Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175168	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Great Plains Post Acute	7101 E 21st Street North Wichita, KS 67206

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

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. Based on observation, record review, and interview, the facility failed to provide the services of a full-time certified dietary manager for the residents who resided in the facility and received their meals from the kitchen. Findings included:- On 04/20/26 at 08:35 AM, observation revealed that dietary staff in the kitchen prepared the breakfast meal. On 4/20/26 at 09:00 AM, Dietary Staff BB verified the dietary manager was not certified. Staff BB stated the facility had two residents with a pureed diet and eight who required a mechanical soft diet. On 04/20/26 at 03:30 PM, Administrative Staff A verified Dietary Staff BB was not certified. Upon request, the facility failed to provide a Certified Dietary manager policy

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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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review the facility failed to prepare, store, distribute, and serve food under sanitary conditions for the 106 residents in the facility, who receive their meals from the kitchen. Findings included:- On 04/20/26 at 08:20 AM, during initial kitchen tour, observation revealed the following: One 12 inch by 12 inch air vent grill located above the tri compartment sink area was covered with a brownish greasy/sticky substance and gray fuzzy substance on all four edges of the vent, blowing directly on the cleaning area. Two 24 inch by 24 inch return air vent grill located above the cooking stove area covered had brownish grease/sticky substance and gray fuzzy substance blowing directly on the food preparation and stove cooking area. There was brownish splatter behind the cooking stove on the wall approximately four feet from the baseboard. The baseboard was covered with a brownish greasy substance along the floor area. One 36 inch by 36 inch ceiling mounted air conditioner had a brownish gray fuzzy substance that covered the metal grill. The wall behind the wash sink, and the wall behind the tri compartment sink, had two sections of plaster approximately 12 inches by 12 inches falling off the wall and there was plaster on the floor. On 04/20/26 at 11:00 AM, Dietary Staff BB verified the dirty register grill, the splatters/stains behind the stove, and the plaster coming off the wall. Dietary Staff BB verified she was unsure who was responsible for cleaning the vents and stated the plaster on the walls would be maintenance's responsibility to repair. On 04/21/26 at 12:10 PM, Administrative Staff B verified the dirty register grill, the splatters/stains behind the stove, the plaster coming off the wall, the air conditioner grill with brownish gray fuzz covering the grill. The facility's Maintenance Service policy, dated December 2009, documented maintenance services shall be provided to all areas of the building, grounds, and equipment. The maintenance department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times. The maintenance director is responsible for developing and maintaining a schedule of maintenance services to ensure that the buildings, grounds, and equipment are maintained in a safe and operable manner. The Sanitation policy dated April 2026, documented the food service area shall be maintained in a clean and sanitary manner. All kitchen, kitchen areas, and dining areas shall be kept clean, free from litter and rubbish and protected from rodents, roaches, flies and other insects. Food service staff would be trained to maintain cleanliness cleaning their work areas during all tasks, and to clean after each task before proceeding to the next assignment.

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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 observation, interview, and record review, the facility failed to resolve recurring issues reported by the Resident Council. Findings included: - A review of the facility's Resident Council Minutes, from 01/2025 to 03/2026, indicated recurring concerns related to call light response times. The Resident Council Minutes for January 2025, in which 18 residents attended, indicated concerns related to call lights not being answered in a timely manner, and documented the issue would be addressed by nursing administration. The Resident Council Minutes for February 2025, in which 18 residents attended, indicated concerns related to call lights not being answered in a timely manner, and documented the issue would be addressed by nursing administration. The Resident Council Minutes for March 2025, in which 17 residents attended, indicated concerns related to call lights not being answered in a timely manner and documented the issue would be addressed by nursing administration. The Resident Council Minutes for June 2025, in which 17 residents attended, indicated concerns related to call lights not being answered in a timely manner and documented the issue would be addressed by nursing administration. The Resident Council Minutes for September 2025, in which 18 residents attended, indicated concerns related to call lights not being answered in a timely manner and documented the issue would be addressed by nursing administration. The Resident Council Minutes for October 2025, in which 14 residents attended, indicated concerns related to call lights not being answered in a timely manner and documented the issue would be addressed by nursing administration. The Resident Council Minutes for November 2025, in which 14 residents attended, indicated concerns related to call lights not being answered in a timely manner and documented