STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **175564**	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **01/15/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTER AT WATERFRONT LLC	**1541 NORTH LINDBERG CIRCLE , WICHITA, Kansas, 67206**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS The following citations represent the findings of a Health Recertification Survey and complaint survey regarding allegations in 2693970.	F0000		
F0628 SS = E	Discharge Process CFR(s): 483.15(c)(2)(iii)(3)-(6)(8)(d)(1)(2); 483.21(c)(2) §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident,	F0628		

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 reverse for further 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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F0628 SS = E	Continued from page 1 the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge;	F0628		

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F0628 SS = E	Continued from page 2 (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).	F0628		

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F0628 SS = E	Continued from page 3 §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both	F0628		

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F0628 SS = E	Continued from page 4 prescribed and over-the-counter). This REQUIREMENT is NOT MET as evidenced by: The facility had a census of 54 residents. The sample included 14 residents with three residents reviewed for hospitalization. Based on observation, interview, and record review, the facility failed to provide a written bed hold policy and failed to issue written notification as soon as practicable for transfers for Resident (R) 64, R7, and R97. Additionally, one resident reviewed for facility discharge, the facility failed to complete a recapitulation of R66's stay in the facility. Findings included: 1. R64's Electronic Medical Record (EMR) recorded R64 was transferred to the hospital on 10/25/25 hospitalization. R64's EMR lacked evidence the facility provided a bed hold notice or written notification of the transfer to R64 and/or his representative. 2. R7's EMR recorded R7 was transferred to the hospital on 12/13/25 hospitalization. R7's EMR lacked evidence the facility provided a bed hold notice or written notification of the transfer to R7 and/or her representative. 3. R97's EMR recorded R97was transferred to the hospital on 12/31/25 hospitalization. R97's EMR lacked evidence the facility provided a bed hold notice or written notification of the transfer to R97 and/or her representative. 4. R66's EMR recorded R66 was discharged to home on 12/06/25. R66's EMR lacked evidence of a completed recapitulation outlining the course of his stay at the facility. During an interview on 01/14026 at 04:14 PM Licensed Nurse (LN) G reported the facility should do a bed hold and revealed she was unsure if there was a form and thought Social Service Designee (SSD) X would complete the bed hold. During an interview 01/15/26 09:32 AM LN J reported that a provider would go over the discharge medications with the resident/family when a resident discharged. LN J reported that the family/resident would sign a discharge summary that was completed by the interdisciplinary team prior to discharge.	F0628		

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F0628 SS = E	Continued from page 5 During an interview on 01/15/26 at 09:40 AM Administrative Nurse F revealed the discharge summary in EMR was still in progress for R66 dated 12/06/25. Administrative Nurse F reported the therapy section was incomplete as they did not evaluate R66 as he was admitted to facility for one day. Administrative Nurse F reported that R66 should have received a signed copy of his discharge summary. During an interview on 01/15/26 at 10:17 AM SSD X reported that all the bed holds were completed by the Administrative Staff C the Admission Coordinator. SSD X reported all discharge summaries were printed off and reviewed with the patient/family before they discharged with the nurse, and the patient/family should receive a copy. During an interview on 01/15/26 at 10:20 AM Administrative Staff C revealed she would document in EMR about a bed hold and the resident/family is not provided a copy of the bed hold when they go to the hospital. Administrative Staff C reported she was told at the last state survey she only needed to write a note in EMR and revealed she had not provided a written/signed bed hold form for R64, R7, and R97. During an interview on 01/15/26 at 10:50 AM Administrative Nurse D reported she expected staff to complete the discharge summary and the resident/family to receive a copy after signing. Additionally, Administrative Nurse D reported she expected to follow the regulation for the bed hold. The facility's policy "Bed Hold" dated 02/15/19 documented before this facility transfers a resident to a hospital this facility would provide written information to the resident/representative that specifies the duration of the state bed-hold policy at the time of admission and time of discharge/transfer related to hospitalization. Receipt of signature documentation would be maintained in the EMR. The facility's policy "Discharge Policy and Procedures" dated 03/28/24 documented discharge instructions should be given to the patient.	F0628		
F0655 SS = D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans	F0655		

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F0655 SS = D	Continued from page 6	F0655		

§483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must-

(i) Be developed within 48 hours of a resident's admission.

(ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to-

(A) Initial goals based on admission orders.

(B) Physician orders.

(C) Dietary orders.

(D) Therapy services.

(E) Social services.

(F) PASARR recommendation, if applicable.

§483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan-

(i) Is developed within 48 hours of the resident's admission.

(ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).

§483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:

(i) The initial goals of the resident.

(ii) A summary of the resident's medications and dietary instructions.

(iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility.

(iv) Any updated information based on the details of the comprehensive care plan, as necessary.

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F0655 SS = D	Continued from page 7 This REQUIREMENT is NOT MET as evidenced by: The facility identified a census of 54 residents. The sample included 14 residents with one sampled for baseline care plan. Based on observation, interview, and record review, the facility failed to complete a thorough baseline care plan for Resident (R) 97 to include contact isolation for clostridium difficile (C-diff: contagious bacteria characterized by foul-smelling frequent loose bowel movements) and for R70 to include fall interventions. Findings included: - R97's Electronic Medical Record (EMR) documented a diagnosis of dementia (a progressive mental disorder characterized by failing memory and confusion), and C-diff. R97's 12/22/25 "Admission Minimum Data Set" (MDS) documented a Brief Interview for Mental Status (BIMS) of seven, which indicated severely impaired cognition. R97's MDS documented he required total dependence for toileting hygiene. R38's MDS documented he was always incontinent of bowel and bladder. R97's 12/26/25 "Functional Abilities (Self-Care and Mobility) Care Area Assessment" (CAA) documented R97 triggered secondary to assistance required in activities of daily living (ADLs). Contributing factors included generalized weakness, and decreased safety awareness. Risk factors included further ADL decline. The resident received physical and occupational therapy and required staff assistance to get onto and off the toilet. He was always incontinent of bowel and bladder. R97's 12/31/25 "Discharge Return Anticipated MDS" documented BIMS not assessed, staff interview documented moderately impaired cognition. R97's MDS documented he required maximal assistance with toileting hygiene, and he was frequently incontinent of bowels. R97's 01/09/26 "Entry MDS" was completed on 01/13/26. R97's 01/09/26 "Base Line Care Plan" revealed the area to document if the resident was on	F0655		

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F0655 SS = D	Continued from page 8 isolation/transmission-based precautions was answered no. R97's "Physician Orders" documented contact enteric precautions for c-diff every shift for isolation until 01/14/26, dated 01/13/26 at 11:57 AM. During an observation on 01/13/26 at 12:11 PM, a contact precaution sign was on the R97's door, and personal protective equipment (PPE- gowns, face shields, and/or eyeglasses/goggles, and gloves) was observed outside the room. R97 sat in his chair, and his spouse was visiting. R97's family member reported she did not know what the contact precautions were for. During an interview on 01/14/26 at 04:21 PM, Certified Nurse Aide (CNA) M reported she would look at the care plan for reasons a resident would be on isolation precautions. She reported she was educated by the nurse on 01/13/26 that R97 had C-diff. CNA M reported she was unsure of a baseline care plan. During an interview on 01/15/26 at 12:37 PM, Administrative Nurse F (Infection Preventionist) reported she did not complete the baseline care plan for R97 on 01/09/26, and she reported that isolation/ transmission-based precautions should have been answered yes. Administrative Nurse F reported she documented C-diff precautions on the care plan in the EMR on 01/13/26 after the survey began. Administrative Nurse F reported the care plan should have had the C-diff precautions documented immediately. The facility did not provide a policy for baseline care plans. - R70's Electronic Health Record (EHR) revealed the following diagnoses: dementia (progressive mental disorder characterized by failing memory, confusion), and diabetes mellitus (a disease in which the body's ability to produce or respond to the hormone insulin is impaired, resulting in abnormal metabolism of carbohydrates and elevated levels of glucose in the blood and urine). R70's "Admission Minimum Data Set" dated 01/14/26 was in progress.	F0655		

