STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175249	A. Building B. Wing	03/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Health Care Center	1630 W 2nd Street Chanute, KS 66720

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 - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility reported a census of 53 residents. Based on observation, interview and record review, the facility failed to ensure Resident (R) 3 remained free from abuse when he had an unwitnessed fall in his room and Licensed Nurse (LN) G instructed R3 to get onto his hands and knees and lift himself off the floor resulting in feelings of anger and embarrassment for R3.Findings included:- R3's Electronic Health Record (EHR) revealed diagnoses of unspecified sequelae of cerebral infarction (lingering, long-term effects or complications following a stroke [ischemic brain damage] when the specific nature of the aftereffects is not detailed), and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest).R3's Admit Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 14, which indicated intact cognition. The assessment documented R3 utilized a wheelchair and walker for mobility. He was dependent on staff for toileting, lower body dressing and putting on footwear, required partial to moderate staff assistance with upper body dressing, personal and oral hygiene, and required supervision or touching assistance with bathing.The Functional Abilities (Self-Care and Mobility) Care Area Assessment (CAA), dated 02/02/26 documented R3 required staff assistance with all activities of daily living (ADL).The Falls CAA, dated 02/02/26, documented that R3 had fallen at least once since admission and had taken antidepressant (medication used to treat depression) medication, a high-risk medication.The Psychotropic Drug Use CAA, dated 02/02/26, documented that R3 had taken an antidepressant.R3's Care Plan dated 02/19/26 documented R3 was at risk for falls related to weakness and receiving high risk medications. Interventions documented that staff would need to carry out all interventions to prevent R3 from falling.R3's Care Plan dated 02/19/26, documented that R3 had difficulty with personal hygiene, oral care, bathing, bed mobility, toilet use, transfers, dressing, ambulation and locomotion related to post hospital weakness. Interventions instructed staff to provide partial to moderate assistance to R3 with toilet use and repositioning and turning in bed.A Post-Fall Evaluation: Progress Note, documented on 02/12/26 at 02:48 AM, R3 had an unwitnessed fall in his room when trying to self-toilet. R3 fell while trying to transfer from his recliner to his bed.A Nursing: Progress Note, documented on 02/12/26 at 02:31 AM, R3 was sitting up on the floor leaning against the bed, and he had no shoes on and had slick socks on. Staff replaced his socks with gripper socks and donned house slippers on him. Staff then encouraged him to turn around and get on his knees and pull himself up off floor and into bed.An Official Statement, dated 02/12/26, documented Certified Medication Aide (CMA) R received shift report and heard LN G state that R3 had a fall overnight and LN G made R3 remain on the floor, to teach him a lesson, while she completed a few tasks. LN G then made R3 get off the floor without assistance.An Official Statement, dated 02/19/26, documented that R3 had told Administrative Staff A that LN G had instructed him to get into a prayer position and get himself off the floor. The statement further recorded R3 told Administrative Staff A that LN G was upset and argued with him about how many falls he had.On 03/03/26 at 12:17 PM, R3 was in the dining room eating lunch. Staff interacted with him well.On 03/03/26 at 01:50 PM, Certified Nurse Aide (CNA) N stated that if a resident was found on floor, she would make sure they were ok and (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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F 0600 Level of Harm - Actual harm Residents Affected - Few	would then notify the nurse. CNS N said staff should have assisted R3 and not have made him get up by himself.On 03/03/26 at 02:34 PM, Administrative Nurse E stated that she would have assisted R3 up from floor and then followed protocol including notifying the necessary people.On 03/03/26 at 03:05 PM, R3 reported that the nurse on 02/23/26 told him to get into a praying position and to pick himself up off the floor after his fall. He stated the nurse would not assist him and it made him feel angry and very embarrassed.On 03/04/26 at 10:00 AM, Administrative Staff A stated that LN G ?s actions were inappropriate.The facility policy . Abuse, Neglect and Exploitation Policy and Procedure, dated 03/31/20, documented that facility staff would not use or allow others to use verbal, mental, sexual or physical abuse, corporal punishment or unvoluntary seclusion.The facility implemented corrective actions including abuse, neglect and exploitation training completed on of 02/21/26, prior to the onsite survey, therefore the deficient practice was deemed past noncompliance a G representing the actual psychosocial harm for R3.

