STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175567	A. Building B. Wing	06/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Logan County Senior Living Inc	615 Price Ave Oakley, KS 67748

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on record review, observation, and interview, the facility failed to ensure Resident (R) 2 was free from verbal abuse. Findings included:R2's Electronic Medical Record (EMR) documented she had diagnoses of dementia, traumatic brain injury (TBI-an injury to the brain caused by external forces), major depressive disorder, arthritis, and atrial fibrillation (rapid, irregular heartbeat). The Annual Minimum Data Set (MDS), dated 05/15/2026, documented R2 had a Brief Interview for Mental Status (BIMS) score of six, which indicated severely impaired cognition. The MDS documented R2 had functional impairment in both her bilateral upper and lower extremities and she was dependent on staff for transfer, bed mobility, dressing, and mobility in a wheelchair. The MDS documented R2 had verbal behaviors directed towards others one to three days during the look-back period. The Cognitive Loss/Dementia Care Area Assessment (CAA), dated 05/05/2026, documented R2 had the potential for unmet needs, difficulty focusing on tasks and conversations, and mood/behavioral changes related to severe dementia. The Functional Abilities CAA, dated 05/05/2026, documented R2 had the potential for further mobility decline, contractures, falls, and skin breakdown due to arthritis in her bilateral upper shoulders and bilateral lower extremities. The Behavioral Symptoms CAA, dated 05/05/2026, documented R2 had behaviors which could affect her care outcomes and the environment related to R2 refusing care and screaming at others. R2's Care Plan, initiated 04/09/2022, documented R2 had the potential for behavioral problems (being verbally aggressive, confusion, threatening others). The care plan directed staff to provide opportunities for positive interactions, positive attention, and to anticipate and meet R2's needs. The care plan directed staff to explain all procedures to R2 before starting and allow R2 a few minutes to adjust to changes. The care plan documented R2 had limited physical mobility in her upper and lower extremities due to extensive arthritis and directed staff to use a full body lift for transfers. The Behavior Note, dated 04/14/2026, documented R2 yelled out at staff and cussed at staff about taking a bath late. Licensed Nurse (LN) H's notarized Witness Statement documented LN G heard R2 yell at CNA P to Quit. LN H stepped into R2's room and observed CNA P getting R2 ready to transfer to the bath chair to take a bath. R2 calmed down when LN H stepped into the room. LN H left the room. R2 then started yelling again. LN H stepped back into the room, and R2 stopped yelling and stated her arm hurt. CNA P stated she had not touched R2's arm. CNA P followed LN H out of R2's room. LN G stated she told CNA P to get CNA O to help her transfer R2 into the bath chair. CNA O and CNA P took R2 to the bathhouse at 10:00 PM LN H noted she could hear R2 yelling in the bathhouse. LN G stepped into the bathhouse to see what was going on. R2 yelled at CNA P to quit and get out of the bathhouse. CNA O finished the bath while CNA P stepped outside for a breather. At 10:50 PM, CNA O notified LN H that CNA P had yelled at R2 and called R2 a [expletive]. LN H contacted Administrative Nurse D and was instructed to send CNA P home. CNA P had no more contact with any other residents in the building. CNA O's Notarized Witness Statement, dated 04/14/26, documented CNA O went to assist CNA P with transferring R2 from her bed to the shower chair. R2 yelled at CNA P, No, leave me alone. I don't want a bath. It is too late for a bath. I will do it tomorrow. CNA P told R2 she only got two baths a week, so she was going to take a bath. CNA O stated she asked R2 if anything was wrong, and R2 said her arm (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	hurt. CNA O stated she and CNA P got R2 up to the shower chair, and R2 yelled all the way to the bathhouse. CNA O stated about five minutes later, CNA P called on the radio and stated she wanted someone in the bathhouse with her, as R2 was screaming and saying Ouch. CNA O went into the bathhouse, and R2 refused to raise her arms for CNA P to clean her underarms. CNA O noted she asked R2 if she could raise her arms so she could be washed. R2 stated, I will as soon as