STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175157	A. Building B. Wing	11/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Andover	621 W 21st Andover, KS 67002

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility reported a census of 97 residents. The sample included eight residents who were reviewed for abuse. Based on observation, interview, and record review, the facility failed to ensure Resident (R)1 remained free from staff-to-resident abuse. On 09/17/25, R1, a severely cognitively impaired resident with a history of behaviors and traumatic brain injury (TBI-an injury to the brain caused by external forces), demonstrated escalating combative and aggressive behaviors. At approximately 08:30 PM, Licensed Nurse (LN) G intervened in R1's behavioral event, and as a result, R1 grabbed LN G's genitals and called LN G obscene names. LN G yelled at R1, grabbed his arm, and stated he would beat the resident up, then lock the resident in his room. LN G reported he employed a restraint technique that involved grabbing R1 around the neck to prevent further aggressive behaviors. Certified Nurse Aide (CNA) M witnessed this staff to resident abuse but did not report the event to administrative staff until the following day, 09/18/25, when she came in for her evening (02:00-10:00 PM) shift. The facility's failure to ensure residents remained free from physical and verbal abuse placed R1 in immediate jeopardy. Findings Included:- R1's Electronic Medical Record (EMR) revealed diagnoses of traumatic brain injury, cognitive communication deficit (an impairment in organization, sequencing, attention, memory, planning, problem-solving, and safety awareness), and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest).R1's 02/05/25 admission Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of six, which indicated severely impaired cognition. R1's MDS documented he had minimal depression and disorganized thinking or was incoherent (rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject), continually. The MDS documented R1 had behaviors during the lookback period, including yelling, cussing, and hitting staff. The MDS documented R1 received antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality) and antianxiety (a class of medications that calm and relax people) medications.R1's 02/07/25 Behavioral Symptoms Care Area Assessment (CAA) triggered due to physical and verbal abusive behavior towards staff and other residents. R1 was resistant to care, wandered, yelled out, and cursed. The CAA noted risk factors, which included injuring oneself or others, decreased socialization, social isolation, and increased anxiety. R1's would be care planned for interventions to monitor behavior patterns, decrease agitation, and monitor the effectiveness of psychotropic (alters mood or thoughts) medications and any adverse effects of medications.R1's 08/08/25 Quarterly MDS documented a BIMS score of five, which indicated severely impaired cognition. R1 had no depression, and had verbal behavioral symptoms directed towards others, including threatening others, screaming at others, and cursing at others. R1 rejected care during the lookback period. The MDS documented R1 received antipsychotic and anticonvulsant (a class of medication that controls or prevents seizures by stabilizing abnormal electrical activity in the brain) medications.R1's Care Plan dated 02//25/25 instructed staff when R1 became agitated, staff should intervene before the agitation escalated; staff should guide R1 away from the source of/ distress and engage calmly in conversation. If R1's response was aggressive, staff were to walk calmly away and approach later. R1's Care Plan documented staff were instructed to know R1 would use profanity frequently with the staff and directed staff to reapproach and encourage the use of appropriate language.R1's EMR recorded an order for Physician Order Behavior Monitoring documented staff monitored the resident for behaviors including agitation, aggressive, refusal of cares, combativeness, accusatory behaviors, gets hyper-stimulated easily and use of profanity at others Intervention Codes: (1) redirect, (2) 1 on 1, (3) refer to nurse notes, (4) activity, (5) return to room, (6) toilet, (7) give food, (8) give fluids, (9) change position, (10) adjust room temperature, (11) back-rub, and (12) others chart to prog notes. Date ordered 05/06/25.R1's Progress Note on 09/17/25 at 09:20 PM documented at 08:00 PM, R1 lunged toward LN G and R1 attempted to punch the painting in the hallway. CNA M assisted R1 to his room and remained with R1 as a one-on-one for the remainder of the shift. At 08:30 PM, R1 exited his room and spat on the staff. LN G assisted R1 to his room, offered R1 several things, and R1 threw the snacks offered back at the staff. R1 broke the outside door handle to his room and shut his room door, which caused R1 to be locked inside his room for about one hour until it was fixed. Staff advised R1 that to be able to come out of his room, he would need to wear a brief or shorts to have his genitals covered.R1's Progress Note on 09/18/25 at 04:45 AM documented R1 stated he wanted out of the building and started to throw chairs against the doors of resident rooms and the entrance and exit of the building. LN G asked R1 why he was doing this, and R1 stated that he wanted to leave, and no one

