STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175467	A. Building B. Wing	05/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kansas Christian Home	1035 SE 3rd Street Newton, KS 67114

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, record review, and interview, the facility failed to prepare and serve food under sanitary conditions to the residents of the facility appropriately to prevent the potential for food borne bacteria. Findings included:- During an initial tour of the kitchen on 05/12/26 at 10:07 AM, the following areas of concern were noted: 1. The reach-in freezer had food debris on the bottom shelf. 2. The two-doored reach-in refrigerator had dried-on fluids on the bottom shelf. 3. The bottom shelf of the preparation table, holding clean pots and pans, had food debris. 4. There were 13 discolored cutting boards with deep grooves throughout. 5. The trash can by the dish washing sink had dried-on food and fluids on the lid. 6. An unopened box containing 12 packages of eight hot dog buns each, rested directly on the floor of the walk-in freezer. 7. The floor in the dry supply room was completely worn down to the subflooring in several areas of the room. On 05/14/26 at 07:15 AM, Dietary Staff BB confirmed the noted areas were in need of cleaning or repair. The facility policy for Cleaning and Sanitizing, undated, included: All new hires and current employees will be educated on the importance of proper methods for cleaning and sanitizing to prevent the potential for food borne bacteria.

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** Based on observation, record review, and interview, the facility failed to ensure residents received assistance with activities of daily living (ADL) including facial hair removal for Resident (R) 21 and assistance with nail care for R45, R6, R16, and R18. Findings included:1. R21's Electronic Medical Record (EMR) revealed diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion) and needed assistance with personal care. R21's 08/20/25 admission Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) of seven, which indicated severely impaired cognition. R21's MDS documented that she had no rejection of care during the observation period. R21's MDS documented that she required maximal assistance with personal hygiene. R21's 08/25/25 Functional Abilities (Self-Care and Mobility) Care Area Assessment (CAA) documented R21 is a new admission after hospital stay. She has been working with therapy to improve her ability. She often overestimates her ability and will become overwhelmed with too many requests during dressing. R21's Care Plan, dated 08/26/25, documented staff were instructed to provide supervision/touching assistance of one staff to complete personal hygiene. On 05/12/26 at 03:00 PM, R21 was seated in a chair in the television lounge watching tv and reported she had not eaten since yesterday. R21 had several long white facial hairs approximately half inch on her chin. On 05/13/26 at 09:24 AM, R21 was in the therapy room seated on the bench, working with therapy. Several long white facial hairs remained on her chin. On 05/14/26 at 08:39 AM, R21 was in the dining room eating her breakfast. Several long white facial hairs remain on her chin. On 05/13/26 at 09:49 AM, Certified Nurse Aide (CNA) M reported that typically we should look at the resident's facial hair and nails every morning and complete that during morning care. On 05/13/26 at 11:13 AM, Licensed Nurse (LN) H reported the CNA should complete nail care and facial hair removal for non-diabetic residents. 2. R45's EMR recorded diagnoses of depression (a mood disorder that causes a persistent feeling of sadness and loss of interest) and anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear). R45's 11/04/25 admission MDS documented a BIMS of 15, indicating intact cognition. R45's MDS documented that he had no rejection of care during the observation period. R45's MDS documented that he required moderate assistance with personal hygiene. R45's 11/11/25 Functional Abilities (Self-Care and Mobility) CAA documented R45 was a new admission from the hospital. He had weakness and had required additional assistance with his activities of daily living. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R45's Care Plan, dated 05/07/26, documented staff were instructed to provide maximal assistance of one staff to complete personal hygiene. On 05/12/26 10:38 AM, R45 had long fingernails on all his fingers, he reported that he can't cut them himself and the staff should cut them on bath day. R45 reported he did not like his nails being so long. On 05/13/26 at 07:48 AM, R45's fingernails remained long. He reported he had a bath scheduled that day. Nail clippers were observed on the TV stand not in reach of him. On 05/14/26 at 07:55 AM, R45 was in therapy and his fingernails remained long. On 05/14/26 at 09:25 AM, CNA N reported that she did not give R45 his shower on 05/13/26 but that CNA O did. CNA N reported she did not notice R45's fingernails being long. On 05/14/26 at 10:24 AM, Administrative Nurse D revealed she expected the staff to shave residents every shower day or as needed. Administrative Nurse D said she expected the nurses to cut the diabetic residents' fingernails, and the CNAs would let the nurse know when that was needed. 3. R6's Electronic Medical Record (EMR) documented a diagnosis of dementia (a progressive mental disorder characterized by failing memory and confusion). R6's Significant Change Minimum Data Set (MDS), dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of three, indicating severe cognitive impairment. She required partial to moderate staff assistance with personal cares. R6's Activity of Daily Living (ADL)/Functional Abilities Care Area Assessment (CAA), dated 12/24/25, did not trigger. R6's Quarterly MDS, dated [DATE], documented the staff assessment for cognition revealed severe cognitive impairment. She required substantial to maximal staff assistance with personal cares. R6's Care Plan, revised 03/24/26, instructed staff that she required substantial to maximal staff assistance with ADLs. R6's EMR from 04/01/26 through 05/11/26 (41 days), revealed she required moderate to dependent staff assistance with personal hygiene. On 05/12/26 at 01:58 PM, R6 sat at the dining table in her wheelchair. She had a dark brown, dried-on substance underneath her fingernails. On 05/13/26 at 08:57 AM, R6 sat at the dining table in her wheelchair eating breakfast. She continued to have a dark brown, dried-on substance underneath her fingernails. On 05/13/26 at 11:45 AM, Certified Nurse Aide (CNA) M stated residents' fingernails would be cut on their shower days. CNA M confirmed R6's fingernails were long and dirty. On 05/13/26 at 02:47 PM, Certified Medication Aide (CMA) R stated the staff would clean and trim residents' fingernails on their shower days. CMA R stated R6's family would often take her out of the facility to have her nails done. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 05/14/26 at 09:09 AM, Administrative Nurse D stated it was the expectation for staff to trim and smooth residents' fingernails on their shower days and as needed. 