she leaves. CNA P looked at R2 and said, Oh, I'm the [expletive] problem? I will leave. She can deal with you, and threw the washcloth and left. CNA O stated she finished R2's bath. CNA O dried, lotioned, and dressed R2. CNA P came back into the bathhouse to assist with getting the lift sling under R2. CNA P bent down to pull the sling between R2's legs. R2 grabbed CNA P's hair. CNA O got R2 to let go of CNA P's hair. CNA O noted as they lifted R2 in the air with the lift, R2 stated CNA P should have given herself a bath because her private parts probably stink. CNA P laughed and said, What's your smell like? Poo nanny? Nope, you are not going to get any dick in here. R2 then told CNA P to get the [expletive] out of her room and started screaming for her mom. CNA P told R2, Your mom is not coming. She is dead, and you are in a nursing home. R2 told CNA P she hoped she would come down here and deal with you. CNA P replied, I hope she does and takes you with her. I am tired of your [expletive]. R2 told CNA P to just leave her alone and get out. CNA P called R2 [expletive]. On 06/16/2026, at 09:45 AM, observation revealed a CNA assisting R2 back to her room after breakfast. R2 visited calmly with the CNA and was joking with her. On 6/16/2026 at 09:50 AM, R2 had no memory of the situation which happened with CNA P. On 06/16/2026 at 11:00 AM, CNA O stated she did not know what to do when CNA P began to act as she had, so she just stayed in the room to make sure R2 was safe, and then afterwards went and told LN H what had happened. On 06/16/2026 at 01:30 PM, Administrative Nurse D stated when the incident was reported to her by LN H, it was reported CNA P had called R2 a [expletive]. Administrative Nurse D stated after digging into what happened that night and finding out what CNA P had said to R2, she was appalled. She could not believe anyone would talk to a resident in that manner. Administrative Nurse D stated she had been proud of LN H for stepping in and telling CNA P to take a break and getting CNA O to take over for her. Administrative Nurse D stated she did not understand why CNA P came back in to continue to assist R2; it was almost like CNA P was looking for a fight.

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety 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, interviews, and record review, the facility failed to provide the required supervision to prevent Resident (R) 1, a cognitively impaired resident at risk of elopement and a high risk for falls, from exiting the facility without staff knowledge or supervision. The facility also failed to ensure staff performed the required 15-30 minute safety checks; therefore, staff did not identify the resident was out of the facility for one hour and 15 minutes. On 06/06/2026 at 10:00 AM, R1 exited the facility via the North door, which was left ajar by a staff member. At 11:15 AM, Certified Nurse Aide (CNA) M alerted staff that R1 was missing. Staff located R1 lying face down in the grass of the facility at 11:45 AM, one hour and 45 minutes after the resident eloped. The weather at the time was 77-81 degrees Fahrenheit (F) with wind speeds up to 16 miles per hour (mph). The facility was in a residential area with posted speed limits of up to 30 mph on the surrounding streets. The facility's failure to provide adequate supervision and the necessary safety checks placed R1 in immediate jeopardy. Findings Included:- R1's Electronic Medical Record (EMR) documented R1 had diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), severe dementia (a progressive mental disorder characterized by failing memory and confusion) with behavioral disturbance, and unsteadiness on feet. The Significant Change Minimum Data Set (MDS), dated [DATE], documented the Brief Interview for Mental Status (BIMS) interview could not be completed. The MDS documented R1 had short and long-term memory deficits and had severely impaired cognition. The MDS documented R1 was dependent on staff for most of her activities of daily living (ADLs) except bed mobility and ambulation, which were supervision/touching assist. The MDS documented R1 had behavioral symptoms not directed towards others during the look-back period and wandered the facility, which intruded on the privacy of others and put R1 at risk. The Cognitive Loss/Dementia Care Area Assessment (CAA), dated 05/26/2026, documented R1 had a decline in eating, oral hygiene, toilet hygiene, bathing, dressing, and personal