STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175267	A. Building B. Wing	04/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shawnee Gardens Healthcare & Rehab Center	6416 Long Street Shawnee, KS 66216

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. The facility identified a census of 116 residents. The sample included three residents, with one resident reviewed for abuse. Based on observation, record review, and interviews, the facility failed to report an allegation of abuse from Resident (R) 1 towards R2 to the State Agency (SA). Findings included:- The facility's investigation narrative, dated 03/29/26, signed by Administrative Staff A, Administrative Nurse D, and Social Services X, documented on 03/29/26 at approximately 03:30 PM, Licensed Nurse (LN) G texted Administrative Staff A asking him to call her when he had a few minutes. Administrative Staff A contacted LN G and LN G stated to him that she received a call from a staff member with an allegation at the facility. Administrative Staff A merged the call with Administrative Nurse D then asked LN G to repeat the conversation. LN G stated she received a call from Certified Medication Aide (CMA) R related to an interaction the CMA happened upon between two [cognitively impaired] residents in the facility. Administrative Staff A asked Social Services X to report to the facility along with himself and Administrative Nurse D. Administrative Nurse D entered R2's room, where the resident laid in bed and did not appear to be in distress. Administrative Nurse D asked R2 if she had any concerns about any visitors coming into her room, and R2 said she did not. Administrative Nurse D asked R2 if an unwelcomed visitor entered her room, how she would react, and R2 stated she would tell them to get out of the room. R2 stated if the welcomed visitor made any advancements towards her, she would not be offended to have that interaction with them. Social Services X interviewed R1, who had no recollection of any interaction with R2. CMA R reported when she walked down the hallway to another resident's room, she witnessed R1 rolling himself down the hallway. CMA R stated she advised R1 to turn around and head back to his room then continued to the other resident's room, stopping too close to R2's door as she passed by. CMA R stated she entered R2's room and immediately separated R1 and R2 and R2 yelled and asked CMA R what she was doing. CMA R removed R1 from the room and provided him with snacks and took him to his room. According to the video surveillance, R1 entered R2's room and was in there for one minute and 40 seconds before CMA R entered. The investigation conclusion documented Social Services X assessed R1 and R2 for psychosocial well-being and determined neither resident was at risk from the allegation. As an intervention, the facility connected with R1 and R2's representatives to schedule a care conference related to their loved ones' interactions. The facility waited to hear back from representatives related to the care plan meetings. The facility reviewed R1 and R2's care plans. On 04/07/26 at 11:36 AM, CMA R was unavailable for interview. On 04/07/26 at 11:42 AM, LN G stated she received a call from CMA R on 03/29/26 stating she walked in on R1 in R2's room with his pants down. She stated she asked CMA R what R2 was doing during the incident, and CMA R stated R2 was just lying there. LN G stated she notified Administrative Nurse D first, who told her to call Administrative Staff A, which she did. LN G stated that following day, she went into work and had not seen any incidents created in Risk Management about the allegation. She stated the facility did not put any interventions into place to prevent inappropriate touching between R1 and R2. On 04/07/26 at 01:27 PM, Administrative Staff A stated he had received a text from LN G asking him to call her which he did promptly, and LN G reported an incident of inappropriate touching between R1 and R2. He stated he added Administrative (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
	175267	A. Building B. Wing	04/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shawnee Gardens Healthcare & Rehab Center	6416 Long Street Shawnee, KS 66216

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nurse D to the call to better ascertain the circumstances of the allegation. Administrative Staff A stated when the facility finished their investigation, they involved corporate as well. He stated R1 and R2's families were not very prompt with getting back to the facility about a care plan meeting and the facility was unable to corroborate that the allegation occurred. On 04/07/26 at 03:08 PM, Administrative Nurse D stated the biggest intervention the facility put into place after the allegation was the plan to involve the family in the care plan meeting to discuss the allegation, but the facility had not heard back from R2's family and R1's representative was in the hospital. Administrative Nurse D stated an incident was considered reportable to the SA if it was abuse, neglect, or exploitation with intent and the facility had two hours to report it. She stated the facility had worked through the investigation with corporate and decided not to report the incident. Administrative Nurse D stated any incident that was reportable to the SA would also involve the police and the facility sent in the completed investigation within five business days. On 04/07/26 at 03:30 PM, Administrative Staff A stated the reason the facility did not report this incident was because the facility determined the residents could make decisions on the interaction and the facility could not define if there was willful intent of abuse. He stated the facility reported to the SA on anything that fell under the guidance which included abuse, neglect, and misappropriation of funds. Administrative Staff A stated allegations should be reported if the initial investigation substantiated the allegation and the facility had two hours to report it. He stated the facility reported resident-to-resident altercations if there was unwanted contact made. Administrative Staff A stated the facility sent in the completed investigation within five working days. The facility's Resident Rights to Freedom from Abuse, Neglect, and Exploitation Policy and Procedure, dated 2025, directed in response to allegations of abuse, neglect, exploitation, or mistreatment, the facility ensured all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source, and misappropriation of resident property, were reported in the proper time frame pursuant to the policy. The policy directed the facility reported the results of the investigation to the SA within five working days.