

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046102	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/16/2025
NAME OF PROVIDER OR SUPPLIER ALTO		STREET ADDRESS, CITY, STATE, ZIP CODE 10300 INDIAN CREEK PARKWAY OVERLAND PARK, KS 66210		
(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 citations represent the findings of the licensure resurvey with attached complaint numbers 189001, 188126, 183403, 181171, 180464, and 178775, for the above named facility conducted on 01/13/25, 01/14/25, 01/15/25, and 01/16/25.	S 000		
S 190 SS=D	26-39-102 (e) Admission, Transfer, Discharge (e) Before a resident is transferred or discharged involuntarily, the administrator or operator, or the designee, shall perform the following: (1) Notify the resident, the resident ' s legal representative, and if known, a designated family member of the transfer or discharge and the reasons; and (2) record the reason for the transfer or discharge under any of the circumstances specified in paragraphs (d) (1) through (4) in the resident ' s clinical record, which shall be substantiated as follows: (A) The resident's physician shall document the rationale for transfer or discharge in the resident ' s clinical record if the transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met by the adult care home; (B) the resident's physician shall document the rationale for transfer or discharge in the resident ' s clinical record if the transfer or discharge is appropriate because the resident's health has improved sufficiently so that the resident no longer needs the services provided by the adult care home; and (C) a physician shall document the rationale for transfer or discharge in the resident ' s clinical record if the transfer or discharge is	S 190		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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S 190	Continued From page 1 necessary because the health or safety of other individuals in the adult care home is endangered. This REQUIREMENT is not met as evidenced by: K.A.R. 26-39-102 (e) (2) (C) The facility reported a census of 89 residents. 70 residents in the "Assisted Living" section of the facility and 19 residents in the secured specialty unit. The sample included 7 "Residents" (R)'s 1, 2, 3, 4, 5, 6, 7, and 3 closed record reviews for R's 11, 12, and 13. Based on record review and interview the Administrator failed to ensure R12's record contained documentation from her physician listing the rationale for the involuntary discharge was necessary because of the health or safety of other individuals in the adult care home was endangered. Findings included: - Record review for R12 revealed an admission date of 06/21/23 with diagnoses of Alzheimer's Disease, Cognitive decline, Dementia in other diseases classified elsewhere with behavioral disturbances, other insomnia and Transaminitis, Anxiety disorder, and Alcohol abuse with withdrawal, uncomplicated. Review of R12's "Functional Capacity Screen" (FCS) dated 07/14/23 revealed R12 was independent with bathing, transferring, and walking. She required supervision with dressing,	S 190		

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S 190	Continued From page 2 toileting, and eating. She lacked the ability to manage her own medications and was continent. R12 was able to make herself understood and she understood others. She was marked at risk for wandering, socially inappropriate disruptive behavior, and impaired decision making. Section D. Cognition lacked any documentation. Review of R12's "Service Plan" dated 07/14/23 instructed facility staff to provide the following health services: supervision with dressing, toileting, eating, and physical assistance with medication management. Review of R12's electronic "Medical Record" under the "Care Plan" dated tab dated 07/17/23, instructed facility staff to redirect R12 when exhibiting wandering behaviors, and R12 had "a current history of occasional disruptive, aggressive, or socially inappropriate behavior, either verbally or physically improper. May require special tolerance or staff training. Staff to report any change to a charge nurse." Review of the facility provided document titled "Wellness Assessment" dated 06/21/23 and signed by licensed nurse F revealed R12 had a small bruise and skin tear on the right arm and R12 was able to make her needs known. Under the section titled "Orientation" it was marked R12 had "Moderate Impairment" and handwritten was R12 was disorientated to person, place, time and needed frequent reminders from staff. Under the section titled "Judgement Impairment" it was marked R12 had "Minimal: Resident has current occasional poor judgement, needs protection and supervision because participant makes unsafe or inappropriate decisions. Resident may resist	S 190			

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S 190	Continued From page 3 care at times. May have behavior management plan in place". Under the section titled "Social Appropriateness/Behaviors-Current" R12 was marked "Moderate: Resident has current frequent disruptive, aggressive, or socially inappropriate behavior, either verbally or physically improper. May require professional consultation or staff training. May have behavior management plan in place". Handwritten was R12 "Does aggressive behavior". The section titled "Substance Abuse" lacked any documentation. The section titled "Potential Risk" lacked any documentation for "Combative Behavior/Resistant to Redirection. Review of R12's paper "Nursing Notes" dated 06/21/23 to 08/23/23 revealed the following entries: 06/21/23 at 03:30 PM R12 arrived at the facility at 01:00 PM with her family. The family stated she had some behaviors and anxiety. R12 was orientated to only person and had a small skin tear to the right arm. 06/22/23 at 10:00 AM the writer was contacted at 09:00PM the night prior and R12 was having inappropriate behavior. R12 was trying to jump through a window and physically attacked a staff member. R12 was banging on the doors of the other residents. R12 was sent to the emergency room for evaluation. R12 returned to the facility at 09:00AM on 06/22/23 and was a "one-on-one". 06/23/23 at 08:00 PM R12 was admitted to the memory care unit on 06/21/23, she was very confused and anxious. R12 had behaviors of	S 190		

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S 190	Continued From page 4 "hitting and fighting" staff. 06/28/24 A new order for Donepezil 5 milligrams every day by mouth in the morning. Donepezil is for the treatment of memory loss and confusion for people with Alzheimer's disease. 06/30/23 (no time identified) R12 was having behaviors. "She was out of control, pacing up and down, yelling at staff. She tried to hit staff". The provider gave an order for R12 to go to the hospital. 06/30/23 A new order for Quetiapine 12.5 milligrams once daily for agitation, and Tylenol 650 milligrams three times a day. 07/01/23 R12 returned from the hospital at 01:20 PM. The "Hospital report" revealed R12 had "all the major testing" performed that included a geriatric psychiatric evaluation. 07/02/23 R12 had no behaviors. 07/05/23 A new order for Trazadone 0.25 milligrams twice daily, discontinue Risperidone, and Seroquel 0.5 milligrams two times daily, schedule a neurological consultation. 07/06/23 An order to Discontinue "Old Seroquel. Start Seroquel 12.5 milligrams in the morning and increase 25 milligram at bedtime. Trazadone 25 milligram for morning and noon, and increase 50 milligram at bedtime" 07/07/23 at 05:00 PM A new order for Melatonin 3 milligrams at bedtime.	S 190		