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F0655 SS = D	Continued from page 9 R70's "Baseline Care Plan" revealed R70 was at risk for falls related to impaired mobility secondary to weakness and debility. R70 was also at risk for falls related to her current drug regimen. R70's "Nurses Progress Notes" dated 01/09/26 at 07:45 PM documented R70 was found sitting on the floor in front of her power recliner with the footrest still up. R70 was attempting to get up off the floor, with the indwelling catheter (tube placed in the bladder to drain urine into a collection bag) still hooked to the recliner. R70 did not have any injurie R70's "Nurse Note," dated 01/10/26 at 05:02 AM, documented R70 attempted to get out of bed all night. Since her fall on 01/09/26, a mattress was placed to the left of her bed for safety. R70 was found on the mattress beside the bed with the bed in the lowest position, with the urinary catheter pulled out. R70 was lying naked on the mattress on the floor. She had no injuries. R70's "Baseline care Plan" lacked intervention for the fall on 01/09/26 and 01/10/26. On 01/14/26 at 08:15 AM, during an observation, R70 laid in bed. A therapist was in her room setting up her breakfast tray. Further observation revealed a mattress on the left side of the bed on the floor with no sheet covering the mattress. During an observation on 01/15/26 at 09:20 AM, R70 remained in bed with her eyes closed. There was a full mattress on the left side of the bed, and a sheet. Interviewed on 01/15/26 at 10:45 AM, Administrative Nurse D said during the risk management meeting every morning, staff discussed the falls, but they did not have the information on the investigation to change the care plans. The policy "High Fall Risk Protocol," dated 1/22/19, documented each patient staying in this community would be provided services and care which ensured the environment remained as free from accident hazards as possible, would receive adequate supervision, and would receive assistive devices to reduce accidents. Every patient will be assessed for the causal risk factors for falling at the time of admission, upon return from	F0655		

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F0655 SS = D	Continued from page 10 a health care community, and after every fall.	F0655		
F0677 SS = D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is NOT MET as evidenced by: The facility reported a census of 54 residents. The sample included 14 residents with one resident reviewed for activities of daily living (ADLs). Based on observation, interviews, and record review the facility failed to offer and provide assistance with facial hair removal for Resident (R) 38. Findings included: - R38's Electronic Medical Record (EMR) revealed diagnoses of metabolic encephalopathy (a condition in which brain function is disturbed either temporarily or permanently due to different diseases or toxins in the body), bacteremia (presence of bacteria in the blood), and muscle weakness. R38’s 01/05/26 "Admission Minimum Data Set" (MDS) documented a Brief Interview for Mental Status (BIMS) score of 13, which indicated intact cognition. R38’s MDS documented he required touch supervision assistance with personal hygiene. R38’s 01/07/26 "Functional Abilities (Self-Care and Mobility) Care Area Assessment" (CAA) documented R38 triggered secondary to assistance required in activities of daily living (ADLs). Contributing factors included generalized weakness, and decreased safety awareness. Risk factors include further ADL decline. R38’s "Care Plan," dated 12/30/25, directed staff to provide assistance with grooming, bathing, and personal hygiene as per the resident's preferences. Review of R38’s "Shower Sheet," dated 12/30/25 and 01/05/26, revealed the area to document if the resident was shaved lacked a yes/no answer on either shower	F0677		

