STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B089102	A. BUILDING: _____ B. WING _____	12/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDERSGATE VILLAGE HOME PLUS SOUTH	7201 SW UXBRIDGE TOPEKA, KS 66614

(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) COMPLETE DATE
S 000	INITIAL COMMENTS The following represent the findings of a resurvey for the above named Home Plus facility conducted on 12/18/23 - 12/19/23.	S 000		
S5029 SS=F	26-42-101 (g) Availability of policies and procedures (g) Availability of policies and procedures. Each administrator or operator shall ensure that policies and procedures related to resident services are available to staff at all times and are available to each resident, legal representatives of residents, case managers, and families during normal business hours. A notice of availability shall be posted in a place readily accessible to residents. This REQUIREMENT is not met as evidenced by: KAR 26-42-101(g) The operator reported a census of 10 residents. Based on observation and interview the administrator failed to ensure a notice of availability of policies and procedures related to resident services was posted in a place readily accessible to residents. Findings included: - On 12/18/23 at 12:05 PM during the initial tour of the facility a notice of availability of policies and procedures was not located. On 12/19/23 at 12:50 PM Administrative Staff A confirmed a sign of availability of policies and	S5029		

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

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S5029	Continued From page 1 procedures was not posted. The administrator failed to ensure a notice of availability of policies and procedures was posted in a place readily accessible to residents.	S5029		
S5050 SS=F	26-42-101 (k) Ombudsman (k) Ombudsman. Each administrator or operator shall ensure the posting of the names, addresses, and telephone numbers of the Kansas department on aging and the office of the long-term care ombudsman with information that these agencies can be contacted to report actual or potential abuse, neglect, or exploitation of residents or to register complaints concerning the operation of the home. The administrator or operator shall ensure that this information is posted in a common area accessible to all residents and the public. This REQUIREMENT is not met as evidenced by: KAR 26-42-101(k) The facility reported a census of 10 residents. Based on observation, the facility failed to ensure a copy of the ombudsman contact information was posted in a common area for residents and the public to examine. Findings included: - The facility was opened for business during March of 2023.	S5050		

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S5050	Continued From page 2 On 12/18/23 at 12:05 PM during the initial tour of the facility no posting of the ombudsman information was located. The administrator failed to ensure a copy of the ombudsman information was available in a common area for residents and any other individuals wishing to examine them.	S5050		
S5085 SS=D	26-42-201 (c) Functional Capacity Screen Reassessment (c) Designated staff shall conduct a screening to determine each resident ' s functional capacity according to the following requirements: (1) At least once every 365 days; (2) following any significant change in condition as defined in K.A.R. 26-39-100; and (3) at least quarterly if the resident receives assistance with eating from a paid nutrition assistant. This REQUIREMENT is not met as evidenced by: KAR 26-42-201(c)(2) The facility reported a census of 10 residents. The sample included three residents. Based on interview, and record review the operator failed to ensure designated staff completed a "Functional Capacity Screen" (FCS) for resident (R)103 following a significant change in condition. Findings included:	S5085		

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S5085	Continued From page 3 - R103's medical record revealed she moved into the facility on 07/13/23 with a diagnosis of Alzheimer's Disease. The 07/13/23 FCS revealed R103 was independent with transfers. The 08/17/23 "Aldersgate Village Addendum to Negotiated Service Agreement" documented hospice services was added to R103's NSA. The 08/17/23 "Health Status Note" documented R103 returned (from the hospital) and was admitted with hospice services in place. On 12/19/23 at 10:12 AM Certified Medication Aide (CMA) D stated R103 used to be independent with transfers and mobility but had declined in condition and now required assistance with transfers. On 12/19/23 at 11:25 AM Licensed Nurse (LN) C acknowledged a significant change FCS was not completed when R103 admitted to hospice. The administrator failed to ensure designated staff completed a FCS for R103 when she experienced a significant change in condition.	S5085		
S5095 SS=D	26-42-201 (d) Functional Capacity Screen Accurate (d) Designated staff shall ensure that each resident ' s functional capacity at the time of screening is accurately reflected on that resident ' s screening form.	S5095		

