STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175273	A. Building B. Wing	03/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lincoln Care and Rehab	4007 E Lincoln Street Wichita, KS 67218

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50659 The facility reported a census of 39 residents with five residents sampled. Based on observation, interview, and record review the facility failed to develop a comprehensive care plan for Resident (R) 3's risk for elopement (when a cognitively impaired resident leaves the facility without the knowledge or supervision of staff). This deficient practice placed the resident at risk for inadequate care and services. Findings included: - The Electronic Health Records (EHR) documented R3 had diagnoses, which included dementia (progressive mental disorder characterized by failing memory, confusion) and depression. The 01/03/25 Admission Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of eight, which indicated moderately impaired cognition. R3 had a total mood severity score of 00, indicating no depression and there were no behaviors documented on the assessment. R3 was independent with all his activities of daily living (ADLs). R3 wore a Wander Guard (bracelet that sets off an alarm when residents wearing one attempt to exit the building without an escort) used less than daily. The 01/15/25 Cognitive Loss/Dementia Care Area Assessment (CAA) documented R3 had cognitive decline. R3 had poor recall and was not always oriented to situation. R3 was previously homeless prior to hospital stay. The Care Plan lacked any interventions related to R3's elopement potential or actual elopement on 02/22/25. The Physician Orders lacked any orders for a Wander Guard at the time R3's elopement. The 12/23/24 at 02:45 PM Wandering & Elopement Evaluation Admission revealed the resident had a low risk for elopement score of four. The Physician Orders revealed a Wander Guard was ordered on 12/23/25 at 01:18 PM. (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
	175273	A. Building B. Wing	03/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lincoln Care and Rehab	4007 E Lincoln Street Wichita, KS 67218

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 12/2024 Treatment Administration Record (TAR) revealed the resident's Wander Guard was signed off on 12/25/24 as checked daily as that was the first time the Wander Guard order showed up on the TAR. The 12/26/24, unknown time, Physician Progress Note documented a [AGE] year-old male recently admitted to the facility. R3 reported he was previously homeless. R3 stated he wanted to leave the facility and the note indicated the resident used a Wander Guard. Staff would continue to monitor the resident. The 01/05/25 at 11:22 AM Progress Note revealed a new order to discontinue R3's Wander Guard as he had not been exit seeking and no longer talked about wanting to leave the facility. The 01/2025 TAR revealed the resident's Wander Guard was discontinued on 01/05/25. The 02/05/25 at 05:11 PM Progress Note revealed R3 approached staff and asked how to get out of the facility. R3 was advised that he could not leave, became verbally angry, and stated he would leave and find a way. Administrative Staff M was notified of R3 wanting to leave the facility and they placed a Wander Guard on R3's left wrist. The 02/06/25 01:24 PM Progress Note revealed R3 removed the Wander Guard from his wrist and refused to have it placed back on. R3 verbalized he did not want to leave the facility and wanted to have a meeting with his guardian. R3 agreed he would stay at the facility until he could make different plans with his guardian. The 02/08/25 at 12:00 PM Progress Note revealed R3 verbalized to other peers that he could leave facility when he chose to. The facility doors were under maintenance at that time and alarms at the front door were disabled. R3 was asked if he would put a Wander Guard bracelet on, but staff were unable to fit it over his hand. The 02/10/25 at 10:53 AM Progress Note revealed R3 requested a day pass to go out in the community and R3 was reminded that he had a guardian and the facility would need approval from the guardian for the pass. The 02/10/25 at 11:03 AM Progress Note revealed R3 refused to wear the Wander Guard, stating, I will not wear no bracelet for nobody. R3 had the Wander Guard bracelet in his pocket and stated, he would keep it in his pocket. R3 pulled the bracelet out and showed the writer. R3 was not exit seeking at this time, calmly walking around facility, and interacting with staff and others. R3's provider was made aware he refused to wear the wander guard. The 02/22/25 at 01:00 PM Progress Note revealed Licensed Nurse (LN) E was alerted by another resident, that R3 left the facility. LN E ran to the front door and observed R3 walking eastbound on [NAME] Street. LN E called out for R3, and he waved her off. Certified Nurse Aide (CNA) L was instructed to keep an eye on R3 when LN F returned into the facility to retrieve keys to their vehicle and instructed Certified Medication Aide (CMA) H to take CNA L with her in the car to return R3 back to the facility. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175273	A. Building B. Wing	03/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lincoln Care and Rehab	4007 E Lincoln Street Wichita, KS 67218