hygiene. The CAA documented R1 had potential for unmet needs, was unaware of her surroundings, and had poor safety awareness related to her diagnosis of severe dementia. The Functional Abilities CAA, dated 05/26/2026, documented R1 frequently wandered into other residents' rooms, handling and picking up objects that did not belong to her, and tried to open doors. She displayed pacing, exit seeking, and repetitive movements during the look-back period. The CAA documented R1 wore a WanderGuard (a bracelet that helps monitor residents who are at risk of wandering) due to being a high risk for elopement. The Fall CAA, dated 05/26/2026, documented R1 had the potential for falls with injury related to her diagnosis of Alzheimer's disease, balance problems, muscle weakness, and pacing/wandering. Staff were to minimize R1's risk for falls. R1's Care Plan, documented R1 was a high risk for falls and needed a safe environment. An intervention dated 06/04/2026 directed staff to perform 15-minute safety checks on R1 due to a fall. R1's Care Plan documented R1 had behaviors of wandering, packing, attempting to follow staff leaving the facility, or entering other residents' rooms and taking items and becoming aggressive with staff when they attempted to redirect her. An intervention dated 09/10/2024 documented R1 had a WanderGuard on her left ankle. An intervention dated 03/18/2026 documented R1 was a high risk for elopement and directed staff to distract R1 with pleasant diversions, structured activities, food, conversation, television, or a book. An intervention dated 05/20/2026 documented the resident was on 30-minute safety checks. R1's Wandering Risk Score, dated 05/26/2026, documented R1 had a risk score of 20.0, which indicated a high risk for wandering. R1's Fall Risk Score dated 06/04/2026, documented R1 had a risk score of 17.0, which indicated R1 was at high risk for falls. The Fall Progress Note dated 06/06/2026, documented R1 had a fall outside the facility at 11:45 AM on the north side of the facility. Staff found R1 lying in the grass, and R1 did not recall the events which led to the fall. The fall was unwitnessed, neurological (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	checks were initiated, and R1 could move all of her extremities. Staff assisted R1 into a wheelchair and took her to the dining room. The factors which contributed to the fall were identified as an unfamiliar area and uneven surfaces. CNA N's notarized Witness Statement, dated 06/06/2026, documented at about 09:55 AM, CNA N witnessed R1 in the beauty shop resting with her eyes closed in the beauty chair. CNA N documented she took a break. At 11:15 AM, CNA M came to CNA N's assigned hall and asked for assistance locating R1. All staff looked for R1 in all the rooms, closets, storage rooms, and pantry. When CNA N walked to the dining room, another resident in the dining room stated R1 went out the north dining room door. CNA N stated she grabbed the key to the dining room door and immediately unlocked it. CNA N found R1 lying face down in the grass just outside the building. CNA N stated she called for help at 11:45 AM. CNA M's notarized Witness Statement, dated 06/06/2026, documented CNA M last saw R1 at approximately 09:55 AM. CNA M stated she then went down the other hall to assist with toileting another resident. CNA M headed back down her hall and assisted two other residents to get up and ready for lunch. CNA M stated she assisted another resident with toileting and ambulation then she walked back down the hall looking for R1 to get her to lunch. CNA M stated she looked in several rooms, the bathroom, and other areas, and then asked the other CNAs and nurse for assistance in finding R1. Licensed Nurse (LN) G's notarized Witness Statement, dated 06/06/2026, documented LN G witnessed R1 entered the nurse's station at 09:55 AM, then R1 wandered into the dining room. At 11:15 AM, CNA M notified LN G she could not find R1. Staff immediately began searching the facility. LN G stated she checked each room, bathrooms, and locked doors. Staff were unable to locate R1. LN G stated, I never heard the WanderGuard alarm go off, and the only door without one is the dining room and kitchen. CNA N opened the dining room door and found R1 lying face down in the grass on the north side of the building at 11:45 AM. The facility's incident report, dated 06/15/2026, documented at approximately 11:30 AM on 06/06/2026, staff noted R1 was not present in the