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	B078029	A. BUILDING: _____ B. WING _____	08/21/2025

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HAVEN HOUSE	410 NORTH RENO AVENUE HAVEN, KS 67543

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S 000	INITIAL COMMENTS The following citations represent the findings of Re-Licensure Survey with complaint investigations 196326, 196292, 196741, and 196755 for the above named Home Plus Facility conducted on 08/20/25 and 08/21/25.	S 000		
S 135 SS=D	26-39-103 (h) Resident Right Notification of Changes (h) Notification of changes. (1) The administrator or operator shall ensure that designated facility staff inform the resident, consult with the resident's physician, and notify the resident's legal representative or designated family member, if known, upon occurrence of any of the following: (A) An accident involving the resident that results in injury and has the potential for requiring a physician's intervention; (B) a significant change in the resident's physical, mental, or psychosocial status; (C) a need to alter treatment significantly; or (D) a decision to transfer or discharge the resident from the adult care home. (2) The administrator or operator shall ensure that a designated staff member informs the resident, the resident's legal representative, or authorized family members whenever the designated staff member learns that the resident will have a change in room or roommate assignment. This STANDARD is not met as evidenced by: K.A.R. 26-39-103 (h)(1)(C)	S 135		

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

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S 135	Continued From page 1 The facility reported a census of seven residents. The sample included three residents and one closed record review. Based on record review and interview the operator failed to ensure designated staff informed one (R4) of three sampled residents guardian when the physician ordered Seroquel (an antipsychotic) for the resident's hallucinations. Findings included: - Review of R4's medical record revealed she moved into the facility on 06/05/24 with a diagnosis of dementia. R4's "Functional Capacity Screen" dated 04/30/25 identified she required physical assistance with bathing and dressing, was unable to manage her medications, had impaired cognition and wandered. R4's "Negotiated Service Agreement/Health Care Service Plan" identified certified medication aides and licensed nurses would administer medications. It also identified R4 required redirection, cues, wore a wanderguard and was forgetful. R4's record included authorization and acknowledgement that the facility was to contact R4's daughter for any care plans or treatment. It also included guardianship papers that once R4 was placed in a facility, her sister would become the guardian. Review of R4's observation notes dated 04/11/25 revealed a new medication, Seroquel	S 135		

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S 135	Continued From page 2 (antipsychotic) was ordered, text sent to guardian with no return call at this time. Interview on 08/21/25 at 08:06 AM Administrative Licensed Nurse/Operator A reported her normal process for informing R4's guardian, is via text. She stated: we got the order, and I automatically documented that I texted the guardian and got busy or something and failed to follow through and text her. The operator failed to ensure the licensed nurse notified R4's guardian when she received a new order for and antipsychotic medication.	S 135		
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. This REQUIREMENT is not met as evidenced by: KAR 26-42-201(d) The facility reported a census of seven residents(R). The sample include three residents and one focused record review. Based on observation, interview, and record review the operator failed to ensure designated staff completed one (R4) of three sampled resident's "Functional Capacity Screen" accurately to reflect the resident's functional ability related to	S5095		

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S5095	Continued From page 3	S5095		

socially inappropriate behaviors. .

Findings Included:

- Review of R4's medical record revealed she moved into the facility on 06/05/24 with a diagnosis of dementia.

R4's "Functional Capacity Screen" dated 04/30/25 identified she required physical assistance with bathing and dressing, had impaired cognition and wandered. It failed to identify she had inappropriate behaviors.

Review of R4's "Observation Notes" revealed multiple entries of resident yelling at staff, trying to sign for medications saying she is a nurse, follows around and is possessive of male resident, trying to enter bath house when male resident is in the bath, stating he is her husband, and getting mad at staff when they redirect her.

Observation on 08/20/25 at 11:34 AM R4 had a folder in her had with different papers saying how she had to make the reports because the pastor needed them.

Interview on 08/20/25 at 12:12 PM Certified Medication Aide D reported R4 can be pretty good during the day and fairly easy to redirect with activities but in the evening she gets very irritable almost in a fight or flight mode and will raise her voice and say things like she is a nurse and she can do that. There is also a male resident that she thinks is her husband and she tends to follow him around.

Interview on 08/21/25 at 08:31 AM Administrative

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S5095	Continued From page 4 Licensed Nurse/Operator A reviewed the "Functional Manual Guidance" and confirmed she should have coded R4 as having socially inappropriate behaviors. The operator failed to ensure designated staff completed R4's FCS section accurately related to her socially inappropriate behaviors.	S5095		
S5105 SS=F	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 seven residents (R). The sample included three residents and one closed record review. Based on interview for	S5105		

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S5105	Continued From page 5	S5105		

all residents, and record review for three (R4, R5, R6) of three sampled residents, the operator failed to ensure designated staff developed a "Negotiated Service Agreement" based on the resident's "Functional Capacity Screen" and service needs that included a description of services to be provided.

Findings included:

- Review of R4's medical record revealed she moved into the facility on 06/05/24 with a diagnosis of dementia.

R4's "Functional Capacity Screen" (FCS) dated 04/30/25 identified she required physical assistance with mamagement of medicaations and medical treatments.

