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 _____	06/09/2025

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 represents the findings of a resurvey for the above named home plus facility conducted on 06/05/25 & 06/09/25.	S 000		
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) The facility reported a census of ten residents with three included in the sample. Based on interview, observation, and record review the administrator failed to ensure the Negotiated Service Agreement (NSA) for Residents (R)1, R2, and R3 described the services they received based on their Functional Capacity Screens (FCS).	S5105		

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

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S5105	Continued From page 1 Findings included: - Record review for R1 revealed an admission date of 04/03/24 with diagnoses of repeated falls, hypothyroidism, atrial fibrillation, constipation, aortic abdominal aneurysm, and hypertension. The 03/20/25 Functional Capacity Screen (FCS) identified R1 required physical assistance with bathing, dressing, toileting, and transfers; required supervision with eating; was unable to perform walking/mobility, management of medications and treatments; was usually incontinent of bladder; had short-term memory, memory/recall, and decision making cognitive difficulties; was usually understandable and usually understood others during communication; and was marked for impaired hearing and impaired decision-making. The 03/04/25 Negotiated Service Agreement (NSA) documented facility staff to provide R1 assistance of one or two staff with bathing, dressing, toileting, incontinence, transfers, and mobility with a wheelchair; and staff managed medications and treatments. The NSA failed to provide services for cognition difficulties, impaired hearing, and impaired decision-making. An addendum was added on 03/20/25 to include side rails to R1's bed provided by hospice. During interview on 06/09/25 at 10:35 AM R1 stated "I can't hear very good." He confirmed staff have to talk loud and straight to his face for him hear. Observation on 06/09/25 at 10:38 AM Certified	S5105		

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S5105	Continued From page 2	S5105		

Medication Aide E repeated self for R1 to hear and understand. She asked if R1 needed anything before she left the room and repeated herself for him to hear and give time for a decision to be made.

On 06/09/25 at 11:24 AM Licensed Nurse C stated R1 needed reminders and help with cognition at the time of the last FCS but since, it has improved.

On 06/09/25 at 11:33 AM Licensed Nurse C confirmed R1's NSA failed to describe the services provided based on his FCS.

- Record review for R2 revealed an admission date of 04/03/24 with diagnoses of diabetes mellitus type two, obesity, glaucoma, weakness, and difficulty in walking.

The 04/03/25 FCS identified R2 required physical assistance with bathing, dressing, toileting, transfers, and walking/mobility; was independent with eating; was unable to perform management of medications and treatments; was incontinent of bladder; had short-term memory and decision-making cognitive difficulties; and was usually understandable and usually understood others during communication.

The 04/03/25 NSA directed facility staff to provide R2 assistance of one staff with bathing, dressing, bladder incontinence, and toileting; two person assist with lift for transfers; supervision with eating; and staff provided management of medications and treatments. The NSA failed to provide service and provider of service for mobility and cognition difficulties.

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S5105	Continued From page 3 Observation on 06/09/25 at 11:52 AM staff pushed R2 in wheelchair to dining room table for meal. Observation on 06/09/25 at 12:00 PM Certified Medication Aide E assisted to eat. She asked R2 questions and would remind him of what to do and reorientate. On 06/09/25 at 11:33 AM Licensed Nurse C confirmed R2's NSA failed to describe the services provided based on his FCS. - Record review for R3 revealed an admission date of 03/13/25 with a diagnosis of Alzheimer's disease and Parkinson's disease. The 03/20/25 FCS identified R3 was unable to perform bathing, management of medications, and management of treatments; required physical assistance with dressing, toileting, transfers, walking/mobility, and eating; was incontinent of bladder; had short-term and long term memory, memory/recall, and decision making cognitive difficulties; was usually understandable and usually understood others during communication; and was marked for falls and impaired decision making. The 03/13/25 NSA directed facility staff to provide R3 assistance of one or two staff with dressing, toileting, transfers, walking/mobility, and bladder incontinence; staff assist twice a week with bathing; supervision and reminders with eating; staff provide management of medications and treatments; and staff reminded of meals for cognition. Falls, unsteadiness, and	S5105		