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S5095	Continued From page 4 This REQUIREMENT is not met as evidenced by: KAR 26-42-201(d) The facility reported a census of 10 residents with three included in the sample. Based on observation, interview, and record review the administrator failed to ensure a resident's (R)104's "Functional Capacity Screen" (FCS) accurately reflected the resident's status by the failure to identify the use of a mechanical lift. Findings included: - R104 was admitted on 06/05/23 with a diagnosis of metabolic encephalopathy. The 06/05/23 Admission FCS identified R104 required total assist with transfers and utilized a walker and wheelchair. The 06/05/23 "Healthcare Service Plan" (HSP) documented two qualified staff would provide R104 transfer assistance. On 12/19/23 at 11:55 AM an observation revealed there was a sit-to-stand lift stored in R104's bathroom. On 12/19/23 at 10:18 AM Certified Medication Aide (CMA) D stated R104 was a two-person assist with transfers using a sit-to-stand lift. On 12/19/23 at 10:29 AM Licensed Nurse (LN) C stated R104 required staff assist with transfers	S5095		

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S5095	Continued From page 5 using a sit-to-stand lift. LN C acknowledged the FCS did not identify the use of a mechanical lift. The administrator failed to ensure R104's FCS accurately reflected his status by the failure to document the use of a mechanical lift.	S5095		
S5105 SS=E	26-42-202 (a) Negotiated Service Agreement a) The administrator or operator of each home plus shall ensure the development of a written negotiated service agreement for each resident, based on the resident ' s functional capacity screening, service needs, and preferences, in collaboration with the resident or the resident ' s legal representative, the case manager, and, if agreed to by the resident or the resident ' s legal representative, the resident ' s family. The negotiated service agreement shall provide the following information: (1) A description of the services the resident will receive; (2) identification of the provider of each service; and (3) identification of each party responsible for payment if outside resources provide a service. This REQUIREMENT is not met as evidenced by: KAR 26-42-202(a)(1)(3) The facility reported a census of 10 residents with three residents included in the sample. Based on interview, and record review the administrator failed to ensure the "Negotiated Service Agreement" (NSA) was fully developed on what triggered in the "Functional Capacity	S5105		

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S5105	Continued From page 6 Screen" (FCS) for resident (R)102, R103, and R104. Findings included: - R102's medical record revealed the resident moved into the facility on 03/19/23. The 03/21/23 FCS identified R102 triggered for falls, impaired vision, and impaired hearing. The 03/21/23 NSA did not address falls, impaired vision, and impaired hearing. On 12/19/23 at 10:24 AM Licensed Nurse (LN) C stated the NSA did not address all that triggered on R102's FCS. The administrator failed to ensure R102's NSA was fully developed to include all items that triggered in the FCS. - R103's medical record revealed she moved into the facility on 07/13/23. The 07/13/23 FCS identified R103 triggered for impaired hearing. The 07/12/23 NSA did not address R103's impaired hearing. On 12/19/23 at 11:25 AM LN C acknowledged R103's NSA did not address all that triggered on the FCS. The administrator failed to ensure R103's NSA was fully developed to include all items that	S5105		

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S5105	Continued From page 7 triggered in the FCS. -R104's medical record revealed he moved into the facility on 06/05/23. The 06/05/23 FCS identified R104 triggered for impaired vision, hearing, and decision-making. The 06/05/23 NSA did not address R104's impaired vision, hearing, and decision-making. On 12/19/23 at 10:29 PM LN C stated R104's NSA did not address everything that triggered on the FCS. The administrator failed to ensure R104's NSA was fully developed to include all items that triggered in the FCS.	S5105		
S5215 SS=F	26-42-104 (d) Disaster and Emergency Preparedness Education (d) Each administrator or operator shall ensure disaster and emergency preparedness by ensuring the performance of the following: (1) Orientation of new employees at the time of employment to the home ' s emergency management plan; (2) education of each resident upon admission to the home regarding emergency procedures; (3) quarterly review of the home ' s emergency management plan with employees and residents; and (4) an emergency drill, which shall be conducted at least annually with staff and residents. This drill shall include evacuation of the residents to a secure location.	S5215		

