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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175452	A. Building B. Wing	01/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Orchard Gardens	1600 S Woodlawn Blvd 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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. The facility had a census of 72 residents. The sample included eight residents, with three residents reviewed for involuntary discharge. Based on interview and record review, the facility failed to provide a complete recapitulation of Resident (R) 3's stays in the facility, including medication reconciliation, and further failed to ensure the involuntary discharge notice included the required information. Findings include:-R3's Electronic Health Record (EHR) documented a diagnosis of schizoaffective disorder (a mental disorder characterized by gross distortion of reality, disturbances of language and communication, and fragmentation of thought) and borderline intellectual functioning. R3's 09/22/25 admission Minimum Data Set (MDS) documented a Brief Interview Mental Status (BIMS) of 15, which indicated intact cognition. R3's MDS documented he had no depression, but he had verbal behavioral symptoms directed towards others during the look-back period. R3's MDS documented he required setup for activities of daily living (ADL) care. R3's MDS documented he had no plans for discharge and planned to remain at the facility. R3's 10/03/25 Cognitive Loss / Dementia Care Area Assessment (CAA), documented he had a potential for alteration in cognitive patterns, based on his diagnosis of schizoaffective disorder. R3 had verbal behaviors noted towards others, and staff would continue to observe and report any pertinent concerns and notify the provider as needed. R3's EHR lacked evidence that a comprehensive care plan was developed. R3's Physician Orders lacked a discharge order. R3's Involuntary Discharge Notice dated 12/09/25 documented the letter served as the required written notification of involuntary discharge from the facility and listed the reason or the discharge as the safety of individuals in the facility was endangered due to the behaviors of R3 when on 12/08/25, R3 engaged in actions that posed an immediate and serious risk of fire which required staff intervention to prevent a building fire. The notice cited the resident's ongoing explosive, aggressive, and unsafe behaviors. The notice included the date, 30 days from the date of the notice, as well as a discharge locations. The notice included the appeals rights but lacked the information on how to file an appeal and who in the facility would assist the resident with the appeal. The notice included the Ombudsman's telephone number but lacked the Ombudsman's name and email contact information. The notice further lacked the contact information for the State Agency (SA) responsible for the protection and advocacy of individuals with developmental disabilities and the SA responsible for the protection and advocacy of individuals with a mental disorder.R3's Progress Note on 12/9/25 at 03:30 PM documented that staff spoke with the family that R3 would return to the facility and be on one-on -one supervised care. R3 would receive an evaluation with a mental health provider, and the facility would assist in locating a new facility. R3 received an involuntary discharge notice as soon as possible, and R3 would be discharged with medication for 30 days. The note indicated that R3's family was educated that if R3 had any signs of aggression, it was recommended that they call 911. R3's Progress Note on 12/9/25 at 06:35 PM documented R3 discharged home with family members. R3 was discharged with all medications, clothing, and other items. R3's family member had all (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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	questions answered prior to leaving the facility. R3's Social Service Progress Note on 12/10/25 at 10:04 AM, documented after R3 was discharged from the facility, Social Service Designee (SSD) X contacted the hospital social worker and inquired if R3 completed a State Mental Health Screener Assessment in order to get admitted into a State Mental Health hospital. The hospital social worker was initiating the process of assessment and said it would be completed. R3's Progress Note on 12/10/25 at 03:02 PM documented that R3's family member stood in the reception area holding a bag of medications and reported she needed clarification on how to give R3's medications. The nurse was notified to assist with this request. During an interview on 01/21/26 at 09:52 AM, Licensed Nurse (LN) G stated that the administrative staff prepares the paperwork for all discharges, with two copies of all forms. LN G reported phone numbers for various resources were included in the discharge information. LN G said no narcotics are sent with residents upon discharge. During an interview on 01/21/25 at 11:55 AM, SSD X stated that upon an involuntary discharge, she followed facility policy. She said if it was a planned discharge, the discharge begins at the time of admission and involved starting certain assessments, addressing Medicare/Medicaid concerns, involving the resource team with communications regarding the resident, establishing needs for medical equipment then later, having a team meeting with resources provided at that time, and then, completion of all necessary discharge paperwork.During an interview on 01/21/26 at 04:00 PM, Consultant GG confirmed there was no recapitulation completed, and he was unable to provide a medication list of what was sent with R3 when the resident was involuntarily discharged . Consultant GG stated the resident's family member was verbally notified of the 30-day eviction notice. Consultant GG provided a copy of a progress note dated 12/10/25, which documented that R3's family member had a bag of medications at the time of discharge. Consultant GG stated the resident's family member was verbally notified of the 30-day eviction notice, and he believed the involuntary discharge paperwork was in order. The facility policy, Discharge Summary and Plan, dated October 2021, documented that when a resident's discharge is anticipated, a discharge summary and post-discharge plan will be developed to assist the resident to adjust to his/her new living environment. The discharge summary would include a recapitulation of the resident's stay.