the issue would be addressed by nursing administration. The Resident Council Minutes for December 2025, in which 15 residents attended, indicated concerns related to call lights not being answered in a timely manner and documented the issue would be addressed by nursing administration. The Resident Council Minutes for January 2026, in which 20 residents attended, indicated concerns related to call lights not being answered in a timely manner, and documented the issue would be addressed by nursing administration. The Resident Council Minutes for February 2026, in which 20 residents attended, indicated concerns related to call lights not being answered in a timely manner and documented the issue would be addressed by nursing administration. On 04/22/26 at 10:47 AM, the Resident Council President, Resident (R) 87, reported ongoing concerns with call lights not being answered in a timely manner. R87 stated staff would answer the call lights and inform the residents they would return shortly, but that staff often did not return promptly. R87 said the call light wait time was between 30 minutes to an hour. R87 also stated that when agency staff were on duty, mostly on the second and night shift, longer call light wait times occurred. R87 also confirmed the Resident Council did not have information related to where the state agency reports and Ombudsman information were kept, and felt staff should address the residents by name and not use terms such as Momma and Grandma. On 04/22/26 at 12:32 PM, Activity Staff Z stated that the Resident Council concerns were reported to the department director. Activity Staff Z reported the facility had implemented a program with ancillary staff to assist with resident concerns of call light response, especially around meals and the smoking breaks of the residents. Activity Staff Z verified the lack of documentation informing the Resident Council where to locate the state agency reports and the Ombudsman information. On 04/22/26at 12:38 PM, Administrative Nurse D reported being invited to the Resident Council meeting with the previous facility administrator to address the call light response. The facility initiated a program to assist with call light response and concerns of the residents, especially around mealtimes and smoke breaks. Administrative Nurse D verified that the staff should address the residents by name and not by Momma or Grandma. The facility's Grievances/Complaints policy, dated 04/2017, documented that the administrator and staff will make prompt efforts to resolve grievances to the satisfaction of the resident and/or representative. All grievances, complaints, or recommendations stemming from residents or family groups concerning (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	issues of resident care in the facility will be considered. Actions on such issues will be responded to in writing, including a rationale for the response.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement alternative communication methods for one resident. Resident (R) 22, who spoke in Bengali.Finding included:- The Electronic Medical Record (EMR) for R22 documented diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion), pain, and anxiety (a mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear.The Quarterly Minimum Data Set (MDS), dated [DATE], documented R93 had severely impaired cognition. R93 was dependent upon staff assistance for toileting, showers, dressing, and personal hygiene. R93 required substantial staff assistance for mobility and transfers. R93 made herself understood and had unclear speech.R93's 03/23/26 Care Plan included the following interventions:06/14/24- R93 required a translator to communicate and ensure the availability and functioning of adaptive communication equipment. Provide a translator as necessary to communicate with the resident. The translator is in Bengali. Staff should anticipate her needs.On 04/21/26 at 11:40 AM, Certified Nurse Aide (CNA) N and CNA O woke R93 up and told her it was time for lunch. CNA O assisted R93 to a seated position and placed a gait belt around her waist. R93 spoke to the CNAs in her native language and then started to hit them. R93 was transferred into her wheelchair. CNA N stated there was a therapy staff member who had a translator on her phone, but she did not work every day, so it was hit or miss if they were able to understand what R93 needed. CNA O stated R93 would point at different things she needed but did not always know what she needed.On 09/22/26 at 10:30 AM, Licensed Nurse (LN) H stated there were signs posted with translator phone numbers in the rooms of residents who spoke different languages that staff were supposed to use if they need to translate anything. LN H further stated that a family member would also assist if needed, but has said that with R93's dementia, sometimes she does not make sense with what she wants. On 04/22/26 at 10:45 AM, observation of a sign hanging in R93's room on the wall reminded staff that the room had audio and visual equipment, and underneath that sign was another sign with the translator's phone numbers, which was not visible to staff.On 04/22/26 at 01:00 PM, Administrative Nurse D stated that the sign should be accessible to staff so that they are aware there are ways to communicate with R93.The facility's Limited English Proficiency or Impairments in Communication policy, undated, documented that the facility would provide for communication with persons with impairments in communication. They would ensure adequate provisions are made for meeting the communication needs of patients, staff, and others. When a significant portion of the facility (25% or greater) understands one language that was not English, they would provide required written materials in that language to patients.