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S5215	Continued From page 8 This REQUIREMENT is not met as evidenced by: KAR 26-42-104(d)(3) The facility reported a census of 10 residents. Based on record review and interview for all residents and all facility employees, the administrator failed to ensure disaster and emergency preparedness by ensuring performance of quarterly review of the facility's emergency management plan with employees and residents. Findings included: - On 12/18/23 documentation of quarterly reviews of the emergency management plan was requested from Administrative Staff A. On 12/18/23 at 01:40 PM Administrative Staff D stated he did not have documentation for quarterly reviews of the emergency management plan with staff and residents. The administrator failed to ensure the performance of quarterly reviews of the emergency management plan with employees and staff.	S5215		
S5225 SS=F	26-42-207 (a) (b) (1)(2)(3)(4) Infection Control a) The administrator or operator of each home plus shall ensure the provision of a safe, sanitary, and comfortable environment for residents.	S5225		

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S5225	Continued From page 9 (b) Each administrator or operator shall ensure the development of policies and implementation of procedures to prevent the spread of infections. These policies and procedures shall include the following requirements: (1) Using universal precautions to prevent the spread of blood-borne pathogens; (2) techniques to ensure that hand hygiene meets professional health care standards; (3) techniques to ensure that the laundering and handling of soiled and clean linens meet professional health care standards; (4) providing sanitary conditions for food service; This REQUIREMENT is not met as evidenced by: KAR 26-42-207(a) The facility had a census of 10 residents. The administrator failed to ensure the provision of a sanitary environment for residents, staff and visitors by not providing disposable towels for use to dry off hands after washing them. Findings included: - On 12/18/23 at 12:05 PM an observation revealed there was no means for individuals to dry their hands after washing them at the sink located off the front entrance, adjacent to the dining room. On 12/18/23 at 12:53 PM an observation of the West public restroom revealed there were no disposable hand towels available but instead a multi-use cloth hand towel hung next to the sink.	S5225		

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S5225	Continued From page 10 On 12/19/23 at approximately 12:50 PM Administrative Staff A stated the cloth towel in the West public restroom was for decoration only and not to be used to dry hands after washing. On 12/19/23 at 04:02 PM a policy on hand hygiene was requested from Administrative Staff A but no policy was provided. The administrator failed to ensure the provision of a sanitary environment.	S5225		
S5230 SS=F	26-42-207 (b)(5)(6) (c) Infection Control Policies (b)(5) prohibiting any employee with a communicable disease or any infected skin lesions from coming in direct contact with any resident, any resident ' s food, or resident care equipment until the condition is no longer infectious; (6) providing orientation to new employees and employee in-service education at least annually on the control of infections in a health care setting; (c) Each administrator or operator shall ensure the home ' s compliance with the department ' s tuberculosis guidelines for adult care homes adopted by reference in K.A.R. 26-39-105. This REQUIREMENT is not met as evidenced by: KAR 26-42-207(c) The facility reported a census of 10 residents. Based on interview and record review the	S5230		

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S5230	Continued From page 11 administrator failed to ensure the facility remained in compliance with the department's tuberculosis (TB) guidelines for adult care homes adopted by reference in KAR 26-39-105 for five of five newly hired employees reviewed and one of three residents reviewed. Findings included: - Review of Certified Medication Aide (CMA) E's employee record revealed a hire date of 11/17/23. The facility failed to ensure a two-step TB skin test was completed. Review of CMA F's employee record revealed a hire date of 08/21/23. The administrator failed to ensure a two-step TB skin test was completed. Review of CMA G's employee record revealed a hire date of 07/13/23. The administrator failed to ensure a two-step TB skin test was completed. Review of CMA H's employee record revealed a hire date of 11/13/23. The administrator failed to ensure a two-step TB skin test was completed. Review of CMA I's employee record revealed a hire date of 03/27/23. The administrator failed to ensure a two-step TB skin test was completed. The June 2013 "Tuberculosis (TB) Guidelines for Adult Care Homes" documented, "Each new ...employee shall receive a two-step TST or an IGRA for Mycobacterium tuberculosis within 7 days of ...employment ..." The administrator failed to ensure the facility	S5230		

