the bath sheets. She stated the facility had hired bath aides in 05/26, and the expectation going forward was that bathing would be performed for each resident and charted in the residents EMR. She stated bathing refusals should be charted in the resident's progress notes. The facility ADLs policy dated 02/01/26 documented the facility would, based on the resident's comprehensive assessment and consistent with the resident's needs and choices, ensure a resident's abilities in ADLs do not deteriorate unless deterioration is unavoidable. Care and services would be provided for the following activities of daily living, bathing, dressing, grooming and oral care.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. Based on observation, record review, and interview, the facility failed to implement an activities program to support Resident (R)10's social needs with involvement in both individual and group activities to support his highest psychosocial well-being when staff failed to offer and provide activities of his choice. Findings included:- R10's Electronic Medical Record (EMR) documented from the Diagnoses tab documented diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), cognitive communication deficit (an impairment in organization, sequencing, attention, memory, planning, problem-solving, and safety awareness), and senile degeneration of brain (progressive, age-related cognitive decline).R10's Quarterly Minimum Data Set (MDS) dated 05/15/26 documented a Brief Interview of Mental Status (BIMS) score of zero, which indicated severely impaired cognition. The MDS documented R10 was rarely or never understood. The MDS documented R10 was dependent on staff for all activities of daily living (ADLs).R10's Care Plan documented the following interventions:02/09/24-Stff to invite R10 to all scheduled activities. Invite and encourage R10 to attend activities, and offer assistance for locomotion as indicated. Staff to provide in-room activities as desired.03/28/25-R10 would be present for activities but does not always participate.05/22/25- Staff was to encourage R10 to participate in activities that promote exercise, physical activity for strengthening, and improved mobility.02/04/26-Staff to provide R10 with orientation to activities, dietary schedule a general daily schedule of the facility.Review of R10's EMR under Reports tab of the Care Records from 03/01/26-06/01/26 revealed one activity of 1:1 visit on 05/04/26.On 06/01/26 at 08:27 AM, R10 laid in his bed on his back with his eyes shut. R10's head of bed was elevated, and his bed was in a low position, with a fall mat next to his bed.On 06/01/26 at 10:40 AM, R10 laid in his bed, with his head elevated with his bed in a low position. R10's eyes were open, and his TV was on.On 06/01/26 at 12:47 PM, R10 laid in bed on his back, with his bed in a low position. R10's eyes were open, and the TV was on.On 06/02/26 at 08:34 AM, R10 laid in his bed with head of bed elevated, legs bent with his eyes open.On 06/02/26 at 12:17 PM, R10 laid on his back in his bed, his eyes were shut. R10's bed was in a low position.On 06/02/26 at 03:22 PM, R10 laid on his back in his bed. R10's eyes were open. R10 had his TV on.On 06/03/26 at 09:52 AM, Administrative Nurse E stated R10 liked to watch TV and listen to music. She stated there had been a lot of turnover in the last few months in the activities department. She stated there used to be an activities person that would do activities in the memory unit. She stated the residents like to watch TV, and when there were activities, the residents would be involved. She stated she was aware there had not been activities in memory care in the last few days.On 06/03/26 at 01:31 PM, Administrative Nurse D stated there had been a lot of turnover in the activities department, and she was not sure how many people there had been in the last few months. She stated she knows the facility was lacking in activities. She stated she was aware there were no activities in the memory unit.The facility's Dementia Care policy dated 02/01/26 documented it was the policy of this facility to provide the appropriate treatment and services to every resident who displays signs of or is diagnosed with dementia to meet his or her highest practicable physical, mental, and psychosocial well-being.