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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, interview, and record review, the facility failed to provide consistent bathing services as care planned for one sampled resident, Resident (R) 107. Findings included:- The Electronic Medical Record (EMR) for R107 documented diagnoses of anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear, diabetes mellitus (DM-when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), and obesity (excessive body fat).The Quarterly Minimum Data Set (MDS), dated [DATE], documented R107 had a Brief Interview for Mental Status (BIMS) score of nine, indicating moderately impaired cognition. R107 was dependent upon staff assistance for toileting hygiene, dressing, mobility, and transfers. The MDS documented R107 did not receive showers during the assessment period.The Annual MDS, dated 04/01/26, documented R107 had a BIMS score of 13, indicating intact cognition. R107 was dependent upon staff assistance for lower body dressing, personal hygiene, and toileting hygiene. The MDS documented R107 did not receive showers during the assessment period.R107's Care Plan, dated 04/13/26, initiated on 03/06/25, documented she preferred showers on Tuesday, Thursday, and Saturday evenings. The care plan lacked documentation that R107 refused her showers.The February 2026 Bathing Record and Shower Sheets documented R107 did not receive a bath or shower for the following days: 02/08/26 - 02/23/26 (16 days)The EMR documented R107 refused her baths or showers on 02/12/26, 02/14/26, 02/17/26, and 02/19/2.The March 2026 Bathing Record and Shower Sheets documented R107 did not receive a bath or shower for the following days: 03/06/26 - 03/18/26 (13 days)The EMR documented R107 refused her baths or showers on 03/12/26.The April 2026 Bathing Record and Shower Sheets documented R107 did not receive a bath or shower for the following days: 04/10/26 - 04/21/26 (12 days)The EMR documented R107 refused her baths or showers on 04/11/26, 04/14/26, and 04/16/26.On 04/21/26 at 07:45 AM, R107's room had Enhanced barrier Precautions (EBP-infection control interventions designed to reduce transmission of resistant organisms, which employ targeted gown and glove use during high contact care) signage at the room entrance. Certified Nurse Aide (CNA) M and CNA O gowned but did not put on a gown. The CNAs removed R107's incontinence brief, and CNA M started to perform personal care to R107. R107 asked them if she needed to hold up her belly for them to wipe. CNA M stated, Yes, and after she held up her belly, CNA M wiped, and R107 said it hurt. R107 had a small open area under her belly. Licensed Nurse (LN) H was informed of the opening and came in, without a gown, and applied a cream to the area and stated she would get an order for treatment from the physician. The CNAs finished personal care with R107 and got up for breakfast. Upon leaving the room, observation revealed the EBP signage was no longer hanging by the door. CNA M stated she did not think she had to wear the EBP anymore as R107 no longer had a catheter (a tube inserted into the bladder to drain urine into a collection bag). CNA M stated that when R107 refused baths, she was reapproached and offered different times when she could get another bath.On 04/22/26 at 11:30 AM, Licensed Nurse H stated R107 often refused her baths, but they tried to give her a washcloth so that she could wash her face and arms. R107 was a check and change, so she expected staff to perform good peri care to help with her lack of bathing.On 04/22/6 at 01:00 PM, Administrative Nurse D stated she expected staff to continue to offer alternatives to baths or showers.The facility's Activities of Daily Living (ADL) Supporting policy, dated March 2018, documented residents would be provided with care, treatment, and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs). If a resident refused care and treatment, the resident or representative would be informed of the risks versus benefit of the care and treatment. The residents are offered alternative interventions to minimize decline.