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S 190	Continued From page 5 07/10/23 A new order for Losartan 25 milligram daily for hypertension, and Buspirone 5 milligrams two times a day for anxiety. 07/11/23 A new order for" Venaxazine" 37.5 milligrams by mouth daily for depression, and Hydroxyzine 25 milligrams as needed by mouth for anxiety. 08/02/23 New order for Venlafaxine needed to be verified. 08/03/23 An order to discontinue "Ventofaxine" 37.5 milligrams by mouth twice a day and Increase Buspirone 10 milligrams twice a day. 08/11/23 A new order for Memantine 5 milligrams twice a day for dementia. 08/11/23 A new order to discontinue Seroquel 12.5 milligrams at noon. Start Seroquel 25 milligrams at noon and at hour of sleep. 08/23/23 (no time was identified) R12 was having "behaviors today". R12 became extremely anxious, disrespectful, and yelled at staff. R12 "threw a musical instrument at staff and was banging on windows and doors trying to wake up residents". The nurse was notified, and staff instructed to call 911. The only documentation of inappropriate behavior was documented on: 06/22/23 06/23/23 06/30/23 08/23/23	S 190		

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S 190	Continued From page 6 Record review of R12's electronic "Medical Record" Under the "Progress Notes" tab revealed the following entries: On 08/23/23 at 09:50 PM "Licensed Nurse" (LN) B wrote the facility staff called her and in the background she could hear the resident banging on the walls and windows, R12 was screaming obscenities. The facility staff claimed the resident picked up a guitar and tried to hit her with it. LN B instructed facility staff to call 911 and send the patient to the hospital for evaluation. On 08/24/23 at 11:30 AM LN B wrote that she called her regional nurse regarding R12's behavior. LN B was instructed to contact the Executive Director and notify the family that R12 would require a one-on-one sitter if readmitted to the facility. LN B wrote the Regional Nurse would contact the Vice President to discuss a discharge notice due to R12 exhibiting behaviors that were harmful to herself and others. 08/24/23 at 05:30 PM LN B wrote that she received a call back from her Executive Director and "per her conversation with the Vice President" they would not be taking R12 back into the community. 08/24/23 at 07:13 PM R12's son was notified the facility would not be accepting R12 back to the facility. Record review of the facility provided document titled "Psychiatric Evaluation" dated 07/11/23 revealed a chief complaint of agitation and physical aggression. "The spouse reports agitation and wandering. Patient Sundown's in	S 190		

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S 190	Continued From page 7 the afternoon." Patient reported feeling lonely because she had been married for so long to her husband and now, he has to stay home, and she has to be in a facility due to her memory. R12 reported feeling depressed and having high stress. The provider wrote "Continue psychotropic medication(s) as presently prescribed. Patient currently benefits psychiatrically and behaviorally at current dose(s). Record review of the facility provided document titled "Psychiatric Periodic Evaluation" dated 08/08/23 revealed the following; "Patient is seen in the activity area with other residents. Nursing staff reports less anxiety but patient Sundown's in the afternoon". The provider wrote "Continue psychotropic medication(s) as presently prescribed. Patient currently benefits psychiatrically and behaviorally at current dose(s). R12's record from the provider lacked documentation of behaviors indicating the health and safety of other individuals in the adult care home was endangered. Interview on 01/16/25 at approximately 02:45 PM with Administrator A and Licensed Nurse B confirmed R12's medical record lacked documentation from her provider that a discharge was necessary because of the health or safety of other individual in the adult care home was endangered. The Administrator failed to ensure R12's record contained documentation from her physician the rational for the involuntary discharge was	S 190		

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S 190	Continued From page 8 necessary because of the health or safety of other individuals in the adult care home was endangered.	S 190		
S3080 SS=D	26-41-201 (a) (b) Functional Capacity Screen on Admission a) On or before each individual ' s admission to an assisted living facility or residential health care facility, a licensed nurse, a licensed social worker, or the administrator or operator shall conduct a screening to determine the individual ' s functional capacity and shall record all findings on a screening form specified by the department. The administrator or operator may integrate the department ' s screening form into a form developed by the facility, which shall include each element and definition specified by the department. (b) A licensed nurse shall assess any resident whose functional capacity screening indicates the need for health care services. This REQUIREMENT is not met as evidenced by: K.A.R. 26-41-201 (a) The facility reported a census of 89 residents. 70 residents in the "Assisted Living" section of the facility and 19 residents in the secured specialty unit. The sample included 7 "Residents" (R)'s 1, 2, 3, 4, 5, 6, 7, and 3 closed record reviews for R's 11, 12, and 13. Based on record review and interview the Administrator failed to ensure a screening determining R12's Functional Capacity was performed prior to or at the time of admission and recorded on a screening form	S3080		

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S3080	Continued From page 9 integrated into the facility assessment and included each element and definition specified by the department. Findings included: - Record review for R12 revealed an admission date of 06/21/23 with diagnoses of Alzheimer's Disease, Cognitive decline, Dementia in other diseases classified elsewhere with behavioral disturbances, other insomnia and Transaminitis, Anxiety disorder, and Alcohol abuse with withdrawal, uncomplicated. Review of R12's "Functional Capacity Screen" (FCS) dated 07/14/23 revealed R12 was independent with bathing, transferring, and walking. She required supervision with dressing, toileting, and eating. She lacked the ability to manage her own medications and was continent. R12 was able to make herself understood and she understood others. She was marked at risk for wandering, socially inappropriate disruptive behavior, and impaired decision making. Section D. Cognition lacked any documentation. Review of R12's "Service Plan" dated 07/14/23 instructed facility staff to provide the following health services: supervision with dressing, toileting, eating, and physical assistance with medication management. Review of R12's electronic "Medical Record" under the "Care Plan" dated tab dated 07/17/23, instructed facility staff to redirect R12 when exhibiting wandering behaviors, and R12 had "a current history of occasional disruptive, aggressive, or socially inappropriate behavior,	S3080		

