STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175532	A. Building B. Wing	05/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avita Health and Rehab at Reeds Cove	2114 N 127th Court East Wichita, KS 67228

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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 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** Based on observation, record review, and interview, the facility failed to prepare and serve food under sanitary conditions to prevent potential for food borne bacteria.Findings included:- The initial kitchen tour of [NAME] house on 05/05/26 at 08:25 AM revealed a plate of food in the refrigerator with no date, ketchup and mustard which lacked an open date, a container of liquid eggs opened half of the container used with no open date. Freezer had an open bag of hotdogs open with no date and crystals on the hotdogs. In the pantry between the two kitchens, a container of molasses opened 01/03/26 had lines of syrup down the front and the back of the bottle causing the shelf to be sticky and the freezer and refrigerator logs only had documentation for 05/01/26 and 05/05/26 but lacked other documentation.During the initial tour of [NAME] House on 05/05/26 at 08:30 AM, temperature logs documented freezer and refrigerator temps obtained on 05/01/26, 05/02/26, and 05/03/26 in the PM; lunch and breakfast lacked temps on 05/04/26. The freezer had three packages of open hamburgers and/or sausage patties not labeled or dated. A jar of peanut butter located on top of the refrigerator had peanut butter on the outside of the container.The initial tour of Saghbene house on 05/05/26 at 08:54 AM revealed a bag of hotdogs left open and brussels sprouts open to air, located in the freezer with no date. The pantry had a bag of honey oats, which lacked a date, and a caramel dip, which was not sealed.During the initial tour of [NAME] house on 05/05/26 at 09:00 AM, the food temperature logs lacked temperatures on 4/30/26 for lunch, 05/03/26 lacked temps for dinner, and on 05/04/26 there were no food temps for lunch or dinner; 04/18/26 lacked temperature for sanitation and there was no log sheet for sanitation available.On 05/06/26 at 08:16 AM in an interview, Dietary Manager BB revealed she expected all items to be kept in a clean and sealed container with dates, expected all food items to be temp for safe food distribution, and stated there should be no holes regarding the temperature log.On 05/07/26 at 11:33 AM Administrative Staff A stated all food in the refrigerators should be closed or sealed and a date and the information required should be placed to maintain regulatory compliance.The facility's policy Food Preparation and Handling Policy, dated 12/7/23, documented the facility will store, prepare, distribute, and serve food in accordance with professional standards for food service safety. Food that requires time/temperature control for safety to limit the growth of pathogens (bacterial or viral organisms capable of causing disease formation).

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on interviews, observation, and record review, the facility failed to ensure adequate hand hygiene during dressing change and medication administration for Resident (R) 48. Additionally, the facility failed to properly transport clean personal linens.Findings included:1. 05/06/26 at 08:26 AM Licensed Nurse (LN) G removed soiled dressing from R48's gastrostomy tube (G-tube: tube surgically placed through an artificial opening into the stomach) site and discarded the dressing into the garbage. LN G started to open a dressing then removed her gloves with no hand hygiene performed. LN G applied new gloves and cleansed the G-tube site. LN G removed her gloves with no hand hygiene performed and applied a new pair of gloves. LN G applied a new dressing and labeled the tape with the date; she then removed her gloves with no hand hygiene performed and administered medications to R48 through the feeding tube. 2. 05/06/26 at 12:05 PM LN G entered R48's room picked up a cup and went to the bathroom and filled it with water; she then applied her personal protective equipment (PPE- gowns, face shields and/or eyeglasses/goggles, and gloves) with no hand hygiene performed prior to applying PPE. On 05/06/26 at 12:22 PM LN G reported that she should have washed her hands when she removed her gloves each time and before applying new gloves.3. 