STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N008013	A. BUILDING: _____ B. WING _____	01/22/2026

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THE MAPLETON ANDOVER, LLC	1419 W CENTRAL AVE ANDOVER, KS 67002

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S 000	INITIAL COMMENTS The following citations represent the findings of a Re-Licensure Survey with complaint investigations 192041, 193396, 193897, 193898, 194817, 194836, 194915, 195645, 196630, 196752, 197430, 197467, 197629, 197695 for the above named Assisted Living facility conducted on 01/20/26, 01/21/26, and 01/22/26.	S 000		
S3155 SS=G	26-41-204 (a) Health Care Services . (a) The administrator or operator in each assisted living facility or residential health care facility shall ensure that a licensed nurse provides or coordinates the provision of necessary health care services that meet the needs of each resident and are in accordance with the functional capacity screening and the negotiated service agreement. This REQUIREMENT is not met as evidenced by: KAR 26-41-204 (a) The facility reported a census of 29 residents (R). The sample included three residents, three closed record reviews, and two focused record reviews. Based on observation, interview, and record review, the Administrator failed to ensure a Licensed Nurse (LN) provided or coordinated the provision of necessary health care services to meet the needs of one (R3) of three sampled residents who had a history of pressure ulcers and then later developed a pressure ulcer on his	S3155		

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

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S3155	Continued From page 1 right outer ankle. Findings included: - Review of R3's medical record revealed he moved into the facility on 04/01/24 with diagnoses of dementia and Parkinsons disease. R3's "Functional Capacity Screen" (FCS) dated 03/25/25 revealed R3 required physical assistance with dressing and toileting and only needed supervision with toileting and mobility. He had impaired cognition and was usually continent. R3's FCS dated 08/25/25 as a significant change identified he was not able to participate in dressing, toileting and now required physical assistance with mobility as well transfers and started Hospice services. R3's "Negotiated Service Agreement" (NSA) dated 08/25/25 revealed staff would assist R3 with getting up from bed, dressing and undressing, assist with toileting and provide peri-care - and required assist of 2 with all transfers. It also identified a Licensed Nusee or Certified Medication Aide would complete all treatments with wound care provided by Hospice. R3's "Health Care Service Plan" (HCSP) dated 08/25/25 included the same services as the NSA including the need to provide wound care. However, both documents lacked a description of services related to the promotion of R3's wound healing and services to reduce the risk of the development of additional wounds.	S3155		

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S3155	Continued From page 2 Review of R3's medical provider notes dated 07/02/25, 07/09/25 and 08/01/25 included identification R3 had a stage 3 pressure ulcer on his coccyx. Review of R3's medical record included the following nursing progress notes: 04/27/25 - resident with a sore on his bottom apply barrier cream and rotate from side to side. 04/29/25 - Rotated resident every 2 hours on sides to keep resident off his bottom and cleaned thoroughly with check and changes. The nursing progress notes lacked any documentation related to the resident's sore from 04/29/25 to 07/02/25 when new orders were received for wound care to be conducted by home Health. 07/25/25 - staff changed dressing due to being soiled, resident denies pain other than to his bottom. 08/18/25 - referral order for wound care - change two times per week and as needed, to be done by Home health. 08/19/25 - medical provider progress note received and identified wound had significantly improved. 08/21/25 - Nurse notified resident had new breakdown on bottom that had opened. Home Health instructed to cover area with boarder gauze until Nurse able to assess. 09/03/25 - new orders for wound dressing. 09/09/25 - Hospice Nurse reported wound healed with no need for continued dressing changes. The nursing progress had no further documentation related to skin until 10/16/25: 10/16/25 -identified the resident had a quarter size pressure sore on his right ankle, nurse	S3155		