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S5105	Continued From page 4 impaired decision-making were not addressed on the NSA. An NSA addendum on 03/20/25 added a service of side rails to R3's bed. On 06/09/25 at approximately 11:46 AM staff reminded R3 of the next meal and asked if he was ready to eat. On 06/09/25 at 10:49 AM Certified Medication Aide E stated staff asked R3 yes or no questions to make decision making simple. To prevent falls she stated that staff kept him in visual line of sight. On 06/09/25 at 11:18 AM Licensed Nurse C stated R3 was given reminders for activities by staff and his non-verbal cues were watched for fall prevention. On 06/09/25 at 11:33 AM Licensed Nurse C confirmed R3's NSA failed to describe the services provided based on his FCS. The facility's "Admission, Transfer and Discharge Rights of Residents In Home Plus" dated 12/01/22 explained the written agreement would detail the services the resident would receive. The administrator failed to ensure the NSA for R1, R2, and R3 described the services they received based on their Functional Capacity Screens (FCS).	S5105		
S5126 SS=E	26-42-202 (h) NSA Signatures (h) Each individual involved in the development of the negotiated service agreement shall sign the agreement. The administrator or operator	S5126		

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S5126	Continued From page 5 shall ensure that a copy of the initial agreement and any subsequent revisions are provided to the resident or the resident's legal representative. This REQUIREMENT is not met as evidenced by: KAR 26-42-202(h) The facility reported a census of ten residents with three residents included in the sample. Based on interview and record review the administrator failed to ensure signatures of each individual involved in the development of the Negotiated Service Agreements (NSA) were obtained for Resident (R) 1, R2, and R3. Findings included: - Record review for R1 revealed an admission date of 04/03/24 with diagnoses of repeated falls, hypothyroidism, atrial fibrillation, constipation, aortic abdominal aneurysm, and hypertension. The 03/20/25 Functional Capacity Screen (FCS) identified R1 required physical assistance with bathing, dressing, toileting, and transfers; required supervision with eating; was unable to perform walking/mobility, management of medications and treatments; was usually incontinent of bladder; had short-term memory, memory/recall, and decision making cognitive difficulties; was usually understandable and usually understood others during communication; and was marked for impaired hearing and impaired decision-making.	S5126		

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S5126	Continued From page 6 The 03/04/25 Negotiated Service Agreement (NSA) documented facility staff to provide R1 assistance of one or two staff with bathing, dressing, toileting, incontinence, transfers, and mobility with a wheelchair; and staff managed medications and treatments. The NSA was only signed by Licensed Nurse B and failed to have signatures from all those involved in the development. The 03/20/25 NSA addendum added a service of side rails to R1's bed. The addendum was only signed by Licensed Nurse D. On 06/09/25 at 10:58 AM Licensed Nurse C confirmed R1's record lacked evidence of documentation of each individual's signature involved in the development of the NSA and the addendum. - Record review for R2 revealed an admission date of 04/03/24 with diagnoses of diabetes mellitus type two, obesity, glaucoma, weakness, and difficulty in walking. The 04/03/25 FCS identified R2 required physical assistance with bathing, dressing, toileting, transfers, and walking/mobility; was independent with eating; was unable to perform management of medications and treatments; was incontinent of bladder; had short-term memory and decision-making cognitive difficulties; and was usually understandable and usually understood others during communication. The 04/03/25 NSA directed facility staff to provide R2 assistance of one staff with bathing, dressing, bladder incontinence, and toileting; two	S5126		

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S5126	Continued From page 7	S5126		

person assist with lift for transfers; supervision with eating; and staff provided management of medications and treatments. The NSA failed to provide service and provider of service for mobility and cognition difficulties. The NSA was only signed by Licensed Nurse D.

On 06/09/25 at 10:58 AM Licensed Nurse C confirmed R2's record lacked evidence of documentation of each individual's signature involved in the development of the NSA.

- Record review for R3 revealed an admission date of 03/13/25 with a diagnosis of Alzheimer's disease and Parkinson's disease.

The 03/20/25 FCS identified R3 was unable to perform bathing, management of medications, and management of treatments; required physical assistance with dressing, toileting, transfers, walking/mobility, and eating; was incontinent of bladder; had short-term and long term memory, memory/recall, and decision making cognitive difficulties; was usually understandable and usually understood others during communication; and was marked for falls and impaired decision making.