4. R16's EMR documented a diagnosis of intellectual disability (a significantly below-average score on a test of mental ability or intelligence and limitations in the ability to function in areas of daily life). R16's Annual MDS, dated 10/17/25, documented the staff assessment for cognition revealed severe cognitive impairment. He required substantial to maximal staff assistance with personal hygiene. R16's Activity of Daily Living (ADL)/Functional Abilities Care Area Assessment (CAA), dated 10/17/25, did not trigger. R16's Quarterly MDS, dated [DATE], documented the staff assessment for cognition revealed severe cognitive impairment. He required substantial to maximal staff assistance with personal hygiene. R16's Care Plan, revised 04/11/26, instructed staff he was dependent on staff for ADLs. R16's EMR from 04/01/26 through 05/11/26 (41 days), revealed he required partial/maximal to dependent staff assistance with personal hygiene. On 05/12/26 at 10:09 AM, R16 sat in the commons area. He had long, dirty fingernails. On 05/13/26 at 07:20 AM, R16 sat at the dining table. He continued to have long, dirty fingernails. On 05/13/26 at 11:45 AM, Certified Nurse Aide (CNA) M stated residents' fingernails would be cut on their shower days. CNA M confirmed R16's resident's fingernails were long and dirty. On 05/13/26 at 02:47 PM, Certified Medication Aide (CMA) R stated the staff would clean and trim residents' fingernails on their shower days. On 05/14/26 at 09:09 AM, Administrative Nurse D stated it was the expectation for staff to trim and smooth residents' fingernails on their shower days and as needed. 5. R18's EMR documented a diagnosis of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure). R18's Annual Minimum Data Set (MDS), dated [DATE], documented the staff assessment for cognition revealed severe cognitive impairment. He was dependent on staff for personal hygiene. R18's Activity of Daily Living (ADL)/Functional Abilities Care Area Assessment (CAA), dated 12/17/25, did not trigger. R18's Quarterly MDS, dated [DATE], documented the staff assessment for cognition revealed severe cognitive impairment. He was dependent on staff for personal hygiene. R18's Care Plan, revised 03/12/26, instructed staff that he was totally dependent on staff for personal hygiene. R18's EMR from 04/01/26 through 05/11/26 (41 days), revealed he required partial/maximal to (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	dependent staff assistance with personal hygiene. On 05/12/2 at 08:07 AM, R18 sat at the dining table. He had long, dirty fingernails. On 05/13/26 at 07:20 AM, R18 sat at the dining table. He continued to have long, dirty fingernails. On 05/13/26 at 11:45 AM, Certified Nurse Aide (CNA) M stated residents' fingernails would be cut on their shower days. CNA M confirmed that R18's resident's fingernails were long and dirty. On 05/13/26 at 02:47 PM, Certified Medication Aide (CMA) R stated the staff would clean and trim residents' fingernails on their shower days. On 05/14/26 at 09:09 AM, Administrative Nurse D stated it was the expectation for staff to trim and smooth residents' fingernails on their shower days and as needed. The facility did not provide a policy for ADLs, as requested.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure informed consent including purpose, risks versus benefits, and expected therapeutic benefits for the use of antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality), anti-anxiety (medication used to treat symptoms of anxiety, hypnotics (a class of medications used to induce sleep) and antidepressant (a class of medications used to treat mood disorders) medications for R4. This placed the resident at risk for adverse side effects of the medications and uninformed decisions. Findings included:- R4's Electronic Medical Record (EMR) documented the following diagnoses: anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), insomnia (inability to sleep), bipolar disorder (a major mental illness that causes people to have episodes of severe high and low moods) and obsessive-compulsive disorder (OCD- an anxiety disorder characterized by recurrent and persistent thoughts, ideas, and feelings of obsessions severe enough to cause marked distress, consume considerable time, or significantly interfere with the resident's occupational, social, or interpersonal functioning). R4's Annual Minimum Data Set (MDS), dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of six, indicating severe cognitive impairment. R4 received antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality), antianxiety (medication used to treat symptoms of anxiety), antidepressant (a class of medications used to treat mood disorders), and hypnotic medications during the assessment period. R4's Psychotropic Drugs Care Area Assessment, (CAA), dated 05/30/25, documented R4 received several psychotropic medications which the pharmacy consultant and physician reviewed monthly, to maintain therapeutic uses. R4's Quarterly MDS, dated [DATE], documented she had a BIMS score of seven, indicating severe cognitive impairment. R4 received antipsychotic, antianxiety, antidepressant and hypnotic medications during the assessment period. R4's Care Plan, revised 03/02/26, instructed staff to monitor and report any adverse side effects from the psychotropic medications. R4's EMR documented the following Physician's Orders (PO): Clonazepam (a benzodiazepine used to treat the symptoms of anxiety), 2 milligrams (mg), every bedtime (QHS), by mouth (po), for a diagnosis of bipolar disorder, ordered 03/02/26. Clonazepam, 1 mg, every day (QD), po, for a diagnosis of bipolar disorder, ordered 03/02/26. Duloxetine (an antidepressant medication), 60 mg, QD, po, for a diagnosis of bipolar disorder, ordered 03/02/26. Seroquel (an antipsychotic medication), 100 mg, at 02:00 PM, po, for a diagnosis of bipolar disorder, ordered 03/02/26. Seroquel, 150 mg, every morning (QAM), po, for a diagnosis of bipolar disorder, ordered 03/02/26. Seroquel, 300 mg, QHS, po, for a diagnosis of bipolar disorder, ordered 03/02/26. Sertraline (an antidepressant medication), 75 mg, QAM, po, for a diagnosis of OCD, ordered 03/02/26. Zolpidem (a hypnotic, used to induce sleep), 12.5 mg, QHS, po, for a diagnosis of insomnia, ordered 03/02/26. Ativan (an antianxiety medication), 0.5 mg, four times per day, as needed (PRN), po, for a diagnosis of anxiety, ordered 03/07/26. Lorazepam (an antianxiety medication), 1 mg, Q 3 hours, po, PRN for a diagnosis of anxiety, not to exceed six doses per day, ordered 03/02/26. R4's Medication Administration Record (MAR) for April and May 2026, revealed staff administered medications, as ordered. R4's EMR lacked evidence of psychotropic medication consent including the risks vs benefits and the expected therapeutic benefit of the medications, as required. On 05/13/26 at 09:37 AM, Administrative Nurse D stated R4's EMR lacked signed consent forms for his psychotropic medications. The facility policy for Psychotropic Medication Use, undated, included: Psychotropic medications will only be initiated after an informed consent is completed and signed. A new consent will be completed with each dosage change.