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S3155	Continued From page 3 notified. 12/03/25 - resident complained of pain in right ankle, area cleaned and applied bandage to sore on right ankle. 12/03/25 -New orders from medical provider to start Betadine to right outer ankle, apply calcium alginate to wound bed, cover with boarder foam and change three times a week and as needed. 01/03/26 -Nurse assessed right outer ankle wound and area noted with yellow/tan slough with areas of darkened tissue present. Surrounding skin is red, intact, and slightly inflamed. This nurse cleansed the area with betadine, applied calcium alginate to wound bed, and covered with boarder foam per Provider's orders. 01/13/26 -Nurse assessed right outer ankle wound due to dressing came off. Wound noted with white slough in wound bed and surrounding skin is red, intact, and slightly inflamed. 01/14/26 - New wound orders - cleanse with wound cleanser and soak for five minutes. Scrub wound bed with dry woven gauze to remove unhealthy tissue. Apply Betadine to skin around wound and a dime size amount of triad into wound bed, covered with a single layer woven gauze, secure with bordered foam and change three times weekly. R3's Nursing notes lacked documentation of interventions related to R3's coccyx or right ankle wound, effectiveness of the interventions and progression of R3's wounds. Hospice Notes included the following: 10/06/25 - indicated resident had red sore on	S3155		

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S3155	Continued From page 4	S3155		

right ankle
Hospice care plan identified he had a stage one wound on right ankle and then on 12/15/25 the right ankle wound measured 2 centimeters (cm) x 1.5 cm with 90% green eschar (dead tissue) and is now unstageable. Nurse educated staff to report skin changes to Hospice team immediately.
12/31/25 - Hospice measured wound - 2.5 cm x 2.6 cm., partial thickness wound with serosanguinous (semi-thick reddish drainage) drainage and bright red skin surrounding wound.
.
01/05/26 - Hospice did not take measurements but noted small amount of serosanguineous drainage, partial thickness, no necrotic tissue in wound bed and surrounding skin a bright red.
01/07/26 - Hospice did not take measurements, identified wound had moderate amount of serosanguinous drainage with yellow necrotic tissue that was 50-75% of wound bed with bright red surrounding skin. Encourage staff to check and ensure resident had not kicked of heel boot during the night.
On 01/12/26 the wound now measured 5.4 cm x 4.7 cm identified as a "full thickness" wound with yellow slough (dead tissue, usually cream or yellow in color) in wound bed with purulent (producing or containing pus) drainage and bright red skin surrounding wound.

Observation on 01/20/26 at 11:31 AM revealed staff brought resident to the dining room table and brought him a protein drink. He had on a blue foam boot on his right foot and a cushion in his wheelchair.

Observation on 01/21/26 at 07:54 AM Certified

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S3155	Continued From page 5 Nurse Aide (CNA) C and CNA D went in to assist resident to get up for the day. The bed was in the lowest position and a fall mat on the floor beside the bed. CNA C raised the bed and explained everything to the resident. CNA C pulled covers back which revealed a pillow between his knees, one under his knees, and a blue heel boot on his right foot. When CNA D removed the boot to get resident dressed revealed a foam dressing on his right outer ankle. Both staff finished helping R3 get dressed for the day and transferred him into his wheelchair, which had an air cushion in it and put his feet up on the wheelchair pedals. CNA C put the blue boot back on his right ankle. Observation on 01/21/26 at 10:15 AM CNA C and CNA D assisted R3 to transfer onto the toilet. Observation revealed R3's coccyx was reddened but had no open areas. Observation on 01/21/26 at 01:48 PM Hospice Nurse was in room and had removed the dressing to R3's right ankle and had wet gauze soaking the wound bed. She removed the gauze which revealed a pressure ulcer approximately the size of a quarter on his lower ankle. The wound bed was deep, beefy red with whitish slough in areas. Hospice Nurse gently rubbed the lower part of the wound bed, and the slough was loose but did not come off. The Hospice Nurse then applied Triad cream and covered the wound bed with gauze and then foam pad. Interview on 01/21/26 at 1:35 PM CNA C reported R3 required total assistance from staff and that he had declined quickly.	S3155		