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record reviews, and interviews, the facility failed to provide adequate catheter (a flexible tube inserted through a narrow opening into a body cavity, particularly the bladder, for removing fluid) acre for Resident (R) 5 when staff failed to secure the tubing with an anchoring device to prevent pulling and injury and further failed to provide a dignity bag for the urine collection bag. Findings Included:- R5's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of chronic obstructive pulmonary disease (COPD- a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), major depressive disorder (major mood disorder that causes persistent feelings of sadness), neuromuscular dysfunction of the bladder (the muscles that control the flow of urine out of the body do not relax and prevent the bladder from fully emptying), and diabetes mellitus (DM-when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin.R5'sSignificant Change Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of 15, which indicated intact cognition. The MDS documented R5 had an impairment of the extremities on both sides of his lower body. The MDS documented R5 needed setup or cleanup assistance with eating and oral hygiene, and dependent on staff for toileting, bathing, and dressing. The MDS documented R5 had a Foley catheter during the observation period.R5's Urinary Incontinence/Indwelling Catheter Care Area Assessment (CAA) dated 03/09/26 documented R5 triggered for alteration in elimination and the need for an indwelling catheter due to activities of daily living (ADLs). The CAA documented that assistance was required with toileting, perineal care, use of a bed pan for bowel elimination needs, and indwelling catheter care, therefore placing him at risk for alterations in elimination needs.R5's Care Plan documented:02/04/26-R5 was incontinent with bowels and risk for impaired skin, rashes, and irritation in the peri-area. Staff were to check R5 every two hours and assist him with toileting as needed. Staff to keep R5's call light within his reach to use to notify nursing if R5 needed assistance with toileting or incontinence episodes. Staff were to provide loose fitting, easy to remove clothing.R5's Care Plan lacked staff direction for care of R5's urinary catheter.R5's EMR revealed the following physician orders:Indwelling urinary catheter is irrigated with 60 milliliters (mls) of normal saline every sift for catheter care.Complete catheter care, hang catheter to dependent drainage, and keep inside a dignity bag. Chart output every shift, every shift for urine retention.On 06/01/26 at 08:10 AM, R5 laid in his bed with his eyes shut. R5's urinary catheter bag was three quarters full of yellow urine and hung from R5's bed. R5's catheter tubing was placed under his right leg, and the bag was not secured to the bed, it was dangling from the bed. R5 did not have a dignity bag.On 06/01/26 at 12:05 PM, R5's urinary catheter bag laid on the foot pedals of his electric wheelchair. The urinary catheter bag was one quarter full of yellow urine. R5's catheter bag did not have a dignity bag.On 06/02/26 at 08:24 AM, R5's urinary catheter laid on the foot pedals of his electric wheelchair. R5's urinary catheter bag had a trace of urine in the bag. R5 did not have a dignity bag.On 06/02/26 at 12:05 PM, R5 stated the facility had never offered to put his catheter bag in a dignity bag. R5 stated the facility did not have an anchor for his catheter. He stated the nurse offered a piece of paper tape to place across the tubing. R5 stated the tubing for the catheter pulls with the paper tape.On 06/03/26 at 09:51 AM, Certified Nurse Aide (CNA) Q stated R5 did let him know the nurse had put tape on his leg to help secure his catheter tubing. He stated he was unsure if the facility had any anchoring device. CNA Q stated the tubing should be anchored. He stated catheter bags should be hung on the wheelchair, placed below the bladder, and in a blue privacy bag.On 06/03/26 at 09:36 AM, Licensed Nurse (LN) I stated all catheter tubing should be secured with an anchor but stated she was unsure who would be responsible for putting the anchor on the catheter tubing. LN I stated she thought the CNA could also apply the anchor. LN I stated the catheter bag (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	should be secured to the wheelchair or bed and not allowed to dangle from the bed. She stated catheter bags should be in a dignity bag.On 06/03/26 at 01:31 PM, Administrative Nurse D stated she was sure the facility had anchors available for resident's catheter tubing, and an anchor should be applied to secure the catheter tubing. She stated the facility had moved the storage room, and the anchors could have gotten misplaced. Administrative Nurse D stated R5 did not like the staff messing with his catheter as it was always placed at the Veterans clinic. She stated R5 not wanting staff to mess with the catheter was the reason he did not have a dignity bag. Administrative Nurse D stated R5 did not want a dignity bag but acknowledged that it was not in R5's plan of care.The facility's Catheter Care policy dated 02/01/26 documented It was the policy of the facility to ensure that residents with indwelling catheters receive appropriate catheter care and maintain their dignity and privacy when indwelling catheters are in use.