

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046086	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 08/03/2026
NAME OF PROVIDER OR SUPPLIER ADDINGTON PLACE OF PRAIRIE VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 2700 SOMERSET DRIVE PRAIRIE VILLAGE, KS 66206		
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S 000	INITIAL COMMENTS The following represents the findings of a resurvey with attached complaints 199324, 199332, 199258, 199139, 199102, 199090, 199044, 198956, 198702, 198619, 197938, 197701, and 194509 at the above named assisted living conducted on 07/28/26, 07/29/26, 07/30/26, and 08/03/26.	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 necessary because the health or safety of other individuals	S 190		

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

TITLE

(X6) DATE

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S 190	Continued From page 1 in the adult care home is endangered. This REQUIREMENT is not met as evidenced by: KAR 26-39-102(e)(2)(A) The facility reported a census of 63 residents with six residents included in the sample and one focused review. Based on observation, record review, and interview the facility failed to ensure Resident (R) 6's physician documented a rationale for why it was necessary for R6 to transfer to a special care unit for her welfare. Findings included: - Record review for R6 revealed an admission date of 04/14/25 with diagnoses of dementia, psychotic disturbance, hearing loss, and bilateral macular degeneration. R6's record lacked evidence of documentation of a "Functional Capacity Screen" (FCS) and "Negotiated Service Agreement" (NSA). The 06/02/26 at 09:45 PM "Observation Note" documented R6 had transferred from assisted living to a memory care unit. R6's record lacked evidence of documentation of a rationale by her physician why a transfer to a special care unit was necessary. Observation on 07/30/26 at approximately 11:15 AM revealed R6's name on a door in the memory care unit. R6 was in the apartment using her bathroom.	S 190		

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S 190	Continued From page 2 On 07/29/26 at approximately 02:38 PM Certified Medication Aide (CMA) J stated R6 had to move to a memory care unit due to confusion. On 08/03/26 at 04:32 PM a transfer to a higher level of care policy was requested, which the facility failed to provide. The facility failed to ensure R6's physician documented a rationale for why it was necessary for R6 to transfer to a special care unit for her welfare.	S 190		
S3080 SS=E	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: KAR 26-41-201(a) The facility reported a census of 63 residents with six residents included in the sample and one	S3080		

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S3080	Continued From page 3 focused review. Based on interview and record review the facility failed to ensure evidence of documentation a "Functional Capacity Screen" (FCS) was conducted for two residents. Findings included: - Record review for Resident (R)5 revealed an admission date of 09/06/24 with diagnoses of muscle weakness and difficulty in walking. R5's record lacked evidence of documentation a FCS was conducted on or before admission. - Record review for R6 revealed an admission date of 04/14/25 with diagnoses of dementia, psychotic disturbance, hearing loss, and bilateral macular degeneration. R6's record lacked evidence of documentation a FCS was conducted on or before admission. On 07/30/26 at 01:57 PM Administrative Staff B confirmed R5 and R6's records lacked evidence of documentation of FCSs. The 04/01/25 facility's "Resident Assessments" policy documented a resident assessment would be completed prior to move and updated 30 days after move in, every six months, and whenever there was a significant change in resident status. The facility failed to ensure evidence of documentation an "FCS" was conducted for R5 and R6 on or before admission to the facility.	S3080		
S3085 SS=E	26-41-202 (a) Negotiated Service Agreement (a) The administrator or operator of each assisted	S3085		

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S3085	Continued From page 4 living facility or residential health care facility 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 26-41-202(a) The facility reported a census of 63 residents with six residents included in the sample and one focused review. Based on interview and record review the facility failed to ensure the development of a "Negotiated Service Agreements" (NSA) for Residents (R) 1, R2, R3, R5, R6, and R7. Findings included: - Record review for R1 revealed an admission date of 03/03/22 with diagnoses of dementia and schizoaffective disorder. The 01/06/26 "Functional Capacity Screen " (FCS) identified R1 required physical assistance	S3085		

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S3085	Continued From page 5 with bathing, dressing, toileting, and walking/mobility. She was unable to perform management of medications and treatments, was incontinent of bladder, and had short-term and long-term memory, memory/recall, and decision-making cognitive difficulties. R1 was at risk impaired decision-making. R1's record lacked evidence of documentation of a NSA. - Record review for R2 revealed an admission date of 04/01/25 with a diagnosis of Alzheimer's disease. The 01/05/26 "FCS" identified R2 required physical assistance with bathing, dressing, and toileting. She was unable to perform management of medications and treatments, was occasionally incontinent of bladder, and had short-term and decision-making cognitive difficulties. R2 was at risk for impaired decision-making and wandering. R2's record lacked evidence of documentation of a NSA. - Record review for R3 revealed an admission date of 03/16/26 with a diagnosis of muscle weakness and falls. The 03/16/26 "FCS" identified R3 required supervision for bathing, was usually continent of bladder and was at risk for falls. R3's record lacked evidence of documentation of a NSA. - Record review for R5 revealed an admission date of 09/06/24 with diagnoses of muscle	S3085		