The 03/13/25 NSA directed facility staff to provide R3 assistance of one or two staff with dressing, toileting, transfers, walking/mobility, and bladder incontinence; staff assist twice a week with bathing; supervision and reminders with eating; staff provide management of medications and treatments; and staff reminded of meals for cognition. Falls, unsteadiness, and impaired decision-making were not addressed on the NSA.

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S5126	Continued From page 8 The 03/20/25 NSA addendum added a service of side rails to R3's bed. The addendum was only signed by Licensed Nurse D. R3's NSA addendum lacked evidence of documentation of each individual's signature involved in the development. On 06/09/25 at 10:58 AM Licensed Nurse C confirmed R3's record lacked evidence of documentation of each individual's signature involved in the development of the NSA addendum. The facility's 12/01/22 "Admission, Transfer and Discharge Rights of Residents In Home Plus" policy documented the NSA would be signed by all parties who participate. The facility's 08/01/18 "Negotiated Service Agreement - Amendments" policy documented the NSA would include signatures of those participating. The administrator failed to ensure signatures of each individual involved in the development of the Negotiated Service Agreements were obtained for Resident (R) 1, R2, and R3.	S5126		
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	S5215		

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S5215	Continued From page 9 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. This REQUIREMENT is not met as evidenced by: KAR 26-42-104(d)(3) The facility reported a census of ten residents. Based on interview and record review the administrator failed to provide quarterly reviews of the facility's emergency management plan with all residents and staff. Findings included: - Review of quarterly reviews since last survey revealed reviews were provided on 03/06/24, 04/09/24, 06/10/24, 09/05/24, 12/02/24, 03/05/25, and 06/02/25 with topic of "emergency preparedness." During interview on 06/05/25 at 01:19 PM Administrative Staff F stated he was in charge of the quarterly reviews and provided residents pertinent topics only. He confirmed he did not complete reviews of the facility's entire emergency management plan with residents each quarter. The facility's "Emergency Preparedness Plan"	S5215		

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S5215	Continued From page 10 policy explained the plan would be reviewed quarterly with residents including "all contingencies" ..."e.g., evacuation, shelter-in-place, surge capacity, etc.)" The administrator failed to provide quarterly reviews of the facility's emergency management plan with all residents and staff.	S5215		
S5315 SS=E	26-42-205 (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 regulations. (1) Licensed nurses or medication aides shall store non-controlled medications and biologicals managed by the home in a locked medication room, cabinet, or medication cart. Licensed nurses and medication aides shall store controlled medications managed by the home 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	S5315		

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S5315	Continued From page 11 stored by the home. (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: KAR 26-42-205(h) The facility reported a census of ten residents. Based on observation and interview the administrator failed to ensure that all medications and biologicals are stored in accordance with federal and state laws and regulations. Findings included: - Observation on 06/05/25 at 12:31 PM Certified Medication Aide E unlocked the medication room. The medication cart stored two one-pound containers of hydrocortisone cream 1%, one with expiration date of 09/24, the other 03/25. On 06/05/25 at 12:31 PM Certified Medication Aide E confirmed the containers of hydrocortisone cream were past dates of expiration. - Observation on 06/05/25 at approximately 12:33 PM Certified Medication Aide E unlocked the medication room refrigerator which revealed two zippered bags each holding three bisacodyl 10 milligram suppositories with expiration date of 11/22, one zippered bag holding six bisacodyl 10 milligram suppositories with expiration date of	S5315		

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S5315	Continued From page 12 01/25, and one vial of Tubersol with opened date of 04/03/25. The Tubersol box label read to discard opened product after 30 days. On 06/05/25 at 12:35 PM Administrative Staff A confirmed the medications were past date of use. The facility's undated "Medication Storage Information" policy instructed staff to check medication carts at least monthly for dates and expiration. Page 2 of the policy listed opened Tubersol to have an expiration of 30 days. The administrator failed to ensure that all medications and biologicals are stored in accordance with federal and state laws and regulations.	S5315		