STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175501	A. Building B. Wing	03/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Family Health & Rehabilitation Center	639 S Maize Court Wichita, KS 67209

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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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. The facility identified a census of 66 residents. The sample included 18 residents. Based on observation, record review, and interview, the facility failed to ensure Resident (R) 12 had been assessed for the ability to safely self-administer his physician-ordered Fluticasone propionate nasal spray (a corticosteroid used to relieve allergy and nasal inflammation symptoms).Findings included:- R12's Electronic Medical Record (EMR) documented diagnoses of allergic rhinitis, anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), and unspecified dementia (progressive mental disorder characterized by failing memory, confusion).R12's Annual Minimum Data Set (MDS) dated 10/06/25 documented he had a Brief Interview for Mental Status (BIMS) score of 13, which indicated intact cognition. R12 used a wheelchair to assist with mobility and had no impairment in upper or lower extremities.R12's Quarter MDS dated 01/06/26 documented a BIMS score of 13, which indicated intact cognition. R12 used a walker or wheelchair to assist with mobility and had no impairment in upper or lower extremities.R12's Psychotropic Drug Use Care Area Assessment (CAA) dated 10/06/25 documented he had his medications managed and overseen by the nurse and physician team.R12's Care Plan lacked documentation he kept Fluticasone Propionate Nasal Spray at his bedside.Review of R12's physician orders documented Fluticasone Propionate Nasal Suspension 50 micrograms per action, spray once in both nostrils one time a day for allergic rhinitis, dated 10/03/24.R12's Assessment tab lacked the Self-Administration of Medication/Treatment Data Collection Tool for Fluticasone Propionate Nasal Spray.On 03/02/26 at 09:09 AM, R12 was seated in his recliner with his feet raised, listening to music. On the dresser right in front of his recliner sat a bottle of Fluticasone Propionate Nasal Spray. R12 stated he did his own nasal spray. R12 reported the nasal spray was not on a schedule, and he took it when he was stopped up.On 03/04/26 at 11:25 AM, the Fluticasone Propionate Nasal Spray sat on R12's dresser. Licenses Nurse (LN) H confirmed that is what was on R12's dresser and that if he had that in his room, he would have been assessed to keep the medication in his room. LN H reviewed R12's chart and confirmed that he did not have the assessment to keep Fluticasone Propionate Nasal Spray in his room. LN H stated she would get that off of R12's dresser and remove it from his room due to him not having the assessment indicating he could keep it in his room.On 03/04/26 at 12:28 PM, Administrative Nurse D stated that if there was no assessment completed for self-administration of the medication, then the resident could not keep any medications in his room. Administrative Nurse D stated R12 should not have had the nasal spray in his room.The facility's undated Self-Administration of Medication policy documented self-administration of medications by residents was generally allowed. The policy documented the competency of the resident was assessed prior to allowing a resident to self-administer medications by the interdisciplinary team. The procedure directed that an assessment would be performed annually and after a significant change of condition.

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 66. The sample included 18 residents. Based on record review and interviews, the facility failed to develop a comprehensive care plan for Resident (R) 65.Findings included:-R65's Electronic Medical Record (EMR) recorded diagnoses of irritable bowel syndrome, hypertension (high blood pressure), chronic respiratory failure, and urine retention.R65's admission Minimum Data Set (MDS) dated [DATE] recorded a Brief Interview for Mental Status (BIMS) score of 14, which indicated intact cognition. The MDS noted R65 was dependent upon staff assistance for toileting, dressing, and transfers. She had one non-injury fall.R65'S 12/18/25 Falls Care Area Assessment (CAA) triggered secondary to impaired balance with transitions and transfers and her need for assistance with activities of daily living. The CAA noted contributing factors included restricted mobility, medication usage, a need for assistance with transfers and a urinary catheter (tube inserted into the bladder to drain urine). Her risk factors included falls and injuries from falls, pain, and skin breakdown. A care plan would be reviewed to assist in preventing falls and injuries related to falls. R65's Care Plan recorded one Focus, related to activities initiated on 12/08/25. The interventions, initiated on 12/08/25, directed staff to assist R65 to and from activities and to educate the resident daily of the available activities. The plan lacked further Focus areas, goals or interventions.On 03/04/26 at 08:36 AM, Licensed Nurse (LN) J reported that the MDS nurse would complete the comprehensive care plan within 21 days of admission.On 03/04/26 at 09:40 AM, Administrative Nurse E stated R65's Care Plan should have been completed in the timeframe of 21 days and said that R65 had moved the skilled side to the long-term care side around the holidays. Administrative Nurse E stated she had not realized R65's comprehensive plan had not been developed. On 03/04/26 at 01:55 PM, Administrative Nurse D said she expected the admission comprehensive care plan to be completed within 21 days of admission.The facility provided the policy Care Plan Revisions revised on 01/18/26, which noted the Care Planning process included patient assessment, goal setting, interventions, referrals to other health care professionals, evaluation of patient responses to treatment and revision of care and treatment in order to meet the patient's needs.