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/10/25 at 11:35 AM CNA F reported R3 was the only resident who was an elopement risk at the facility and noted an elopement book in the nurse's office. R3's picture and information were in the book. CNA F reported she would look on the resident's care plan to know the care she needed to provide. During an interview on 03/10/25 at 03:20 PM LN D reported R3's care plan did not have elopement risk and or WanderGuard on his care plan until 02/22/25. LN D reported that Administrative Nurses completed the care plans. During an interview on 03/11/25 at 01:38 PM, Administrative Nurse C reported R3 should have been care planned for elopement prior to him eloping. Administrative Nurse C was not aware of why R3 did not have his elopement/elopement risk care planned. The facility's policy 'Comprehensive Care Plans dated 08/2024 documented an individualized comprehensive person centered care plan that includes measurable objectives and time frames to meet the resident's medical, nursing, mental, cultural and psychological needs is developed for each resident. The comprehensive care plan is based on a thorough assessment that includes, but is not limited to, the MDS and physicians' orders. The facility failed to develop a comprehensive care plan for R3's risk for elopement. This deficient practice placed the resident at risk for inadequate care and services.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175273	A. Building B. Wing	03/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lincoln Care and Rehab	4007 E Lincoln Street Wichita, KS 67218

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 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** 50659 The facility reported a census of 39 residents with five residents sampled and one resident reviewed at risk for elopement (when a cognitively impaired resident leaves the facility without the knowledge or supervision of staff). Based on observation, interview, and record review the facility failed to provide adequate supervision to cognitively impaired, independently mobile Resident (R)3, identified as a moderate risk for elopement. At approximately 11:28 AM on 02/22/25 R3 exited the facility when Certified Nurse Aide (CNA) L opened the exit door at the front entrance for another resident to enter into the facility. CNA L reported R3 quickly went out the door and she came back into the facility leaving R3 outside by himself, to inform the Licensed Nurse (LN) E. This deficient practice could potentially result in an injury. Findings included: - The Electronic Health Records (EHR) documented R3 had diagnoses, which included dementia (progressive mental disorder characterized by failing memory, confusion) and depression. The 01/03/25 Admission Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of eight, which indicated moderately impaired cognition. R3 had a total mood severity score of 00, indicating no depression and there were no behaviors documented on the assessment. R3 was independent with all his activities of daily living (ADLs). The 01/15/25 Cognitive Loss/Dementia Care Area Assessment (CAA) documented R3 had cognitive decline. R3 had poor recall and was not always oriented to situation. R3 was previously homeless prior to hospital stay. The Care Plan lacked any interventions related to the resident's elopement risk or elopement on 02/22/25. The Physician Orders lacked any orders for a Wander Guard (bracelet that sets off an alarm when residents wearing one attempt to exit the building without an escort) at the time of the elopement on 02/22/25. The 12/23/24 at 02:45 PM Wandering & Elopement Evaluation Admission revealed the resident had a low risk for elopement. The Physician Orders revealed R3's Wander Guard was ordered on 12/23/25 at 01:18 PM. The 12/2024 Treatment Administration Record (TAR) revealed the resident's Wander Guard was signed off on 12/25/24 as checked daily as that was the first time the Wander Guard order showed up on the TAR. The 12/26/24 unknown time Physician Progress Note documented a [AGE] year-old male recently admitted to facility. R3 reported he was previously homeless. R3 stated he wanted to leave the facility and the note indicated the resident used a Wander Guard. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175273	A. Building B. Wing	03/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lincoln Care and Rehab	4007 E Lincoln Street Wichita, KS 67218