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S3155	Continued From page 6 Interview on 01/21/26 at 02:12 PM Medical Provider E reported she thought the white center area was bone based on her assessment of the wound last week when she changed orders. Medical Provider E reported when the ulcer was first identified it was pretty small and in a matter of no time it is the size it is now. Interview on 01/22/26 at 11:34 AM Certified Medication Aide (CMA) F reported when R3 had the sore on his bottom staff would have him up in the recliner with a cushion in the chair and he also had a cushion in his wheelchair. CMA F reported he had wedges to put under his calves so that his heels did not rub on the sheets. CMA F reported she did not know if staff used the wedges all the time or not because he then developed the ulcer on his ankle. Interview on 01/22/26 at 11:44 AM Administrative Licensed Nurse B reported staff knew what to do from word of mouth and shift report. She reported staff just do what Hospice tell them to do and currently he wears the heel protectors, and he had a bad habit of crossing his feet, so staff were to put a pillow between his feet to keep his feet separated and padded. The administrator failed to ensure a Licensed Nurse developed and coordinated the provision of necessary health care services to meet the needs of a resident who had a coccyx pressure ulcer that healed and then developed a pressure ulcer on his right heel.	S3155		
S3175 SS=E	26-41-205 (a) (1) Self Administration of Medication	S3175		

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S3175	Continued From page 7 (a) Self-administration of medication. Any resident may self-administer and manage medications independently or by using a medication container or syringe prefilled by a licensed nurse or pharmacist or by a family member or friend providing this service gratuitously, if a licensed nurse has performed an assessment and determined that the resident can perform this function safely and accurately without staff assistance. (1) An assessment shall be completed before the resident initially begins self-administration of medication, if the resident experiences a significant change of condition, and annually. This REQUIREMENT is not met as evidenced by: KAR 26-41-205(a)(1) The facility reported a census of 29 residents (R). The sample included three residents, three closed record reviews, and two focused record review. Based on interview and record review the executive director failed to ensure a licensed nurse completed an assessment for self-administration of medications for two (R16 and R17) of two focused record reviews prior to the residents self-injecting their insulin. Findings included: - R16's record revealed she moved into the facility on 02/17/25 with a diagnosis of diabetes	S3175		

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S3175	Continued From page 8	S3175		

mellitus.

R16's "Functional Capacity Screen" dated 02/10/25 identified she was unable to manage her medications or medical treatments.

R16's "Negotiated Service Agreement" (NSA) dated 02/17/25 identified a Licensed Nurse or Certified Medication Aide dialed R16's insulin pen and the resident would self-inject her insulin.

Review of R16's medical record lacked evidence a licensed nurse conducted an assessment to ensure R16 could safely and accurately self-inject her insulin after staff prepared the pen.

Interview on 01/21/26 at 09:37 AM Administrative Licensed Nurse B reported they do checks on the CMA to teach them how to dial and prepare the pens and the resident demonstrate they can self-inject. She confirmed she had nothing to show R16 had been assessed to identify she could self-inject her insulin.

The administrator failed to ensure a licensed nurse completed a self-administration assessment for R16 to ensure she could safely and accurately self-inject her insulin.

- Review of R17's record revealed he moved into the facility on 06/16/25 with a diagnosis of diabetes mellitus.

R17's "Functional Capacity Screen" dated 05/20/25 revealed he needed physical assistance with management of his medications and medical treatments.

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S3175	Continued From page 9 R17's "Negotiated Service Agreement" (NSA) dated 06/16/25 identified a Licensed Nurse or Certified Medication Aide would administer all medications and medical treatments. The NSA failed to identify the resident self injected his insulin. Review of R17's record on 01/21/26 lacked evidence a licensed nurse conducted an assessment to identify R17's could safely and accurately self inject his insulin. Interview on 01/22/26 at 05:00 PM Administrative Licensed Nurse B confirmed she had not conducted and assessment to ensure R17 could safely and accurately self-inject his insulin. The administrator failed to ensure a licensed nurse completed a self-administration assessment for R17 to ensure he could safely and accurately self-inject his insulin.	S3175		
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 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	S3215		

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S3215	Continued From page 10 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: KAR 26-41-205(h)(1)(4) The facility reported a census of 29 residents. Based on observation and interview, the executive director failed to ensure staff stored insulin pens according to manufacturer's recommendations to ensure staff did not administer the medication beyond the manufacturer's recommended date of expiration. Findings included: - Observation on 01/20/26 at 10:33 AM Certified Medication Aide (CMA) K unlocked the "Little House" medication cart for inspection revealed	S3215		