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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. The facility identified a census of 66. The sample included 18 residents. Based on observation, interviews, and record review, the facility failed to ensure Resident (R) 39 received the necessary staff assistance with oral hygiene.Findings included:- R39's Electronic Medical Record (EMR) recorded a diagnosis of multiple sclerosis (MS- progressive disease of the nerve fibers of the brain and spinal cord). R39's 01/21/26 Annual Minimum Data Set (MDS) documented R39 had a Brief Interview for Mental Status (BISM) score of five, which indicated severe cognitive impairment. The MDS noted R39 was dependent upon staff assistance for oral hygiene.R39's Care Plan recorded interventions dated 12/31/25, which directed staff that R39 required supervision and partial/moderate assistance with eating. He required moderate assistance for oral hygiene tasks and staff should encourage and/or assist him with oral care in the morning and evening. R39's Orders noted an order dated 02/20/25 for staff to offer to brush R39's teeth twice daily (every shift). The consultant dentist's visit summary dated 08/04/25 documented R39 was missing teeth #28-31 (right lower teeth). The cleaning summary noted R39 had heavy food debris, moderate to severe inflammation of the gums, and his oral hygiene was poor though he was cooperative with the cleaning. The summary included directions to staff to please remind/assist R39 with brushing twice daily, focusing on the gumline. The visit summary dated 01/26/26 noted no new findings. The summary indicated R39 had moderate to heavy food debris and generalized severe gum inflammation. R39 had poor oral hygiene but he was cooperative with the cleaning procedure. The summary left directions to staff to remind and/or assist R39 to brush twice daily, focusing on the gumline. Observation on 03/03/26 at 07:50 AM revealed staff assisted R39 with morning care but did not offer oral care at that time. Observation on 03/03/26 at 08:15 AM revealed R39 had a battery-operated toothbrush as well as toothpaste in his bathroom in an emesis basin. The emesis basin and the toothbrush were dry. On 03/02/26 at 10:31 AM, R39's representative reported she was concerned that the staff does not perform oral care on R39 as they should. She reported that she did address these concerns at the care plan meeting she attended about a month ago. On 03/03/26 at 10:23 AM, Licensed Nurse (LN) I reported that he did not provide oral care to R39. He just signed it off on the treatment record and followed up with the aides to make sure they completed it during morning care. On 03/03/26 at 12:08 PM, Certified Nurse Aide (CNA) M reported that she would usually do R39's oral care after breakfast. CNA M said she did not provide R39 oral care that day as she forgot to do it. CNA M verified that R39 could not brush his own teeth. On 03/04/26 at 09:12 AM, Administrative Nurse D revealed she expected the staff to complete R39's oral care. The facility policy Oral Health Care, revised 02/10/25 documented every resident will receive oral care twice daily to ensure the highest level of oral health and oral function.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. The facility identified a census of 66. The sample included 18 residents. Based on observation, record review and interviews, the facility failed to identify and implement interventions for Resident (R) 19 to address a nine-day period with no bowel movement.Findings included: -R19's Electronic Medical Record (EMR) recorded a diagnosis of dementia (a progressive mental disorder characterized by failing memory and confusion). R19's 11/07/25 Annual Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of three, which indicated severely impaired cognition. The MDS recorded R19 required maximal assistance with transfers and toileting hygiene and was frequently incontinent of bowel. R19's 11/17/25 Cognitive Loss/Dementia Care Area Assessment (CAA) documented R19 had a diagnosis of dementia with behaviors and had an order for medication. R19's Care Plan initiated on 11/07/25 and revised 12/29/25 noted R19 was at risk for altered nutrition and hydration related to dementia and chronic constipation. The plan noted R19 experiences pain related to osteoarthritis. Interventions dated 12/29/25 directed staff to administer medications as ordered and monitor for signs of constipation, such as abdominal distention, decreased bowel sounds, diarrhea, decreased appetite and no bowel movement for two days when administering narcotics. R19's Orders recorded the following physician orders.Enulose Solution (laxative) 10 grams per 15 milliliters (ml), give 30 ml in the morning for constipation dated 07/18/24.Milk of Magnesia suspension (laxative) 400 milligrams (mg) per ml, give 30 ml by mouth as needed for constipation daily, dated 10/27/24. Review of R19's bowel movement task record revealed R19 had a small bowel movement (BM) on 02/02/26 and then had no BM noted from 02/03/26 through 02/11/26. A medium BM was recorded on 02/12/26. Review of R19's February 2026 Medication Administration Record (MAR) revealed the Enulose was not administered on 02/04, 02/07, and 02/08 due to the resident was sleeping (indicated by a 13 on MAR). The MAR indicated the Milk of Magnesia was not administered in the month of February 2026. R19's Progress Notes from 02/02/26 through 02/12/26 lacked evidence a bowel assessment or abdominal assessment was conducted. On 