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record review, the facility failed to ensure Resident (R) 38 received the opportunity to participate in the care planning process when staff failed to invite R38, or their responsible party to the care pan meetings. Findings included:- R38's Electronic Medical Record (EMR) revealed diagnoses of anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear) and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest). R38's Annual Minimum Data Set (MDS), dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. R38's MDS documented that she required maximal assistance with activities of daily living (ADLs). R38's MDS documented that she had no behaviors. R38's Functional Abilities (Self-Care and Mobility) Care Area Assessment (CAA), dated 02/13/26, documented R38 participated with restorative programs. She made some improvements over the look back period. R38's Care Plan, dated 09/17/24, documented staff would encourage R38 to make her own decisions and will provide support as needed. R38's Care Conference Note, dated 09/10/25, at an undocumented time documented the quarterly care plan meeting. Some follow up with a meeting from last week. R38 reported that her brother was coming to help her with sorting her papers. R38 had no concerns with any other department and reported she liked it at the facility and received good care. R38's EMR lacked evidence of a care plan conference after 09/10/25. On 05/12/26 at 08:13 AM, R38 reported she was unsure about the last time she attended or was invited to a care plan meeting. On 05/13/26 at 09:00 AM, R38 was in her room seated up in her bed watching television. On 05/14/26 at 09:16 AM, Social Service Designee (SSD) X reported that an email would be sent out to the resident's durable power of attorney (DPOA- a legal document that names a person to make healthcare decisions when the resident is no longer able to) and the resident was given an invitation by hand to attend the care plan meeting. SSD X reported that she believed Administrative Nurse E would document a note in the EMR when a care plan meeting was held. On 05/14/26 at 09:20 AM, Administrative Nurse E reported in the past EMR, the care plan meeting would be documented in a care conference note and in the new EMR a care plan meeting would be documented in a progress note. On 05/14/26 at 9:40 AM, Administrative Nurse E reported the last care conference note that she could locate in EMR was on 09/10/25. Administrative Nurse E expected the care plan meetings to be offered and completed every three months. The facility's undated policy Care Planning -Interdisciplinary Team documented the resident, the resident's family, and/or the resident's legal representative are encouraged to participate in the development of and revisions to the resident's care plan, and every effort will be made to schedule care plan meetings at the best time of the day for the resident and family.

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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** Based on observation, interview, and record review, the facility failed to obtain a stop date for an as needed (PRN) antianxiety medication for R4 and R3's lorazepam (an antianxiety medication). Findings included:1. R4's Electronic Medical Record (EMR) documented a diagnosis of anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear). R4's Annual Minimum Data Set (MDS), dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of six, indicating severe cognitive impairment. R4 received antianxiety (medication used to treat symptoms of anxiety) during the assessment period. R4's Psychotropic Drugs Care Area Assessment (CAA), dated 05/30/25, documented R4 received several psychotropic medications which the pharmacy consultant and physician reviewed monthly, to maintain therapeutic uses. R4's Quarterly MDS, dated [DATE], documented a BIMS score of seven, indicating severe cognitive impairment. R4 received antianxiety medication during the assessment period. R4's Care Plan, revised 03/02/26, instructed staff to monitor and report any adverse side effects from the psychotropic medications. R4's EMR documented the following Physician's Order (PO): Lorazepam, 1 mg, every 3 hours, PRN for a diagnosis of anxiety, not to exceed six doses per day, ordered 03/02/26. The PRN medication lacked a stop-date, as required. On 05/13/26 at 09:37 AM, Administrative Nurse D confirmed R4's PRN lorazepam order lacked a stop date. 2. R3's Electronic Medical Record (EMR) included diagnoses of diabetes mellitus (DM-when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), hearing loss, need for assistance with personal care, anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear) disorder, dementia (a progressive mental disorder characterized by failing memory and confusion), senile degeneration of the brain (progressive, age-related decline in brain function), and fracture (broken bone) of left femur (thigh bone). R3's Significant Change Minimum Data Set (MDS), dated [DATE], documented that R3 had moderately impaired cognition and delusions (untrue persistent belief or perception held by a person although evidence shows it was untrue). R3 required substantial/maximal assistance with toileting hygiene, rolling left and right, sitting to lying, lying to sitting on the side of bed, sitting to standing, and chair/bed-to-chair transfers. R3 required partial/moderate assistance with upper body dressing and personal hygiene. The MDS further documented that R3 had received scheduled pain medications and as-needed (PRN) pain medication and non-medication interventions for pain. R3 had a condition/chronic disease that may result in a life expectancy of less than six months and had hospice care (specialized end-of-life care). R3 took an antidepressant (a class of medications used to treat mood disorders), an anticoagulant (a class of medications used to prevent the blood from clotting), an opioid (a class of controlled drugs used to treat pain), and a hypoglycemic (a class of (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medications used to treat elevated blood sugar). The Psychotropic (alters mood or thought) Drug Use Care Area Assessment (CAA), dated 03/17/26, documented R3 had an order for an antidepressant, and that the medication was reviewed by the Interdisciplinary Team (IDT), including hospice, pharmacy