STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175324	A. Building B. Wing	01/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
El Dorado Care and Rehab	900 Country Club Lane El Dorado, KS 67042

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility reported a census of 37 residents. The sample included eight residents who were reviewed for misappropriation. Based on observation, interview, and record review, the facility failed to ensure Resident (R)1, R2, and R3 remained free from misappropriation when staff wrote checks and forged signatures to cash the checks without appropriate authorization.Findings included:- R1's Electronic Health Record (EHR) revealed diagnoses that included dementia (a progressive mental disorder characterized by failing memory and confusion), cognitive communication deficit, generalized muscle weakness, and a need for assistance with personal care.R1's Annual Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 11, which indicated moderately impaired cognition. The assessment documented that R1 had minimal difficulty hearing but did not have hearing aid devices. R1 required supervision or setup assistance with most activities of daily living (ADL).R1's Quarterly MDS dated [DATE] documented a BIMS score of nine, which indicated moderately impaired cognition. The assessment documented R1 had minimal difficulty hearing but did not have hearing aid devices. R1 was dependent on staff for lower body dressing, including shoes, and required substantial or maximal assistance for most other ADL; she required partial or moderate assistance for eating and oral hygiene.R1's Cognitive Loss / Dementia Care Area Assessment (CAA) documented R1 had a diagnosis of dementia.R1's EHR lacked evidence of authorization from R1 or R1's representative to manage R1's personal funds.Review of facility investigation notes revealed the following information: On [DATE] at approximately 04:45 PM, R1's representative called Administrative Staff A to Administrative Staff B's office. R1's representative informed Administrative Staff A that R1's bank notified her of two suspicious checks that were deposited into Administrative Staff B's personal account. Administrative Staff B gave a written statement of the incident and was placed on suspension pending the outcome of an investigation by the facility. The facility informed Law Enforcement ([NAME]) regarding the suspicion of a crime. On [DATE], the facility terminated Administrative Staff B's employment.Administrative Staff B's undated and unnotarized Witness Statement noted Administrative Staff B started employment at the facility in [DATE]. Administrative Staff B noted that at that time, she received permission from R1's representative to take full responsibility for R1's financials and to pursue the facility being the representative payee for R1. Administrative Staff B stated in [DATE] she wrote a check for around $15,000, but she had to sign for R1 since R1 was unable to sign. The amount of the check was applied to R1's liability towards the facility. Administrative B stated in [DATE], in order to do a spend-down required to get R1's Medicaid application approved, she wrote two checks, one for $764.00 and one for $1800.00, made out to the facility, in care of herself. She stated she took the checks to her personal bank and cashed them. Administrative Staff B documented that she brought the money to the facility and put it in the safe. When the bank called to inquire, she attempted to explain the situation, but the bank recalled the checks, which dropped the balance of Administrative Staff B's personal account for the (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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	amounts of the checks, so Administrative Staff B took the cash and deposited it in her personal account. Administrative Staff B documented R1's representative took R1's checkbook.R1's representative's notarized statement, dated [DATE], documented that the bank's fraud department contacted her about checks that had been written on R1's account. The bank advised her to go talk with whoever oversaw R1's accounts at the facility and to try to find out what was happening. The bank notified R1's representative that they had contacted Administrative Staff B, so that is whom she talked to when she came to the facility. R1's representative stated that Administrative Staff B reported the bank had called, so she had returned the money, so it should not be a problem. R1's representative noted that Administrative Staff B said that she put the money in the closet because R1 would not have any spending money once she went on Medicaid. Administrative Staff B indicated she planned to put the money back into R1's account after Medicaid was started. Administrative Staff B wanted R1's representative call the bank back to tell them everything was okay, so R1's representative left the facility, went home, and called the bank to relay the message. The bank then directed R1's representative to go back to the facility, get the checkbook, and get Administrative Staff A involved. R1's representative returned to the facility and met with Administrative Staff A and Administrative Staff B. Administrative Staff B admitted she had deposited R1's checks into her personal account, then Administrative Staff A immediately took Administrative Staff B to another office to write a statement.During an observation on [DATE] at 12:45 PM, R1 sat in a wheelchair in a common area near the front door with peers and staff present.During an interview on [DATE] at 09:32 AM, Administrative Staff A stated that on [DATE] at approximately 04:45 PM, she was contacted by R1's representative, who was at the facility and was visibly upset. R1's representative alleged that Administrative Staff B had deposited two checks from R1's private account into her personal account. R1's representative reported that they were contacted by the bank's fraud department about suspicious activity. The bank's fraud department had marked a check for $768.00 and a check for $1,800.00 as suspicious, as they were deposited into Administrative Staff B's personal account rather than the facility's business account. Administrative Staff A reported that Administrative Staff B had received permission from R1 and R1's representative to spend down the balance of R1's account so R1 would meet Medicaid's asset requirements. Administrative staff A revealed that Administrative Staff B's rationale was to deposit monies from R1's account into Administrative Staff B's personal account, then withdraw the cash and bring it to the facility to place in the facility's safe for R1 to use after the authorization or start of Medicaid. Administrative Staff A stated the facility's expectation was that the monies should have been placed either in the resident's trust account or applied to the resident's outstanding bill to the facility. Administrative Staff A reported that Administrative Staff B was taken to Administrative Nurse D's office, where she provided a written statement, then was suspended pending the outcome of the facility's investigation and was terminated on [DATE]. Administrative Staff A reported the incident to local [NAME] for them to investigate.During an interview on [DATE] at 12:57 PM, R1's representative confirmed she was R1's representative and stated she received a telephone call from R1's bank's fraud department, which perceived that there were irregularities with the approved signatures on R1's checks; the bank advised her to go to the facility and retrieve R1's checkbook. R1's representative stated she went to the facility on [DATE] and confronted Administrative Staff B. She said Administrative Staff B appeared nervous and confirmed she had deposited checks from R1's checkbook into her personal account so that R1 would have money after Medicaid was initiated. R1's representative said that Administrative Staff B said she planned on putting the money in a closet and planned to return the money to R1 after Medicaid started. She said Administrative Staff B reported receiving a call from R1's (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	bank informing her that they had returned the money to R1's account. Administrative Staff B told her to go home and call the bank because the money had already been returned to R1's account. R1's representative said she then left the facility without R1's checkbook, went home, and called the bank, which then advised her to go back to the facility and demand that R1's checkbook be returned to her. R1's representative said she returned to the facility and contacted Administrative Staff A. R1's representative provided a document from R1's bank that documented the check for $769.00 and the check for $1,800.00 were returned to R1's account.In an email on [DATE], Administrative Staff A stated the facility's ongoing investigation revealed two additional instances where Administrative Staff B forged her signature to cash checks. The issue resulted in misappropriation of $10.56 for R2 and $115.07 for R3. Administrative Staff A stated the facility had returned the monies to those deceased residents and updated [NAME].The facility's Abuse Prevention Program F600 policy, dated 08/2025, documents that residents have the right to be free from misappropriation of property and exploitation.The facility's Management of Residents' Personal Funds F567 policy dated 08/2025 documented that the facility would manage the personal funds of residents who request the facility to do so. The authorization from the resident or their representative would be in writing, and a copy of such authorization must be in the resident's EHR.