03/03/26 at 09:56 AM, R19 sat on the edge of the bed while Licensed Nurse (LN) I administered his medication. R19 had difficulty swallowing his medications but was provided with juice and R19 was able to swallow the medications. On 03/03/26 at 12:14 PM, Certified Medication Aide (CMA) S reported that the staff has to document incontinence and bowel movements in separate tasks and when documenting the actual BM, she always documented the incontinence section first, as if she knew the resident was incontinent, she would document that even if they did not have a BM. Then, if the resident had a BM she would go back and document the BM. She reported that the dashboard only showed the CMA the last 24-48 hours for records of BM, and the charge nurse had to print off a BM sheet to reflect the last three days. She stated if a resident required any as needed medication for constipation, the charge nurse would give that direction. On 03/03/26 at 12:25 PM, LN I reported that the night nurse would print off the BM report for day shift nurse for residents and reported that it was just the size of BM or none in the past three days. He reported that the facility had a standing order if a resident did not have a BM for three days. LN I reviewed R19's bowel record for February 2026 and counted the nine days of no BM and confirmed the MAR did not indicate that any as needed constipation medications were administered. LN I said that nursing staff were responsible for completing an abdominal assessment when there was no BM and it should be documented in the EMR. On 03/04/26 at 09:12 AM, Administrative Nurse D said that she reviewed R19's BM record that was requested and went on to say that she did not believe the documentation that R19 had no BM during the nine-day period between 02/03/26 and 02/11/26. She stated R19's provider saw him on 02/11/26 and had no issues and said that an abdominal assessment was done then. Administrative Nurse D said she expected the nurse on night shift to run a BM (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	report and give that to the day nurse so the resident could receive as needed bowel medications for constipation. She confirmed the facility had a bowel protocol standing orders and reported that she expected the staff to document in the EMR and to update the provider what interventions were given. She said she expected staff to complete and document an abdominal assessment until the resident had a BM. The facility's policy Bowel and Bladder Management, revised 01/06/26, directed all residents will have bowel patterns monitored each shift through CNA documentation in the electronic charting system. The licensed nurse on each shift will review the bowel report at the beginning of the shift and initiate the bowel protocol when indicated. When a resident has not had a bowel movement approaching three (3) days, the licensed nurse should assess the resident, including: the date and description of last bowel movement, presence of abdominal pain, cramping, nausea, or vomiting, bowel sounds and abdominal assessment, recent dietary and fluid intake, current medications, vital signs and signs of dehydration and stool characteristics (color, consistency, presence of blood, etc.). The bowel protocol is as follows:Step 1: Administer Milk of Magnesia (MOM) 30 ml orally.Step 2: If no bowel movement occurs within 24 hours, administer lactulose 20 ml orally every 2 hours for up to three (3) doses or until bowel movement occurs.Step 3: If no bowel movement occurs after lactulose administration, administer Dulcolax(Bisacodyl) suppository 10 mg per rectum.Step 4: If no bowel movement occurs following the suppository, administer one (1) Fleet enema.Step 5: If there is still no bowel movement following the above interventions, notify the provider for further evaluation and treatment orders.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 66 residents. The sample included 18 residents, with one reviewed for tube feeding (administration of nutritionally balanced liquified foods or nutrients through a tube). Based on observation, record review, and interview, the facility failed to provide appropriate care and services for Resident (R) 4 when staff administered a medication and provided a tube feeding without using the physician's order for the amount of water before and after the procedure. Findings included: - R4's Electronic Medical Record (EMR) documented R4 had diagnoses of artificial openings of the gastrointestinal tract (surgical creation of an artificial opening into the stomach through the abdominal wall) R4's Quarterly Minimum Data Set (MDS), dated [DATE], documented the resident had severely impaired cognition. The MDS documented R4 required total staff assistance with activities of daily living (ADLS), had no swallowing disorders, and received tube feedings. R4's Care Plan, revised on 02/17/26, documented R4 dependent with tube feeding and water flushes and instructed staff to provide them per the physician's order. The Physician Order, dated 01/12/26, instructed staff to administer one carton (250 milliliters (ml) of Nutrent 2.0 (nutrition supplement that provides complete, balanced nutrition for long - or short -term tube feeding with increased calorie and protein needs) daily at 10:00 AM and flush the tube with 100ml of free water before and after each bolus feeding. On 03/03/26 at 10:45 AM, observation revealed Licensed Nurse (LN) G, placed gloves on, placed a catheter tip syringe into R4's feeding tube, poured 50 ml of