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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. The facility had a census of 72 residents. The sample included eight residents. Based on observation, record review, and interview, the facility failed to develop a comprehensive care plan with interventions to address the care for Resident (R) 2.Findings included:- R2's Electronic Medical Records (EMR), documented diagnoses which included suspected adrenal insufficiency (a condition where the adrenal glands don't produce enough essential hormones like cortisol and aldosterone, leading to symptoms such as severe fatigue, weakness, weight loss, abdominal pain, and low blood pressure, sometimes culminating in a life-threatening adrenal crisis), hypothyroidism (a condition characterized by decreased activity of the thyroid gland), myxedema (severe hypothyroidism), and cerebral infarction (stroke - sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain).R2's 07/30/25 admission Minimum Data Set (MDS) documented R2 had a Brief Interview for Mental Status (BIMS) of 15, indicating intact cognition. R2 had an impairment on one side of her body and used a walker for mobility. R2 required supervision or touching assistance for care. R2 had a thyroid disorder. R2 took an antidepressant (a class of medications used to treat mood disorders) and an opioid (a class of controlled drugs used to treat pain).R2's 07/30/25 Visual Function Care Area Assessment (CAA) stated R2's vision in her right eye was blurry due to a previous stroke. The CAA documented visual function would be addressed in the care plan.R2's 07/30/25 CAAs for Functional Abilities (Self-Care and Mobility), Urinary Incontinence and Indwelling Catheter, Falls, Nutritional Status, Pressure Ulcer/Injury, and Psychotropic Drug Use, each documented all the areas would be addressed in the care plan.R2's Care Plan dated 08/12/25, documented R2 wished to stay in the facility and was a full code. The care plan lacked any additional information.R2's Physicians Orders revealed a current order for levothyroxine sodium oral tablet 137.5 micrograms (mcg) in the morning for myxedema, start date 01/21/25. Scheduled at 06:00 Am. R2's Physicians Orders revealed a current order for trazodone (an antidepressant medication) 25 milligrams (mg) at bedtime for insomnia, ordered on 01/20/26.R2's Physicians Orders revealed a current order for Methadone (medication used to treat pain for people with opioid addiction issues) 10 mg, give eight tablets by mouth one time a day for pain, ordered on 01/10/26.R2's Physicians Orders revealed a current order for two liters of oxygen continuous, ordered on 01/08/26.On 01/21/26 at 01:35 PM, Certified Medication Aide (CMA) S stated the staff should follow the care plan to care for residents.On 01/21/26 at 03:37 PM, Licensed Nurse (LN) H stated she did not enter things in the care plan.On 01/21/26 at 04:12 PM, Administrative Nurse E stated that they had an offsite MDS person who started the care plan, and the interdisciplinary team added things as needed. Administrative Nurse E said the team had not kept up with updating the care plan, so the facility had implemented a new process where the team would look at the care plans a few days prior to the care plan meeting and update the plans at that time. Administrative Nurse E verified the facility had not actually started it yet, but it was the plan.On 01/21/26 at 05:02 PM, Administrative Nurse D said it was her expectation that the care plans reflect the resident's care, and it would be started and updated as needed.The facility's 10/2021Care Plans, Comprehensive Person-Centered policy stated that a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs is developed and implemented for each resident.