05/06/26 at 02:26 PM Certified Nurse Aide (CNA) M exited the clean/laundry work room with a full basket of uncovered, clean personal laundry. CNA M reported that he had just taken it out of the dryer and was not sure what resident the linen belonged to and said that he generally covered the linen with a bag. CNA M transported the uncovered linen down the hallway to a resident's room. On 05/07/26 at 09:48 AM LN H reported the laundry that comes in and out of the soiled/clean laundry areas are required to be covered during transportation. On 05/07/26 at 10:17 AM Administrative Nurse E revealed she expected staff to perform hand hygiene before applying gloves and after gloves are removed. Administrative Nurse E was unsure whether clean linen required to be covered when transported to the residents' rooms.On 05/07/26 at10:55 AM Administrative Nurse E reported the laundry was to be covered in and out of the laundry rooms. The facility's policy Infection Control, dated 02/02/26, documented this facility will follow Standard Precautions for Infection Control and Prevention to protect residents, staff and visitors to ensure staff do not carry infectious pathogens on hands perform hand hygiene before and after contact with a resident and immediately after removing gloves.The facility's policy Laundry Protocols, dated 03/19/26, documented each piece of laundry will be handled, processed, stored, and transported in a manner designed to prevent transmission of infection. Laundered articles will be transported in enclosed, linen hampers with removable liners in enclosed carts or dollies or securely wrapped.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, and record review, the facility failed to address and resolve a grievance for Resident (R) 18 and failed to notify the resident of any actions or the status of the grievance. Findings included:- The Electronic Medical Record (EMR) for R18 documented a diagnosis of major depressive disorder (major mood disorder that causes persistent feelings of sadness) and anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear).R18's Annual Minimum Data Set (MDS), dated [DATE], documented a Brief Interview for Mental Status (BIMS) of 15 indicating intact cognition. R18's MDS documented no behavior was noted. R18's Psychotropic Drug Use Care Area Assessment (CAA), dated 02/20/26, documented triggered secondary to use of psychotropic medication to manage illness and conditions. A licensed nurse would monitor side effects every shift, and the physician is to be notified for any abnormal findings.R18's Care Plan, dated 10/31/24, instructed staff to provide opportunities for expression of feelings related to situational stressors.On 05/06/26 at 04:00 PM, R18 was outside sitting in his scooter with staff and another resident enjoying the weather and watching a [NAME] in the water. R18 reported he was quite upset no one had come back and spoke to him about the grievance he filed the previous week, R18 reported the unknown Certified Nurse Aide (CNA) that he had a concern with did come back the next day to apologize to him though no one from management spoke to him about his grievance he filed. On 05/06/26 at 04:45 PM, Administrative Nurse D delivered the original grievance form R18 submitted on 04/24/26 which documented the resident was at the dinner table and requested CNA assistance for another resident as the table. R18 was concerned that the other resident may have been having difficulty with swallowing food and might have required assistance. R18 reported the CNA disregarded his request and did not check on the resident or notify the nurse. R18's Grievance/Complaint Report, date submitted 04/24/26, revealed the grievance section that asked if the resolution was resolved was checked off yes, however it lacked any documentation what the resolution was as the form stated describe the resolution. The form was signed by Administrative Nurse D with no date. On 05/06/26 at 04:54 PM, Administrative Nurse D reported that she did get back to R18 about his grievance the next day verbally. She reported she would give the resident a copy of the completed grievance form if they requested the form. Administrative Nurse D confirmed R18's 04/24/26 grievance form lacked documentation what the resolution was and the date she signed the form.On 05/07/26 at 09:17 AM, Administrative Staff A delivered a copy of R18's 04/24/26 grievance which documented a resolution that R18 was ok at that time and would notify Administrative Staff A and or Administrative Nurse D if he still had concerns after that day, dated 05/06/26 by Administrative Staff A. The facility's policy Grievance/Concern Policy, dated 01/07/26, documented the person(s) voicing the concern would be informed of any/all mechanisms of resolution within seven (7) days of filing the concern with the facility by the Administrator or designee.