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. The facility identified a census of 53 residents. Based on record review, observation, and interview, the facility failed to ensure narcotic reconciliation which included regular narcotic counts of all narcotics, including the narcotics stored as overflow. Findings included:-In a facility reported incident, the facility reported that on 02/13/26 at approximately 02:00 PM, staff reported 12 hydrocodone (a potent semi-synthetic opioid analgesic and antitussive used to treat severe pain) were missing.The facility Facility Narcotic Dispensing Record for R1's hydrocodone medication documented that a count of 30 had been crossed out with a line and a count of 18 had been written in and initialed by two individuals and dated and times 02/12/26 at 11:00 PM. It was documented and initialed an amount given of one with the remaining amount of 17.Licensed Nurse (LN) H's Witness Statement, dated 02/16/26, documented that on 02/12/26 she was asked to pull a hydrocodone from the overflow medication, and she and Certified Medication Aide (CMA) R performed a count of the medication in the bottle pulled from the cabinet. There were 18 pills in the bottle, and the count sheet documented 30 pills. LN H then documented that she performed a count correction on the sheet by crossing out the 30 and writing 18, She noted that she became busy and forgot to notify administration of the error.CMA R's Witness Statement, dated 02/13/26, documented that she needed to replace R1's hydrocodone in the CMA medication cart and asked LN H to assist her in retrieving the medication from the overflow cabinet. CMA R documented that when they counted the bottle of pills on 02/12/26, there were only 18 in it and the count sheet said there were 30, CMA R documented that LN H said that the 30 count was another LN's handwriting and LN H changed the count to 18. CMA R documented that she forgot to report the error to the charge nurse until the next day, on 02/13/26.The facility's investigation, dated 02/13/26, documented on 02/12/26 at approximately 10:00 PM, LN H and CMA R pulled R1's hydrocodone from the overflow cabinet to move the medication into the medication cart. When LN H and CMA R counted the pills in the bottle it, there were 12 pills missing. The bottle and narcotic count sheet both stated a count of 30 but the bottle only had 18 pills at that time. This was reported to the Administrative Staff A on 02/13/26 at approximately 02:00 PM and an investigation was initiated. A full narcotic count on all medication storage in the facility was completed at that time with no other discrepancies identified. Residents were monitored for pain out of their normal, and none had been observed.During the investigation the following was revealed:-On 02/06/26, CMA S picked up the bottle of hydrocodone from a third-party pharmacy between 04:43-04:46 PM. This was confirmed with the pharmacist at the pharmacy. The medication was in a brown paper bag and stapled shut with the information sheet attached to the outside of the bag when it arrived at the facility. LN G opened the paper bag and was seen on camera footage locking the bottle up in the overflow cabinet. LN G then made out a narcotic count sheet but did not count the bottle at that time. On 02/06/26 at 06:33 PM, LN G and LN I counted the pills in the bottle and found the count to be correct. The contents of the bottle were not counted again until 02/12/26. Re-education on narcotic count, overflow, re-ordering of medications, and the pulling of medications for destruction was performed; and the overflow count form was changed, and the prescription number was added.Observed on 03/03/26 at 10:20 AM, the medication room near the east entrance was locked and the overflow narcotics were in a cabinet with a red breakaway lock on the cabinet and padlock. Administrative Nurse D and Administrative Nurse E demonstrated that the cabinet could not be opened without unlocking the padlock and the breakaway lock and administrative staff had to replace the breakaway lock.On 03/03/26 at 10:20 AM, CMA T stated that the overflow medications were kept in a medication room behind two locks. CMA T said that the nurses would count the overflow narcotics at shift change and then during the shift when the medications were used, the shift the CMA and nurse performed the count. She said that if the count was off, multiple re-counts were performed for verification and if the count was not correct then Administrative Nurse D and (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administrative Staff A were immediately notified.On 10/20/25 at 10:30 AM, Administrative Nurse D and E stated that the overflow narcotics were kept behind two locks in the medication room, and the padlock on the narcotic cabinet had a red breakaway lock on it and if the tag was intact then a count was not needed, the nurses at shift change performed the count if needed, CMAs were not allowed to perform overflow narcotic counts.On 10/20/25 at 10:40 AM, Administrative Nurse D stated that if a CMA needed a narcotic refill on their cart, then two nurses performed the count and provided the medication to the CMA for the cart. Administrative Nurse D said that if the count was off then several re-count verifications were performed and if the count remained incorrect then she and Administrative Staff A were immediately notified along with the prescribing provider and the medical director, and the facility would get a new prescription to refill the medication so the resident would not be without. On 3/04/26 at 01:45 PM, Administrative Staff A stated that the facility contacted a contractor and had the locks to the medication rooms and cabinets replaced and that the facility contacted the facility pharmacy and paid to have the missing hydrocodone replaced and the facility paid for them.Review of the facility investigation revealed all corrective actions to the onsite survey therefore the deficient practice was deemed past noncompliance.The facility policy Controlled Substance Administration & Accountability, date 02/13/26, documented that it was the policy of the facility to promote safe, high quality patient care, compliant with state and federal regulations regarding monitoring the use of controlled substances. The policy also documented that the facility would have safeguards in place to prevent loss, diversion or accidental exposure.