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S3215	Continued From page 11 R17 had Tresiba FlexTouch pen that staff had used, but did not have the date it was initiated to ensure staff did not use it after expiration. Interview on 10/20/26 at 10:34 AM CMA K reported whoever takes it out of the refrigerator is supposed to put the date they took it out on the pen. Review of manufacturer recommendations revealed when stored at room temperature, Tresiba is to be discarded after 56 days, even if some insulin remains in the pen. - Observation on 01/20/26 at 10:44 PM CMA F unlocked the medication cart in the "Big House' for inspection which revealed R16 had three insulin pens in the top drawer including Tresiba with a little over 150 units remaining with no date opened or expiration date and Lispro with a little over 220 units remaining with no date opened or expiration date. Interview on 01/20/26 CMA F reported when staff put the pen in the cart they are to put an expiration date on the pen. Review of the manufacturer recommendations for Lispro when stored at room temperature once opened it is to be discarded after 28 days even if insulin remains in the pen. Review of manufacturer recommendations revealed when stored at room temperature, Tresiba is to be discarded after 56 days, even if some insulin remains in the pen The administrator failed to ensure designated	S3215		

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S3215	Continued From page 12 staff dated insulin pens, so staff knew when to discard it according to manufacturers recommended date of expiration.	S3215		
S3261 SS=E	26-41-105 (f) (11) Resident Record Documentation of Incidents (f) (11) documentation of all incidents, symptoms, and other indications of illness or injury including the date, time of occurrence, action taken, and results of the action This REQUIREMENT is not met as evidenced by: KAR 26-41-105(f)(11) The facility reported a census of 29 residents (R). The sample included three residents, three closed record reviews, and two focused record review. Based on observation, interview and record review the administrator failed to ensure two (R3 and R4) of three sampled residents records contained documentation of all incidents, symptoms, and other indications of illness or injury, what was done, and the results of action taken related to increased edema. Findings included: -- Review of R3's medical record revealed he moved into the facility on 04/01/24 with diagnoses of dementia and Parkinsons disease. R3's "Functional Capacity Screen" (FCS) dated 03/25/25 revealed R3 required physical	S3261		

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S3261	Continued From page 13	S3261		

assistance with dressing and toileting and only needed supervision with toileting and mobility. He had impaired cognition and was usually continent.

R3's FCS dated 08/25/25 as a significant change identified he was not able to participate in dressing, toileting and now required physical assistance with mobility as well transfers and started Hospice services.

R3's "Negotiated Service Agreement" (NSA) dated 08/25/25 revealed staff would assist R3 with getting up from bed, dressing and undressing, assist with toileting and provide peri-care - and required assist of 2 with all transfers. It also identified a Licensed Nusee or Certified Medication Aide would complete all treatments with wound care provided by Hospice.

R3's "Health Care Service Plan" (HCSP) dated 08/25/25 included the same services as the NSA including the need to provide wound care.

Review of R3's medical provider notes dated 07/02/25, 07/09/25 and 08/01/25 included identification R3 had a stage 3 pressure ulcer on his coccyx.

Review of R3's medical record included the following nursing progress notes:
04/27/25 - resident with a sore on his bottom apply barrier cream and rotate from side to side.
09/09/25 - Hospice Nurse reported wound healed with no need for continued dressing changes.

From 04/27/25 when staff identified R3 had a

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"sore" on his bottom to 09/09/25 when the stage 3 pressure ulcer on his coccyx had healed the licensed nurse failed to docment her assessing of the wound including measurements, description of the wound and dinterventions in place to help promote healing and results of interventions.

R3's nursing progress notes further included the following:
10/16/25 -identified the resident had a quarter size pressure sore on his right ankle, nurse notified.
01/03/26 -Nurse assessed right outer ankle wound and area noted with yellow/tan slough with areas of darkened tissue present. Surrounding skin is red, intact, and slightly inflamed. This nurse cleansed the area with betadine, applied calcium alginate to wound bed, and covered with boarder foam per Provider's orders.
01/13/26 -Nurse assessed right outer ankle wound due to dressing came off. Wound noted with white slough in wound bed and surrounding skin is red, intact, and slightly inflamed.

