STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175383	A. Building B. Wing	03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wesley Towers Inc	700 Monterey Pl Hutchinson, KS 67502

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. The facility reported a census of 45 residents, including 13 residents in the sample. Based on observation, interview and record review the facility failed to Ensure adequate infection control practices related to clean Hoyer lift slings. Findings included:- On 03/10/26 at 09:30 AM, an observation of the clean linen room revealed wall pegs to hold the Hoyer lift (mechanical device used to transfer individuals between surfaces) slings, 14 slings were placed on the pegs in the clean linen room these pegs did not keep the slings or the straps from lying on the floor. On 03/10/26 at 11:30 AM, an interview with Housekeeping Staff V revealed the slings touching the floor in the clean laundry room were like this since Housekeeping Staff V started working at the facility. 03/10/26 at 11:40 AM, an interview with Housekeeping Staff U during the observation of the clean linen room storage room revealed the slings have always hung on the pegs attached to the wall and the slings have always touched the floor since starting here one and half years ago. 03/10/26 at 2:40 PM, during the second observation of the clean linen room, the slings were placed correctly on the pegs which prevented the slings and straps from touching the floor. On 03/10/26 at 2:45 PM, an interview with Administrative Staff D revealed she expected the staff to keep the slings off the floor. The facilities policy Infection Prevention and Control Policy, revised on 10/25, revealed the facility has established and maintains an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment to help prevent the development and transmission of communicable diseases and infection as pre accepted national stands and guidelines. Per Equipment Protocol, all reusable items and equipment requiring special cleaning, disinfection, or sterilization shall be cleaned in accordance with our current procedure governing the cleaning and sterilization of soiled or contaminated equipment.

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 45 residents. The sample included 13 residents, of which five residents were reviewed for unnecessary medications. Based on observation, record review, and interview, the facility failed to ensure Resident (R) 2 received as-needed (PRN) Clonazepam (an antianxiety medication that would calm and relax people with excessive restlessness, nervousness and tension) without a 14 day stop date or definitive end date for use. Findings included: - Resident 2's diagnoses included anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), gastroparesis (a chronic condition where stomach muscles work poorly, causing delayed emptying of food into the small intestines without a physical blockage), and gastroesophageal reflux disease (GERD-backflow of stomach contents to the esophagus) and nausea. The quarterly Minimum Data Set (MDS), dated [DATE], recorded the R2 had a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS recorded R2 received antianxiety (class of medications that calm and relax people) and antidepressant (class of medications used to treat mood disorders) medications. The Psychotropic Drug Use Care Area Assessment (CAA), dated 10/04/25, documented R2 received psychotropic medications, and staff would monitor R2 every shift for side effects and the physician would be notified of abnormal findings. The CAA documented that a pharmacist consultant would review R2's medications monthly and the primary care physician would review R2's medication with each visit. R2 received the medication due to a history of insomnia and anxiety. The Care Plan, dated 02/17/26, recorded R2 received Clonazepam (antianxiety medication) for anxiety including restlessness, worrying, frequent repetitive health concerns and questions, sleep disturbance, and refusal of care. The care plan documented staff would monitor R2 for adverse reactions, which included drowsiness, lack of energy, clumsiness, slurred speech, confusion, and impaired thinking and judgement. The Physician Order, dated 03/04/26, directed staff to administer Clonazepam, 0.5 milligrams, one tablet, every 12 hours as needed for anxiety. The resident's medical record lacked documentation the PRN Clonazepam had a 14 day stop date or specific date to stop the medication. On 03/10/26 at 07:50 AM, an observation revealed R2 in her recliner, dressed in pajamas. Licensed Nurse (LN) H administered the resident's morning medications. On 03/11/26 at 07:50 AM, Administrative Nurse D verified the resident PRN order for Clonazepam, one tablet every 12 hours as needed. Administrative Nurse D also stated R2 routinely used the medication twice daily and verified the order did not have a 14 day stop date and lacked an end date for use. The facility's Psychotropic Medication policy, dated December 2022, recorded residents were not administered psychotropic medications unless the medication was necessary to treat a specify condition as diagnosed and documented in the clinical record, and the medication is beneficial to the resident, as demonstrated by monitoring and documentation of the resident's response to the medication. The policy documented PRN orders for all psychotropic medications would be used only when the medication was necessary to treat a diagnosed specific condition that is documented in the clinical record, and for a limited duration-such as 14 days. If the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she shall document their rationale in the resident's medical record and indicate the duration for the PRN order.