consultant, and Primary Care Provider (PCP), to maintain therapeutic use. The Care Plan, dated 03/17/26, documented R3 had depression related to dementia and decline in her ability. The Care Plan directed staff to administer medications as ordered, monitor for side effects and assess effectiveness. Monitor/document/report PRN and signs or symptoms of depression, including hopelessness, anxiety, sadness, insomnia (inability to sleep), anorexia (lack or loss of appetite), verbalizing negative statements, repetitive anxiousness, or health-related complaints, and tearfulness. The Physician Orders, dated 03/23/26, directed staff to administer lorazepam (an antianxiety, a class of medications that calm and relax people) 0.5 milligrams (mg) by mouth every six hours PRN for anxiety and restlessness. The order lacked a stop date. The Physician Orders, dated 03/25/26, directed staff to administer lorazepam two mgs/milliliter (ml) oral concentrate, give 0.5 ml every six hours/PRN for agitation/restlessness. The order further instructed staff to keep both types of lorazepam on a four-hour schedule and not to give both within four hours. The order lacked a stop date. The Electronic Medication Administration Record (EMAR) documented R3 utilized PRN lorazepam 15 times in the month of April, and five times in the month of May. On 05/12/26 at 01:19 PM, R3 was eating from a meal tray in her room. R3 reported being hard of hearing and asked to write questions on a piece of paper. R3 did not have complaints but would like someone to tell her family members to come and visit more often, as she was lonely. On 05/14/26 at 09:51 AM, Administrative Nurse D stated the PRN lorazepam should have a stop date, and verified the pharmacist had not caught it on the monthly reviews. The facility's undated Psychotropic Medication Use documented that any resident admitted with a PRN psychotropic will have a 14-day stop date. Prior to the end of the 14-day period, the ordering practitioner will assess the resident's response to the PRN medication and will document a thoughtful risk-benefit rationale statement for continued use of the medication.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to report an allegation of abuse to the State Agency (SA) within the required time frame of the alleged incident(s) as required for Resident (R) 59. Findings included:- R59's Electronic Medical Record (EMR) documented diagnoses which included dementia (a progressive mental disorder characterized by failing memory and confusion), and encephalopathy (a broad term for any brain disease that alters brain function or structure). R59's Annual Minimum Data Set (MDS), dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of 15 indicating intact cognition. R59's MDS documented no behaviors. R59's Communication Assessment (CAA), dated 07/02/25, documented R59 had dementia, and hearing loss bilaterally, R59 did not wear hearing aids. R59 spoke clearly, he is generally understood and understands others, he does sometimes have more difficulty with communication when he is tired and can be confused at times. R59's Quarterly MDS, dated [DATE], documented a BIMS score of six indicating severely impaired cognition. R59's MDS documented no behaviors. R59's Care Plan, dated 11/20/23, instructed staff that R59 appreciated his wife sleeping in his room overnight as she would provide him support. R59's Progress Note, dated 10/21/25 at 02:42 PM, documented staff notified Social Service Designee (SSD) X of a possible family event. The facility established visiting hours as follows: 08:00 AM - 08:30 AM for breakfast; 10:15 AM - 01:00 PM for fitness, bingo, and lunch; 04:30 PM - 06:00 PM for trivia and dinner. The facility established visitation rules as follows: Resident's wife is not to stay the night, the door must remain open, and the resident's wife must leave when cares are being given. R59's wife acknowledged these visiting hours. R59's Skin Assessment Note, dated 10/21/25 at 05:13 PM, documented no skin issues noted during shower. R59's Progress Note, dated 10/29/25 at 10:20 AM, documented updated visitation schedule for resident's wife is as follows: 08:00 AM - 02:00 PM and 04:00 PM - 06:00 PM. The facility also updated the visitation rules for the resident's wife as follows: door to remain open, resident's wife will not stay the night unless weather is bad (no more than two consecutive nights), resident's wife is to not have clothes here, and the resident's wife is to leave room when cares are being given. On 05/13/26 at 11:43 AM, Certified Nurse Aide (CNA) O reported R59's wife slapped him sometime in October of 2025, CNA O could not recall where R59's wife slapped him she reported maybe his leg or head. CNA O stated she reported the incident to the Charge Nurse and wrote a witness statement. CNA O reported CNA P was in the room when the slap occurred and CNA P had to write a statement also. On 05/14/26 at 11:11 AM, SSD X reported that CNA O, who was SSD X's family member, reported to her that R59's wife slapped him. SSD X reported that she felt there was a conflict in interest, so she reported the alleged abuse to Administrative Nurse D. SSD X reported that R59's wife would interfere with his cares and was unable to speak for himself and that is why R59's wife was given limited visiting hours. On 05/14/26 at 11:36 AM, Administrative Nurse D reported CNA O went home and told SSD X that R59's wife hit him. Administrative Nurse D stated SSD X did not report the alleged abuse until several days later, and SSD X had placed R59's wife on restricted visits. Administrative Nurse D reported after the incident was reported, it was investigated and found out that R59's wife did not slap him. Administrative Nurse D reported the facility did not report the alleged abuse to the state agency as it was days later and did not substantiate that it occurred. On 05/14/26 at 12:05 PM, Administrative Staff A reported that he thought Administrative Nurse D had made a report to the State Agency and he expected any allegation of abuse to be reported to the State Agency. The facility's policy Abuse, Neglect, Exploitation and Misappropriation Prevention Program, dated 05/26/22, documented identify and investigate all possible incidents of abuse, neglect, mistreatment, or misappropriation of resident property. Investigate and report any allegations within timeframes required by federal requirements.