R3's Nursing notes lacked documentation from the facility nurse of his ankle wound between 10/16/25 when it was identified and 01/03/26 which identified measurements of the wound, description of the wound bed and surrounding tissue, interventions to promote healing and the results of interventions.

Observation on 01/21/26 at 07:54 AM Certified Nurse Aide (CNA) C and CNA D went in to assist resident to get up for the day. The bed was in the lowest position and a fall mat on the floor

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S3261	Continued From page 15 beside the bed. CNA C raised the bed and explained everything to the resident. CNA C pulled covers back which revealed a pillow between his knees, one under his knees, and a blue heel boot on his right foot. When CNA D removed the boot to get resident dressed revealed a foam dressing on his right outer ankle. Both staff finished helping R3 get dressed for the day and transferred him into his wheelchair, which had an air cushion in it and put his feet up on the wheelchair pedals. CNA C put the blue boot back on his right ankle. Observation on 01/21/26 at 10:15 AM CNA C and CNA D assisted R3 to transfer onto the toilet. Observation revealed R3's coccyx was reddened but had no open areas. Observation on 01/21/26 at 01:48 PM Hospice Nurse was in room and had removed the dressing to R3's right ankle and had wet gauze soaking the wound bed. She removed the gauze which revealed a pressure ulcer approximately the size of a quarter on his lower ankle. The wound bed was deep, beefy red with whitish slough in areas. Hospice Nurse gently rubbed the lower part of the wound bed, and the slough was loose but did not come off. The Hospice Nurse then applied Triad cream and covered the wound bed with gauze and then foam pad. Interview on 01/22/26 atd 11:46 AM Administrative Nurse B reported she looked at the wound when the Hospice Nurse does the treatmenet. She confirmed she had not documented any nursing progness notes related to the wound and relied on Hospice providing their notes.	S3261		

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S3261	Continued From page 16 The administrator failed to ensure designated staff documented all symptoms of illness, incidents, what action was taken, and effectiveness of that action taken for R3 related to his pressure ulcers. - Review of R4's medical record she moved into the facility on 05/26/22 with a diagnosis of Alzheimers disease. R4's "Functional Capacity Screen" dated 10/24/25 identified shes was unable to participate in bathing dressing and toileting, and needed physical assistance with transfers and mobility. It also identified she had cognitive impairment was unable to administer he medications. R4's "Negotiated Service Agreement" dated 10/24/25 identified staff would assist her with activities of daily living and would administer all of her medications. Review of R4's physicians orders revealed: 03/31/25 - New order for Lasix 20 milligrams (mg) as needed (PRN) once a day for 30 days. 04/02/25 - Clarrification order for Lasix - 20 mg in the morning and and 20 mg in afternoon PRN - 10/23/25 - Trazodone 50 mg Review of R4's nursisng note documentation revealed the following: 03/25/25 - Resident having swelling in both ankles. 03/31/25 -New order for Lasix 20mg as needed daily for 30 days. 04/02/24 -Clarrification order for Lasix - 20 mg	S3261		

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in the morning and and 20 mg in afternoon PRN
The record lacked documentation related to the effectiveness of the Lasix.
05/05/25 - Resident seen at Urgen Care with new ofrer for Robitussin cough-chest 10 ml every 408 hours for 5 days for Acute Bronchitis.
The record lacked follow up as to the results of administering the cough medicine for 5 days.
10/23/25 - Family request Hospice get resident something tohelp her sleep such as Trazadone ro Seroquel. New order received for Trazadone 50 mg every bedtime.
10/25/25 - new order for Lorazepam .25mg every bed time for restlessness.
The record lacked documentation as to the effectiveness of the Trazadone and Lorazepam to help R4 sleep during the night.
12/19/25 - complaining of pain in right lower leg, Hospice and Nurse notified.
12/20/25 - PRN Tylenol given for leg swelling and pain - effective.
12/19/25 - left leg swelling.
12/20/25 - swelling in left leg.
The record lacked further documentation if R4's swelling resolved.