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F0677 SS = D	Continued from page 11 sheet. During an observation and interview on 01/13/226 at 02:56 PM, R38 laid in his bed. He had unkempt, shaggy facial hair, and he reported that he wished that the staff would offer him a shave. R38 reported he could not shave himself. During an observation on 01/14/26 at 08:04 AM, R38 laid in his bed; his unkempt, shaggy facial hair remained unchanged from the 01/13/26 observation. Observation revealed an electric razor on his windowsill, not in reach for the resident. During an interview on 01/14/26 at 04:26 PM, Certified Nurse Aide (CNA) N reported that when a resident required a shave for facial hair, it would be completed and/or offered on their shower day or as needed. CNA N reported the shower list had not been updated since last week, so was unsure when R38 would receive a shower. CNA N reported that R38 slept a lot and had not asked to be shaved, but therapy would complete a lot of the resident's ADLs. CNA N reported she did not realize R38 had an electric razor in his room. During an interview on 01/15/26 at 08:45 AM, Licensed Nurse (LN) W reported he expected the staff to complete morning care, including facial hair removal. LN W reported the staff should ask the resident if they were able to answer, and if not, ask the family what their preferences were for facial hair removal. During an interview on 01/15/226 at 8:57 AM, Consultant Staff JJ reported that the therapy staff would complete morning care, but not every day. Consultant Staff JJ reported she had therapy sessions with R38 a few times and had not assisted R38 with shaving during those therapy sessions. Consultant Staff JJ reported the nursing staff would provide residents with ADL care, unless the therapy staff wrote on the communication board in the resident's rooms that day, then the therapy staff would complete ADL care. During an interview on 01/15/226 at 12:37 PM, Administrative Nurse F revealed she expected the staff to provide assistance when needed or requested by the residents. She expected the staff to shave residents who were unable to shave themselves.	F0677		

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F0677 SS = D	Continued from page 12 The facility policy "ADL Care Provided for Dependent Patients," dated 02/15/19, documented a patient who is unable to carry out ADLs would receive the necessary services to maintain good nutrition, grooming, and personal hygiene.	F0677		
F0689 SS = D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: The facility reported a census of 54 residents with a sample of 14 residents which included two reviewed for accidents/falls. Based on observation, interview, record review, the facility failed to thoroughly investigate a fall to identify causative factors in order to implement appropriate immediate interventions following falls for Residents (R)64 and R75. Findings included: - R64’s Electronic Health Record (EHR) documented diagnoses which included repeated falls, unspecified injury to the head, cerebral infarction (CVA-stroke- sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain), atrial fibrillation (irregular heartbeat), scalp laceration, mood disorder (category of mental health problems, feelings of sadness, helplessness, guilt, and wanting to die were more intense and persistent than what may normally be felt from time to time), generalized weakness, and a need for assistance with personal care. R64's "Admission Minimum Data Set" (MDS), dated 10/16/25, documented a Brief Interview for Mental Status (BIMS) score of 10, indicating moderate cognitive impairment. He did not display any behaviors or reject care. R64 used a walker as an assistive	F0689		

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F0689 SS = D	Continued from page 13 device. He required substantial/maximal assistance of staff for toilet transfers and was frequently incontinent of urine and occasionally incontinent of bowel. He reported occasional pain that rarely interfered with therapy activities. He exhibited shortness of breath or trouble breathing with exertion (e.g., walking, bathing, transferring) and with lying flat. The resident had a fall prior to admission. He experienced one non-injury fall and two falls with minor injuries after admission; he had skin tears. He received antidepressant (medication used to treat mood disorders) and antiplatelet (medication used to thin the blood) medication. R64 did not receive therapy and/or restorative nursing programs. The "Falls Care Area Assessment" (CAA), dated 10/20/25, documented the resident was at risk for falls as evidenced by falls during the lookback period. He was admitted to the facility following hospitalization for frequent falls due to balance issues, CVA, and atrial fibrillation. He had a head injury. R64 was at risk for falls due to decreased mobility, weakness, a history of falls prior to admission, and he had three falls since admission. R64's "Baseline Care Plan," dated 10/10/25, directed staff the resident was at risk for falls due to impaired mobility secondary to weakness and debility. The plan noted he had a history of falls prior to admission. His drug regimen was a contributing fall risk factor. R64's "Progress Notes," dated 10/25/25 at 01:33 PM, documented the resident transferred to the hospital due to a change in condition following a fall. The resident sustained a head laceration to the right rear of his head and a skin tear to the top of his left wrist/forearm measuring approximately five inches. R64 reported pain in his head. The documentation included the resident was alert to self. R64's EHR lacked documentation of a thorough investigation to determine the causative factors that contributed to the fall or the implementation of interventions to prevent further falls. Upon request, the facility was unable to provide the fall investigation. On 01/14/26 at 04:22 PM, Licensed Nurse (LN) F reported R64 had a witnessed fall on 10/25/25 at 09:15 AM. She confirmed the EHR lacked details of the fall, and investigation documentation was not available for review. LN F said R64 was out of the facility,	F0689		