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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** Based on observation, interview, and record review, the facility failed to identify and implement resident-centered fall interventions for Resident (R) 4, who was at risk for falls. Findings included:- R4's Electronic Medical Record (EMR) documented a diagnosis of bipolar disorder (a major mental illness that causes people to have episodes of severe high and low moods). R4's Annual Minimum Data Set (MDS), dated [DATE], documented R4 had a Brief Interview for Mental Status (BIMS) score of six, indicating severe cognitive impairment. He had one non-injury fall and one injury (except major) fall since his prior assessment. R4's Falls Care Area Assessment (CAA), dated 05/30/25, documented the resident was at a high risk for falls, with two falls since his prior assessment. R4's Quarterly MDS, dated [DATE], documented he had a BIMS score of seven, indicating severe cognitive impairment. He had two or more non-injury falls since his prior assessment. R4's Care Plan, revised 03/02/26, instructed staff to utilize a gait belt with one staff for all transfers. Staff were to place brightly colored signs in his room reminding him to use the call light to call staff when he needed to transfer. R4's EMR under Assessments documented fall assessments completed on 02/06/26, 02/16/26, 02/24/26 and 04/11/26, which placed the resident at a high risk for falls. R4's EMR under Prog Notes, on 03/02/26, documented R4 had a non-injury fall on 03/02/26 while in the shower room. The staff member attempted to transfer him from the shower chair to his wheelchair when R4 lost his balance and was lowered to the floor. The staff member had not used a gait belt during the transfer. The resident had no injuries from the fall and staff were reminded to use a gait belt while transferring the resident. R4's EMR under Prog Notes, on 04/11/26, documented R4 had a non-injury fall on 04/11/26 while in his room. R4 attempted to transfer himself from his recliner to his wheelchair unassisted when he fell to the floor. The resident had no injuries from the fall and staff were instructed to do 15-minute checks for four hours to prevent further falls. R4's EMR lacked further documentation of falls after the non-injury 04/11/26 fall. On 05/13/26 at 11:45 AM, Certified Nurse Aide (CNA) M stated he was unsure of R4's fall interventions. On 05/14/26 at 08:20 AM, Licensed Nurse (LN) G stated when a resident falls, the staff will implement a new intervention to prevent further falls. Usually, Administrative Nurse D was responsible for implementing new fall interventions following a resident's fall. On 05/14/26 at 09:09 AM, Administrative Nurse D confirmed the fall interventions were not appropriate for preventing further falls. The facility policy for Falls and Fall Risk, Managing, undated, included: Based on previous evaluations, the staff shall identify interventions related to the resident's specific risks to try to prevent further falls.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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** Based on observation, interview, and record review, the facility failed to monitor Resident (R) 6's physician-ordered fluid restriction. Findings included: -R6's Electronic Medical Record (EMR) included diagnoses of diabetes mellitus (DM-when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), major depressive disorder (major mood disorder that causes persistent feelings of sadness), chronic pain syndrome, nutritional deficiency, generalized anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear) disorder, chronic kidney disease, personal history of urinary calculi (kidney stones), and urinary tract infection (UTI-an infection in any part of the urinary system). R6's Significant Change Minimum Data Set (MDS), dated [DATE], documented that R6 had staff assessment of moderately impaired cognition, continuous inattention, and disorganized thinking behavior, along with hallucinations (sensing things while awake that appear to be real, but the mind created) and delusions (untrue persistent belief or perception held by a person although evidence shows it was untrue). R6 required setup or cleanup assistance with eating, was dependent on toileting hygiene, and required substantial/maximal assistance with lower-body dressing, rolling left and right in bed, sit-to-lying, lying-to-sitting, sit-to-standing, and chair/bed-to-chair transfers. R6 had an indwelling catheter (tube placed in the bladder to drain urine into a collection bag), received a scheduled pain medication regimen, and complained of coughing or choking during meals or when swallowing medication, and was provided with a therapeutic diet. The MDS further recorded that R6 received an antidepressant (a class of medications used to treat mood disorders), antibiotic (a class of medication to treat infections), a diuretic (a medication to promote the formation and excretion of urine), and an opioid (a class of controlled drugs used to treat pain). The Nutritional Status Care Area Assessment (CAA), dated 02/06/26, documented R6 was a readmit with medications that may impact fluid shifts and weight trends. The CAA further documented R6 had a no concentrated sweet (NCS) diet with 1800 milliliter (ml) fluid restriction. R6's Care Plan, dated 08/21/22, documented R6 had a nutritional status of moderate risk, with a NCS diet with a fluid restriction of 1800 ml. The plan directed the dietary department to provide 720 ml of fluids with breakfast, 240 ml of fluids with lunch, and evening meal. The plan directed nursing to provide 240 ml of fluid for the day and evening shift and 120 ml through the night shift. The Physician Order, dated 03/09/26, documented that R6 should receive a two-gram sodium diet with a 1800 ml fluid restriction and fortified foods. The physician's order also included 120 ml of 2Cal (high-calorie, protein-dense nutrition formulas) and a house supplement three times a day. The Progress Note, dated 03/19/26 and 03/26/26, documented the Interdisciplinary Team (IDT) meeting for R6 with a diagnosis of acute cystitis (inflammation of the bladder) with hematuria (blood in the urine). R6 currently receives an NCS pureed diet with 1800 ml fluid restriction, along with 2Cal 120 ml three times and house shake three times a day. The EMR lacked evidence of tracking R6's fluid intake. On 05/12/26 at 04:28 PM, R6 was sitting