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F 0689 Level of Harm - Minimal harm or potential for actual harm 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, interview, and record review, the facility failed to evaluate the effectiveness of fall interventions for two residents, Resident (R) 29 and R93, who had multiple falls, to prevent further falls. Findings included:- The Electronic Medical Record (EMR) for R29 documented diagnoses of cerebellar ataxia (impaired ability to coordinate movement), autistic disorder (a developmental disability caused by differences in the brain), weakness, restlessness, and agitation (feeling of aggravation or restlessness brought on by a provocation or a medical condition).The Significant Change Minimum Data Set (MDS), dated [DATE], documented R29 had severely impaired cognition. R29 was dependent upon staff assistance for all activities of daily living (ADLs). R29 had no upper or lower functional impairment and had two or more non-injury falls.The Quarterly MDS, dated 04/01/26, documented R29 had severely impaired cognition. R29 was dependent upon staff assistance for all adl's. R29 had no upper or lower functional impairment and had two or more non-injury falls. The Fall Risk Assessments, dated 08/08/25, 10/23/25, 11/22/25, 12/02/25, 03/03/2, 03/19/26, and 04/01/26 documented R29 was at a high risk for falls.R29's 04/13/26 Care Plan included the following interventions for R29:10/10/22- Be sure R29's call light is within reach and encourage them to use it for assistance as needed.11/17/22- Staff to leave and re-approach when R29 was restless during care. 03/14/23- Frequent checks when R29 was in his room unattended07/26/23- Identify if agitated with staff before providing care.03/07/25- Mattress on the floor on the side of the bed.03/30/25- wedges for positioning.06/10/25- Dycem (non-slip mat used for stabilization and gripping to prevent slipping) and place a touchpad call light near the edge of the bed.06/27/25- If he becomes agitated with cares, find a stopping point and complete tasks after he has calmed. If he was agitated, do not transfer.08/08/25- Provide frequent comfort and positioning checks when the resident was in his wheelchair.10/23/25- Ensure the bed brakes are always locked.03/18/26- Offer him an earlier rise time if he is awake.03/03/26-Ensure R29 was cleaned up after a haircut. The Fall Investigation, dated 08/08/25 at 06:00 PM, documented that R29 was in his chair by the nurse's station and was moving around in his chair when he fell over the right side of the chair. R29 was oriented to the person, was unable to explain what he was doing, and he did not sustain any injury. The Fall Investigation, dated 10/23/25 at 06:42 PM, documented R29 was on the floor next to the wall and bed. R29 was oriented to self and could not give a description of what he was doing. R29 was assessed and transferred by two staff members into his bed. Staff were educated regarding locking the bed.The Fall Investigation, dated 03/03/26 at 06:43 PM, documented at 11:55 AM, R29 had an unwitnessed fall with contusion. The nursing staff heard a loud thud and observed R29 on the floor in the hallway in front of the nurse's desk, lying on his stomach by his wheelchair. R29 was assessed and was unable to communicate the sequence of events as he is alert to self and non-verbal. The physician ordered the staff to send R29 to the emergency room for evaluation. The Nurse's Notes, dated 03/15/26 at 09:59 AM, documented the nurse and two support staff attempted to get R29 up. R29 was moaning and thrashing around so much that he got himself out of the sling before barely rising from the bed. R29 was lifted above the bed just far enough to fix the head of the bed wheels. The wheels were somehow flipped almost a full 180 degrees around from where they should have been. After the legs were flipped, R29 was placed back into bed without any further incident at this time. The EMR lacked an investigation regarding this incident.On 04/21/26 at 10:20 AM, Certified Nurse Aide (CNA) M, CNA N, and CNA O gowned and gloved. CNA O placed the sling for the full body mechanical lift (a specialized medical device designed to safely transfer individuals with limited mobility who are unable to bear any weight on their own) under R29. When asked why there were three staff to assist with the lift transfer, CNA N stated the R29 often got anxious and had fallen out of the sling during a transfer, so they felt more comfortable with an extra staff person to assist with (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the transfer. CNA M and CNA O attached the sling to the full lift and safely transferred him into his reclining wheelchair. R29 was not anxious or agitated during the transfer. CNA N stated they try to keep him out by the nurse's station because he has had falls where he fell over the side of the wheelchair. On 04/22/26 at 10:30 AM, Licensed Nurse (LN) H stated they keep R29 by the nurse's station so that they can keep an eye on him because he has periods of anxiousness and agitation. LN H stated R29 was better with staff that he was familiar with, and that one of his falls occurred after he had received a haircut, and there was some hair inside his shirt that bothered him.On 04/22/26 at 01:00 PM, Administrative Nurse D stated R29 had multiple falls after admission, but with consistent staffing, they know his routine. Administrative