dining room for the noon meal. Staff checked R1's room and common areas without locating her. LN G initiated a facility search and subsequently located R1 lying face down in the grass outside the facility, approximately six to eight feet from the exit door. R1 was assessed immediately upon discovery, and no apparent injuries were identified. R1 was unable to communicate effectively due to her severe cognitive impairment. Neurological checks were initiated and were normal per R1's baseline. The weather conditions at the time R1 was located were approximately 77 degrees (Fahrenheit) in the area with partial sun. R1 wore a black short-sleeved shirt, purple pants, and gripper socks. Skin assessment monitoring was initiated due to the environmental exposure. Assessments continued to not indicate any injury or skin concerns. The investigation revealed R1 exited through the unalarmed north side dining room door that had not been fully latched after a staff member accessed the supply shed. R1 was outside for an unknown period at the time of discovery. LN G was directed to review surveillance footage and complete protocol documentation. Camera review later determined that R1 exited the facility at approximately 10:00 AM, which indicated R1 had been outside and unsupervised for approximately ninety minutes. At the time of the resident's exit, one CNA and two dietary staff members were on break. On 06/16/2026 at 10:00 AM, observation revealed the north door was locked, and an exit alarm was located on the left side of the door. LN G unlocked the north door, and the door alarm sounded. Outside the door, there was a concrete sidewalk leading to the storage area. The concrete was raised two inches off the ground. To the west of the exit was an air conditioning unit, and to the west of the sidewalk, three feet from the wall of the facility, into the grass area were rocks. To the east of the exit was a grassy area with a big tree that shaded the northeast side of the building. Beyond the tree is the sidewalk and then a four-inch curb before the street. LN G pointed to the area where R1 was found, approximately eight feet off the sidewalk in the grass. The facility was in a residential area with streets surrounding with posted speeds of up to 30 mph. On 06/16/2026 at 10:30 AM, observation revealed R1 lay in bed with her eyes closed and the lights off. On 06/16/2026 at 10:30 AM, LN G stated R1 was a known wanderer and an exit seeker. LN G stated CNA M did not know R1 was missing until 11:15 AM when CNA M came to (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	other staff and asked for help finding R1. LN G stated R1 was on hospice, and since the fall outside, R1's health status had declined. LN G stated CNA M did not perform the 15-minute safety checks per her assignment. On 06/16/2026 at 01:30 PM, Administrative Nurse D stated CNA M had failed to perform the 15-minute safety checks to ensure R1's safety on 06/06/2026. Administrative Nurse D stated CNA M admitted she had not informed other staff she was not going to be able to complete the safety checks for R1, so other staff could take over the checks. The facility's Wandering and Elopements Policy, revised March 2019, documented the facility would identify residents who are at risk of unsafe wandering and strive to prevent harm while maintaining the least restrictive environment for residents. If identified as at risk for wandering, elopement, or other safety issues, the resident's care plan will include strategies and interventions to maintain the resident's safety. On 06/16/2026 at 02:00 PM, Administrative Nurse D was provided the Immediate Jeopardy [IJ] Template and was notified of the facility's failure to provide adequate supervision for R1, and placed R1 in IJ. The facility completed all corrective actions by 06/06/2026, prior to the onsite survey.The corrective actions included: Education with staff to ensure that all doors were latched and locked when leaving an area. Education to ensure all staff performed safety checks as assigned, Elopement education, and immediate verbal education to the CNA M of the importance of safety checks. The north dining room door was evaluated for mechanical issues, and an alarm was placed on the door to alert staff when the door opens. Due to the corrective actions being completed prior to the onsite survey, the deficient practice was deemed past noncompliance and remained at the scope and severity of J (isolated, immediate jeopardy).