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S3080	Continued From page 10 either verbally or physically improper. May require special tolerance or staff training. Staff to report any change to a charge nurse." Review of the facility provided document titled "Wellness Assessment" dated 06/21/23 and signed by licensed nurse F revealed in Section "II. Functional Screen" R12 was Independent with bathing, dressing, toileting, transferring, walking, and eating. R12 lacked the ability to manage her own medications and was usually continent. The following sections lacked documentation for R12's Functional Ability; "Short Term Memory" "Long Term Memory" "Memory/Recall" "Decision Making" "Communication 1. Expresses Information content" "Communication 2. Ability to understand others" "Current or Recent Problems and Risks" Interview on 01/16/25 at approximately 02:45 PM with Administrator A and Licensed Nurse B confirmed R12's medical record lacked documentation of a screening being performed prior to or at the time of admission determining her functional capacity. The Administrator failed to ensure a screening determining R12's Functional Capacity was performed prior to or at the time of admission and recorded on a screening form integrated into the facility assessment and included each element and definition specified by the	S3080		

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S3080	Continued From page 11 department.	S3080		
S3081 SS=D	26-41-201 (c) Functional Capacity Screen Reassessment (c) Designated facility 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: K.A.R. 26-41-201 (c) (2) The facility reported a census of 89 residents. 70 residents in the "Assisted Living" section of the facility and 19 residents in the secured specialty unit. The sample included 7 "Residents" (R)'s 1, 2, 3, 4, 5, 6, 7, and 3 closed record reviews for R's 11, 12, and 13. Based on record review and interview the Administrator failed to ensure a screening determining R2's functional ability after she discharged to the hospital on 11/27/24 and returned to the facility on 01/07/25 and was admitted to the secured specialty unit of the facility on 01/09/25. Findings included: - Record review for R2 revealed an admission	S3081		

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S3081	Continued From page 12 date of 10/19/21 with diagnoses of unspecified dementia and edema. Review of R2's "Functional Capacity Screen" (FCS) dated 08/23/24 revealed R2 required physical assistance with bathing and dressing. R2 was independent with toileting, transferring, walking, and eating. R2 required supervision with her medications, and she was usually continent. R2 had impaired short-term memory, impaired memory recall, and impaired decision making. She was able to make herself understood and she understood others. She was marked with impaired hearing and used a walker mobility device. Review of R2's FCS dated 01/14/25 revealed R2 required physical assistance with bathing, dressing, toileting, transferring, walking, and supervision with eating. She lacked the ability to manage her own medications and was occasionally incontinent. R2 had impaired short-term memory, impaired memory recall, and impaired decision making. She was usually able to make herself understood and she usually understood others. She was marked at risk for falls, having impaired hearing and impaired decision making. Review of R2's electronic "Medical Records" under the progress notes tab revealed the following entries; On 11/27/24 at 04:32 AM R2 was found next to her bed, on the floor at 03:40 AM. On 11/27/24 at 10:45 AM R2's husband called the nurse and wanted R2 looked at after her fall	S3081		

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S3081	Continued From page 13 earlier in the morning. He stated R2 was now complaining of pain in her left arm. The writer of the note revealed the arm and hand were swollen. Hospice nurse and R2's daughter were notified. X rays were ordered and confirmed a fracture of the shoulder and a dislocation of the left wrist. R2 went to the hospital for evaluation and treatment. On 01/14/25 R2 returned to the facility at 11:45 AM. R2 "was getting out of her wheelchair and trying to go into other residents' rooms". The nurse informed the family that R2 would require one-on-one until her transition to the facility memory care unit. On 01/09/25 R2 "and some of her belongings were moved" to the secured memory care unit. Interview on 01/16/25 with Administrator A and Licensed Nurse B confirmed the medical record for R2 lacked documentation of a screening determining R2's functional ability after her return from a hospital stay and they further confirmed R2 did not have a screening performed determining her functional ability when she was admitted to a secured memory care unit. The Administrator failed to ensure a screening determining R2's functional ability after she discharged to the hospital on 11/27/24 and returned to the facility on 01/07/25 and was admitted to the secured specialty unit of the facility on 01/09/25.	S3081		
S3090 SS=D	26-41-202 (c) Admission Negotiated Service Agreement	S3090		

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(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
S3090	Continued From page 14 (c) Each administrator or operator shall ensure the development of an initial negotiated service agreement at admission. This REQUIREMENT is not met as evidenced by: K.A.R. 26-41-202 (c) The facility reported a census of 89 residents. 70 residents in the "Assisted Living" section of the facility and 19 residents in the secured specialty unit. The sample included 7 "Residents" (R)'s 1, 2, 3, 4, 5, 6, 7, and 3 closed record reviews for R's 11, 12, and 13. Based on record review and interview the Administrator failed to ensure a written "Negotiated Service Agreement" (NSA) was developed for R12 at the time of her admission to the secured specialty unit of the facility. Findings included: - Record review for R12 revealed an admission date of 06/21/23 with diagnoses of Alzheimer's Disease, Cognitive decline, Dementia in other diseases classified elsewhere with behavioral disturbances, other insomnia and Transaminitis, Anxiety disorder, and Alcohol abuse with withdrawal, uncomplicated. Review of R12's "Functional Capacity Screen" (FCS) dated 07/14/23 revealed R12 was independent with bathing, transferring, and walking. She required supervision with dressing, toileting, and eating. She lacked the ability to	S3090		

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S3090	Continued From page 15 manage her own medications and was continent. R12 was able to make herself understood and she understood others. She was marked at risk for wandering, socially inappropriate disruptive behavior, and impaired decision making. Section D. Cognition lacked any documentation. Review of R12's "Service Plan" dated 07/14/23 instructed facility staff to provide the following health services: supervision with dressing, toileting, eating, and physical assistance with medication management. Review of R12's electronic "Medical Record" under the "Care Plan" dated tab dated 07/17/23, instructed facility staff to redirect R12 when exhibiting wandering behaviors, and R12 had "a current history of occasional disruptive, aggressive, or socially inappropriate behavior, either verbally or physically improper. May require special tolerance or staff training. Staff to report any change to a charge nurse." Review of the facility provided document titled "Wellness Assessment" dated 06/21/23 and signed by licensed nurse F revealed in Section "II. Functional Screen" R12 was Independent with bathing, dressing, toileting, transferring, walking, and eating. R12 lacked the ability to manage her own medications and was usually continent. The following sections lacked documentation of R12's Functional Ability; "Short Term Memory" "Long Term Memory" "Memory/Recall"	S3090		