in a wheelchair. R6 reported having difficulty with UTIs due to the long-term use of indwelling catheters and was currently being treated with an antibiotic. On 05/13/26 at 12:15 PM, R6 was sitting in the dining room with a 240 ml of brown liquid in a glass. On 05/13/26 at 12:18 PM, Dietary Service BB reported that the dietary staff provided R6 with 720 ml of fluids with breakfast and 240 ml of fluids with lunch and the evening meal, and the nursing department provided R6 with supplements. On 05/13/26 at 12:22 PM, Licensed Nurse (LN) J reported she thought R6's fluid restriction had been discontinued. Upon review of the physician orders, LN J confirmed it had not been discontinued. LN J explained that nursing staff would record the fluid intake at the end of each shift, but the fluid intake had not been recorded. On 05/13/26 at 12:36 PM, Administrative Nurse D reported the facility had failed to transfer the fluid restriction to the new EMR when the facility changed software providers. Administrative Nurse D verified that R6's fluid intakes should have been monitored and recorded, and R6 had many changes, had declined, and been (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	hospitalized with UTIs. The facility's undated Fluid Restriction policy documented the facility was to provide residents who have a written physician order for fluid restriction an appropriate amount of fluids each day, while allowing nursing adequate fluid to supply medications, etc. A fluid restriction plan of care is to be filled out and placed in the resident's chart under the care plan selection.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility's pharmacy consultant failed to report irregularities to the resident's physicians, the facility administrator and the director of nursing regarding the lack of stop dates for as needed (PRN) antianxiety medication for Resident (R)4 and R3's PRN lorazepam (an antianxiety medication). Findings included:1. R4's Electronic Medical Record (EMR) documented a diagnosis of anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear). R4's Annual Minimum Data Set (MDS), dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of six, indicating severe cognitive impairment. R4 received antianxiety (medication used to treat symptoms of anxiety) during the assessment period. R4's Psychotropic Drugs Care Area Assessment, (CAA), dated 05/30/25, documented R4 received several psychotropic medications which the pharmacy consultant and physician reviewed monthly, to maintain therapeutic uses. R4's Quarterly MDS, dated [DATE], documented he had a BIMS score of seven, indicating severe cognitive impairment. R4 received antianxiety medication during the assessment period. R4's Care Plan, revised 03/02/26, instructed staff to monitor and report any adverse side effects from the psychotropic medications. R4's EMR documented the following Physician's Order (PO): Lorazepam, 1 mg, every 3 hours, PRN for a diagnosis of anxiety, not to exceed six doses per day, ordered 03/02/26. The PRN medication lacked a stop-date, as required. R4's EMR, under the Prog Notes documented the following consultant pharmacist reviewed R4's medications on 04/26/26, 03/25/26, 02/22/26, and 01/25/26. On 05/13/26 at 09:37 AM, Administrative Nurse D confirmed R4's PRN lorazepam order lacked a stop date and verified the CP failed to identify it. 2. R3's Electronic Medical Record (EMR) included diagnoses of diabetes mellitus (DM-when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), hearing loss, need for assistance with personal care, anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear) disorder, dementia (a progressive mental disorder characterized by failing memory and confusion), senile degeneration of the brain (progressive, age-related decline in brain function), and fracture (broken bone) of left femur (thigh bone). R3's Significant Change Minimum Data Set (MDS), dated [DATE], documented that R3 had moderately impaired cognition and delusions (untrue persistent belief or perception held by a person although evidence shows it was untrue). R3 required substantial/maximal assistance with toileting hygiene, rolling left and right, sitting to lying, lying to sitting on the side of bed, sitting to standing, and chair/bed-to-chair transfers. R3 required partial/moderate assistance with upper body dressing and personal hygiene. The MDS further documented that R3 had received scheduled pain medications (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and as-needed (PRN) pain medication and non-medication interventions for pain. R3 had a condition/chronic disease that may result in a life expectancy of less than six months and had hospice care (specialized end-of-life care). R3 took an antidepressant (a class of medications used to treat mood disorders), an anticoagulant (a class of medications used to prevent the blood from clotting), an opioid (a class of controlled drugs used to treat pain), and a hypoglycemic (a class of medications used to treat elevated blood sugar). The Psychotropic (alters mood or thought) Drug Use Care Area Assessment (CAA), dated 03/17/26, documented R3 had an order for an antidepressant, and that the medication was reviewed by the Interdisciplinary Team (IDT), including hospice, pharmacy consultant, and Primary Care Provider (PCP), to maintain therapeutic use. R3's Care Plan, dated 03/17/26, documented R3 had depression related to dementia and decline in her ability. The plan directed staff to administer medications as ordered, monitor for side effects and assess effectiveness. Monitor/document/report PRN and signs or symptoms of depression, including hopelessness, anxiety, sadness, insomnia (inability to sleep), anorexia (lack or loss of appetite), verbalizing negative statements, repetitive anxiousness, or health-related complaints, and tearfulness. The Physician Orders, dated 03/23/26, directed staff to administer lorazepam (an antianxiety, a class of medications that calm and relax people) 0.5 milligrams (mg) by mouth every six hours PRN for anxiety and restlessness. The order lacked a stop date. The Physician Orders, dated 03/25/26, directed staff to administer lorazepam two mgs/milliliter (ml) oral concentrate, give 0.5 ml every six hours/PRN for agitation/restlessness. The order further instructed staff to keep both types of lorazepam on a four-hour schedule and not to give both within four hours. The order lacked a stop date. The Consultant