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F0689 SS = D	Continued from page 14 currently admitted to the hospital. On 01/15/26 at 10:45 AM, Administrative Nurse D confirmed the facility did not have documentation of an investigation to determine the cause and/or contributing factors of R64's fall. She stated the facility staff were trying to get the fall investigation information collected from the current staff. She confirmed the employees were not interviewed at the time of the fall. Review of the facilities policy titled "High Fall Risk Protocol," dated 04/22/19, documented every resident will be assessed for falling after every fall, and the care plan will be updated. - R75's Electronic Health Record (EHR) documented diagnoses which included traumatic pneumothorax (accumulation of air and blood in the area around the lungs), peripheral vascular disease (PVD- slow and progressive circulation disorder causing narrowing, blockage, or spasms in a blood vessel), a history of pulmonary embolus (an obstruction in a blood vessel due to a blood clot or other foreign matter that gets stuck while traveling through the bloodstream), hypertension (high blood pressure), atrial fibrillation (rapid, irregular heart beat), and atherosclerotic heart disease (a buildup of fats, cholesterol, and other substances in an don the artery walls). R75's "Minimum Data Set Tracking/Discharge Roster" documented the resident admitted on 01/12/26. R75's "Baseline Care Plan," dated 01/12/26, directed staff R75 was at high risk for falls. He had a fall with a major injury. The plan directed staff to place a "Call Don't Fall" sign in the resident's room to remind him to call for assistance. Staff were to ensure adequate lighting and cue the resident to transfer and change positions slowly. The resident had Occupational Therapy (OT) and Physical Therapy (PT) evaluations to treat as indicated. R75's "Nursing Note," dated 01/13/26 at 01:38 PM, documented the nurse was notified R75 had an unwitnessed fall. Upon entering the resident's room, R75 was lying on his back next to his recliner with a Certified Nurse Aide (CNA) and another nurse at the bedside. The nurse assessed the resident's range of motion (ROM) and then assisted R75 to his wheelchair. The resident stated he had hit his head. R75 stated he was trying to get up when he fell. The resident was alert and oriented to self on assessment.	F0689		

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F0689 SS = D	Continued from page 15 R75's EHR lacked documentation of a thorough investigation to determine the causative factors that contributed to the fall or the implementation of interventions to prevent further falls. On 01/14/26 at 02:08 PM, CNA S reported R75 was admitted two days ago. She stated he was at risk for falls. CNA S reported the resident moved a room closer to the nurses' station for closer observation, and interventions to prevent falls included a call light within reach, and staff were to encourage him to call staff for assistance when needing to get up. She stated she was not aware of R75 being a fall risk prior to the recent fall. CNA S said if a resident fell, staff should fill out paperwork and try to determine the cause of the fall. On 01/15/26 at 10:43 AM, Administrative Nurse D stated she expected the staff to initiate an investigation to determine the root cause of the fall and place an immediate intervention to prevent further falls. She said staff should also identify any injuries or skin conditions on assessment and document the characteristics of the injury with description, measurements, and treatment. She confirmed the resident's EHR lacked the root cause analysis to determine causative factors to develop appropriate interventions to prevent further falls. Review of the facilities policy titled "High Fall Risk Protocol," dated 04/22/2019, documentation included every resident will be assessed for falling after every fall, and the care plan will be updated.	F0689		
F0730 SS = F	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(e)(7) §483.35(e)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is NOT MET as evidenced by: The facility reported a census of 54 residents. The facility identified five Certified Nurse Aides (CNA) employed for more than 12 months. Based on interview and record review, the facility failed to complete an annual performance review at least once every 12 months for the five CNAs reviewed, to ensure adequate	F0730		