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S3090	Continued From page 16 "Decision Making" "Communication 1. Expresses Information content" "Communication 2. Ability to understand others" "Current or Recent Problems and Risks" Interview on 01/16/25 at approximately 02:45 PM with Administrator A and Licensed Nurse B confirmed the facility does not have a document titled "NSA" and the document titled "Service Plan" contains the required information. They further confirmed R12's record lacked a "Service Plan" being completed at the time of admission to the facility. The Administrator failed to ensure a written NSA was developed for R12 at the time of her admission to the secured specialty unit of the facility.	S3090		
S3171 SS=D	26-41-204 (i) Health Care Services Standards of Practice (i) All health care services shall be provided to residents by qualified staff in accordance with acceptable standards of practice. This REQUIREMENT is not met as evidenced by: K.A.R. 26-41-204 (i) The facility reported a census of 89 residents. 70 residents in the "Assisted Living" section of the facility and 19 residents in the secured specialty unit. The sample included 7 "Residents" (R)'s 1, 2, 3, 4, 5, 6, 7, and 3 closed record reviews for	S3171		

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S3171	Continued From page 17 R's 11, 12, and 13. Based on observation, record review and interview the Administrator failed to ensure health care services were provided within professional standards of practice when Administrator A failed to ensure an assessment was performed for R3 showing R3's bed assist device posed no risk for entrapment, confirmed the device was not a restraint, and assessed R3's ability to safely use the bed assist device. Administrator A further failed to ensure all coordinated healthcare services were provided in accordance with acceptable standards of practice when the hospice provider providing outside services for R3 failed to return verbal physician orders signed by the physician within seven days of the verbal orders. Findings included: - Record review for R3 revealed an admission date of 10/19/21 with diagnoses of spinal stenosis, carpal tunnel, and open wound of the ankle, foot and toes. Review of R3's "Functional Capacity Screen" (FCS) dated 12/05/24 revealed R3 required physical assistance with bathing, dressing, toileting, transferring, and walking. R3 was independent with eating. He was independent with managing his own medications and required physical assistance with medical treatments. R3 was frequently incontinent and was cognitively intact. R3 was able to make himself understood and he understood others. R3 was marked at risk for falls, impaired vision, and impaired hearing. He used a walker and wheelchair mobility devices.	S3171		

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S3171	Continued From page 18 The comments section in the FCS lacked documentation of the bed assist device. Review of the facility document titled "Service Plan" dated 12/05/24 instructed facility staff to provide assistance with placement of R3's hearing aides, R3 may require "hands on assistance" for mobility and ambulation, and "May use a bed cane/rail to aide in bed mobility and transfers". R3 did not require assistance with medication administration with administration of his Over-the-Counter medications. R3 was hospice services and R3 needed medication administration assistance when the hospice team ordered medications. Bathing assistance was provided by the hospice provider. The facility staff were to provide "extensive" assistance with dressing. R3's "Service Plan" lacked a description of the device, its purpose and any special instructions on use and monitoring of the assistive device. R 3's record lacked the documentation of an assessment being performed to confirm the device was not a restraint, R 1's ability to safely use the device and documentation of the findings in R3's record. Review of R3's electronic "Medical Record" under the "Progress Notes" Tab revealed the following entries. On 11/01/24 at 07:37 PM "Resident has new order per the hospice nurse" give Valium 1 milligram by mouth daily at bedtime. On 11/5/24 at 05:06 PM Hospice Registered	S3171		

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S3171	Continued From page 19 Nurse called "and gave a verbal order for Lasix 40 milligrams for seven days and then as needed, for 3+ (moderate) pitting edema. On 12/24/24 at 05:18 PM Hospice nurse here to see resident. New orders written and faxed to the pharmacy. New orders are as follows: Lasix 40 milligrams daily for 7 days then decrease back to Lasix 20 milligram daily for Edema. Keflex 500 milligram one three times daily for 5 days for infection of left calf. Record review of the facility provided documents titled "Patient Care Order" from R3's hospice provider revealed the following orders were signed by the hospice provider on 01/16/25. "Order Date 12/02/24" On 12/02/24 an order for Doxycycline hyclate 100 milligrams oral tablet 1 tablet twice daily for infection; "read back and confirmed start date 12/02/24" and signed electronically by the hospice Registered Nurse on 01/16/25. "Order Date 12/11/24" Discontinue - effective 12/11/24 diazepam 5 milligram/5 milliter oral solution; Take 2 milligrams oral once at bedtime for leg spasms "read back and confirmed (Ordered 12/11/24)" On 12/11/24 diazepam 5 milligram/5 milliliter oral solution ; take two milligrams oral once (at bedtime) for leg spasms "Read back an confirmed; start date: 12/11/24" Discontinue- effective 12/11/24 Lasix 20	S3171		

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S3171	Continued From page 20 milligram oral tablet; Take 1 tablet orally once a day for edema "Read back and confirmed (Ordered 12/11/24)" Electronically signed by the hospice Registered Nurse on 01/16/25. Electronically signed by the provider on 01/16/25. Review of the document titled "Patient Care Order (Written Order)" On 12/24/24 Apply compression stockings in the morning and remove in the evening. Signed by the hospice provider and hospice nurse on 01/16/25. On 12/12/24 an order for Lasix 40 milligram tablets orally once a day for seven days for edema was read back and confirmed by the hospice nurse. The provider signed the order on 01/16/25. The order was signed 23 days after the verbal order was read back and confirmed. Observation on 01/16/25 at approximately 12:40 PM of R3's bed revealed an inverted "U" shaped assistive device that measured approximately 14 inches in width and approximately 35.5 inches in height. There was a nylon bag attached in the "U" shaped opening and the device was securely attached to the bed. Interview on 01/16/24 at approximately 02:45 PM with Administrator A and Licensed Nurse B confirmed R3's medical record lacked documentation of an assessment being	S3171		

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S3171	Continued From page 21 performed to confirm the device was not a restraint, R 3's ability to safely use the device and documentation of the findings in R3's record. Administrator A and Licensed Nurse B further confirmed the resident record lacked documentation of the hospice provider signing the verbal orders within seven days of providing the order. The FDA (food and drug administration) "Bedrails in Assisted Living, Residential Health Care and Home Plus Facilities" recommended the following: Complete an assessment of the resident to confirm that the device is not a restraint. Complete an assessment of the resident to determine the purpose of the device and the resident's ability to safely use the device and document the findings in the resident's record. Complete an assessment of the device using the recommendations in the FDA guidance to ensure the device is securely attached to the bed or bedframe and poses no risk for entrapment and document the findings in the resident record. If the purpose of the device is to assist the resident with transfers, the FCS should document the resident's functional capacity based on the use of the device and should be listed in the comments section. Include a description of the device, its purpose and special instructions on use and monitoring in the resident's NSA.	S3171		