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 01/05/25 at 11:22 AM Progress Note revealed new order to discontinue R3's Wander Guard as he was not exit seeking and did not talk about wanting to leave the facility. The 02/05/25 05:11 PM Progress Note revealed R3 approached staff and asked how to get out of the facility. Staff advised R3 he could not leave the facility and became verbally angry, stating he would leave and find a way. Administrative Staff M was notified and placed a Wander Guard on R3's left wrist. The 02/06/25 01:24 PM Progress Note revealed R3 removed the Wander Guard from his wrist and refused to have it placed back on. R3 verbalized he did not want to leave the facility and wanted to have a meeting with his guardian. R3 agreed he would stay at the facility until he could make different plans with his guardian. The 02/08/25 at 12:00 PM Progress Note revealed R3 verbalized to other peers that he could leave the facility when he chose to. The doors were under maintenance at the time of the note and alarms at the front door were disabled. R3 was asked if he would put a Wander Guard bracelet on, but staff were unable to fit it over his hand. The 02/10/25 at 10:53 AM Progress Note revealed R3 requested day pass to go out in the community. R3 was reminded he had a guardian, and the facility would need approval from the guardian before giving the pass. The 02/10/25 at 11:03 AM Progress Note revealed R3 refused to wear wander guard stating, I will not wear no bracelet for nobody. R3 had Wander Guard bracelet in his pocket and stated, he would keep it in his pocket. R3 pulled the bracelet out and showed the writer. R3 was not exit seeking at the time, calming walking around the facility and interacting with staff and others. R3's provider was made aware refused to wear the wander guard. The 02/22/25 at 01:00 PM Progress Note revealed LN E was alerted by another resident, R3 left the facility. LN E ran to the front door and observed R3 walking eastbound on [NAME] Street. LN E called out for R3, and he waved her off. CNA L was instructed to keep an eye on R3, LN F returned into the facility to retrieve keys to their vehicle and instructed CMA H to take CNA L with her in the car to return R3 back to the facility. The 02/24/25 at 10:37 AM Wandering & Elopement Evaluation revealed the resident had a moderate risk of elopement, with a score of 13. During an interview on 03/10/25 at 11:35 AM CNA F reported R3 was the only resident who was an elopement risk at the facility and noted the elopement book in the nurse's office. R3's picture and information were located in the book. During an observation on 03/10/25 at 11:40 AM R3 had no Wander Guard on his body, R3 was independent with ambulation and required no device. R3 was in his room packing sugar and creamer packets into a gift bag and drinking coffee. R3 was able to lift up his pant legs and arm sleeves and said I cut it off the other day when that nurse put it on my ankle as he pointed to his right ankle. R3 stated I told them I was not going to wear it, and I would get it off. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175273	A. Building B. Wing	03/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lincoln Care and Rehab	4007 E Lincoln Street Wichita, KS 67218

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/10/25 at 11:47 AM, LN D was asked to complete an electronic check on R3's Wander Guard. LN D grabbed the device to check the Wander Guard and went to R3's room to show how it worked. The nurse could not locate R3's Wander Guard. LN D reported she had checked R3's device earlier in the morning and it worked. She placed R3 on a one-on one at that time and reported R3 had removed his device three times since it was placed back on him. During an interview on 03/10/25 at 12:19 PM CNA G reported she was assigned to complete the one-on-one supervision with R3 as he had no Wander Guard on. CNA G reported R3 always made comments that he could leave or wanted to leave since he admitted to the facility, and staff just kept a close eye on him. During an interview on 03/10/25 at 03:20 PM LN D reported R3 returned the Wander Guard bracelet that he had on earlier in the day. LN D reported the bracelet had not been cut, but the band had been stretched so R3 could slide the bracelet off of his foot. R3 remained a one-on-one at this time. LN D confirmed R3 did not have a Wander Guard