Pharmacist(CP) Medical Record Review (MRR), dated 03/24/26, documented that R3 was receiving hospice services and recommended the physician consider evaluating the need to continue atorvastatin, calcium, vitamin D, multivitamin with minerals, and vitamin B12. The CP did not include a request for a stop date for the lorazepam PRN. The CP's MMR, dated 04/25/26, referred to the payment source and did not include a stop date for the lorazepam PRN. On 05/12/26 at 01:19 PM, R3 was eating from a meal tray in her room. R3 reported being hard of hearing and asked to write questions on a piece of paper. R3 did not have complaints but would like someone to tell her family members to come and visit more often, as she was lonely. On 05/14/26 at 09:51 AM, Administrative Nurse D stated the PRN lorazepam should have a stop date and verified the pharmacist had not caught it on the monthly reviews. The undated Pharmacy Services-Role of the Consultant Pharmacist policy documented that the CP would provide specific activities related to medication regimen review, including: a documented review of the medication regimen of each resident at least monthly, or more frequently under certain conditions, based on applicable federal and state guidelines. Appropriate communication of information to prescribers and facility leadership about potential or actual problems related to any aspect of medications and pharmacy services, including medication irregularities, and pertinent resident-specific documentation in the medical record, as indicated.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure collaboration between the facility and hospice which included a hospice (a program that gives special care to people who are near the end of life) service visit frequency, medications, medical equipment, and the resident representative's preference for Resident (R) 3. Findings included: -R3's Electronic Medical Record (EMR) included diagnoses of diabetes mellitus (DM-when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), hearing loss, need for assistance with personal care, anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear) disorder, dementia (a progressive mental disorder characterized by failing memory and confusion), senile degeneration of the brain (progressive, age-related decline in brain function), and fracture (broken bone) of left femur (thigh bone). R3's Significant Change Minimum Data Set (MDS), dated [DATE], documented that R3 had moderately impaired cognition and delusions (untrue, persistent belief or perception held by a person although evidence shows it was untrue). R3 required substantial/maximal assistance with toileting hygiene, rolling left and right, sitting to lying, lying to sitting on the side of bed, sitting to standing, and chair/bed-to-chair transfers. R3 required partial/moderate assistance with upper body dressing and personal hygiene. The MDS further documented that R3 had received scheduled pain medications and as-needed (PRN) pain medication and non-medication interventions for pain. R6 had a condition/chronic disease that may result in a life expectancy of less than six months and had hospice care (specialized end-of-life care). R6 took an antidepressant (a class of medications used to treat mood disorders), an anticoagulant (a class of medications used to prevent the blood from clotting), an opioid (a class of controlled drugs used to treat pain), and a hypoglycemic (a class of medications used to treat elevated blood sugar). R3's Care Plan, dated 03/17/26, documented that R3 had a terminal prognosis related to senile degeneration of the brain. The plan included the hospice service of choice name, address, and phone number. The plan directed staff to consult with the physician and social services to have hospice care for the resident in the facility. The plan did not include the frequency of licensed nurses, clergy, nurse aides, social services, medication, supplies, and medical equipment provided by the hospice provider. The Physician Order, dated 02/26/26, directed staff to admit R3 to the hospice provider for a terminal diagnosis of senile degeneration of the brain. On 05/12/26 at 01:19 PM, R3 was eating from a meal tray in her room. R3 reported being hard of hearing and asked to write questions on a piece of paper. R3 did not have complaints but would like someone to tell her family members to come and visit more often, as she was lonely. On 05/13/26 at 10:20 AM, Certified Nurse Aide (CNA) O reported R3's hospice provider had staff come to the facility three times a week. The hospice nurse came once a week, and the hospice aide came twice a week for bathing and other care the resident needed. CNA O reported the hospice provider was responsible for personal care items of briefs, wipes, incontinence under pads, and creams. CNA O reported that if staff needed supplies, they would tell the charge nurse. On 05/14/26 at 08:32 AM, Licensed Nurse (LN) K reported R3's physician orders contained the hospice agency and phone number. LN K reported that the physician orders would be where she would look to find a contact number, and was not clear on the use of the care plan for references to the hospice agency services and supplies. On 05/14/26 at 09:51 AM, Administrative Nurse D reported R3's care plan had contained information related to the hospice services, medication, and supplies, but the facility had changed software providers, and the information had not been transferred to the current care plan. The facility's undated Hospice Services policy documented that each resident would receive, and the facility would provide, the necessary care and services to attain and maintain the highest practicable physical, mental, and psychosocial well-being in accordance with the comprehensive assessment and plan of care. The facility would coordinate care planning with the (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	hospice provider, including all services and supplies provided by the hospice provider, including: nursing services, nurse aide services, social services, chaplaincy services, durable medical equipment, medications, and grief support to family members.