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S3171	Continued From page 22 Document periodic reassessments of the resident's use of the device and their ability to use it safely and reassessment of the safety of the device in the resident's record. The Administrator failed to ensure health care services were provided within professional standards of practice when Administrator A failed to ensure an assessment was performed for R3 showing R3's bed assist device posed no risk for entrapment, confirmed the device was not a restraint, and R3's ability to safely use the bed assist device. Administrator A further failed to ensure all coordinated healthcare services were provided in accordance with acceptable standards of practice when the hospice provider providing outside services for R3 failed to return verbal physician orders signed by the physician within seven days of the verbal order.	S3171		
S3211 SS=E	26-41-205 (g) (3) OVER THE COUNTER DRUGS (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 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.	S3211		

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S3211	Continued From page 23 This REQUIREMENT is not met as evidenced by: K.A.R. 26-41-205 (g) (3) The facility reported a census of 89 residents. 70 residents in the "Assisted Living" (AL) section of the facility and 19 residents in the secured specialty unit. Based on observation, record review and interview the Administrator failed to ensure the "Licensed Nurses" (LN)'s or the licensed Pharmacist placed the full name of the resident on the bottles of "Over-the-Counter" (OTC) medications. Findings included: - Observation on 01/13/25 at approximately 03:00 PM CMA D unlocked the Assisted Living second floor medication cart which contained the following OTC medication bottles that lacked the full name of the resident; 1 bottle of Areds Preservision 1 bottle of Adult Ches Multi Vitamin 1 bottle of B12 1000 micrograms 1 bottle of Gaviscon liquid anti acid 1 bottle of Vitamin B6 50 milligrams 1 bottle of Tylenol 500 milligrams 1 bottle of Fiber gummies 1 bottle of Vitamin of D3 50 micrograms 1 bottle of Bayer low dose Aspirin 81 milligrams 1 bottle of Vitamin D3 25 micrograms 1 bottle of Tylenol 650 milligrams Record review of the facility provided policy titled "Medication Management; Assistance with or Supervision of Self-Administration dated	S3211		

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S3211	Continued From page 24 12/06/23 revealed the following; "Each resident must have their own supply of any OTC medications (such as Tums and Advil) as the Community is not permitted to maintain a "Stock Supply". OTC medication is not required to be in "Unit dose packaging; however non unit dose packaging must be in the original manufacturer's container and labeled by the pharmacy as outlined below without obscuring the manufacturer's label. Community associates my not label any medication except with the resident's name and apartment number and/or a sticker reading "check Medication Record" if applicable. If OTC medication is being supplied by the family (rather than being supplied to the Community directly from the pharmacy) the medication must be clearly marked with the resident's name without obscuring any part of the original manufacturer's label." Interview on 01/16/25 at approximately 02:45PM with Administrator A and LN B confirmed the OTC bottles on the second floor AL medication cart lacked the full name of the resident. The Administrator failed to ensure the LN's or the licensed Pharmacist placed the full name of the resident on the bottles of OTC medications.	S3211		
S3215 SS=E	26-41-205 (h) Medication Storage (h) Storage. Licensed nurses and medication aides shall ensure that all medications and biologicals are securely and properly stored in accordance with each manufacturer ' s recommendations or those of the pharmacy provider and with federal and state laws and	S3215		

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S3215	Continued From page 25 regulations. (1) Licensed nurses or medication aides shall store non-controlled medications and biologicals managed by the facility in a locked medication room, cabinet, or medication cart. Licensed nurses and medication aides shall store controlled medications managed by the facility in separately locked compartments within a locked medication room, cabinet, or medication cart. Only licensed nurses and medication aides shall have access to the stored medications and biologicals. (2) Each resident managing and self-administering medication shall store medications in a place that is accessible only to the resident, licensed nurses, and medication aides. (3) Any resident who self-administers medication and is unable to provide proper storage as recommended by the manufacturer or pharmacy provider may request that the medication be stored by the facility. (4) A licensed nurse or medication aide shall not administer medication beyond the manufacturer ' s or pharmacy provider ' s recommended date of expiration. This REQUIREMENT is not met as evidenced by: K.A.R. 26-41-205 (h) (1) (4) The facility reported a census of 89 residents. 70 residents in the "Assisted Living" section of the facility and 19 residents in the secured specialty unit. The sample included 7 "Residents" (R)'s 1, 2, 3, 4, 5, 6, 7, and 3 closed record reviews for	S3215		

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S3215	Continued From page 26 R's 11, 12, and 13. Based on observation, record review and interview the Administrator failed to ensure the "Licensed Nurses" (LN)'s and "Certified Medication Aides" (CMA)'s stored all medications and biologicals in accordance with each manufacturer's recommendation or those of the pharmacy. The Administrator further failed to ensure the LN's and CMAs did not administer medications or biologicals beyond the manufacturers or pharmacy's recommended date of expiration. Findings included: - Observation on 01/13/25 at approximately 02:45 PM CMA C unlocked the Assisted Living first floor medication cart and in the first drawer were the following insulin pens; 1 pen of Lantus 100 units/milliliter that had approximately 20 units left in the pen. The pen lacked a date of when it was accessed. 1 pen of Lantus 100 units/milliliter that had not been accessed. 1 pen of Novolog 100 units/milliliter that had approximately 75 units left in the pen. The pen lacked a date of when it was accessed. 1 pen of Novolog 100 units/milliliter that had not been accessed. Interview on 01/13/25 at approximately 02:45 PM with CMA C confirmed the Lantus and Novolog insulin pens lacked a date of when they were opened. He further confirmed the second Lantus and Novolog pens and not been accessed. Review of the manufacturers recommendation for Lantus Insulin Pens revealed the following;	S3215		