Nurse D was unaware that three staff were in the room when he was transferred, as he often got anxious with too much stimulation. Administrative Nurse D verified that the incident on 03/15/26 was a fall and should have been investigated. The facility's Falls and Fall Risk, Managing policy, dated 03/18, documented the staff, with the input of the attending physician, would implement a resident-centered fall prevention plan to reduce the specific risk factors of falls for each resident at risk or with a history of falls. If a systemic evaluation of a resident's fall risk identifies several possible interventions, the staff may choose to prioritize interventions. If falling recurs despite initial interventions, staff would implement additional or different interventions or indicate why the current approach remains relevant. - The Electronic Medical Record (EMR) for R93 documented diagnoses of weakness, unsteadiness on the feet, and hypertension (high blood pressure).The Annual Minimum Data Set (MDS), dated [DATE], documented R93 had a Brief Interview for Mental Status score (BIMS) of seven, indicating severely impaired cognition. R93 required partial staff assistance for toileting, personal hygiene, dressing, and supervision for transfers and mobility. R93 had no functional impairment and had two or more non-injury falls.The Quarterly MDS, dated 01/07/26, documented R93 had a BIMS score of eight, indicating moderately impaired cognition. R93 required supervision of staff for transfers, toileting, dressing, mobility, and ambulation. R93 had no functional impairment and had one non-injury fall.R93's Fall Risk Assessments, dated 08/23/25, 09/11/25, 11/25/25, and 03/10/26, indicate a high risk for falls.R93's 04/20/25 Care Plan included the following interventions:11/14/20-Be sure R93's call light is within reach and encourage her to use it for assistance as needed.12/27/23-Encourage R93 to use her call light and wait for assistance.02/08/25-Non-skid strips in front of the heater.02/22/25- Non-skid strips in front of toilet.03/09/25- No-skid strips to bathroom entryway.04/03/25- Anti-rollbacks to wheelchair.09/11/25- Care plan meeting with family regarding general decline and increased confusion.09/27/25- Do a 3-night sleep diary11/07/25- Dycem (non-slip mat used for stabilization and gripping to prevent slipping) in wheelchair.03/10/26- Maintenance to assess toilet seat04/10/26- Place a sign in the bathroom to use her call light. The Fall Investigation, dated 09/11/25 at 07:30 AM, documented R93 was on the floor in her room, she was fully clothed, had on shoes, and her coat. When staff asked her what she was doing, she stated, I don't know. R93 was assessed and had no injuries. The care plan intervention was to have a care plan meeting with the family regarding her decline. The Fall Investigation, dated 09/27/25 at 02:33 AM, documented R93 was observed on the floor of her room with the wheelchair behind her, and the brakes were unlocked. R92 did not complain of pain and denied she had hit her head. The care plan intervention was to complete a 3-day sleep diary. The EMR lacked documentation; a sleep diary was completed. The Fall Investigation, dated 10/06/25 at 05:53 AM, documented R93 yelled for assistance and was found on the floor with her feet pointing toward the air conditioner. She stated she leaned too far forward in her wheelchair and slid out. She was assessed for injuries and assisted back to her wheelchair. The immediate intervention was to place a bedside table in front of her when she wants to sit in front of the heater. The care plan lacked documentation of the intervention that was put into place.On 04/21/26 at 10:00 AM, R93 sat on the toilet in her bathroom. Certified Nurse Aide (CNA) M told her that if she was done, she needed to wipe herself. R93 finished, then stated she needed assistance to transfer into her wheelchair. CNA M stated that she could transfer herself. R93 used her left hand to (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	grab the handrail on the wall and started to stand up. She was unsteady and tried to pull up her pants by herself. R92 turned to the right and started to sit down in the wheelchair and almost missed the seat. R93 tried to maneuver her wheelchair out of the small bathroom and asked CNA M for assistance and was told she could get herself to her bed. It took multiple tries to get out of the bathroom, but R93 was able to propel herself to her bed. She again asked CNA M to assist her and was told that we could transfer her. R93 stood up, pivoted to her left, and sat down on the edge of the bed. CNA M stated, You need to scoot back on the bed and take R93's legs and swung them up onto the bed. R93 asked to be covered up, and CNA M covered her with a blanket.On 04/21/26 at 10:15 AM, CNA M stated R93 was supervised with toileting and transfers, and that R93 only asked for assistance because I was in the room watching. CNA M stated she had multiple falls, and there are non-skid strips in the room to prevent her falls.On 04/22/26 at 12:26 PM. Licensed Nurse (LN) H stated R93 was a stand-by assist for falls. Staff are to encourage her to do things for herself, but if she needs assistance, they should help her. LN H verified that a 3-night sleep study had not been completed as per the care plan.On 04/22/26 at 01:00 PM, Administrative Nurse D stated she expected her staff to assist R93 if she requested it. Administrative Nurse D stated the sleep study should have been completed and verified that a family conference was not an appropriate care plan intervention for the resident.The facility's Falls and Fall Risk, Managing policy, dated 03/18, documented the staff, with the input of the attending physician, would implement a resident-centered fall prevention plan to reduce the specific risk factors of falls for each resident at risk or with a history of falls. If a systemic evaluation of a resident's fall risk identifies several possible interventions, the staff may choose to prioritize interventions. If falling recurs despite initial interventions, staff would implement additional or different interventions or indicate why the current approach remains relevant.