STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B023021	A. BUILDING: _____ B. WING _____	09/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADEL'S HOUSE	1701 RESEARCH PARK DR LAWRENCE, KS 66047

(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 with attached complaint 189417 at the above named home plus facility conducted on 09/11/25.	S 000		
S5085 SS=D	26-42-201 (c) Functional Capacity Screen Reassessment (c) Designated staff shall conduct a screening to determine each resident ' s functional capacity according to the following requirements: (1) At least once every 365 days; (2) following any significant change in condition as defined in K.A.R. 26-39-100; and (3) at least quarterly if the resident receives assistance with eating from a paid nutrition assistant. This REQUIREMENT is not met as evidenced by: KAR 26-42-201(c)(2) The facility reported a census of 10 residents with three included in the sample. Based on interview and record review the operator failed to complete a "Functional Capacity Screen" (FCS) for Resident (R) 3 following a significant change in condition. Finding included: - Record review for R3 revealed an admission date of 07/14/25 with diagnoses of Parkinson's and dementia The 07/14/25 admission FCS identified R3	S5085		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B023021	A. BUILDING: _____ B. WING _____	09/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADEL'S HOUSE	1701 RESEARCH PARK DR LAWRENCE, KS 66047

(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
S5085	Continued From page 1 required supervision with bathing, dressing, toileting, eating; was unable to perform management of medications and treatments; was incontinent of bladder; had short-term memory, long-term memory, memory/recall, and decision-making difficulties; was usually understandable and sometimes understood others with communication; and had impaired decision-making, disruptive inappropriate behavior, and wandered. The 08/05/25 "Addendum to Negotiated Service Agreement" identified facility staff would provide R3 assistance of one staff for bathing, dressing, toileting, and eating. R3 was a fall risk due to unsteady gait and had a mattress on floor per R3 request. R3's record lacked evidence of documentation of a significant change FCS when the Negotiated Service Agreement was amended. On 09/11/25 at 02:10 PM Administrative Nurses B and C confirmed R3 had a significant change and his record lacked documentation of a significant change FCS. The operator failed to ensure an FCS was completed for R3 following a significant change.	S5085		
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	S5105		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B023021	A. BUILDING: _____ B. WING _____	09/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADEL'S HOUSE	1701 RESEARCH PARK DR LAWRENCE, KS 66047

(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
S5105	Continued From page 2	S5105		

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 10 residents with three included in the sample. Based on interview, observation, and record review the operator 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).

Findings included:

- Record review for R1 revealed an admission date of 10/07//24 with a diagnosis of dementia.

The 12/12/24 FCS identified R1 was unable to perform bathing, dressing, toileting, transfers, walking/mobility, and management of medications and treatments; was incontinent of bladder; had short term memory, long term memory, memory/recall, and decision-making difficulties; was rarely or never understood or understandable with communication; and was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B023021	A. BUILDING: _____ B. WING _____	09/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADEL'S HOUSE	1701 RESEARCH PARK DR LAWRENCE, KS 66047

(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
S5105	Continued From page 3	S5105		

marked at risk for falls, impaired decision-making, and inappropriate behavior.

The 12/12/24 Negotiated Service Agreement/Health Care Service Plan is the facility's combined NSA/HSP which documented staff provided complete assistance with bathing, dressing, toileting, transfers, and walking/mobility; yes or no questions for cognition; administered medications and treatments; and staff assisted with transfers to reduce falls. The NSA/HSP failed to describe the services he received for communication.

Observation on 09/11/25 at 04:14 PM R1 did not open eyes when talked to. Questions were repeated multiple times to receive an answer.

On 09/11/25 at 02:47 PM Administrative Staff D stated R1 had to be asked to repeat himself due to talking fast and staff talked slowly for him to process.

- Record review for R2 revealed an admission date 02/28/23 with diagnoses of dementia.

The 03/14/25 FCS identified R2 required physical assistance with bathing, dressing, toileting, transfers, and walking/mobility; was unable to perform management of medications and treatments; was incontinent; had difficulty with short term memory, long term memory, memory/recall, and decision making; was rarely or never understood and sometimes could understand when communicating; and was at risk of falls and had inappropriate behavior.

The 03/14/25 NSA/HSP failed to describe the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B023021	A. BUILDING: _____ B. WING _____	09/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADEL'S HOUSE	1701 RESEARCH PARK DR LAWRENCE, KS 66047

(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
S5105	Continued From page 4 services she received for communication. Observation on 09/11/25 at 04:10 PM R2 only responds to questions when repeated and said slow. - Record review for R3 revealed an admission date of 07/14/25 with diagnoses of Parkinson's and dementia The 07/14/25 admission FCS identified R3 required supervision with bathing, dressing, toileting, eating; was unable to perform management of medications and treatments; was incontinent of bladder; had short-term memory, long-term memory, memory/recall, and decision-making difficulties; was usually understandable and sometimes understood others with communication; and had impaired decision-making, disruptive inappropriate behavior, and wandered. The 03/14/25 NSA/HSP failed to describe the services she received for communication. Observation on 09/11/25 at 04:14 PM R3 repeated the question asked of him but was unable to put together a response that made sense. On 09/11/25 at 03:32 PM Administrative Staff A, C, and E confirmed R1, R2, and R3's NSAs failed to describe the services provided based on their FCS. The operator failed to ensure the NSA for R1, R2, and R3 described the services provided based on their FCS.	S5105		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B023021	A. BUILDING: _____ B. WING _____	09/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADEL'S HOUSE	1701 RESEARCH PARK DR LAWRENCE, KS 66047

(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