STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175215	A. Building B. Wing	06/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tonganoxie Terrace	1010 East Street Tonganoxie, KS 66086

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 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews, the facility failed to provide Resident (R) 1 with the necessary behavioral health care and services, that included adequate supervision to prevent unwanted touching by R1 to other residents. Findings included:- R1 admitted to the facility on [DATE]. R1's Electronic Medical Record (EMR) documented a diagnosis of personal history of traumatic brain injury (TBI-an injury to the brain caused by external forces). The admission Minimum Data Set (MDS) dated 03/14/26 documented R1 had a Brief Interview for Mental Status (BIMS) score of four, which indicated severe cognitive impairment. R1 had no behaviors in the assessment period. The Cognitive Loss/Dementia Care Area Assessment (CAA) documented R1 had a TBI that affected her cognition. R1's 04/09/26 Care Plan documented she had a behavior problem related to sexual inappropriateness. The Care Plan documented an intervention, dated 04/09/26, that directed, if reasonable, staff to discuss R1's behavior and explained/reinforced why her behavior was inappropriate and/or unacceptable to R1. R1's 04/29/26 Care Plan documented she had a tendency to invade other people's personal space and interrupt conversations. The Care Plan documented the following interventions:- 04/29/26 Staff assisted R1 to develop more appropriate methods of interacting with others.- 04/29/26 Caregivers provided R1 opportunities for positive interaction and attention, including stopping to talk to her as they passed by.- 04/29/26 Staff intervened as necessary to protect the rights of others. Staff approached R1, spoke in a calm manner, diverted her attention, removed R1 from the situation, and took her to alternate locations as needed. R1's EMR documented the following: A Behavioral Note on 04/28/26 at 02:15 PM, documented R1 repeatedly self-propelled in her wheelchair toward a male resident who was engaged in a conversation with another resident. The male resident verbally requested that R1 maintained personal space and to not interrupt his conversation. R1 continued to approach the male resident despite the verbal redirection. Staff intervened, provided redirection, and guided R1 away from the area. R1 engaged in alternate activity. There was no physical contact. Staff continued to monitor for boundary awareness and provided redirection as needed. A Behavioral Note on 05/14/26 at 06:22 PM, documented R1 reached out to touch another resident. Staff immediately redirected R1. A Behavioral Note on 05/15/26 at 01:34 PM, linked to the note on 05/14/26 at 06:22 PM, documented the nurse did not witness the incident. Staff reported to the nurse that R1 attempted to touch another resident, but staff redirected her. R1 did not understand personal boundaries and had to be redirected at times. A Nurses Note on 05/17/26 at 03:11 PM, documented staff reported R1 was observed with her hand down the front of another resident's pants in the activity room. Staff separated the residents. R1 was unable to give a description of the event. Staff assessed R1 and found no new skin issues. Staff placed R1 on one-on-one supervision with staff. The facility notified R1's provider and representative of the incident. The facility's Investigation dated 05/22/26, documented on 05/17/26 at approximately 11:30 AM, R2 worked on a puzzle at a table in the North activity room with the back of his wheelchair facing the hallway camera. Housekeeper U walked past the activity room and saw R1 with her hands inside R1's pants. Review of the camera footage revealed at approximately 11:15 AM, R1 talked to another (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175215	A. Building B. Wing	06/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tonganoxie Terrace	1010 East Street Tonganoxie, KS 66086