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Great Plains Post Acute	7101 E 21st Street North Wichita, KS 67206

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews, the facility failed to identify trauma-based triggers related to Resident (R)41 and R13 post-traumatic stress disorder (PTSD - a mental disorder characterized by an acute emotional response to a traumatic event or situation involving severe environmental stress) and failed to implement individualized interventions to prevent re-traumatization. Findings included:- R41's Electronic Medical Record (EMR) documented diagnoses of PTSD, dementia (progressive mental disorder characterized by failing memory, confusion), and anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear). R41's Quarterly Minimum Data Set, dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS indicated the resident was dependent on activities of daily living (ADLs). The MDS further documented R41 had no physical behaviors. R41's Care Plan, dated 01/13/26, documented R41 had behavioral symptoms including yelling at staff, hitting, refusal of medications and treatment, refusal of meals, and sexually inappropriate behavior. The care plan documented that R41 had PTSD, bipolar and mood disorder and directed staff to administer medications as physician ordered, notify the physician of inappropriate behavior, and provide R41 to express herself. The care plan lacked what the resident's PTSD triggers are and what staff were to do to manage her triggers. The Physician's Order, dated 11/12/25, directed staff to administer Latuda (antipsychotic medication) 20 milligram (mg), one tablet at bedtime for schizophrenia (a mental disorder characterized by gross distortion of reality, disturbances of language and communication, and fragmentation of thought). A Nurse's Notes, dated 04/16/26 at 00:00 AM, documented R41 had history of mental and behavioral disorders. The note documented R41 was upset and stated she recently had a care plan meeting, and they stated she had a diagnosis of schizophrenia and underlying mental health conditions. R41 denied any signs or symptoms of depression or anxiety. R41's EMR lacked evidence of a trauma informed care assessment. On 04/21/26 at 03:30 PM, Administrative Nurse D verified resident-specific interventions had not been developed to address R41's PTSD diagnosis on admission to the facility on [DATE]. The facility's Behavioral Health Services policy, dated February 2019, documented the facility would provide all residents with behavioral health services as needed to attain or maintain the highest practicable physical, mental, and psychosocial well-being in accordance with the comprehensive assessment and plan of care. Behavioral health services are provided to residents as needed, as part of the interdisciplinary, person-centered approach. Safety training, regarding behavioral health services includes, but is not limited to protocols and guidelines related to the treatment of mental disorders, psychosocial adjustment difficulties, history of trauma, and post-traumatic stress disorder. Staff must promote dignity, autonomy, privacy, socialization, and safety as appropriate for each resident and are trained in ways to support residents in distress. Behavioral health services are provided by staff who are qualified in behavioral Health and trauma informed care. - The Electronic Medical Record (EMR) for R13 documented diagnoses of PTSD, depressive disorder (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Great Plains Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 7101 E 21st Street North Wichita, KS 67206	

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(a mood disorder that causes a persistent feeling of sadness and loss of interest), traumatic brain injury (TBI - an injury to the brain caused by external forces), and panic disorder (a chronic anxiety disorder characterized by unexpected, recurring panic attacks). The Quarterly Minimum Data Set (MDS), dated [DATE], documented R13 had a Brief Interview for Mental Status (BIMS) score of 13, indicating intact cognition. R13 required partial staff assistance with toileting hygiene, personal hygiene, and lower body dressing. The MDS documented R13 had no behaviors and received an antipsychotic (a class of medication used to treat major mental conditions that cause a break from reality) and antidepressant (a class of medication used to treat mood disorders) medication regularly. The EMR lacked documentation of a trauma-informed assessment with triggers being completed for R13. The 03/09/26 Care Plan included the following interventions for R13. 