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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 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (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 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility reported a census of 97 residents. The sample included eight residents who were reviewed for abuse. Based on observation, interview, and record review, the facility failed to ensure Resident (R)1 remained free from staff-to-resident abuse. On 09/17/25, R1, a severely cognitively impaired resident with a history of behaviors and traumatic brain injury (TBI-an injury to the brain caused by external forces), demonstrated escalating combative and aggressive behaviors. At approximately 08:30 PM, Licensed Nurse (LN) G intervened in R1's behavioral event, and as a result, R1 grabbed LN G's genitals and called LN G obscene names. LN G yelled at R1, grabbed his arm, and stated he would beat the resident up, then lock the resident in his room. LN G reported he employed a restraint technique that involved grabbing R1 around the neck to prevent further aggressive behaviors. Certified Nurse Aide (CNA) M witnessed this staff to resident abuse but did not report the event to administrative staff until the following day, 09/18/25, when she came in for her evening (02:00-10:00 PM) shift. The facility failure to report abuse immediately to the administrator placed RI in immediate jeopardy. (See F600)Findings Included:- R1's Electronic Medical Record (EMR) a Progress Note on 09/17/25 at 09:20 PM documented at 08:00 PM, R1 lunged toward LN G and R1 attempted to punch the painting in the hallway. CNA M assisted R1 to his room and remained with R1 as a one-on-one for the remainder of the shift. At 08:30 PM, R1 exited his room and spat on the staff. LN G assisted R1 to his room, offered R1 several things, and R1 threw the snacks offered back at the staff. R1 broke the outside door handle to his room and shut his room door, which caused R1 to be locked inside his room for about one hour until it was fixed. Staff advised R1 that to be able to come out of his room, he would need to wear a brief or shorts to have his genitals covered.R1's Progress Note on 09/18/25 at 04:45 AM documented R1 stated he wanted out of the building and started to throw chairs against the doors of resident rooms and the entrance and exit of the building. LN G asked R1 why he was doing this, and R1 stated that he wanted to leave, and no one would let him out. R1 wrecked the furniture in the dayroom. LN G requested R1 to refrain from trying to wake everyone up and to quit damaging the chairs. LN G advised R1 that there would be coffee coming with his breakfast, and that it was not too long away. R1 continued to throw wheelchairs. CNA M's Witness Statement dated 09/17/25 documented R1 started to have extreme behaviors, which included running around the unit, cursing, and throwing cups. CNA M noted that she tried to keep R1 away from LN G and the other residents, but R1 grabbed LN G's genitals and LN G then grabbed R1 by his arm, pushed him away, and stated that if he could, he would lock R1 in a room and beat the living [expletive] out of R1. LN G's Witness Statement dated 09/17/25 documented on that date, R1 yelled obscenities and slapped a picture frame with his hand, so LN G yelled at R1 to stop. R1 continued to slap the picture and make noise, so LN G walked over to the area, and R1 stopped. LN G noted when he returned to the medication cart, R1 started hitting a picture with a closed fist, so LN G ran over to stop the resident. R1 began calling LN G obscenities, and LN G documented that he told R1 to stop and noted I grabbed him around the neck, without applying any pressure to his trachea, using a MAST [sic] maneuver that I learned as a last resort to keep him from doing this.The facility's 09/18/25 Investigation 2621768 documented after the incident, LN G asked CNA M to take R1 to his room and stay with him until the completion of her shift. The investigation noted CNA M did not notify anyone of this incident at the completion of her shift. The investigation documented the incident was reported to Administrative Nurse F on 09/18/25 when CNA M worked her afternoon shift (02:00 PM to 10:00 PM). The facility placed LN G on suspension on 09/18/25 and terminated his employment on 09/26/25.During an observation on 10/06/25 at 10:15 AM, R1 sat in the dining room with his breakfast tray in front of him. A female resident sat at the same table to R1's left side. R1 hit his cup of coffee with his left hand backwards, and the coffee went on that female resident and on to the floor. Staff intervened immediately.During an interview on 10/06/25 at 10:40 AM, Administrative Nurse D stated she expected staff to report any type of abuse alleged or witnessed immediately to the administrative staff.The facility's policy Abuse Prevention dated 05/06/25 documented all alleged or suspected violations involving mistreatment, abuse, neglect, injuries of unknown origin (e.g., bruising and skin tears) will be immediately reported to theadministrator and/or director of nursing. All associates are mandated to immediately report suspected resident abuse and/or neglect to their immediate supervisor and/or facility representative. All residents, families, resident representatives, and visitors are encouraged to immediately report incidents of suspected resident abuse and/or neglect to facility administration. When an incident of resident abuse is suspected, the incident must be reported to thesupervisor regardless of the time lapse