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S3215	Continued From page 27 "Before opening, store Lantus in the refrigerator (36 degrees Fahrenheit to 46 degrees Fahrenheit). "Before you inject Lantus, remove it from the refrigerator for an hour or two". After the first use of the Lantus Insulin pen keep it at room temperature only (below 86 degrees Fahrenheit), and after 28 days throw the Lantus Pen away even if it still had insulin in it. Review of the Pharmacy packaging for the Novolog Pen revealed a fluorescent pink sticker on the bottom of the package which read "Refrigerate Pen When Not In Use. Do Not Refrigerate Insulin Pens After First Use. Discard 28 Days After Opening." - Record review for R2 revealed an admission date to the secured specialty unit on 01/15/25 with diagnoses of moderate unspecified dementia, unspecified symptoms and signs involving cognitive functions following unspecified cerebrovascular disease. Review of R2's "Functional Capacity Screen" (FCS) dated 01/14/25 revealed R2 lacked the ability to manage her own medications/medical treatments. Review of R2's "Service Plan" instructed qualified facility staff to administer R2's medications. Observation on 01/16/25 at approximately 01:00 PM of R2's private bathroom in the secured specialty the first drawer in the bathroom cabinet	S3215		

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S3215	Continued From page 28 was a bottle of Fluticasone nasal spray 50 micrograms. - Record review for R7 revealed an admission date of 06/25/24 with diagnoses of generalized muscle weakness, unsteadiness on feet, and cognitive deficits following nontraumatic intracerebral hemorrhage. Review of R7's FCS dated 11/22/24 revealed R7 required physical assistance with the management of her medications/medical treatments. Review of R7's "Service Plan" instructed staff to provide hands on assistance for medication management. "Staff to assist with ordering, refill and administer medications" to R7 per provider orders. Observation on 01/16/25 at approximately 12:40 PM of R7's Bathroom in the Assisted Living part of the facility were the following bottles of Over-the-Counter Medications. Acetaminophen 500 milligrams St. Joseph low dose Aspirin 81 milligrams Melatonin 10 milligrams Calcium 600 milligrams Liquid Childrens Ibuprofen 100 milligrams/5 milliliters 1 prescription bottle of Polytrim eye drops. The instructions stated "Instill 1 drop in right eye four times a day until 01/14/21. 1 prescription bottle of Polytrim eye drops. The instruction stated instill 1 drop in right eye four times a day until 01/13/21. This bottle contained	S3215		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046102	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/16/2025
NAME OF PROVIDER OR SUPPLIER ALTO		STREET ADDRESS, CITY, STATE, ZIP CODE 10300 INDIAN CREEK PARKWAY OVERLAND PARK, KS 66210		
(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
S3215	Continued From page 29 3 oval shaped pills with the stamp of "APO" on one side, and ATV40 on the other side. - Record Review for R3 revealed an admission date of 10/19/21 with diagnoses of spinal stenosis, carpal tunnel and open wound of ankle, foot, and toes. Review of R3's FCS dated 12/05/24 revealed R3 was independent with the management of his medications and required supervision with the management of his medical treatments. Review of R3's "Service Plan" dated 12/05/24 revealed R3 did not require assistance with medication assistance with his "Over-the-Counter" medications. R3 was on hospice service and needed medication administration assistance when the hospice provider ordered any medications. Observation on 01/16/25 at approximately 12:30 PM of R3's bedside table revealed a prescription bottle of Diazepam 2 milligrams which was filled on 09/12/23 and expired on 09/12/24. The bottle contained small white circular tablets. Interview on 01/16/25 with Administrator A and LN B confirmed the insulin pens lacked a date of when opened, they further confirmed all medications for R's 2 and 7 were administered by qualified facility staff, and R3 received Diazepam from the qualified facility staff per the written provider order. The Administrator failed to ensure the LN's and CMA's stored all medications and biologicals in	S3215		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046102	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/16/2025
NAME OF PROVIDER OR SUPPLIER ALTO		STREET ADDRESS, CITY, STATE, ZIP CODE 10300 INDIAN CREEK PARKWAY OVERLAND PARK, KS 66210		
(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
S3215	Continued From page 30 accordance with each manufacturer's recommendation or those of the pharmacy. The Administrator further failed to ensure the LN's and CMAs did not administer medications or biologicals beyond the manufacturers or pharmacy's recommended date of expiration.	S3215		
S3270 SS=F	26-41-104 (b) Written Emergency Plan (b) Each administrator or operator shall ensure the development of a detailed written emergency management plan to manage potential emergencies and disasters, including the following: (1) Fire; (2) flood; (3) severe weather; (4) tornado; (5) explosion; (6) natural gas leak; (7) lack of electrical or water service; (8) missing residents; and (9) any other potential emergency situations. This REQUIREMENT is not met as evidenced by: K.A.R. 26-41-104 (b) (2) (3) (4) (5) (6) (7) The facility reported a census of 89 residents. 70 residents in the "Assisted Living" section of the facility and 19 residents in the secured specialty unit. Based on record review and interview the Administrator failed to ensure the development of a detailed written emergency management plan was developed to manage potential emergencies and disasters which included the following; fire,	S3270		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046102	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/16/2025
NAME OF PROVIDER OR SUPPLIER ALTO		STREET ADDRESS, CITY, STATE, ZIP CODE 10300 INDIAN CREEK PARKWAY OVERLAND PARK, KS 66210		
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S3270	Continued From page 31 flood, sever weather, tornado, explosion, natural gas leak, lack of electrical or water, missing residents and any other potential emergency situations. Findings included: - Review of the facility provided electronic employee training provided at the time of hire revealed the following courses; "Fire Safety: The Basics" "Understanding Wandering and Elopement" "Workplace Emergencies and Natural Disasters: An Overview"; revealed the following; This course is a basic overview of natural disasters and workplace emergencies. It is designed to supplement your awareness of disasters and emergencies and to complement your use of workplace-specific emergency plans established by your employer. Section 2; Workplace Emergency Plan "4. Follow your workplace Emergency Plan." "Workplace Safety: The Basics" included the following topics: Fire Safety, Emergency Preparedness, Hazardous Chemicals and Workplace Violence. Under the section titled "Emergency Preparedness" ; "Preparation is the key to any successful emergency plan. People in your care depend on you during emergencies such as fires, floods, power outages, bomb threats, other crises." "An emergency plan is a plan of action that is created before an emergency occurs and should identify: what to	S3270		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046102	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/16/2025
NAME OF PROVIDER OR SUPPLIER ALTO		STREET ADDRESS, CITY, STATE, ZIP CODE 10300 INDIAN CREEK PARKWAY OVERLAND PARK, KS 66210		
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S3270	Continued From page 32 do if an emergency occurs, responsibilities for each employee and ways they work as a team." Review of the facility provided policy titled "Disaster and Emergency Preparedness" dated 04/21/23 revealed the following: "The Company recognizes the importance of protecting the health and wellbeing of our residents and associates during disasters or emergencies. Disasters and emergencies are considered to be; fire, flood, sever weather, tornado, explosion, natural gas leak, lack of electrical or water service, missing residents, and any other potential emergency situations." "The Executive Director Must Ensure:" 1. The community had a detailed written emergency management plan made available to associates, residents, and visitors. 4. Associates are oriented with the Emergency Management Plan during onboarding. 6. Quarterly associate and resident reviews of the Emergency Management Plan. Review of the New Resident reference book revealed a page titled "Resident Emergency Protocols" which included instructions for the resident for the following emergencies: Fire Alarm Tornado Watch Tornado Warning Flood Earthquake Sever Weather Power Outage Terroristic Threat	S3270		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046102	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/16/2025
NAME OF PROVIDER OR SUPPLIER ALTO		STREET ADDRESS, CITY, STATE, ZIP CODE 10300 INDIAN CREEK PARKWAY OVERLAND PARK, KS 66210		
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S3270	Continued From page 33 Interview on 01/16/25 at approximately 02:45 PM with Administrator A confirmed the facility emergency management plan did not include all required topics. The Administrator failed to ensure the development of a detailed written emergency management plan was developed to manage potential emergencies and disasters which included the following; fire, flood, sever weather, tornado, explosion, natural gas leak, lack of electrical or water, missing residents and any other potential emergency situations.	S3270		
S3280 SS=F	26-41-104 (d) Disaster and Emergency Preparedness (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 facility ' s emergency management plan; (2) education of each resident upon admission to the facility regarding emergency procedures; (3) quarterly review of the facility ' 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.	S3280		