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews, the facility failed to provide adequate respiratory care and services for Resident(R) 5, who had a respiratory infection, when staff failed to store R5's continuous positive airway pressure (CPAP- ventilation device that blows a gentle stream of air into the nose to keep the airway open during sleep) and his nasal cannula in a sanitary manner when not in use. Finding Included:- R5's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of chronic obstructive pulmonary disease (COPD- a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), major depressive disorder (major mood disorder that causes persistent feelings of sadness), neuromuscular dysfunction of the bladder (the muscles that control the flow of urine out of the body do not relax and prevent the bladder from fully emptying), and diabetes mellitus (DM-when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin. R5's Significant Change Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. The MDS documented R5 had an impairment of the extremities on both sides of his lower body. The MDS documented R5 needed setup or cleanup assistance with eating and oral hygiene and was dependent on staff for toileting, bathing, and dressing. The MDS documented R5 was on continuous oxygen and used CPAP during the observation period.R5's Functional Abilities Self-Care Mobility Care Area Assessment CAA dated 03/09/26 documented R5 triggered for alterations in function abilities and self-care/mobility due to requiring assistance with activities of daily living (ADLs), set-up assistance for meals, oral care, and total care for self-care needs, such as bathing, toileting, turning, and mobility needs.R5's Care Plan documented:04/23/26-R5 was on a pulmonary program related to pulmonary prevention.R5 would tolerate full pulmonary treatment without taking breaks.R5 was to wear oxygen as ordered.R5 was to wear his CPAP every night and at naps as tolerated by residents. Per resident preference, he preferred to sleep with nasal cannula on with his CPAP mask over the nasal cannula.R5's EMR documented the following physician's order:Cephalexin (antibiotic) 500 milligrams (mg) give one capsule by mouth three times a day for infection for seven days dated 05/29/26.Oxygen at three liters/minute (ml/min) via nasal cannula every shift dated 04/28/26.CPAP: application assists residents with application of CPAP every bedtime, confirms settings of 12cmH20, and confirm oxygen is hooked up at 3 lt/min and ensure oxygen tubing is attached to both the unit or mask and concentrator. Assist the resident in creating a proper seal date 04/28/26.CPAP: clean mask frame daily after use with CPAP cleaning wipe or soap and water. Dry well. Cover with plastic bag or completely enclosed in machine storage when not in use, dated 04/28/26.CPAP: Empty the reservoir and refill at night as needed until 07/01/26 dated 05/01/26.Once a month, respiratory therapists educate resident on CPAP to review rational for the resident on CPAP reviewing rational for the resident's usage of CPAP, inclusive of applicable diagnosis, fit and adjustment of mask, any titration of pressure, review of one time a day starting on the last day of the month, dated 05/01/26.CPAP: Cleanse the reservoir as needed or weekly on Wednesday on day shift dated 05/01/26.CPAP: Replace mask, tubing, accessories, and device upon degradation as needed or per provider recommendation dated 05/01/26.R5's EMR under Progress Notes dated 05/30/26 documented the following Infection Note; R5 continues antibiotics for respiratory infection, he remains without fever and had no complaints of respiratory distress. The oxygen saturations were 97 percent with oxygen; no signs of adverse reactions were noted.On 06/01/26 at 12:05 PM, R5's CPAP and nasal oxygen tubing laid on his bed. R5's respiratory equipment was not stored in a sanitary container.On 06/02/26 at 08:24 AM, R5's CPAP mask was draped over his CPAP machine on his bedside table; his and nasal oxygen tubing laid on his bed. R5's respiratory equipment was not stored in a sanitary container.On 06/03/26 at 09:51 AM, Certified Nurses Aide (CNA) Q stated respiratory equipment should be stored in a bag and the bag should be pulled shut. He (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated it was all the nurse's department to duty to place the respiratory equipment in a bag.On 06/03/26 09:39 AM, Licensed Nurse (LN)I stated she was unsure how the respiratory equipment should be stored. She stated she was a new nurse, and she did not apply the CPAP or nasal cannula for R5. She stated during the day respiratory department takes care of respiratory issues. LN, I stated she would find out from her director of nursing.On 06/03/26 at 01:31 PM, Administrative Nurse D stated all respiratory equipment should be placed in a bag when not in use, and all staff could place the respiratory equipment in the bags.The facility did not provide storage of respiratory equipment as requested on 06/03/26.