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 45 residents. The sample included 13 residents, with one reviewed for nutrition/hydration status. Based on observation, record review, and interview, the facility failed to update Resident (R) 11's care plan, who was at risk for elopement with a section with instructions to staff on interventions to prevent R11 from eloping. Findings included:- R11's Electronic Medical Record (EMR) documented diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion), anxiety disorder (a progressive mental disorder characterized by failing memory and confusion), and psychotic disturbance (any major mental disorder characterized by a gross impairment in reality perception). R11's Quarterly Minimum Data Set (MDS), dated [DATE], documented she had a Brief Interview for Mental Status (BIMS) score of one, which indicated severely impaired cognition. The MDS documented R11 required supervision with ambulation and used a walker or wheelchair for mobility. The MDS documented R11 had no upper or lower extremity impairment. The MDS documented R11 had no falls since the prior assessment. The Elopement Assessment, dated 12/20/25, documented the resident had a score of five, which indicated R11 was at risk for elopement. R11's Care Plan, revised 12/23/25, documented R11 required supervision to substantial staff assistance with activities of daily living (ADLs). The care plan lacked a section regarding elopement with instructions to staff for interventions to prevent elopement. On 03/11/26 at 11:00 AM, observation revealed R11 sat in a chair by the dining room window in the front entrance hallway, eating a snack with her walker in front of her. On 03/11/26 at 08:30 AM, Administrative Nurse D verified R11's care plan lacked a section regarding elopement, and the 12/20/25 elopement assessment placed her at risk for elopement. Administrative Nurse D stated residents are assessed for elopement risk on admission, quarterly, with significant change, and annually. The facility's Comprehensive Care Plans Policy, revised 10/25, documented the comprehensive care plan would be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly MDS assessment, and significant change assessment.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 45 residents. The sample included 13 residents, with one reviewed for activities of daily living (ADL). Based on observation, record review and interview, the facility failed to provide care and services for Resident (R)29 regarding personal hygiene and grooming. Findings included: - R29's Quarterly Minimum Data Set (MDS), dated [DATE], indicated the resident had a Brief Interview for Mental Status (BIMS) score of 15 indicating resident was cognitively intact. The MDS documented R29 was independent with staff oversight for personal hygiene; The MDS noted that a shower or bath was not attempted due to medical condition or safety concerns. R29's Care Plan, dated 01/31/26, indicated R29 had ADL self-care performance deficits and staff would check her nail length and trim and clean on bath days and as necessary and report any changes to the nurse. The care plan lacked further documentation on bathing needs. On 03/09/26 at 03:30 PM, observation revealed R29 sat in a recliner in her room, dressed in street clothes. Her hair was uncombed, and she had white hair visible on her chin. On 03/10/26 at 08:00 AM, observation revealed R29 sat at the dining room table with other residents eating lunch. Her hair was uncombed, and she had white hair visible on her chin. On 03/10/26 at 12:30 PM, Administrative Nurse D verified R29 had white hair stubble on her chin and said staff should shave R29's face on shower days. Administrative Nurse D stated the shower/bath sheets were for staff to documents if they shaved the residents and verified R29 had a shower on 03/06/26 and staff did not shave her face. The facility ADL policy, dated November 2023, documented all residents are bathed as often as necessary to maintain cleanliness, refresh, and stimulate circulation. Tub baths and showers are provided by all nursing staff two times a week, as tolerated, and/or as needed. Residents skin conditions are monitored with each bath. The policy documented that staff would assist the residents with bathing as needed and to dress and shave.