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NAME OF PROVIDER OR SUPPLIER ALTO		STREET ADDRESS, CITY, STATE, ZIP CODE 10300 INDIAN CREEK PARKWAY OVERLAND PARK, KS 66210		
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S3280	Continued From page 34 This REQUIREMENT is not met as evidenced by: K.A.R. 26-41-104 (d) (3) The facility reported a census of 89 residents. 70 residents in the "Assisted Living" section of the facility and 19 residents in the secured specialty unit. Based on record review and interview the Administrator failed to ensure the detailed written emergency management plan was reviewed on how to manage potential emergencies and disasters which included the following; fire, flood, sever weather, tornado, explosion, natural gas leak, lack of electrical or water, missing residents and any other potential emergency situations at least quarterly with all staff and all residents. Findings included: - Review of the facility provided electronic employee training provided at the time of hire revealed the following courses; "Fire Safety: The Basics" "Understanding Wandering and Elopement" "Workplace Emergencies and Natural Disasters: An Overview"; revealed the following; This course is a basic overview of natural disasters and workplace emergencies. It is designed to supplement your awareness of disasters and emergencies and to complement your use of workplace-specific emergency plans established by your employer. Section 2; Workplace Emergency Plan "4. Follow your workplace Emergency Plan."	S3280		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046102	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/16/2025
NAME OF PROVIDER OR SUPPLIER ALTO		STREET ADDRESS, CITY, STATE, ZIP CODE 10300 INDIAN CREEK PARKWAY OVERLAND PARK, KS 66210		
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S3280	Continued From page 35 "Workplace Safety: The Basics" included the following topics: Fire Safety, Emergency Preparedness, Hazardous Chemicals and Workplace Violence. Under the section titled "Emergency Preparedness" ; "Preparation is the key to any successful emergency plan. People in your care depend on you during emergencies such as fires, floods, power outages, bomb threats, other crises." "An emergency plan is a plan of action that is created before an emergency occurs and should identify: what to do if an emergency occurs, responsibilities for each employee and ways they work as a team." Review of the facility provided policy titled "Disaster and Emergency Preparedness" dated 04/21/23 revealed the following: "The Company recognizes the importance of protecting the health and wellbeing of our residents and associates during disasters or emergencies. Disasters and emergencies are considered to be; fire, flood, sever weather, tornado, explosion, natural gas leak, lack of electrical or water service, missing residents, and any other potential emergency situations." "The Executive Director Must Ensure:" 1. The community had a detailed written emergency management plan made available to associates, residents, and visitors. 4. Associates are oriented with the Emergency Management Plan during onboarding. 6. Quarterly associate and resident reviews of the Emergency Management Plan. Review of the New Resident reference book	S3280		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046102	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/16/2025
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S3280	Continued From page 36 revealed a page titled "Resident Emergency Protocols" which included instructions for the resident for the following emergencies: Fire Alarm Tornado Watch Tornado Warning Flood Earthquake Sever Weather Power Outage Terroristic Threat Interview on 01/16/25 at approximately 02:45 PM with Administrator A confirmed the facility emergency management plan was assigned at the time of hire and annually for all staff, and the residents were provided the emergency management information at the time of admission and there was a page of instructions for emergency's included in the new resident reference book that is kept in the resident rooms at all times. Administrator A further confirmed the emergency management plan is now reviewed quarterly with all staff and residents. The Administrator failed to ensure the detailed written emergency management plan was reviewed on how to manage potential emergencies and disasters which included the following; fire, flood, sever weather, tornado, explosion, natural gas leak, lack of electrical or water, missing residents and any other potential emergency situations at least quarterly with all staff and all residents.	S3280		
S3310 SS=F	26-41-207 (b) (5-6) (c) Infection Control Policies	S3310		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046102	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/16/2025
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S3310	Continued From page 37 (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; and (c) Each administrator or operator shall ensure the facility ' 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: K.A.R. 26-41-207 (c) The facility reported a census of 89 residents. 70 residents in the "Assisted Living" section of the facility and 19 residents in the secured specialty unit. The sample included 7 "Residents" (R)'s 1, 2, 3, 4, 5, 6, 7, and 3 closed record reviews for R's 11, 12, and 13, and 5 newly hired employees. Based on record review and interview the Administrator failed to ensure the facility's compliance with the department's "Tuberculosis" (TB) guidelines for adult care homes adopted by reference in K.A.R. 26-39-105 for newly hired Administrator A, Certified Medication Aides C and G, Certified Nurse Aide E, Licensed Nurse B and Residents R2, R3, R4, R5 and R7.	S3310		