Interview on 01/22/26 at 01:22 PM Administrative Nurse B reported certified staff docuement on "Change of Condition" with new medications or problems that are identified. Administrative Nurse B confirmed she had assessed and documented related to the results of new medications and if they were effective or not.

The operator failed to ensrue designated staff documented all symptoms of illness, incidents, what action was taken, and effectiveness of that action taken for R4 related to the initiation of new

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S3261	Continued From page 18 medications to help with leg swelling, restlessness and ability to sleep.	S3261		
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. This REQUIREMENT is not met as evidenced by: KAR 26-41-104(d)(4) The facility reported a census of 29 residents. Based on record review and interview the administrator failed to ensure disaster and emergency preparedness by ensuring the completion of an annual emergency evacuation drill. Findings included:	S3280		

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S3280	Continued From page 19 - On 01/20/26 at 10:33 AM surveyor requested emergency management preparations including evidence of completion of an annual emergency evacuation drill for 2024 and 2025. Interview on 01/22/26 at 04:52 PM maintenance staff I reported that he had looked for the evacuation drill but could not find the documentation. Interview on 01/22/25 at 05:00 PM Administrator A confirmed she could not find documentation of an annual evacuation drill for 2025. The administrator failed to ensure designated staff conducted an annual emergency evacuation drill.	S3280		
S3290 SS=F	26-41-206 (a) (b) Dietary Services (a) Provision of dietary services. The administrator or operator of each assisted living facility or residential health care facility shall ensure the provision or coordination of dietary services to residents as identified in each resident ' s negotiated service agreement. If the administrator or operator of the facility establishes a contract with another entity to provide or coordinate the provision of dietary services to the residents, the administrator or operator shall ensure that entity ' s compliance with these regulations. (b) Staff. The supervisory responsibility for dietetic services shall be assigned to one employee. (1) A dietetic services supervisor or licensed dietician shall provide scheduled on-site	S3290		

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S3290	Continued From page 20 supervision in each facility with 11 or more residents. (2) If a resident ' s negotiated service agreement includes the provision of a therapeutic diet, mechanically altered diet, or thickened consistency of liquids, a medical care provider ' s order shall be on file in the resident ' s clinical record, and the diet or liquids, or both, shall be prepared according to instructions from a medical care provider or licensed dietitian. This REQUIREMENT is not met as evidenced by: KAR 26-41-206(b)(1)(2) The facility reported a census of 29 residents (R). The sample included three residents, three closed record reviews, and one focused record review. Based on interview, the administrator failed to have a dietetic services supervisor or a dietitian with the appropriate accreditation according to the department assigned to the supervisory responsibility of dietary services. The administrator also failed to ensure dietary staff had approved instructions from a medical provider or a dietitian for one (R4) of three sample residents who had an order for mechanical diet. Findings included: - Interview on 01/21/26 at 05:25 PM Administrator A confirmed they used "Grove Menus" for their menus and they did have a dietitian. She reported she did not think the dietitian ever came to the facility. Administrator	S3290		

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reported she had planned to offer Dietary Staff G the supervisory role of the main cook and managing the dietary department.

Interview on 01/22/26 at 10:28 AM associate with the facility contracted dietary services company reported their dietitian does not go to the facilities.

01/22/26 at 10:30 AM Administrator A confirmed Dietary staff G did not have specific training to be a dietary manager.

The administrator failed to designate the role of dietary supervision to someone with appropriate training to be a dietary manager.

- Review of R4's medical record revealed she moved into the facility on 05/26/22 with a diagnosis of Alzheimer's disease.

R4's "Functional Capacity Screen" (FCS) dated 10/24/25 revealed R4 required physical assistance with eating and had impaired cognition.

R4's record included an "Amended Negotiated Service Agreement' dated 07/30/24 noting R4's diet changed to a mechanical soft diet.

R4's "Negotiated Service Agreement' dated 10/24/25 identified she was on a regular, mechanical soft diet and staff needed to provide a banana in the morning and to offer boost if she does not eat.