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 45 residents. The sample included 13 residents, with one reviewed for hydration. Based on observation, record review, and interview, the facility staff failed to consistently monitor Resident (R) 20's fluid intake related to a physician-ordered fluid restriction. Findings included:- R20's Electronic Medical Record (EMR) documented diagnoses of chronic respiratory failure and ascites (an abnormal buildup of fluid in the abdomen that may cause swelling). R20's Quarterly Minimum Data Set (MDS), dated [DATE], documented a Brief Interview of Mental Status (BIMS) score of 13, which indicated intact cognition. The MDS documented R20 required supervision with upper body dressing and rolling left to right in bed; partial to moderate assist with toileting hygiene, showering, putting on and taking off footwear, personal hygiene, and transfers; substantial to maximal assist with lower body dressing. She was dependent on staff for mobility in a manual wheelchair. R20's Care Plan, revised on 01/18/26, documented she had a 1500 milliliter (ml) fluid restriction per day. The Physician Order, dated 03/05/26, instructed staff to provide R20 with a 1500 ml fluid restriction daily (650 ml 06:00 AM-02:00 PM, 650 ml 02:00 PM-10:00 PM, and 200ml 10:00 PM-06:00 AM) R20's March 2026 Medication Administration Record (MAR) lacked amounts of fluid intake on each shift. The [NAME] (computer documentation system) used by the nurse aides had documentation of fluid intake for one shift on two days. On 03/11/26 at 08:00 PM, observation revealed R20's bedside table had a pitcher on it with 600 ml of water. On 03/11/26 at 07:55 AM, Certified Nurse Aide (CNA) M stated the facility had one resident on a fluid restriction. CNA M stated that at the end of her shift, she gave the nurse a piece of paper with the amount of fluid R20 drank during that shift. On 03/11/26 at 08:00 AM, Licensed Nurse (LN) G verified R20's MAR lacked documentation regarding the amount of fluid R20 consumed on each shift and stated the CNAs should document the amounts intake. On 03/11/26 at 08:22 AM, Dietary Staff CC stated she did not record fluid intake for the residents at meals. Dietary Staff CC stated she was told to give R20 a 12-ounce glass of whatever fluid she requested. On 03/11/26 at 08:11 AM, Administrative Nurse D verified staff were not consistently documenting R20's fluid intake in the [NAME] system and stated they should be. The facility's Fluid Restriction Policy, revised 11/23, documented that fluid restrictions would be documented in the EMR records by CNA/CMA with a check mark noting that the CNA/CMA is aware of the fluid restriction. The CNA/CMA would document the fluid intake on the meal percentage sheet each meal, and at the end of the shift would give the total intake to the LN/CMA to document in the vital stats tab in the EMR.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. The facility reported a census of 45 residents and two kitchens. Based on observation, interview, and record review, the facility failed to ensure staff served meals at safe and appetizing temperatures. This was evident by the low temperature of food items on the last meal tray (test tray) from the kitchen on 03/11/26. Findings included:- During an observation on 03/11/26 at 11:35 AM, Dietary Staff (DS) DD prepared six servings of cooked roast beef with a temperature of 171 degrees Fahrenheit (F), cooked mashed potatoes and brown gravy with a temperature of 152 degrees F, and cooked peas with a temperature of 158 degrees F. Dietary Staff DD placed the cooked food onto covered heated plates which were then placed onto an open serving cart. On 03/11/26 at 11:50 AM, upon delivering the last meal tray (test tray) from the kitchen to the surveyor, DS DD took the temperature of the food items upon the tray and reported: cooked roast beef temperature of 122 degrees F, and cooked peas temperature of 132 degrees F. During an interview on 03/11/26 at 11:50 AM, Dietary Staff DD stated he expected the temperature of all hot cooked food items served to residents to be around 145 degrees F. During an interview on 03/11/26 at 11:40 AM, Staff CC stated hot food should have a temperature of at least 145 degrees, before it is served to residents. During an interview on 03/11/26 at 11:50 AM, Dietary Staff BB stated she expected the dietary staff to serve hot food to residents at the appropriate temperatures, over 140 degrees F. Staff BB said she expected staff to not serve hot food to residents that was not at least 140 degrees F. During an interview on 03/10/26 at 2:00 PM, R40 stated the food was cold most of the time. During record review on 03/10/26, Summary of Resident Council Meeting Minutes for the year 2026 revealed resident complaints of cold food from 19 residents in attendance at the meeting. The facility's policy Food Preparation and Handling, dated 03/25/21, documented all food items and products served to elders that will be prepared or served from/in a central kitchen and/or neighborhood kitchen/serving area will be according to standardized recipes. Food items would be prepared using methods and techniques designed to preserve maximum nutritive value, enhance flavor and be free of injurious organisms and substances. The facility's policy lacked the holding temperature of food.