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F0730 SS = F	Continued from page 16 appropriate cares and services provided to the residents of the facility. Findings included: - Review of CNA personnel files revealed the following: CNA O, hired on 08/15/24, lacked an annual performance evaluation. CNA P, hired on 09/13/24, lacked an annual performance evaluation. CNA Q, hired on 10/02/24, lacked an annual performance evaluation. CNA S, hired on 08/11/24, lacked an annual performance evaluation. Certified Medication Aide (CMA) R, hired on 10/01/24, lacked an annual performance evaluation. During an interview on 01/14/26 at 02:55 PM, Administrative Nurse D reported she expected 100 percent compliance in having the annual performance evaluations completed annually. The facility policy "Inservice Training Program, Nurse Aide," dated 04/02/24, documented in-service training would be based on the outcome of the annual performance reviews, addressing weaknesses identified in the reviews.	F0730		
F0759 SS = E	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is NOT MET as evidenced by:	F0759		

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F0759 SS = E	Continued from page 17 The facility reported a census of 54 residents. Thirty-nine medication administrations were observed. Based on observation, interview and record review the facility failed to ensure a medication error rate of less than five percent when 30 errors were identified, resulting in a medication error rate of 79.62 percent. Findings included: 1. Resident (R) 67's January 2026 "Medication Administration Record/Treatment Administration Record" (MAR/TAR) documented six oral medications scheduled at 08:00 AM. On 01/14/26 at 10:13 AM, observation revealed Licensed Nurse (LN) L administered the 08:00 AM scheduled medications to R67, outside of the one-hour before or after protocol. R67 received six late oral medications. 2. R56's January 2026 "MAR/TAR" documented seven oral medications scheduled at 08:00 AM. On 01/14/26 at 10:29 AM, observation revealed LN L administered the 08:00 AM scheduled medications to R56, outside of the one-hour before or after protocol. R56 received seven late oral medications. 3. R98's January 2026 "MAR/TAR" documented five oral medications scheduled at 08:00 AM. On 01/14/26 at 10:38 AM, observation revealed LN L administered the 08:00 AM scheduled medications to R98, outside of the one-hour before or after protocol. R98 received five late oral medications. 4. R38's January 2026 "MAR/TAR" documented 10 oral medications scheduled at 08:00 AM, and two intravenous (IV-administered directly into the bloodstream via a vein) medications scheduled at 08:00 AM. On 01/14/26 at 10:47 AM, observation revealed LN G administered the 08:00 AM scheduled medications to R38, outside of the one-hour before or after protocol. R38 received 10 late oral medications.	F0759		

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F0759 SS = E	Continued from page 18 On 01/14/26 at 11:13 AM, observation revealed LN G administered the 08:00 AM scheduled IV medications to R38, outside of the one-hour before or after protocol. R38 received two late IV medications. During an interview on 01/14/26 at 11:00 AM, LN L revealed the medications were over an hour late when administered. LN L stated she did not have a certified medication aide on the schedule. During an interview on 01/14/226 at 11:52 AM, LN G reported she knew she was late administering medications and reported she would do the best she could with what staff she had. During an interview on 01/14/26 at 12:00 PM, Administrative Nurse D verified the medications were scheduled for 08:00 AM and confirmed the facility did not have a liberalized medication pass time. Administrative Nurse D said she expected all medications to be administered on time. The facility policy "Medication Administration," dated 08/22/22, documented all medications are to be administered as prescribed by the attending physician.	F0759		
F0812 SS = F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility.	F0812		

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F0812 SS = F	Continued from page 19 §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: The facility reported a census of 54 residents and one main kitchen. 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: - On 01/13/26 at 08:00 AM, the initial tour of the main kitchen revealed trash on the floor behind the ice machine. Observation of the refrigerator revealed one bag of pork chops left open; observation of the freezer revealed one bag of hamburger patties left open to air. On 01/14/26 at 11:20 AM, Dietary Staff CC prepared to serve food with gloves on. Dietary Staff CC grabbed the plated holders and then placed the plate in the holders. She then picked up bread to put on the plates, grabbed trash off the counter to throw away, and then picked up lettuce, tomatoes, and cheese without changing gloves or washing her hands. Dietary Staff CC obtained a utensil to place the hamburger on the bun, but ended up touching the hamburger patty and ground meat with the same soiled gloves, then touched the bowls to put the corn in, with the same gloves touching the ground ham. On 01/14/26 at 11:30 AM, when asked about the process of serving the food, Dietary Staff CC refused to answer the question. In an interview on 01/06/26 at 08:00 AM, Dietary Staff BB said his expectations were for staff to wash their hands and replace their gloves. The policy “Dietary,” revised on 02/08/21, documented on the same day food products are delivered to the facility, they are to be inspected for safety and quality. Each item is to be accurately dated upon receipt. When items are opened or in use, the use-by dates are to be labeled upon them, followed by storing	F0812		