R4's record included a physician's order dated 07/29/24 for a mechanically soft diet, make sure

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S3290	Continued From page 22 all food is cut up. Interview on 01/22/26 at 10:17 AM Dietary Staff H stated she knew how to prepare a mechanical soft diet from her years of experience working in dietary department and confirmed she did not have any specific directions on how to prepare a mechanical diet. She found recipes on top of the refrigerator but said they did not really follow the recipes. The recipes included direction for different diets including mechanical soft diet. 01/22/26 at 10: 23 AM Dietary Staff G reported he knew how to prepare a mechanical diet from when he was initially trained. He stated you cut it up into small pieces and if you can't do that you put it in a blender on low setting. Dietary Staff G said he did not have directions on how to prepare a mechanical soft diet. He provided surveyor with recipes that were on top of the refrigerator but confirmed he did not have recipes for all of the foods he prepares. The administrator failed to ensure dietary department had instructions approved by the medical provider or a dietitian on how to property prepare a mechanical diet for R4.	S3290		
S3298 SS=F	26-41-206 (d) Food Preparation (d) Food preparation. Food shall be prepared using safe methods that conserve the nutritive value, flavor, and appearance and shall be served at the proper temperature. (1) Food used by facility staff to serve to the residents, including donated food, shall meet all applicable federal, state, and local laws and regulations.	S3298		

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S3298	Continued From page 23 (2) Food in cans that have significant defects, including swelling, leakage, punctures, holes, fractures, pitted rust, or denting severe enough to prevent normal stacking or opening with a manual, wheel-type can opener, shall not be used. (3) Food provided by a resident ' s family or friends for individual residents shall not be required to meet federal, state, and local laws and regulations. This REQUIREMENT is not met as evidenced by: KAR 26-41-206(d) The facility reported a census of 29 residents. Based on interview, and record review the administrator failed to ensure dietary staff prepared foods in a way to ensure flavor, appearance and maintain proper serving temperature of food. Findings included: - During initial tour on 01/20/26, food temperature logs had been completed with food temperatures documented within appropriate temperature ranges of preparing food. Observation on 01/21/26 at 12:25 PM in the "Big House" , Dietary Staff H had set five plates on the kitchen island had put potatoes one each plate and then the meat. Dietary Staff H and Certified Nurse Aide C cut meat and then Dietary staff H put gravy on the potatoes and meat and then served to residents. At 12:48 PM Dietary	S3298		

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S3298	Continued From page 24 Staff H provided surveyor a sample tray in which temperatures of food read as follows: potatoes 127.9 degrees Fahrenheit (F), meat 128.5 degrees F, mixed vegetables read 117.8 degrees F. Dietary staff H reported the holding/serving temperature of foods needed to be 140 degrees F. Dietary staff H also confirmed that some residents do complain of the food not being hot enough when they get it. Observation on 01/22/26 at 08:00 AM in the "Little House" to observe breakfast.. Upon entering the kitchen area, toast was on the griddle that was black on one side with scrambled eggs in the skillet with the fire off and sausage in the skillet on low heat. There were 14 plates on the island with a banana on them and some had toast on them getting cold. Dietary staff G had to go to the other house to start breakfast as the cook did not show up for work and returned at 08:29 AM and turned the heat back on under the eggs and turned the heat up on the sausage. At 08:30 A Dietary staff G took the toast off the griddle, which had black areas on both sides, put them on the plates, and then spread more butter on the griddle and put slices on top to toast them. At 08:33 AM Dietary Staff G turned off the heat under the sausage, added cheese to the eggs, and put a scoop of eggs on each plate at 08:34 AM. The eggs were steaming at the time he put them on the plates. At 08:35 AM dietary staff G put sausage on the plates, but he did not take the temperature of the sausage to ensure staff cooked it thoroughly. At 08:38 AM he flipped the bread, and the toast had black areas on it again. Surveyor asked dietary staff G what the temperature was for the sausage, and he stated he would when he got a chance.	S3298		