order in the EHR, from 01/05/25 thru 02/22/25. LN D reported she completed the Wandering & Elopement Evaluation Admission on 12/23/24 and the four score was correct. When LN D reviewed the 02/24/25 Wandering & Elopement Evaluation she reported that R3's should have had a dementia diagnosis and had a history of exiting checked off on that assessment and that would probably make the score higher than a moderate risk of 13. LN D reported that the Wander Guard that was placed in the physician orders on 12/23/25 could have been generated from an admission batch of orders in the EHR, and those orders would have to be confirmed before they would be started on a TAR on 12/25/24. During an interview on 03/10/25 at 05:40 PM, LN E reported she was at the facility the day R3 eloped and stated when CNA L opened the door to let another resident back into the facility and the resident exited. LN E reported she believed CNA L had her eyes on R3 at all times as she saw her at the door after the other resident notified her of R3 exiting. LN E reported she instructed CNA L to watch R3 and then retrieved her vehicle keys and instructed CMA N and CNA L to take the car to bring R3 back to facility. LN E reported R3 crossed the road and headed approximately two blocks from the facility. LN E reported R3 would remove his Wander Guard at times, and staff would keep a close eye on R3 when he made comments of wanting to leave. During an interview on 03/11/25 at 01:38 PM, Administrative Nurse C reported R3 should have been care planned for elopement prior to him eloping. Administrative Nurse C was not aware of why R3 did not have his elopement risk or actual elopement identified on his care plan. Administrative Nurse C reported R3 should have had an Wandering & Elopement Evaluation completed the day he eloped, and the diagnosis of dementia and history of exit should have been checked off on the 02/24/25 Wandering & Elopement Evaluation which may have created a high risk for elopement score. Administrative Nurse C reported R3 should have had a Wandering and Elopement Evaluation completed 02/05/25 when the Wander Guard bracelet was applied. Administrative Nurse C reported staff would keep a close eye on R3 when he made verbal comments that he wanted to leave, but he wanted candy or money to buy candy. The staff would purchase R3 the items he requested. The facility's policy Accident - Elopement dated 08/2024 documented elopement is a situation in which a resident leaves the premises or a safe area without the facility's knowledge or supervision. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175273	A. Building B. Wing	03/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lincoln Care and Rehab	4007 E Lincoln Street Wichita, KS 67218

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's investigation for Incident # KS00193761 the facility implemented a plan of correction with all staff education, all residents reviewed for elopement, all care plans updated, policies reviewed, and elopement drill and audits were completed by 03/02/2025. The surveyor verified the above corrective actions were completed prior to the on-site survey on 03/11/25. The facility's policy Accident - Elopement dated 08/24 documented elopement is a situation in which a resident leaves the premises or a safe area without the facility's knowledge or supervision. The facility failed to provide adequate supervision to cognitively impaired, independently mobile Resident (R)3, identified as a moderate risk for elopement. Due to the corrective actions the facility completed prior to the onsite survey, the deficient practice was deemed past noncompliance at a D (isolated, potential for harm) scope and severity.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175273	A. Building B. Wing	03/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lincoln Care and Rehab	4007 E Lincoln Street Wichita, KS 67218

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 0805 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. 50659 The facility reported a census of 39 residents with five residents sampled and one resident reviewed for served food in a form that met the resident's individual needs. Based on observation, interview, and record review, the facility failed to ensure staff provided cognitively impaired Resident (R) 2 with her prescribed mechanical soft diet (a modified diet that consists of soft, easy-to-chew foods that require minimal chewing) with ground meat texture, and instead served cut-up chicken to the resident, on her plate. R2 began to cough and choked on her food. The staff had to suction R2 when R2 could not clear her airway with coughing. The facility transferred R2 to the hospital later that evening. The