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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 14-day stop date or a specified duration with physician rationale for an as-needed (PRN) order for lorazepam (treatment of anxiety) medication for Resident (R) R66. Additionally failed to monitor antipsychotic medication for Resident (R) 18. Findings included:- R66's Physician Orders, dated 12/10/24, revealed the following diagnosis: cerebral palsy (progressive disorder of movement, muscle tone or posture caused by injury or abnormal development in the immature brain, most often before birth), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear). R66's Annual Minimum Data Set (MDS), dated [DATE], Brief Interview for Mental Status (BIMS) score revealed severely cognitive impairment. The MDS noted behaviors towards others which occurred during the look back period one to three days. The behavior impacted or placed others at risk of physical injury. R66's Quarterly MDS revealed a BIMS score of three which indicated severely impaired cognition. There were no changes in behavior. R66's Care Area Assessment, dated 12/02/25, noted behaviors trigged secondary to the resident yelling out throwing cups and personal items. Risk factors included injuring self and increased anxiety. R66's Care Plan revision on 12/11/25 revealed R66's medications would be overseen and managed by nursing and the physician. R66 took medication with black box warnings including lorazepam. The plan directed staff to observe for psychosocial changes and report any changes in mental status caused by situation stressor to the physician. R66's orders included an order dated 04/30/26 for lorazepam oral tablet 0.5 mg (milligrams), one tablet by mouth every eight hours PRN for anxiety. The order lacked a stop date. On 5/07/26 at 08:20 AM Licensed Nurse (LN) H revealed the PRN lorazepam was started on 04/03/26 and verified the order did not have a stop date. LN H stated she would have to clarify the policy regarding stop dates. On 05/07/26 at 01:47 PM Administrative Nurse D said the psychotropic medication use should be monitored for side effects and PRN orders should have a 14-stop dated when obtained. The facility's policy Medication Administration all medication will be administered to every elder as ordered by a physician in a safe and sanitary manner. Psychotropic medications are prescribed only under the following parameters: PRN orders for psychotropic medication are limited to 14 days upon initial orders. At 14 days providers will evaluate and may extend beyond 14-day duration with a documented rationale for the extension. - The Electronic Medical Record (EMR) for R18 documented a diagnosis of major depressive disorder (major mood disorder that causes persistent feelings of sadness) and anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear). (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R18's Annual Minimum Data Set (MDS), dated [DATE], documented a Brief Interview for Mental Status (BIMS) of 15 indicating intact cognition. R18's MDS documented no behaviors noted. R18's MDS documented he was administered antianxiety (a class of medications that calm and relax people), and antidepressant (a class of medications used to treat mood disorders) medications. R18's Psychotropic Drug Use Care Area Assessment (CAA), dated 02/20/26, documented triggered secondary to use of psychotropic medication to manage illness and conditions. A licensed nurse would monitor side effects every shift, and the physician is to be notified for any abnormal findings. R18's Care Plan, dated 10/31/24, instructed staff to administer medications as ordered and monitor/document for side effects and effectiveness. R18's Care Plan, dated 05/06/26, lacked documentation for Abilify (an antipsychotic medication used to treat major depressive disorder). R18's Physician Orders documented Abilify 2 milligrams (mg), give one tablet, by mouth daily for major depressive disorder date ordered, 04/15/26. R18's Electronic Medication Administration Record (EMAR), reviewed 04/15/26 through 05/06/26, lacked documentation of the number of episodes of identified target behaviors and/or side effects, actions taken, and effectiveness of interventions for Abilify. R18's Psych Provider Note, dated 04/08/26 at 04:00 PM, documented to discontinue Remeron (antidepressant) and start Abilify 2mg daily for adjunct depression. Continue all other medications as prescribed follow up in one month. R18's Progress Note, dated 04/14/2026 at 10:28 AM, documented R18 was seen by provider on 04/08/26 start Abilify 2mg daily for depression. On 05/06/26 at 04:00 PM R18 was outside sitting in his scooter with staff and another resident enjoying the weather and watching a [NAME] in the water. On 05/07/26 at 09:25 AM Licensed Nurse (LN) H reported that the EMAR would have a section for the nurse to complete monitoring and what nonpharmacological interventions were used for all psychoactive medications including antipsychotic medications. LN H reported that R18's Abilify was being used for depression, so they were monitoring Abilify like an antidepressant. On 05/07/26 at 09:47 AM Administrative Nurse D revealed she expected that the staff to monitor every psychoactive medication every shift. The facility's policy Medication Administration Policy, dated 03/19/26, documented monitoring the elder's response to medications is an important assessment activity for nurses, physicians, and pharmacists in particular, monitoring the eider's response to the first dose of a new medications is essential to the safety of the elder because any adverse reactions, including serious ones, are more unpredictable if the medication has never been used with the elder in the past. Clinical staff will monitor each eider's response to medication(s) by accounting for actual or potential adverse drug reactions and events.