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure that Resident (R) 1 when staff failed to assess the residents dialysis (a procedure where impurities or wastes are removed from the blood) access site within the standards of practice. The facility additionally failed to ensure R2 had an active physician's order that included the time, place, and days of their dialysis clinic treatments. Findings included: - R1's EMR from the Diagnosis tab documented diagnoses of dependent on dialysis and diabetes mellitus (DM-when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin). The Quarterly Minimum Data Set (MDS) dated 05/04/26 documented a Brief Interview of Mental Status (BIMS) score of 15, which indicated intact cognition. The MDS documented R1 had received hemodialysis during the observation period. R1's Urinary Incontinence and Indwelling CAA, dated 12/05/25 documented she had had feeling of urinary retention related to dialysis. R1's Care Plan, documented the following interventions: 12/01/25 – The Dialysis provider information. Staff would complete the Dialysis flow sheet daily to observe for shunt access site complications-report abnormalities to physician. Staff would not obtain her blood pressure and no needle sticks from right arm. She had a fluid restriction of 1500 milliliters (ml) daily, with dietary determination for allowance for each shift. Staff would obtain lab work as ordered. Facility would provide transportation to the dialysis provider. Staff would observe her for compliance with treatment regime and would educate her as indicated. Staff would observe shunt site for bleeding and notify the physician if bleeding occurred. Staff would obtain here weights per facility protocol.02/04/26- Dialysis chair times Monday, Wednesday, and Friday at 05:50 AM. R1's EMR under the Orders tab revealed the following physician orders: Dialysis Monday, Wednesday, and Friday. Chair time at 05:50 AM dated 01/12/26. The orders also lacked a physician order for the correct days for dialysis. R1 attended dialysis on Monday, Tuesday, Wednesday, and Friday. Review of the Dialysis Communication Sheets revealed staff assessed R1's access site on dialysis days. R1's EMR lacked evidence staff monitored and assessed the access site on non-dialysis days. On 06/03/26 at 08:30 AM, R1 sat at the dining room table as she finished her breakfast. She sat and (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	talked to another resident before she left for dialysis. On 06/03/26 at 09:37 AM, Licensed Nurse (LN) I stated nursing staff would obtain R1's vital signs and a weight post and pre dialysis. LN I stated R1 attended dialysis every day except Thursday, Saturday and Sunday. LN I stated the nursing staff checked R1's access site on the days she would go out for dialysis. LN I stated she was able to find documentation of R1's access site being checked on Thursday, Saturday, and Sunday. On 06/03/26 at 01:33 PM, Administrative Nurse D stated R1's access site should be accessed and documented on the Medication Administration Record (MAR) or on the Treatment Administration Record (TAR) daily. - R2's Electronic Medical Record (EMR) documented under the Diagnosis tab diagnoses of chronic kidney disease stage 4 (CKD- kidneys are severely damaged and are not properly filtering waste from your blood), Type 2 diabetes mellitus (DM-when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin). R2's Significant Change Minimum Data Set (MDS) dated [DATE] documented she had a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. The MDS documented R2 had received hemodialysis during the observation period. R2's Quarterly MDS dated 05/13/26 documented a BIMS score of seven, which indicated a severely impaired cognition. The MDS documented R2 had received hemodialysis during the observation period. R2's Urinary Incontinence and Indwelling Catheter Care Area Assessment (CAA) dated 08/15/25 documented she was incontinent of bladder. She wore incontinence products for protection/dignity. She was dependent on staff for toileting hygiene. She had a diagnosis of DM 2 and CKD stage 4 severe, and bilateral leg amputations (surgical removal of a body part). She received her medications as ordered. R2's Care Plan for dialysis last revised on 08/06/25 documented intervention that directed staff: dialysis days were Tuesday, Thursday, and Saturday at 10:15 AM; a dialysis flow sheet to be completed daily to observe for shunt access site complications-report abnormalities to physician; do not take B/P and no needle sticks in right arm; to be transported to dialysis by facility transportation; observe for compliance with treatment regime and educate resident as indicated; observe shunt site for bleeding-notify physician if bleeding occurs; and weights per facility protocol. R2's Care Plan had not been updated with her current dialysis days of Monday, Wednesday, and Friday with a chair time of 05:15 AM. R2's Care Plan had not been updated with her current outside of the facility transportation provider. R'2 Order Summary in the EMR documented a physician's order dated 10/01/25 to monitor the right arteriovenous fistula (AV-is an abnormal connection between an artery and a vein, allowing blood to flow directly between them while bypassing the tiny capillaries) site for thrill (a fine vibration felt that reflects the blood flow by a dialysis resident's shunt)/bruit (blowing or swishing sound heard when blood flows through a shunt) every shift for shunt. And monitor shunt for signs and symptoms of infection. R'2 Order Summary in the EMR documented a physician's order dated 11/11/25 to remove pressure dressing at bedtime on dialysis days on Monday, Wednesday, and Friday for dialysis. (continued on next page)