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F0812 SS = F	Continued from page 20 the item in the proper area. When storing raw meat, it must be properly sealed and separated from all other foods during storage.	F0812		
F0814 SS = C	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is NOT MET as evidenced by: The facility reported a census of 54 residents. Based on observations and interviews, the facility failed to maintain and/or dispose of kitchen garbage and refuse properly. Findings included: - During the initial tour of the kitchen on 01/13/26 at 08:00 AM, observation of the outside garbage bins with Dietary Manager BB revealed one shred bin and one trash bin, both had a lid up. On 1/13/26 at 08:00 AM, during an interview, Dietary Manager BB said he was not sure why the bins were open; they are usually closed. The facility did not provide a policy regarding waste disposal.	F0814		
F0880 SS = E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:	F0880		

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F0880 SS = E	Continued from page 21 §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.	F0880		

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F0880 SS = E	Continued from page 22 §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: The facility reported a census of 54. Based on observation, interview and record review the facility failed to ensure adequate infection control related to Enhanced Barrier Precautions (EBP-infection control interventions designed to reduce transmission of resistant organisms which employ targeted gown and glove use during high contact care) for residents with indwelling medical devices including urinary catheters (a tube inserted directly into the bladder to drain urine) and peripherally inserted central catheters (PICC-a thin, flexible tube that is inserted into a vein in the upper arm and threaded into a large vein above the heart) and residents with wounds. Findings included: - The “Facility Matrix” identified the following 10 residents with characteristics which met the criteria for staff to follow EBP and to use appropriate PPE, which included gloves and gowns: Resident (R) 38, R89, R45, R67, R70, and R82 were identified with indwelling urinary catheters. R38, R79, and R85 were identified with PICC lines. R41 had an unstageable (depth of the wound is unknown due to the wound bed being covered by a thick layer of other tissue and pus) pressure ulcer. Initial tour of the facility on 01/13/26 at 08:00 AM revealed a lack of signage to identify residents who required EBP. The facility had no visible setup for personal protective Equipment (PPE-gowns and gloves for use with EBP) readily accessible to staff to apply before entering residents’ rooms to provide direct care to the residents of the facility. On 01/13/26 at 11:20 AM, Certified Nurse Aide (CNA) V entered R79’s room, washed her hands, put on gloves, and emptied the resident’s urinal. She did not apply a gown as indicated for R79, who had a PICC line. CNA V	F0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175564	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTER AT WATERFRONT LLC	1541 NORTH LINDBERG CIRCLE , WICHITA, Kansas, 67206

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0880 SS = E	Continued from page 23 reported the resident’s door should have a sign on the door to indicate the staff should wear PPE related to EBP. On 01/14/26 at 09:00 AM, Licensed Nurse (LN) K entered R79’s room to administer daptomycin (antibiotic medication to treat infection) 1000 milligrams (mg) through his PICC in his right upper arm. LN K washed her hands, put on her gloves, removed the PICC line outer secure positioner, and cleaned the hub without applying a gown. LN K stated there were no signs to make staff and visitors aware of EBP and the PPE to be used, though she expected there to be some when EBP was required. She confirmed the resident met the criteria for EBP due to his PICC line. She confirmed she did not use the proper PPE for EBP and said that staff did not wear gowns when giving the residents of the facility direct care. On 01/14/26 at 03:14 PM, LN F and Consultant KK verified the staff should wear PPE to give direct care for residents who had surgical openings, PICC lines, indwelling catheters, and wounds. The facility policy titled “Infection Control,” dated 01/29/25, did not address EBP.	F0880		