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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** Based on observation, interviews, and record review, the facility failed to ensure Resident (R) 48's feeding tube (G-tube: tube surgically placed through an artificial opening into the stomach) was monitored for placement prior to administration of medications and enteral nutrition (provision of nutrients through the gastrointestinal tract when the resident cannot ingest, chew, or swallow food). Findings included:- R48's Electronic Health Record (EHR) documented diagnoses which included dementia (a progressive mental disorder characterized by failing memory and confusion), and diabetes mellitus (DM-when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin).R48's admission Minimum Data Set (MDS), dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of two, which indicated severely impaired cognition. R48's MDS documented he required total assistance with all activities of daily living and R48 had a feeding tube. R48's Feeding Tube Care Area Assessment (CAA), dated 07/21/25, documented the CAA triggered secondary to use of feeding tube for maintenance of nutritional/hydration status. Risk factors included complications related to use of feeding tube such as aspiration, weight changes, and fluid imbalance. R48's Care Plan, dated 07/21/21, instructed staff to check tube placement and gastric contents/residual volume per facility protocol and record.R48's Physician Orders directed staff to administer 50 milliliters (ml) bolus of water before and after each feed every six hours for enteral tube hydration date ordered 08/11/25.R48's Physician Orders directed staff to administer via feeding tube 60 ml water before and after meds every shift, date ordered 08/26/25.R48's Physician Orders, dated 05/06/26, lacked documentation to check for placement or residual of feeding tube. On 05/06/2026 at 08:05 AM R48 was in her bed, eyes closed. On 05/06/26 at 08:26 AM Licensed Nurse (LN) G flushed R48's feeding tube with 60 ml water and administered R48's medications through the feeding tube and flushed with 60 ml of water. LN G did not check placement of feeding tube prior to flushing the feeding tube with water. On 05/06/26 at 12:05 PM LN G removed R48's abdominal binder and connected the syringe to the feeding tube without checking for placement of the tube. LN G administered 50 ml of water and administered the enteral feed; LN G then flushed the tube with 50 ml of water after. On 05/06/26 at 12:22 PM LN G reported that she did not know she had to check placement on that type of feeding tube and verified she did not check for residual either. 05/06/26 at 12:28 PM Administrative Nurse D revealed she expected the nurse to verify placement of all feeding tubes prior to use. The facility's policy Enteral Tube Feeding Policy, dated 02/19/26, lacked documentation to check for placement of a feeding tube.The facility undated competency Procedure Tube Feeding documented to perform abdominal assessment by listening to bowel sounds in four quadrants check abdomen for firmness. Attach syringe to end of tube and inject 10 ml of air while auscultating stomach area with stethoscope, listening for whooshing sound when injected. Attach syringe to end of tube and aspirate all gastric contents of stomach with the syringe and measure to check for residual amount of feeding in stomach; visualize aspirated contents, check for color and consistency; return residual and proceed with feeding if amount of residual does not exceed limit indicated by ordering physician.