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 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident at the nurse's station, and at 11:22 AM she entered the activity room from the left side. The camera only showed the back wheels of R1's wheelchair behind R2's wheelchair. After a short time, R1's wheelchair could no longer be seen on camera as she moved further into the room. At approximately 11:31 AM, Housekeeper U walked past the activity room on the right side and looked inside to witness the interaction between R1 and R2. A short time later, R1 was seen on the right side of the activity room, and a Certified Nurse Aide (CNA) took her to the dining room for lunch. Administrative Staff A arrived at the facility at 12:06 PM to investigate the incident and R2 stated to her that a woman went up to him while he worked on his puzzle and touched his arm. The facility placed R1 on one-on-one supervision immediately after the situation until the psychiatric provider cleared her from the one-on-one and adjusted her medications to help with R1's behaviors. The facility substantiated the incident as abuse for inappropriate touching based on an eyewitness. Housekeeper U's notarized Witness Statement, dated 05/17/26, stated on 05/17/26 at approximately 11:30 AM, she walked by the North nurses station and entered the activity room. She witnessed R1 with her hand inside R2's pants. She stated she immediately informed a CNA. When the CNA arrived, R1 was already leaving the activity room. CNA M's notarized Witness Statement, dated 05/17/26, stated on 05/17/26, she was in the dining room when Housekeeper U told her R1 had her hands in R2's pants in the television (TV) room. She stated she immediately went to the TV room, and R1 wheeled herself out of the doorway. CNA M notified the nurse of the incident and placed R1 in the dining room for lunch. On 06/03/26 at 12:44 PM, R1 sat in her wheelchair at a dining room table. R4 sat at the table immediately to her left. On 06/03/26 at 12:57 PM, R1 self-propelled in her wheelchair in the dining room towards R5. CNA N and CNA O stood in the dining area facing the kitchen door, with their backs to the dining room. R5 stated to R1, no R1, no. R5 asked CNA O to save him. CNA N intervened and propelled R1 out of the dining room. On 06/03/26 at 01:00 PM, CNA N propelled R1 in her wheelchair down the hallway towards the nurse's station. R3 sat in his wheelchair in the area in front of the nurse's station. While CNA N propelled R1 past R3, R1 reached over to R3 and rubbed his right leg as she went by. CNA N did not react to the touching and continued to propel R1 to the front of the nurse's station. Licensed Nurse (LN) G sat behind the nurse's station. On 06/03/26 at 01:56 PM, R5 stated R1 went up to him all of the time, and she was handsy. He stated R1 tried to touch him inappropriately often, but he would run from her. R5 stated R1's behaviors made him feel uncomfortable. He stated that most of the time, there were staff around to tell R1 to stay in her personal space, but not all the time. R5 stated R1 tried to grab his private parts before. He stated he was afraid of having an allegation made against him because of R1's inappropriate behaviors towards him. On 06/03/26 at 12:36 PM, CNA M stated on 05/17/26, she was in the dining room when Housekeeper U stated R1's hands were in R2's pants. CNA M stated when she went to get R1, R1 was already going out of the door. She stated she had last seen R1 about 30 minutes prior at the nurse's station. CNA M stated R1's typical behaviors included touching staff and other residents. She stated R1 tried to wheel up to other residents, and staff redirected her away from the men. She stated she tried to keep an eye on R1 and tried to get her to do activities. CNA M stated she usually took R1 with her to the dining room or to activities or she asked another staff member to keep an eye on her if there were other residents in the area. She stated R1 was easily redirected and was open to activities. On 06/03/26 at 02:22 PM, CNA N stated it was her first day, but she did not get a report when she came in because she moved halls. She stated she thought the CNAs received papers about each resident, but she did not get one. CNA N stated she was not told anything about R1's behaviors. She stated she did see R1 touch R3's leg, but she was unaware of her inappropriate touching behaviors. She stated she did not tell anybody about the leg touch, but she probably should have. On 06/03/26 at 02:26 PM, CNA O stated she received a report sheet that listed the resident's transfer status, their preferred name, and assistance status. She stated the report sheet did not have a resident's behaviors on it unless they were an elopement risk. CNA O stated she knew R1's behaviors from working with her and knew she was very kind which CNA O thought was what made R1 handsy. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175215	A. Building B. Wing	06/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tonganoxie Terrace	1010 East Street Tonganoxie, KS 66086

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 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	She stated most residents did not appreciate R1 touching them. She stated R1 commonly tried to touch residents and staff redirected her, engaged her in activities, or sat her at the nurse's station, which almost always had staff there. On 06/03/26 at 02:50 PM, LN G stated he received a report sheet that gave alerts and cues about the residents. He stated R1 had inappropriate touching behaviors and staff provided cares in pairs and redirection. LN G stated there were usually staff at the nurses station to try and keep an eye on R1. On 06/03/26 at 02:55 PM, Administrative Nurse D stated staff protected other residents from R1's inappropriate touching behaviors by making sure they were kept at an arm's length apart from R1, redirecting R1, and keeping R1 in an area with eyes on her. She stated that all staff were instructed to keep eyes on R1 and try to redirect her. Administrative Nurse D stated staff should always have eyes on R1 while not necessarily having her on one-on-one supervision. She stated there should be a staff member at the nurse's station if R1 was in the area, and they made sure R1 was at an arm's length from other residents. Administrative Nurse D stated staff tried to keep staff around her and to try to not let her touch any other residents. She stated if R1 touched another resident, she expected staff to intervene. She stated R1 was able to inappropriately touch R2 because staff did not have eyes on her, and the facility was aware she had those behaviors, so staff should have kept eyes on her. The facility's Behavioral Health Services policy, dated 2026, directed the facility ensured the necessary behavioral health care services were person-centered and reflected the resident's goals for care, while maximizing the resident's dignity, autonomy, privacy, socialization, independence, choice, and safety. The facility provided behavioral health care and services in an environment conducive to mental and psychosocial well-being.