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S3298	Continued From page 25 Dietary staff G left the kitchen at 08:39 AM and returned at 08:40 AM with a thermometer. He washed the thermometer and then checked the sausage which read 145.5 and was slowly rising but he took it out and said 145. At 08:41 AM Dietary Staff G asked Certified Nurse Aide C to start taking the plates out to residents. She took two plates and surveyor asked Dietary staff G to check the temperature of the last plate he had put eggs on. The plate had been sitting on the island for seven minutes and the temperature of the eggs slowly reached the 131.5 degrees F. Dietary staff G said the holding/serving temperature of food is 145 degrees F and confirmed the eggs were not hot enough. When asked if he was going to heat them up Dietary Staff G stated he couldn't add them back to the pan because it was already contaminated and guessed he could reheat each plate in the microwave, but he did not. Dietary staff stated normally he is not trying to prepare breakfast in both kitchens and stated he normally had all the plates sitting on the island and plated each type of food and then pass out the plates after each plate had been prepared. Interview on 01/22/26 with eight alert and oriented residents between 02:48 PM and 03:36 PM revealed seven out of the eight reported the toast is often cold and burnt. Review of the dietary guidelines for Americans 2005 recommends checking the internal temperature of cooked food to make sure food is cooked to and held at an appropriate temperature and to keep food out of the "danger zone" (40 degrees F to 140 degrees F) where bacteria can multiple rapidly.	S3298		

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S3298	Continued From page 26 Review of the undated food policy revealed food must be served at appropriate temperatures. Serve hot foods at the following temperatures to ensure they arrive at the table hot: vegetables 160 degrees F to 170 degrees F, Meats 155 degrees F to 160 degrees F, soup/hot beverages 140 degrees F to 190 degrees F. The administrator failed to ensure dietary staff prepared and served foods to ensure they maintained flavor, appearance, and proper serving temperature.	S3298		
S3305 SS=F	26-41-207 (a) (b) Infection Control (a) The administrator or operator of each assisted living facility or residential health care facility shall ensure the provision of a safe, sanitary, and comfortable environment for residents. (b) Each administrator or operator shall ensure the development of policies and implementation of procedures to prevent the spread of infections. These policies and procedures shall include the following requirements: (1) Using universal precautions to prevent the spread of blood-borne pathogens; (2) techniques to ensure that hand hygiene meets professional health care standards; (3) techniques to ensure that the laundering and handling of soiled and clean linens meet professional health care standards; (4) providing sanitary conditions for food service; (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	S3305		

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S3305	Continued From page 27 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 (7) transferring a resident with an infectious disease to an appropriate health care facility if the administrator or operator is unable to provide the isolation precautions necessary to protect the health of other residents. This REQUIREMENT is not met as evidenced by: KAR 26-41-207(b)(4) The facility had a census of 29 residents. The facility encompassed two "houses", "Big House - memory care" and the "Little House - assisted living". Each house included a dishwasher that had sanitizer that was pumped into the dishwasher during a sanitization cycle. Based on interview the administrator failed to ensure sanitary conditions for food service by not ensuring the sanitizer strength was being monitored to ensure dishes were sanitized properly to prevent the spread of infections. Findings included: - During initial tour of the "Big House" Dietary Staff J reported he checked the sanitizer jug under the sink to make sure it had sanitizer in it but had never checked the actual sanitization levels in the dishwasher.	S3305		

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THE MAPLETON ANDOVER, LLC	1419 W CENTRAL AVE ANDOVER, KS 67002

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S3305	Continued From page 28 Interview on 01/21/26 at 09:39 AM Dietary Staff H reported she had never checked the sanitization level in the dishwasher but does check to make sure there is sanitizer in the jug under the sink. Interview on 01/21/26 at 11:30 AM Dietary Staff G reported he had no idea how to check the sanitization of the dishwasher. Review of the "Washing and Sanitizing Dishes/Utensils" policy revealed sanitization is a process by which an agent or substance is applied to a clean surface to destroy any germs that may cause an illness. washing and sanitizing dishes and utensils are important procedures to prevent the spread of disease. The administrator failed to ensure dietary staff monitored the level of sanitization int he dishwasher to ensure to was at the proper level to sanitize dishes and utensils.	S3305		