06/10/26- R13 had the potential for behaviors due to PTSD, depression, panic disorder, and directed staff to administer medication as ordered, provide opportunities for positive interactions, explain all procedures to R13, allow him to adjust to changes, and monitor for behaviors. The Physician's Order, dated 11/18/25, directed staff to administer brexpiprazole (an antipsychotic medication), 4 milligrams (mg), by mouth, daily for depressive disorder. The Physician's Order, dated 11/18/25, directed staff to administer quetiapine fumarate (an antipsychotic medication), 400 mg, by mouth, at bedtime, for PTSD and depressive disorder. The Physician's Order, dated 11/19/25, directed staff to administer bupropion ER (an antidepressant), 150 mg, by mouth, daily, for depressive disorder. The Physician's Order, dated 12/11/25, directed staff to administer quetiapine fumarate, 0.5 mg, by mouth, for PTSD related to TBI. On 04/21/26 at 09:15 AM, Certified Medication Aide (CMA) R administered R13's medication without concern as he sat outside smoking. CMA R stated she was unaware of any PTSD trigger R13 had. She stated he did not have behaviors, stayed in his room most of the time, and usually just went out to smoke and eat. On 04/21/26 at 12:57 PM, Social Services X stated she did not know she was to complete a trauma assessment and knew he had PTSD but had not asked what his triggers were. Social Services X stated she would have put the triggers on his care plan if she knew what they were. On 04/22/26 at 11:30 AM, Licensed Nurse (LN) H verified there were no PTSD triggers on his care plan and did not know what they were. LN H stated, R13 did not have any behaviors. On 04/22/2 at 01:00 PM. Administrative Nurse D stated that usually, when the social history assessment was completed, it would trigger a trauma assessment and did not know why it did not do that. Administrative Nurse D stated that they would investigate getting it fixed or getting a trauma assessment. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Behavioral Health Services policy, dated February 2019, documented that the facility would provide and residents would receive behavioral health services as needed to attain or maintain the highest practicable physical, mental, and psychosocial well-being in accordance with the comprehensive assessment and plan of care.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to label Resident (R) 46 and R89s' insulin (a hormone that lowers the level of glucose in the blood) flex pens with an opened date and the facility failed to label the tuberculin vial solution with an opened date. Findings included:- On [DATE] at 09:30 AM, observation of the facility's East Hall nurse medication cart revealed the following: R46's Lantus (long-acting insulin) two flex pen was labeled with a date opened, but it was smeared and not able to be read. R89's Novolog (fast-acting insulin) flex pen was not labeled with a date opened or discard date. On [DATE] at 11:00 AM, Administrative Nurse D verified the nurses should label and date the insulin flex pens with the date opened and the expiration date and discard the expired insulin pens. Medlineplus.gov directs open, unrefrigerated Lantus and Humalog can be used within 28 days; after that time, they must be discarded. The facility's Storage of Medication policy, dated 11/20, documented the facility would store all drugs and biologicals in a safe, secure, and orderly manner. The policy documented drugs containers that have missing, incomplete, improper, or incorrect labels are returned to the pharmacy for proper labeling and storage. Discontinued, outdated, or deteriorated drugs or biologicals are returned to the dispensing pharmacy or destroyed. - On [DATE] at 08:34 AM, during inspection of the west medication room, a multidose vial of Tuberculin Purified Protein Derivative (TB) was found without an open date. Licensed Nurse (LN) G verified the vial had been opened and lacked an open date. LN G verified that the TB solution should be discarded within 30 days of being opened. On [DATE] at 08:54 AM, Administrative Nurse D verified the TB vial should have been dated when put in use. The facility's Storage of Medication, dated 11/2020, documented that drug containers that have missing, incomplete, improper, or incorrect labels are returned to the pharmacy for proper labeling before storing. Discontinued, outdated, or deteriorated drugs or biologicals are returned to the dispensing pharmacy or destroyed.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure a communication process between the hospice provider and the facility for Resident (R)81, which included a plan of care and a description of the services provided, which included contact information, visit frequency, medications, and medical equipment. Findings included:- R81's Electronic Health Record (EHR) revealed a diagnosis of chronic obstructive pulmonary disease (COPD- a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing). R81's Quarterly Minimum Data Set (MDS), dated [DATE], documented R81 had a Brief Interview of Mental Status (BIMS) score of 11, which indicated moderately impaired cognitive impairment. The MDS document R81 required partial to moderate staff assistance with most activities of daily living (ADLs). The MDS documented that R81 received hospice care services. R81's Care Plan, revised 02/17/26, documented R81 had limited physical mobility due to weakness and