hospital admitted R2 for fever, pneumonia, and dehydration. This deficient practice placed all residents at risk in immediate jeopardy. Findings Included: - Review of the Electronic Health Record (EHR) documented R2 had diagnoses of dysphagia (swallowing difficulty), and dementia (progressive mental disorder characterized by failing memory, confusion). The 12/08/24 Annual Minimum Data Set (MDS) documented the resident had a Brief Interview for Mental Status (BIMS) score of 99, which indicated severely impaired cognition. R2 required supervision assistance with activities of daily living (ADL) of eating. R2 required a mechanically altered diet (modifying food textures by chopping, grinding, or pureeing foods to make them easier to chew and swallow, especially for individuals with difficulty swallowing or chewing). The 12/27/24 Nutrition Status Care Area Assessment (CAA) documented R2's weight was stable with a nutritional status identified as at risk for decline. The CAA noted it was important to ensure R2 received adequate nutrition. The resident's plan of care included to ensure adequate nutrition plan is in place. The 12/27/24 Cognitive Loss/Dementia CAA documented R2 had a diagnosis of dementia and dysphagia, R2 could verbalize her needs though was hard to understand R2 at times and required extra time for communications or alternate forms of communications. The 09/19/24 Quarterly MDS documented the resident had a BIMS score of five, which indicated severely impaired cognition. R2 required supervision for eating and a mechanically altered diet. The resident's Care Plan documented R2 was at risk for altered nutritional status. and included the following interventions: 02/22/17 - Staff were instructed to provide set-up assist for eating. 02/21/17 - Staff were instructed to monitor diet texture intolerance or chewing difficulty. 01/24/23 - Staff were instructed to serve diet as ordered and monitor intake and record. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175273	A. Building B. Wing	03/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lincoln Care and Rehab	4007 E Lincoln Street Wichita, KS 67218

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 0805 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	06/04/23 - Staff were instructed to monitor R2 at meals and snack times, as R2 had experienced coughing/choking episode 12/2022. R2 and durable power of attorney (DPOA- legal document that named a person to make healthcare decisions when the resident was no longer able to) educated on risks vs benefits of mechanical soft texture diet, thin liquids. R2's diet was modified per R2's request from a puree texture diet to a mechanical soft texture diet. 06/04/23 - Staff were instructed to serve diet as ordered, mechanical soft, ground meats, and thin liquids. Review of the Physician Orders documented on 02/09/23 the resident required a regular diet, with mechanical soft, ground meat texture ordered, related to dysphagia. The 02/24/25 at 01:50 PM Progress Note revealed Administrative Nurse B was alerted that R2 had a possible choking episode in the dining room. Staff observed R2 in her wheelchair coughing, with blue coloring noted to her lips. R2 was encouraged to cough harder and was able to cough up a moderate amount of mushy substance. Administrative Nurse C suctioned R2, which resulted in a moderate amount of thick clear mucus. After suctioning, R2's lips and skin were pink. The resident's physician ordered a chest Xray. The 02/24/25 at 07:08 PM Progress Note revealed R2 had made loud grimacing sounds, was inconsolable, skin color ashen (pale gray color), and staff noted foam on the corners of her mouth. The resident's oxygen saturation (percentage of oxygen in the blood) measured 77 percent on room air and R2's use of accessory muscles (when more effort is required to breathe) were noted. The resident's pulse was 142 and temperature was 97.8 Fahrenheit. Staff assisted R2 to her wheelchair, applied oxygen at four liters via nasal cannula. Lung sounds of crackles and rhonchi (coarse, low-pitched, rattling sounds heard in the lungs during breathing) were noted to the resident's upper lobes, and staff were unable to assess the lower lobes. During this time chest Xray results were received with new pulmonary opacities (areas of increased density) in the lung bases, which was concerning for bronchopneumonia (a type of pneumonia, a condition that causes inflammation of the lungs). Staff were unable to increase the resident's oxygen saturation reading above 83 percent on oxygen tank. At 07:16 PM the resident's physician was notified and gave an order to send R2 to the hospital. The 02/25/25 at 01:01 AM Progress Note revealed R2 admitted to the hospital for pneumonia, fever, and dehydration. The 02/27/25 Hospital Discharge note revealed R2 had a diagnosis of aspiration pneumonia. During an interview on 03/10/25 at 01:59 PM Certified Nurse Aide (CNA) F reported staff had to be present in the dining room for all meals, if a resident was on an altered mechanical diet. CNA F reported those residents could not eat in their rooms unless someone was present with them. Dietary staff were not to serve diets unless nursing staff were present in the dining room. CNA F reported that R2 received chopped meat for her meals many times prior to her choking episode in February 2025. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175273	A. Building B. Wing	03/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lincoln Care and Rehab	4007 E Lincoln Street Wichita, KS 67218

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 0805 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 03/10/25 at 02:10 PM, Dietary Staff F, reported he was here the day R2 choked on her cut up chicken and reported R2 had no problems days prior to or at breakfast the day of her choking when she ate. R2 received her meat cut up and reported he was told to serve it that way, as that was how R2 wanted her food. Dietary Staff F reported after the resident choked R2's food was served at a mechanical soft consistency, and she pointed at the food processor the cook used to prepare the food. Dietary Staff F reported he received education after R2 choked. Dietary Staff showed the new laminated cards that were created for all the residents. R2's laminated card revealed mechanical soft diet and choking hazard. Dietary Staff F reported the only new item on R2's card was the choking hazard. During an interview on 03/10/25 at 02:22 PM, Dietary Staff I (Cook), reported she was here the day R2 choked on her cut up chicken. Dietary Staff I reported she prepared R2's plate of food, covered it up, placed it in the steam table, and went on lunch break. Dietary Staff I reported she was trained to just cut up R2's food and reported doing that since she was hired in May 2024. Dietary Staff I reported she was suspended until she had education on how to prepare food that was ordered for the residents. Dietary Staff I reported there was new laminated cards created after R2 had the choking episode. She reported the old, laminated card did not state R2 was a choking hazard like the new card stated. Dietary Staff I reported the facility had a total of four residents on mechanical soft diets. Dietary Staff I reported that R6 received her meats just cut up also until R2 had the choking episode. Dietary Staff I reported the other two residents received the correct mechanical soft diet. During an interview on 03/10/25 at 02:32 PM, CNA G reported before dietary staff served the resident in the dining room, nursing staff should be in the dining room to assist the residents. CNA G reported staff should let the dietary staff know if there was a concern with the food and consistency the residents received for their meal. CNA G was not sure how long R2 received cut up food instead of the ground soft food. CNA G stated R2 had not complained since she started receiving ground food after she had a choking episode but noted she would voice it, if she did not like it. During an interview on 03/10/25 at 02:43 PM R6 who had a BIMS 15 reported that her meat was not always ground up she use to receive her meat cut up until recently. During an interview on 03/10/25 at 02:45 PM Dietary Staff F reported R6's meat was cut up before R2 choked and noted now she required a mechanical soft ground meat consistency. During an interview on 03/10/25 at 03:27 PM Licensed Nurse (LN) D reported R2 had a near choking episode on 02/24/25 and reported that Administrative Nurse C and Administrative Nurse B witnessed the choking episode. She reported Administrative Nurse C suctioned R2 to get the food out of her throat. LN D reported R2 required a mechanical soft diet. LN D stated R2 and her DPOA signed a risk versus benefit agreement for no pureed foods a long time ago, but agreement was not for a mechanical soft diet. LN D reported there was not a nurse in the dining room when R2 choked. She reported someone from management, and the medication aide should be in the dining room for meals. LN D reported R2 was left in the dining room by herself and then served her meal the day she had the choking episode. LN D reported she worked the day R2 had a near choking episode and assessed R2 later that day. During an interview on 03/10/25 at 04:06 PM, Activity Director J reported she believed R2 received the correct consistency the day she had the choking episode. Activity Director J reported she did get alarmed as R2 was coughing so Activity Director J stopped Administrative Nurse B and Administrative Nurse C to assess R2 in the dining room. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175273	A. Building B. Wing	03/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lincoln Care and Rehab	4007 E Lincoln Street Wichita, KS 67218