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S5230	Continued From page 12 remained in compliance with the department's tuberculosis guidelines for adult care homes adopted by reference in KAR 26-39-105 regarding newly hired employees. - Resident (R)103 was admitted to the facility on 07/12/23 with a diagnosis of Alzheimer's Disease. Review of R103's medical records revealed a T-SPOT.TB (a blood test that detects the immune response to Mycobacterium tuberculosis) was completed 07/28/23, 10 days after she was admitted to the facility. The June 2013 "Tuberculosis (TB) Guidelines for Adult Care Homes" documented, "Each new resident ...shall receive a two-step TST or an IGRA for Mycobacterium tuberculosis within 7 days of residency ..." The administrator failed to ensure the facility remained in compliance with the department's tuberculosis guidelines for adult care homes adopted by reference in KAR 26-39-105 regarding newly admitted residents.	S5230		
S5313 SS=E	26-42-205 (g) (3) Over the counter medication (g) (3) A licensed nurse or medication aide may accept over-the-counter medication only in its original, unbroken manufacturer ' s package. A licensed pharmacist or licensed nurse shall place the full name of the resident on the package. If the original manufacturer ' s package of an over-the-counter medication contains a medication in a container, bottle, or tube that can be removed from the original package, the	S5313		

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S5313	Continued From page 13 licensed pharmacist or a licensed nurse shall place the full name of the resident on both the original manufacturer ' s medication package and the medication container. This REQUIREMENT is not met as evidenced by: KAR 26-42-205(g)(3) The facility reported a census of 10 residents. Based on observation and interview the administrator failed to ensure a licensed pharmacist or licensed nurse placed the full name of the resident on the original package of "over the counter" (OTC) medications. Findings included: - Observation on 12/18/23 at 01:00 PM revealed the medication cart contained the following OTC medications which were not labeled with a resident's full name: Resident (R)105: One bottle of Bayer Back and Body R103: One bottle of Good Neighbor Pharmacy Nasal Moisturizing Spray Two bottles of Bausch and Lomb Soothe XP eyedrops One box of Dramamine One bottle of Tums antacid R102:	S5313		

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S5313	Continued From page 14 One bottle of Kroger Maximum Strength Antacid One bottle of Mylanta Maximum Strength Antacid and Anti-gas The lower drawer of the medication cart had the following OTC medications: One bottle of Tylenol Extra Strength labeled as house stock. One tube of Medline Remedy Essentials Zinc Paste did not have a resident name written on it. One bottle of Kirkland Signature Mature Multi did not have a resident name written on it. The administrator failed to ensure all OTC medications were labeled with the resident's full name.	S5313		
S9999	Final Observations 9999 39-928 scope and severity F Upon receipt of an application for license, the licensing agency with the approval of the state fire marshal shall issue a license if the applicant is fit and qualified and if the adult care home facilities meet the requirements established under this law. The licensing agency, the state fire marshal, and the county, city-county or multicounty health departments or their designated representatives shall make such inspections and investigations as are necessary to determine the conditions existing in each case and a written report of such inspections and investigations and the recommendations of the state fire marshal and the county, city-county or multicounty health department or their authorized	S9999		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDERSGATE VILLAGE HOME PLUS SOUTH	7201 SW UXBRIDGE TOPEKA, KS 66614

(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) COMPLETE DATE
S9999	Continued From page 15 agents shall be filed with the licensing agency. The licensing agency and the state fire marshal may designate and use county, city-county or multicounty health departments and local fire and safety authorities as their agents in making such inspections and investigations as are deemed necessary or advisable. Such local authorities are hereby authorized, empowered and directed to perform such duties as are designated. A copy of any inspection reports required by this section shall be furnished to the applicant. A license, unless sooner suspended or revoked, shall remain in effect upon filing by the licensee, and approval by the licensing agency and the state fire marshal or their duly authorized agents, of an annual report upon such uniform dates and containing such information in such form as the licensing agency prescribes and payment of an annual fee. Each license shall be issued only for the premises and persons named in the application and shall not be transferable or assignable. It shall be posted in a conspicuous place in the adult care home. If the annual report is not so filed and annual fee is not paid, such license is automatically canceled. Any license granted under the provisions of this act shall state the type of facility for which license is granted, number of residents for which granted, the person or persons to whom granted, the date and such additional information and special limitations as are deemed advisable by the licensing agency. This requirement is not met as evidenced by: The facility reported a census of 10 residents. Based on observation and interview the facility	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B089102	A. BUILDING: _____ B. WING _____	12/19/2023

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S9999	Continued From page 16 failed to ensure a copy of the facility license was posted in a conspicuous place. Findings included: \ - The facility was opened for business during March of 2023. On 12/18/23 at 12:05 PM during the initial tour of the facility no license was located. The administrator failed to ensure the facility license was posted in a common area for residents and any other individuals wishing to examine it.	S9999		