R4's "Negotiated Service Agreement/Health Care Service Plan" (NSA/HCSP) dated 04/30/25 failed to include a description of services related to management of medical treatments.

Interview on 08/21/25 at 08:32 AM Administrative Licensed Nurse/Operator A reviewed R4's NSA/HCSP and confirmed it did not include a description of services for medical treatments as the FCS only identified R4 needed physical assistance with medications. She also comfirmed all residents had the same format for their NSA/HCSP so it would affect all residents who needed any kind of assistance with treatments.

The operator failed to ensure designated staff completed R4's NSA/HCSP to address the need of physical assistance with medical treatments.

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S5105	Continued From page 6 - Review of R5's medical record revealed he moved into the facility on 02/23/23 with diagnosis of Parkinson's. R5's "Functional Capacity Screen" (FCS) dated 04/22/25 identified he needed physical assistance wiht activities of daily living and was unable to manage his medical treatments. R5's "Negotiated Service Agreement/Health Care Service Plan" (NSA/HCSP) dated 04/22/25 failed to include a description of services related to manageent of medical treatments. Interview on 08/21/25 at 08:32 AM Administrative Licensed Nurse/Operataor confirmed his NSA/HCSP did not include services for medical treatments. - R6's medical record revealed she moved into the facility on 06/05/24 with diagnosis of dementia with Lewy body, and psychotic anxiety. R6's "Functional Capacity Screen" dated 07/09/25 identified she had no cognitive impairment, was not able to manage her medications or medical treatments, had impaired vision and impaired hearing. R6's "Negotiated Service Agreement/ Health Care Service Plan" (NSA/HCSP) failed to include a description of services related to medical treatments, impaired vision and impaired hearing. Interview on 08/21/25 at 07:18 AM Administrative Liensed Nurse/Operator confirmed R6's NSA/HSP lacked services for medical	S5105		

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S5105	Continued From page 7 treatments, impaired vision and hearing as identified on the FCS. For R4, R5, and R6, the operator failed to ensure designated staff developed a "Negotiated Service Agreement" based on the resident's "Functional Capacity Screen" and service needs that included a description of services to be provided.	S5105		
S5300 SS=D	26-42-205 (d) (1-2) Facility Administration of Medications (d) Home administration of resident ' s medications. If a home is responsible for the administration of a resident ' s medications, the administrator or operator shall ensure that all medications and biologicals are administered to that resident in accordance with a medical care provider ' s written order, professional standards of practice, and each manufacturer ' s recommendations. The administrator or operator shall ensure that all of the following are met: (1) Only licensed nurses and medication aides shall administer and manage medications for which the home has responsibility. (2) Medication aides shall not administer medication through the parenteral route. This REQUIREMENT is not met as evidenced by: KAR 26-42-205 (d) The facility reported a census of seven residents(R). The sample included three	S5300		

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S5300	Continued From page 8	S5300		

residents and one closed record review. Based on record review and interview the operator failed to ensure staff administered medications according to standards of practice for one (R6) of three sampled residents for whom the facility was responsible for administering medications.

Findings included:

- R6's medical record revealed she moved into the facility on 06/05/2 with diagnosis of dementia with Lewy body, and psychotic anxiety.

R6's "Functional Capacity Screen" dated 07/09/25 identified she could not manage her medications, and had no cognitive impairment.

R6's "Negotiated Service Agreement/ Health Care Service Plan" (NSA/HCSP) the CMA and Licensed Nurse would provide medication assistance.

Review of R6's record and time clock times for administration of medication compared with the times medication were signed out by staff for August 2025 Medication Administration Record revealed the following:
On 08/12/25 staff administered scheduled 08:00 AM Ativan at 10:03 AM
On 08/12/24 staff administered scheduled 12:00 PM Ativan at 03:50 PM
On 08/15/25 staff administered the scheduled 02:00 PM Ativan at 03:32 PM.
On 08/16/25 staff administered the scheduled 08:00 AM Ativan at 10:46 AM
On 08/18/25 staff administered the scheduled 08:00 AM Ativan at 09:18 AM
On 08/20/25 staff administered the scheduled

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S5300	Continued From page 9 02:00 PM Ativan at 12:26 PM Interview on 08/21/25 at 06:52 AM Certified Medication Aide reported if a medication is scheduled at 07:30 or something specific we wake the resident up and will give it to them and let them go they can go back to sleep if they want. If they are going out for an appointment it depends if it is within the time frame for giving it. We may go-ahead and give a scheduled Noon if they leave at 11:00. We do not send out controlled medications and if it is not within the time frame we will wait until they return to the facility and document in the record that is was given late due to out of the building. Interview on 08/21/25 at 07:55 AM Administrative Licensed Nurse/Operator A reviewed the time frames compared to times the Ativan was checked out of the narcotic box and confirmed there were times that R6's Ativan had been administered outside of the standard administration time frames. Review of the "Kansas Certified Medication Aide Curriculum" February 2011 revealed certified medication aides administer "routine medications are to be administered within an hour before or an hour after the scheduled time unless there are specific instructions ordered by the physician". The operator failed to ensure designated staff administered R6's medications within the standard of practice time frame for scheduled medications.	S5300		