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on interviews, observation, and record review, the facility failed to ensure adequate hand hygiene eye medication administration for Resident (R) 47 and during a dressing change for R45. Findings included:1. On 05/12/26 at 04:03 PM, Certified Medication Aide (CMA) T applied one glove to her left hand without performing hand hygiene. CMA T administered one drop of R47's timolol ophthalmic (lower elevated eye pressure) eye drops into each eye. CMA T held onto the bottle of eye drops with her ungloved right hand and then used her left hand to hold R47's eyelid open. CMA T used the same tissue to wipe each eye after the eye drop was administered with her ungloved right hand. On 05/12/26 at 04:10 PM, CMA T reported that she did not realize that she had only worn one glove and she should have used a glove on each hand after she washed in her hands. CMA T reported that she thought she used a different tissue. 2. On 05/13/26 at 07:32 AM, Licensed Nurse (LN) H removed the R45's dressing from his left heel with her right hand and cleansed the open area. LN H then removed R45's right sock and washed his right heel; she removed her gloves and applied new gloves without performing hand hygiene. LN H applied Skin-prep (liquid skin protectant) to the intact skin surrounding the open area of his left heel then she applied Skin-prep to the right heel. LN H removed her gloves and without performing hand hygiene she opened a Hydrogel (water-based gel that donates moisture and aids autolytic debridement) dressing, applied new gloves, and applied the dressing to the left heel and covered that dressing with a foam adhesive dressing. She removed her gloves and performed hand hygiene. LN H took her pen out of her pocket and dated the dressing on the left heel. On 05/13/26 7:45 AM, LN H reported she should have performed hand hygiene when she removed her gloves and before she applied new gloves during the dressing change. On 05/14/26 at 11:30 AM, Administrative Nurse F reported that she expected the staff to wash their hands after they removed gloves before applying new gloves. On 05/14/26 at 12:32 PM, Administrative Nurse D expected staff to wear gloves on both hands when they administered eye drops and to use a separate tissue for each eye. The facility did not provide a policy on hand washing.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. Based on interview and record review the facility failed to offer and provide or obtain an informed declination for the pneumococcal vaccine (vaccine designed to prevent pneumonia [inflammation of the lungs which can be debilitating or lethal in the elderly]) for Resident (R) 4. Additionally, the facility failed to offer and provide or obtain informed declination for the influenza vaccine (vaccine designed to prevent highly contagious viral infection) form to R6. Findings included:1. R4's Electronic Medical Record (EMR) lacked documentation of a pneumococcal vaccine being administered after responsible party wrote wants all near the column of vaccines that were recommend on the Vaccine(s) Declination form COVID-19 vaccine (a vaccine designed to prevent highly contagious respiratory virus), Influenza Vaccine, Pneumococcal Vaccine, and Shingles Vaccine (a vaccines to prevent a viral infection that causes a painful, blistering rash). None of the vaccines had a check mark to decline in box under the declination column. 2. R6's EMR lacked documentation of an influenza vaccine being offered 2025 through 2026 flu season. On 05/14/26 at 10:45 AM Administrative Nurse F produced the requested influenza/pneumococcal vaccine forms and reported that she could not locate an influenza form for R6 for 2025-2026 influenza season. Administrative Nurse F reported that the form R4 responsible party signed 04/10/2024 was a declination form for all the vaccines offered to him in 2024. Administrative Nurse F then reviewed the form again and confirmed that it stated wants all and none of the vaccines were checked off as declined. On 05/14/26 at 10:50 AM Administrative Nurse D reported she expected all the residents to have the Influenza/Pneumococcal Vaccines offered. Administrative Nurse D reported she expected the residents EMR to have the information if the vaccines were offered/administered or declined. The facility's policy Influenza and Pneumonia Immunization Policy, undated, documented recognizing the major impact and mortality of influenza and/or pneumonia disease on residents of nursing homes; and the effectiveness of vaccines in reducing healthcare costs and preventing illness, hospitalization and death, this facility has adopted the following policy statements: All residents, staff and volunteers of this facility will be offered the influenza vaccine annually, unless there is a documented contraindication or if the resident or representative refuses the vaccine(s) after appropriate education related to the risk of the conditions and the risk of failure to receive the vaccine(s) status. All admissions throughout the year will be offered the pneumovax injection as desired by the resident and approved by the primary care physician after investigation/inquiry related to current immunization status. Every year, a log documenting how many people (residents, staff, and volunteers) receive the influenza and pneumovax vaccine, as well as the number who refused and did not receive the vaccination, will be available to the State Health Department and the State Survey Agency.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175467	A. Building B. Wing	05/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kansas Christian Home	1035 SE 3rd Street Newton, KS 67114

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 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. Based on interview and record review the facility failed to offer and provide or obtain an informed declination for the COVID-19 vaccine (a vaccine designed to prevent highly contagious respiratory virus) for Resident (R) 6 and R21. Findings included:1. R6's Electronic Medical Record (EMR) lacked documentation of a COVID-19 vaccine being offered since 2022. 2. R21's EMR lacked documentation of a COVID-19 vaccine being offered since 2021. On 05/14/26 at 10:45 AM, Administrative Nurse F produced the requested COVID-19 vaccine forms and reported that she could not locate a recent COVID-19 offered and provided or obtained an informed declination for R6 and R21. On 05/14/26 at 10:50 AM, Administrative Nurse D reported she expected all the residents to have the COVID-19 Vaccine offered. Administrative Nurse D reported she expected the residents EMR to have the information if the vaccines were offered/administered or declined. The facility did not provide a policy on COVID-19 Vaccine.