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S3310	Continued From page 38 Findings included: - Record review for newly hired Administrator A revealed she began her employment on 06/01/24. Review of her personnel record revealed a lack documentation of a TB symptom screen being performed within seven days of the time of hire, the record further lacked documentation of the required two step TB skin test being performed within seven days of employment. - Record review for newly hired "Certified Medication Aide (CMA) C revealed he began his employment on 06/21/24. His personnel record contained the results of a chest X ray dated 10/25/21. CMA C's personnel record lacked the required TB symptom screen being performed within seven days of the time of hire. - Record review for newly hired "Certified Nurse Aide (CNA) E revealed she began her employment on 09/07/23. Her personnel record contained the results of a QuantiFERON blood draw. Her personnel record lacked documentation of an annual TB symptom screen. - Record review for newly hired CMA G revealed she began her employment on 09/07/23. Her Personnel record contained the results of a QuantiFERON blood draw. Her personnel record lacked documentation of an annual TB symptom screen being performed for 2024. - Record review for newly hired "Licensed Nurse" (LN) B revealed she began her employment on 06/21/23. Her Personnel record contained the results of a QuantiFERON blood draw. Her	S3310		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046102	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/16/2025
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S3310	Continued From page 39 record lacked documentation of the required TB symptom screen being performed within seven days of hire. Record review for R2 revealed an admission date of 10/19/21. Review of R2's medical record revealed a document titled "Tuberculosis Symptom Screen Questionnaire" and was dated 06/30/22. R2's medical record lacked documentation of an annual symptom screen for 2023 and 2024. Record review for R3 revealed an admission date of 10/19/21. Review of R3's medical record revealed a document titled "Tuberculosis Symptom Screen Questionnaire" and was dated 06/30/22. R2's medical record lacked documentation of an annual symptom screen for 2023 and 2024. Record review for R4 revealed an admission date of 04/15/24. Review of R4's electronic "Medical Record" and medical record revealed the records lacked documentation of the required two step TB skin test and the required TB symptom screen being performed within 7 days of admission to the facility. Record review for R5 revealed an admission date of 10/30/23. Review of R5's electronic "Medical Record" and medical record revealed the records lacked documentation of the required two step TB skin test and the required TB symptom screen being	S3310		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046102	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/16/2025
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S3310	Continued From page 40 performed within 7 days of admission to the facility. R5's record further lacked documentation of the required annual TB symptom screen being performed. Record review for R7 revealed an admission date of 05/14/24. Review of R7's medical record revealed a document titled "Baseline Tuberculosis Symptom Screening Questionnaire" dated 05/14/24 revealed the required first step of the TB skin test was administered on 05/14/24 and read negative on 05/17/24. The record lacked documentation of the required second step TB skin test being administered. Interview on 01/26/25 at approximately 02:45 PM with Administrator A and Licensed Nurse B confirmed the Medical Records for R's 2, 3, 4, 5, 7 lacked documentation of the required TB symptom screening being performed, Administrator A and Licensed Nurse B continued to confirm R4, R5 and R7's medical records lacked documentation of the required two step TB skin test being performed within seven days of admission, and Administrator A and Licensed Nurse B confirmed the personnel record for Administrator A lacked the documentation of the required two step TB skin test being performed within seven days of hire and the personnel records for CMA's C and G, CNA E and Licensed Nurse B lacked documentation of the required TB symptom screen being performed within seven days of hire. The Administrator failed to ensure the facility's compliance with the department's TB guidelines	S3310		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046102	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/16/2025
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S3310	Continued From page 41 for adult care homes adopted by reference in K.A.R. 26-39-105 for newly hired Administrator A, Certified Medication Aides C and G, Certified Nurse Aide E, Licensed Nurse B, R2, R3, R4, R5 and R7.	S3310		
S3320 SS=E	28-39-254 CONSTRUCTION (a) The assisted living facility or residential health care facility shall be designed, constructed, equipped and maintained to protect the health and safety of residents, personnel and the public. (b) All new construction, renovation, remodeling and changes in building use in existing buildings shall comply with building and fire codes, ordinances and regulations enforced by city, county, and state jurisdictions, including the state fire marshal. (c) New construction, modifications and equipment shall conform to the following codes and standards: (1) Title III of the Americans with disabilities act, 42 U.S.C. 12181, effective as of January 26, 1992; and (2) "Food Service Sanitation Manual," health, education, and welfare (HEW) publication no. FDA 78-2081, as in effect on July 1, 1981. This REQUIREMENT is not met as evidenced by: K.A.R. 28-39-254 (a)	S3320		

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S3320	Continued From page 42 The facility reported a census of 89 residents. 70 residents in the "Assisted Living" section of the facility and 19 residents in the secured specialty unit. Based on observation, record review and interview the Administrator failed to ensure the secured specialty unit was maintained to protect the health and safety of the residents. Findings included: - Observation on 01/13/25 at approximately 03:30 PM, the entry door to the secured unit required a key fob for entry. Observation revealed in the small kitchenette located on the northeast side of the unit, a white plastic box with unsecured storage drawers that freely opened and contained 2 bottles of fingernail polish remover. The gate entrance to the large kitchen was unsecured and freely opened. Under the kitchen sink the cabinet doors freely opened and there were 2 bottles of Virex II 256 one step disinfectant cleaner. Review of the facility provided policy titled Safe Product Storage dated 03/14/16 revealed the following "Guidelines"; "All cleaning products, deodorizers or any other chemical product must be in a locked cabinet unless a community associate is actively using it." "All toiletry items except non-toxic hand soap must be stored in a secured location unless in use by the resident under direct supervision of an associate or family member. Once use of an item is completed, it must be returned to a	S3320		

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NAME OF PROVIDER OR SUPPLIER ALTO		STREET ADDRESS, CITY, STATE, ZIP CODE 10300 INDIAN CREEK PARKWAY OVERLAND PARK, KS 66210		
(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
S3320	Continued From page 43 secured location." Interview on 01/16/25 at approximately 02:45 PM with Administrator A confirmed all hazardous chemicals are to be secured. The Administrator failed to ensure the secured specialty unit was maintained to protect the health and safety of the residents when chemicals were left unsecured in two locations in the secured specialty unit.	S3320		