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	175078	A. Building B. Wing	06/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy at College Hill	5005 E 21st Street North Wichita, KS 67208

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R'2 Order Summary in the EMR documented a physician's order dated 11/13/25 for Pre-Dialysis: Assess thrill/bruit. Chart if present and if absent. Notify dialysis center if absent. Assess access site (SPECIFY LOCATION/TYPE) and document N for normal, B for signs/symptoms of bleeding, or I for signs and symptoms of infection, and notify dialysis for bleeding or signs of infection. Assess cognition and document A for alert, C for confused, or D for disoriented. Please complete prior to dialysis one time a day every Monday, Wednesday, and Fri for hemodialysis related to CKD Stage 4. R'2 Order Summary in the EMR documented a physician's order dated 12/10/25 for Post Dialysis: Assess thrill/bruit. Chart if present and if absent. Notify dialysis center if absent. Assess access site (SPECIFY LOCATION/TYPE) and document N for normal, B for signs/symptoms of bleeding, or I for signs and symptoms of infection, and notify dialysis for bleeding or signs of infection. Assess cognition and document A for alert, C for confused, or D for disoriented. Please complete prior to dialysis one time a day every Monday, Wednesday, and Fri for hemodialysis related to CKD Stage 4. R'2 Order Summary in the EMR documented a physician's order dated 01/15/26, per Dialysis ensure resident is on 960 cubic centimeter (cc) fluid restriction/24hrs every shift for dialysis. R2's Order Summary in the EMR lacked a physician's order specifying the dialysis clinic, the clinic location, the chair time, or the days of dialysis. On 06/03/26 at 11:25 AM, R2 sat in her wheelchair at a table in the dining room waiting for her lunch. R2 stated she had just returned from dialysis and was tired and hungry. R2 stated she goes to dialysis on Monday, Wednesday, and Friday and had to be there by 05:15 AM. On 06/03/26 at 09:45, Licensed Nurse (LN) I stated that R2 had a dialysis book that has the information in it on when she goes to dialysis and what days. LN I stated that R2 should have a physician's order that stated when, where and what days she had dialysis. LN I stated R2's care plan should have where she goes for dialysis and what days and her chair time. On 06/03/26 at 11:20 AM, Administrative Nurse E stated R2 had a dialysis book she takes with her to each dialysis visit. Administrative Nurse E stated the book should have the name of the dialysis clinic, what days she goes, and what her chair time was. Administrative Nurse E stated the physician's order should be in the orders in the EMR. Administrative Nurse E stated R2 went to dialysis on Monday, Wednesday, and Fridays and had just returned from dialysis. On 06/03/26 at 01:32 PM, Administrative Nurse D stated R2's orders tab should have the physician's order for dialysis in the chart that should include the location, days, and chair times for her to go to the clinic. Administrative Nurse D stated R2's care plan should reflect that same information for staff to know. The policy for Hemodialysis dated 02/01/26 documented the facility would coordinate and collaborate with the dialysis facility to assure that: the resident's needs related to dialysis treatments are met; the provision of the dialysis treatments and care of the resident meets current standards of practice for the safe administration of the dialysis treatments; documentation requirements are met to assure that treatments are provided as ordered by the nephrologist, attending practitioner and dialysis team; and there was ongoing communication and collaboration for the development and implementation of the dialysis care plan by nursing home and dialysis staff. The facility will ensure that the physician's orders for dialysis include: the type of access for dialysis (e.g. graft, arteriovenous shunt, external dialysis catheter) and location; the dialysis schedule; the nephrologist name and phone number; the (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dialysis facility name and phone number; transportation arrangements to and from the dialysis facility; any medication administration or withholding of specific medications prior to dialysis treatments; any fluid restriction if ordered by the physician.