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F 0689 Level of Harm - 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** The facility identified a census of 72 residents. The sample included eight residents with three reviewed for falls. Based on observation, interview, and record review, the facility failed to ensure an environment free of accident hazards for Resident (R) 1. On 12/15/25 at 03:15 PM, per camera footage, Certified Nurse Aide (CNA) M propelled R1 in a wheelchair without the use of foot pedals, down an incline when the resident's right foot dropped under the wheelchair, where it became entangled, causing R1 to fall to the floor. This resulted in a right femur (thigh bone) fracture.Findings included:- R1's Electronic Medical Record (EMR) under the Physician's Orders, dated 01/08/26, documented a diagnosis of displaced fracture at the base of the neck of the right femur.R1's Quarterly Minimum Date Set (MDS), dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. R1 required substantial assistance to total staff dependence for most activities of daily living (ADL) and was wheelchair dependent. The MDS recorded she had no falls.R1's Quarterly MDS dated 01/08/26 indicated no changes in the BIMS score. R1 was dependent on staff for transfers, toileting, and showers, and dependent on staff for mobility in a wheelchair. The MDS noted R1 had a fall with a fracture since the last assessment.R1's Care Plan documented she had an activity of daily living (ADL) self-care deficit. An intervention initiated on 05/23/23 and revised on 04/20/24 directed staff to know R1 required a Hoyer lift (full body mechanical lift) with staff assistance to get out of bed. A Focus, initiated on 09/10/23 and revised on 12/17/25, documented R1 had limited physical mobility related to morbid obesity and was unable to turn and reposition in bed without staff assistance and bedrail. The resident could self-propel in a wheelchair for more independence; foot pedals were to be kept in a bag on the back of the wheelchair when not in use. Staff would monitor safety on an ongoing basis.R1's Care Plan recorded interventions dated 12/17/25, which directed the resident was non-weight-bearing, but did not list which limb. An intervention was listed as The resident requires (SPECIFY assistance) by (X) staff for locomotion using (SPECIFY). Another intervention dated 12/17/25 documented The resident uses (wheelchair) for locomotion. Clean ().R1's Care Plan lacked mention of the right femur fracture or interventions directing staff regarding the use of foot pedals.R1's late entry Nursing Progress Note dated 12/15/25 at 03:15 PM documented the resident was self-propelling on her way to activities when she began to go down the decline too fast. A CNA was not far from the resident and tried to grab the resident's chair to slow her down. By the time the CNA tried helping the resident, R1 put her foot down and toppled over.R1's late entry Nursing Progress Note dated 12/15/25 at 03:50 PM documented R1 was coming down the 200-hallway slope too fast, and her right ankle caught on the foot pedal, and she fell out of her wheelchair, landing on her right side. R1 denied hitting her head but complained of some back pain. She was able to roll from side to side. The resident was taken to her room, and the mobile X-ray provider was called.R1's Nursing Progress note dated 12/15/25 at 06:38 PM documented the mobile X-ray provider report showed a fracture of the right femur and osteoarthritic (degenerative bone changes). R1 went to the Emergency Room. R1's Discharge Notes from the acute hospital documented R1 had a right femoral neck hip fracture, and due to excessive accumulation of body fat, a non-surgical treatment was recommended.Observation on 01/21/26 at 04:58 PM of the camera footage from 12/15/25 with Administrative Staff A revealed that the staff propelled her in her wheelchair down the slope without foot pedals attached. R1's legs were straight out from the wheelchair, not resting on anything. R1's right foot dropped to the floor, and R1 fell out of the wheelchair.On 01/21/26 at 09:45 AM, R1 stated CNA M pushed her in the wheelchair, going too fast. R1 said she did not have any foot pedals on the wheelchair, and her right foot went (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	under the chair and caused her to fall. She stated the physician at the hospital would not do surgery due to her weight, and the fracture would have to heal on its own.On 01/21/26 at 12:10 PM, Administrative Staff E revealed she was sitting in the administrator's office when R1 fell out of her wheelchair. She said she thought the CNA was either pushing or attempting to grab the resident's wheelchair, but the cameras would give the correct information.On 01/21/26 at 03:36 PM, Administrative Staff D said the facility did not have an MDS nurse to update the care plans. On 01/21/26 at 04:30 PM, Administrative Staff E revealed an incident report, witness statements, and/or education were not completed for this incident.On 01/21/26 at 04:58 PM, Administrative Staff A said the nurses' notes on 12/15/25 at 03:15 PM indicated R1 had foot pedals on her wheelchair when CNA M pushed her down the hallway but confirmed the camera footage showed R1 in the wheelchair with her legs straight out and no foot pedals on the chair. Administrative Staff A said she did not know why the nurse would write that foot pedals were in use when the video showed R1 with her legs straight out and no pedals.The facility's policy Fall and Fall Risk, managing dated 10/2021 revealed that, based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risk and causes to try to prevent the resident from falling and to try to minimize complications from falling.