instructed staff to assist with ADL care. The plan documented the resident was admitted to hospice services on 10/31/25. The plan directed the staff to assist with ADLs, establish a daily routine, and encourage activities of choice. The plan directed staff to monitor and report increased weakness or tiredness to the physician, encourage rest as needed, and observe the effectiveness of pain medication and obtain modifications as necessary to pain medication orders. The care plan lacked a contact number for hospice, what supplies, equipment, and medications hospice would provide, when hospice staff would be in the building, and what care they would provide. A review of R81's clinical record revealed the resident was admitted to hospice care on 10/31/25. The Hospice Agreement, dated 10/31/26, documented Hospice and the facility would jointly develop and agree upon a coordinated plan of care. On 04/20/26 at 03:30 PM, observation revealed R81 sat in a wheelchair in the hall across from the east nurse's station and had no signs or symptoms of pain. On 04/22/26 at 08:45 AM, Administrative Nurse D verified R81's Care Plan lacked information regarding hospice visits, phone numbers, and medical supplies Hospice services would provide and stated she would add the information. The facility's Hospice Program Policy, revised 07/17, documented the facility would designate social services to coordinate care provided to the resident by the facility staff and the hospice staff.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to ensure a sanitary and comfortable environment to help prevent the development and transmission of communicable diseases and infections when staff failed to wear appropriate Enhanced Barrier Precautions (EBP-infection control interventions designed to reduce transmission of resistant organisms, which employ targeted gown and glove use during high contact care) for one resident, Resident (R) 107. Findings included:- On 04/21/26 at 07:45 AM, R107's room had EBP signage at the room entrance. Certified Nurse Aide (CNA) M and CNA O gowned but did not put on a gown. The CNAs removed R107's incontinence brief, and CNA M started to perform personal care to R107. R107 asked them if she needed to hold up her belly for them to wipe. CNA M stated, Yes, and after she held up her belly, CNA M wiped, and R107 said it hurt. R107 had a small open area under her belly. Licensed Nurse (LN) H was informed of the opening and came in, without a gown, and applied a cream to the area and stated she would get an order for treatment from the physician. The CNAs finished personal care with R107 and got up for breakfast. Upon leaving the room, observation revealed the EBP signage was no longer hanging by the door. CNA M stated she did not think she had to wear the EBP anymore as R107 no longer had a catheter (a tube inserted into the bladder to drain urine into a collection bag). On 04/21/26 at 08:00 AM, Licensed Nurse (LN) H stated, R107 no longer had a catheter and did not require staff to wear EBP during cares but would talk with the Infection Preventionist to make sure they didn't need to wear it anymore.On 04/21/26 at 08:30 AM, the signage for EBP was placed back on R107's door, and staff were reeducated to wear the EBP during care because R107 had multiple drug-resistant organisms (MDRO-common bacteria that have developed resistance to multiple types of antibiotics).On 04/22/6 at 01:00 PM, Administrative Nurse D stated she expected staff to continue to wear EBP when warranted.The facility's Enhanced Barrier Precautions policy, dated December 2024, documented that EBP was utilized to prevent the spread of multidrug-resistant organisms to residents. EBP employs gown and glove use in addition to standard precautions during high-contact resident care activities when contact precautions do not otherwise apply. Some high contact examples are dressing, bathing, providing hygiene or grooming, changing briefs, assisting with toileting, and transferring.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation, record review, and interview, the facility failed to provide a safe, functional, sanitary, and comfortable environment in the laundry room. Findings included:- On 04/22/26 at 09:49 AM, observation in the laundry room revealed the following:1. Missing floor tile along the front of the two front loader washing machines and behind the washers, approximately five feet (ft) by eight inches (in). 2. Behind the washing machines were two floor grates, approximately two ft by 18 in with grayish-black fuzzy substance on the top of them.3. The right front loader washing machine had numerous different-sized streaks of dried white substance below the door and on the right side.4. Underneath the sink, located in the clean area, had missing tile approximately two ft by 18 in. On 04/22/27 at 09:49 AM, Laundry Supervisor (LS) U verified the above findings and stated maintenance was responsible for cleaning the area, and the tile was supposed to be replaced a year ago. On 04/22/26 at 11:17 AM, Maintenance Supervisor (MS) V verified the above findings and stated he was responsible for cleaning the areas in the laundry room. MS V stated he was aware the tile needed to be replaced and would order some, and it would be no problem to lay it. The facility's Maintenance Service Policy documented the maintenance department was responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times.