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, record review, and interview, the facility failed to ensure pureed food (food has been ground, pressed, and/or strained to a consistency of a soft, smooth, thick paste similar to a thick pudding) had been prepared to conserve the nutritive value, palatable flavor for two residents on a pureed diet. Findings included:- On 06/02/26 at 10:29 AM, Dietary CC washed his hands and put on a clean pair of gloves and stated there were two pureed diets in the facility but he would prepare three in case a resident wanted more. On the counter was a clean Robot Coupe food processor with a clean container, blade and lid. Dietary CC obtained a metal container from the warmer oven that contained three smothered pork chops. Dietary CC added the pork chops to the container and turned it on to begin chopping/processing the food. Dietary CC then went back to the oven to obtain the container of gravy. He placed the container of gravy on the counter and obtained a clean ladle to scoop out the gravy with and pour into the top of the lid to add to the chops. Dietary CC turned the Robot Coupe off and removed the lid to the container and scraped the food in the container with a plastic spatula, then placed the spatula on a towel on the counter. The lid was placed back on the container, and the processor was turned back on, and he added another ladle of gravy to the pork chops. Dietary CC then removed the lid and container from the processor and grabbed the spatula to assist in pouring the pureed pork chops into a clean metal container and covered with foil and labeled the food. During the process of the puree of this food item Dietary CC did not refer to the recipe for the smothered pork chops available for him to follow.On 06/02/26 at 10:35 AM, Dietary CC stated that the facility had weekly menus each month that included the recipes for each food and how they should be prepared which included the recipe for pureed foods. Dietary CC stated he had been cooking the food and preparing the pureed food for a little while and knew what to add to thin or thicken a food when needed.On 06/02/26 at 10:36 AM, Dietary BB stated she had been the dietary manager for only two weeks and was still educating staff on proper procedures. Dietary BB stated she would re-educate Dietary CC to ensure that he followed the recipes provided for the purees.The facility's Puree Food Preparation policy dated 02/01/26 documented that puree foods should be prepared in such a manner to prevent lumps or chunks. The goal is a smooth, soft, homogeneous consistency similar to soft mashed potatoes. Do not use water as an additive to prepare puree foods. Refer to your department's Dietary Services manual for additional policies and procedures. Residents receiving puree diets should always receive portions equivalent to those served on the regular or therapeutic diet ordered per facility policy and procedure. Puree Food Preparation Guidelines per Serving:(More or less may be used depending on the consistency of the cooked food): Meats: Add one teaspoon beef broth or beef gravy Poultry: Add one teaspoon chicken broth or chicken gravy Fish: Add one teaspoon mayonnaise Noodles: Add one teaspoon margarine Vegetables (leaf, stem, or flower): Add two teaspoon mashed potato flakes Vegetables (root, tuber): Add one teaspoon margarine Fruits (EXCEPT grapes, oranges, grapefruit, bananas, plums): Remove peels, skins, cores, pits, and or seeds. Add one tablespoon food thickener (most watery fruits require a food thickener).

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F 0577 Level of Harm - Potential for minimal harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. Based on observation, record review, and interviews, the facility failed to post the previous state inspection information in a location accessible to residents and visitors. Findings included:- On 06/01/2026 at 07:37 AM, observation revealed that the state agency results book was not available. During an interview on 06/03/2026 at 01:40 PM, Administrative Staff D stated that there is a survey book for the facility, but she did not know where it was. The facility was unable to provide a policy related to past survey results availability.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on observation, interview, and record review, the facility failed to ensure the daily nurse staffing sheet was posted and failed to retain the required 18 months of daily nurse staff posting. Findings included:- On 06/01/2026 at 07:37 AM, observation revealed that there was no nurse staffing sheet posted.During an interview on 06/03/2026 at 01:40 PM, Administrative Nurse D stated that staffing should be posted where it could easily be viewed. Administrative Nurse D stated that the facility did not keep documents of all daily posted nurse staffing from the last 18 months due to high turnover.The facility policy Nurse Staffing Posted Information dated 02/01/2026 documented that it was the policy of the facility to make nurse staffing information readily available in a readable format to residents, staff, and visitors at any given time.