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. The facility had a census of 72 residents. The sample included eight residents. Based on observation, record review, and interview, the facility failed to prevent significant medication errors for Residents (R) 2 and R4, who did not receive medications as ordered.Findings included:- R2's Electronic Medical Records (EMR), documented diagnoses which included hypothyroidism (a condition characterized by decreased activity of the thyroid gland), myxedema (severe hypothyroidism), and cerebral infarction (stroke - sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain). R2's 07/30/25 admission Minimum Data Set (MDS) documented R2 had a Brief Interview for Mental Status (BIMS) of 15, indicating intact cognition. R2 had a thyroid disorder. R2's Care Plan dated 08/12/25, documented R2 wished to stay in the facility and was a full code. The care plan lacked any additional information. R2's Encounter progress note dated 11/04/25, documented R2 had been taking levothyroxine sodium tablet 150 micrograms (mcg) for low thyroid hormone. The provider reviewed the lab results with R2 and increased the levothyroxine to 200 mcg every day. R2's Physicians Orders revealed a discontinued order for levothyroxine sodium oral tablet 200 micrograms (mcg) in the morning for hypothyroidism, start date 11/05/25. R2's Physicians Orders revealed a current order for levothyroxine sodium oral tablet 137.5 mcg in the morning for myxedema, start date 01/21/26. Scheduled at 06:00 AM. R2's Medication Administration Record (MAR) reviewed from 11/01/25 to 12/31/25 documented levothyroxine sodium oral tablet 200 mcg was ordered to be given at 08:00 AM, and was not given on 11/05/25, 11/05/25, 11/07/25, 11/08/25, and 11/09/25. R2's MAR lacked an order to hold the medication on the above-listed dates. On 01/21/26 at 09:52 AM, R2 reclined in the bed and watched television. R2 was alert and oriented. R2 stated she has had three stays in the hospital for hypothyroidism. The first time was prior to her stay here, and she was in a coma. In November, R2 stated she was in the hospital intensive care unit and remained hospitalized for 10 days. R2 reported that the staff had not been giving her the thyroid medications correctly. R2 reported that levothyroxine was to be taken before meals, and they gave it to her after meals with the rest of her medications or not at all. On 01/21/26 at 01:35 PM, Certified Medication Aide (CMA) S stated the CMA did not give the thyroid medications because the night shift nurse gave it between 05:00 AM and 06:00 AM. CNA M said she thought it was supposed to be given an hour before meals. CNA M said if a resident did not have a medication available, the staff looked for the medication and marked it as not given with a specific reason documented in a note. On 01/21/26 at 03:37 PM, Licensed Nurse (LN) H stated that if the CMA told her they could not find a medication, LN H would look for the medication and call the pharmacy to verify if it was sent to the facility. If LN H could not find it, she would get it out of the emergency medication kit on site. LN H said if the medications were not there, she would make sure they were ordered and find out if (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	they would be coming during her shift. LN H would document on the MAR the reason it was not given and make a note as well. LN H said the MAR should never be left blank; there should always be an indication that a medication was given or why it was not given, and all medications should be given and documented as ordered and checked prior to leaving for the shift. On 01/21/26 at 05:02 PM, Administrative Nurse D expected the nurse to give medications and complete treatments when they are ordered and chart when they are completed. Administrative Nurse D said if the medication was not given, the reason for it not being given was to be documented, and a note was to be placed in the MAR. The facility's undated Administering Medications policy stated medications shall be administered in a safe and timely manner as prescribed. Medications are administered in accordance with prescriber orders, including any required time frame. Medication administration times are determined by resident need and benefit, not staff convenience. Factors that are considered include enhancing the optimal therapeutic effect of the medication, preventing potential medication or food interaction, and resident preference. - R4's Electronic Medical Record (EMR) revealed diagnoses of anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear) and bipolar disorder (a major mental illness that causes people to have episodes of severe high and low moods). R4's 06/09/25 admission Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of 14, which indicated intact cognition. R4's MDS documented that he was administered an antianxiety medication (a class of medications that calm and relax people). R4's 06/29/25 Psychotropic Drug Use Care Area Assessment (CAA) documented R4 was prescribed several psychotropic (alters mood or thoughts) medications related to depression and bipolar disorder; nursing would provide psychotropic medications as ordered. R4's 12/05/25 Quarterly MDS documented a BIMS of 15, which indicated intact cognition. R4's MDS documented that he was administered an antianxiety medication. R4's Care Plan documented that staff administered medications as ordered, monitored and documented side effects and effectiveness, dated 06/02/25. R4's Physician Orders documented an order for alprazolam (anti-anxiety medication) 0.5 milligrams (mg) give every morning and bedtime for anxiety, date ordered 06/03/25. R4's Medication Administration Record (MAR) documented nine missed doses of alprazolam 0.5 mg every morning and bedtime dated 12/05/25, 12/06/25, 12/07/25, 12/08/25, and 12/09/25. R4's EMAR - Administration Note on 12/05/25 at 05:08 AM documented alprazolam 0.5 mg; pharmacy notified. R4's EMAR - Administration Note on 12/05/25 at 08:20 PM documented that alprazolam 0.5 mg medication was not on hand on order. R4's EMAR - Administration Note on 12/06/25 at 05:36 AM documented alprazolam 0.5 mg; pharmacy notified. (continued on next page)

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