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 0805 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 03/11/25 at 08:12 AM, Administrative Nurse C reported that she was called into the dining room by Activity Director J when she was walking by with Administrative Nurse B. Activity Director J requested assistance for R2 who was coughing. Administrative Nurse C reported R2 had a very wet cough and was not able to clear her airway enough. Administrative Nurse C reported she hit R2's back to assist her and she stopped coughing and made a gurgle sound. Administrative Nurse C reported she placed a glove on her hand and assessed R2's mouth and was able to remove a little piece of chicken and saliva. Administrative Nurse C reported Administrative Nurse B retrieved the crash cart and Administrative Nurse C noticed R2 had her dentures in her mouth and removed the dentures then suctioned R2 with a yankauer suction catheter (a medical device used to remove fluid and debris from the mouth or airway) orally for about thirty seconds. Administrative Nurse C reported she suctioned phlegm and R2 had stopped coughing and a chest Xray was ordered. Administrative Nurse C reported she had not realized what type of diet consistency R2 ordered prior to the choking episode and reported R2 received cut up chicken for her meal that day and not a mechanical soft diet. During an interview on 03/11/25 at 03:58 PM with Consultant Staff K (Registered Dietician) reported the mechanical soft diet order was more for the meat consistency, and she did have a concern R2 received cut up chicken instead of the ground chicken the day R2 choked on her food that was served by the facility staff. The facility's policy Therapeutic Diets dated 10/2024 documented mechanically altered diets mean one in which the texture of diet is altered. When the texture is modified, the type of texture modification must be specific and part of the physician's order. The facility's policy Tray Identification dated 10/2024 documented to assist in setting up and serving the correct food trays/diets to residents. The food service manager or supervisor would check trays for correct diets before the food is transported to designated area. Nursing staff should check each food tray for correct diet before serving resident. If there is an error, the nurse supervisor would notify the dietary staff immediately so the appropriate food could be served. On 03/11/25 at 05:40 PM, Administrative Staff A and Administrative Nurse C were provided the Immediate Jeopardy (IJ) template and notified the facility failed to ensure staff provided cognitively impaired Resident (R) 2 with her prescribed mechanical soft diet with ground meat texture, and instead served cut-up chicken to the resident, on her plate. R2 began to cough and choked on her food. The staff had to suction R2 when R2 could not clear her airway with coughing. The facility transferred R2 to the hospital later that evening. The hospital admitted R2 for fever, pneumonia, and dehydration. This deficient practice placed all residents at risk in immediate jeopardy. The facility identified and implemented the following corrective actions, completed on 03/02/25 after R2's choking episode. 1. Suspended the employee who prepared the food. 2. An Ad Hoc Quality Assurance and Performance Improvement (QAPI) meeting held by interdisciplinary team on 02/26/25. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175273	A. Building B. Wing	03/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lincoln Care and Rehab	4007 E Lincoln Street Wichita, KS 67218

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 0805 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	3. Re-educated staff mitigation for choking to include reeducation on following care plans and food prep per diet classification. 4. Audit of all the residents diet classifications orders and care plans. 5. Audit of tray cards for correct diet classifications. 6. Correction of care plans and tray cards if discrepancies found. 7. Audit diets prepared correctly with two cooks, two times a week for 30 days. 8. Audit of altered diets two times a week for 30 days. 9. Administrator oversight of audits and dietary choking compliance. Due to the corrective actions the facility completed prior to the onsite visit, the deficient practice was deemed past non-compliance and existed at a J (isolated, immediate jeopardy) scope and severity.