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Respond appropriately to all alleged violations. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The facility reported a census of 97 residents. The sample included eight residents who were reviewed for abuse. Based on observation, interview, and record review, the facility failed to ensure Resident (R)1 remained free from staff-to-resident abuse. On 09/17/25, R1, a severely cognitively impaired resident with a history of behaviors and traumatic brain injury (TBI-an injury to the brain caused by external forces), demonstrated escalating combative and aggressive behaviors. At approximately 08:30 PM, Licensed Nurse (LN) G intervened in R1's behavioral event, and as a result, R1 grabbed LN G's genitals and called LN G obscene names. LN G yelled at R1, grabbed his arm, and stated he would beat the resident up, then lock the resident in his room. LN G reported he employed a restraint technique that involved grabbing R1 around the neck to prevent further aggressive behaviors. Certified Nurse Aide (CNA) M witnessed this staff to resident abuse but did not report the event to administrative staff until the following day, 09/18/25, when she came in for her evening (02:00-10:00 PM) shift. The facility's failure to prevent LN G from ongoing and unrestricted access to Rl and all residents on the locked memory care unit after LN G abused Rl placed Rl and all residents on the locked unit in immediate jeopardy. (See F600)Findings Included:- R1's Electronic Medical Record (EMR) revealed diagnoses of traumatic brain injury, cognitive communication deficit (an impairment in organization, sequencing, attention, memory, planning, problem-solving, and safety awareness), and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest).R1's 02/05/25 admission Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of six, which indicated severely impaired cognition. R1's MDS documented that he had minimal depression and disorganized thinking or was incoherent (rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject) continually. The MDS documented R1 had behaviors during the lookback period, including yelling, cussing, and hitting staff. The MDS documented R1 received antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality) and antianxiety (a class of medications that calm and relax people) medications.R1's 02/07/25 Behavioral Symptoms Care Area Assessment (CAA) triggered due to physical and verbal abusive behavior towards staff and other residents. R1 was resistant to care, wandered, yelled out, and cursed. The CAA noted risk factors included injuring oneself or others, decreased socialization, social isolation, and increased anxiety. R1's would be care planned for interventions to monitor behavior patterns, decrease agitation, and monitor the effectiveness of psychotropic (alters mood or thoughts) medications and any adverse effects of medications. R1's 08/08/25 Quarterly MDS documented a BIMS score of five, which indicated severely impaired cognition. The MDS recorded R1 had no depression, and R1 had verbal behavioral symptoms directed towards others, including threatening others, screaming at others, and cursing at others. The MDS recorded R1 rejected care during the lookback period. The MDS documented R1 received antipsychotic and anticonvulsant (a class of medication that controls or prevents seizures by stabilizing abnormal electrical activity in the brain) medications.R1's Care Plan dated 02//25/25 instructed staff when R1 became agitated, staff should intervene before the agitation escalated; staff should guide R1 away from the source of/ distress and engage calmly in conversation. 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CNA M assisted R1 to his room and remained with R1 as a one-on-one for the remainder of the shift. At 08:30 PM, R1 exited his room and spat on the staff. LN G assisted R1 to his room and offered R1 several things, one of which was not coffee since the supply was not refilled. R1 threw the snacks offered back at the staff. R1 broke the outside door handle to his room and shut his room door, which caused R1 to be locked inside his room for about one hour until it was fixed. Staff advised R1 that to be able to come out of his room, he would need to wear a diaper or shorts to have his genitals covered.R1's Progress Note on 09/18/25 at 04:45 AM documented R1 stated that he wanted out of the building and started to throw chairs