free water, administered R4's Zofran (dissolved in 15 ml of water) through the peg tube, provided 250 ml of Nutrent supplement through the tube, then flushed with 50 ml of water. On 03/03/26AM at 10:45 AM, LN G verified she had flushed R4's peg tube with 50 ml before and after R4's administration of Zofran, and 0 ml before peg tube feeding. LN G stated she had read the order wrong and should have flushed R4's peg tube with 100 mL before and after the peg tube feeding. On 03/04/26 at 11:02 AM, Administrative Nurse D stated she would expect the staff to verify the order, check placement, position the resident in the proper position, flush with water per physician order, give medication and supplement, then flush with physician ordered amount of water. The facility's Enteral Tube Feeding Policy, dated 12/12/23, documented for bolus supplementation, the pharmacy or facility would encode orders into the computer under the medication order entry program. Labeling and dispensing would be as with unit-dose medications.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 66 residents and four kitchens. Based on observation, record review, and interviews the facility failed to maintain a sanitary environment and store food adequately to prevent contamination. Findings included:- During the initial kitchen inspection on 03/02/26 at 07:35 AM, observation in the food storage room on main hall revealed several cases of water stored directly on the floor. Dietary BB reported the emergency water had been on the floor for a few months.On 03/02/26 at 07:40 AM, observation in [NAME] House revealed the oven had a large amount of burnt dark residue on the bottom. The refrigerator had a staff member's lunch bag at the bottom. Dietary BB removed the lunch bag of the staff member and reported it should be stored in the employee refrigerator. On 03/02/26 at 07:51 AM, the [NAME] and [NAME] House refrigerator had an undated container of cut up apples with cinnamon and an undated bag of hash browns. The freezer had an undated bag of frozen biscuits. Dietary CC reported that all items should be labeled with a date. On 03/03/26 at 12:56 PM, observation of the [NAME] and [NAME] kitchens revealed broken cupboards, scratched cutting boards and the muffin bakery tins were bent with cooked on dark black/brown residue. The bottom shelf of the freezer in the actual kitchen was quite dirty with drops of food and liquids. On 03/03/26 at 01:05 PM, observation in the [NAME] and [NAME] kitchen revealed missing drawers. The cutting boards were very scratched up, and the muffin bakery tins were bent with cooked on dark black/brown residue. Under the steamer table in [NAME], the shelf was dirty with baked food and dust. There was a broken laundry basket on the floor in the storage area between [NAME] and [NAME] labeled kitchen towels, and the basket contained clean kitchen towels. Dietary BB reported that the dietary staff use the laundry area located in each house and confirmed the basket should not be on the ground. Dietary BB reported that the cutting boards and the bakeware would be replaced.On 03/03/26 at 03:00 PM, Administrative Staff A reported she expected the kitchen equipment to be clean and the kitchen to be in good repair. She expected the food to be labeled with a date and items not to be stored on the floor. The facility's policy Food Preparation and Handling Policy revised 01/20/26, noted 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 will be prepared using methods and techniques designed to preserve maximum nutritive value, enhance flavor, and be free of injurious organisms and substances. The kitchen and equipment would be kept clean, neat, orderly and well maintained.

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F 0814 Level of Harm - Potential for minimal harm Residents Affected - Many	Dispose of garbage and refuse properly. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility reported a census of 66 residents. Based on observations, interviews and record review, the facility failed to maintain and/or dispose of kitchen garbage and refuse properly.Findings included:- On 03/03/2026 at 07:30 AM, observation revealed two garbage receptacles outside, one on the east side and one on the west side. The garbage receptacle outside of the [NAME] House had the lid open on one side, and there were several bags of garbage behind the dumpster that had holes in them as if broken open, gloves, food, and other medical supplies noted. There was garbage on the ground on the side of the dumpster. Dietary CC reported that the lids should always be closed, and the garbage behind and on the side of the container should not be there. On 03/03/2026 at 10:35 AM, Dietary BB reported that there should be no garbage on the ground at the trash dumpsters and the lids should be closed. On 03/03/2026 at 12:30 PM, Administrative Staff A reported that she had been working on a little project regarding the dumpster. She stated the dumpster that had garbage on the ground around it was small, and she was trying to get a new one. She reported she expected the staff to close the lids and not have garbage on the ground. The facility's policy Disposal of Garbage and Refuse Policy, revised on 01/14/26, documented the facility would maintain all outside dumpsters and surrounding refuse storage areas in a clean, sanitary, and well-maintained condition to prevent the creation of a nuisance, pest attraction, or potential contamination risk to food service operations, residents, staff, or visitors.