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S3085	Continued From page 6 weakness and difficulty in walking. R5's record lacked evidence of documentation of a FCS and NSA. - Record review for R6 revealed an admission date of 04/14/25 with diagnoses of dementia, psychotic disturbance, hearing loss, and bilateral macular degeneration. R6's record lacked evidence of documentation of a FCS and NSA. - Record review for R7 revealed an admission date of 01/03/25 with diagnoses of Alzheimer's disease and diabetes mellitus. The 02/03/26 "FCS" identified R7 required supervision with bathing and was unable to perform management of medications and treatments. She was usually continent of bladder and had memory/recall and decision-making cognitive difficulties. R7 was at risk for falls and impaired decision-making. R7's record lacked evidence of documentation of a NSA. On 07/29/26 at 03:18 PM Administrative Staff B confirmed the residents' records lacked a document identified as a NSA. The 04/01/25 facility's "Resident Assessments" policy documented whenever an assessment was updated, the "NSA" should also be updated. The facility failed to ensure the development of a NSA for R1, R2, R3, R5, R6, and R7.	S3085		

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S3171	Continued From page 7	S3171			
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: KAR 26-41-204(i) The facility reported a census of 63 residents with six residents included in the sample and one focused review. Based on observation, interview, and record review the facility failed to ensure designated staff completed an assessment for Resident (R) 5 to confirm her bed assist device was not a restraint, to determine the purposes of the bed assist device, to assess the resident's ability to use the bed assist device safely, that the bed assist device was securely attached to the bed or bedframe, and that it posed no risk for entrapment. Findings included: - Record review for R5 revealed an admission date of 09/06/24 with diagnoses of muscle weakness and difficulty in walking. R5's record lacked evidence of documentation a Function Capacity Screen (FCS) and Negotiated Service Agreement (NSA). R5's record lacked evidence of documentation of a bed assist device assessment.	S3171			

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S3171	Continued From page 8 Observation on 07/30/26 at approximately 10:12 AM revealed a U-shaped bed assist device was attached to the left side of R5's bed. A large gap measured greater than 4.75 inches in width and height and lacked a cover over the gap to prevent risk of entrapment. On 07/30/26 at approximately 10:12 AM Administrative Staff B confirmed R5's bed assist device had a large gap measured greater than 4.75 inches in width and height and lacked a cover over the gap to prevent risk of entrapment. On 07/30/26 at 01:57 PM Administrative Staff B confirmed R5's record lacked evidence of documentation of a bed assist device assessment. The "Assisted Living Residency Agreement" documented a resident would not utilize side rails of any length. Use of other bedside mobility devices must have prior approval and a physician order. The facility failed to ensure designated staff completed an assessment for R5 to confirm her bed assist device was not a restraint, to determine the purposes of the bed assist device, to assess the residents' ability to use the bed assist device safely, that the bed assist device was securely attached to the bed or bedframe, and that it posed no risk for entrapment.	S3171		
S3175 SS=E	26-41-205 (a) (1) Self Administration of Medication (a) Self-administration of medication. Any resident may self-administer and manage medications independently or by using a	S3175		

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S3175	Continued From page 9 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 63 residents with six included in the sample and one focused review. Based on interview and record review the facility failed to ensure a licensed nurse performed an initial assessment to determine if Residents (R) 3 and R7 could begin self-administering medications safely. Findings included: - Record review for R3 revealed an admission date of 03/16/26 with a diagnosis of muscle weakness and falls. The 03/16/26 "Functional Capacity Screen" (FCS) identified R3 was independent with management of medications. R3's record lacked evidence of documentation of	S3175		

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S3175	Continued From page 10 a Negotiated Service Agreement (NSA). R3's record lacked evidence of documentation of an initial assessment before R3 self-administered her own medication that determined she could perform self-administration of medications safely and accurately without staff assistance. On 08/30/26 at approximately 03:30 PM R3 stated she self-administered her own medications. - Record review for R7 revealed an admission date of 01/03/25 with diagnoses of Alzheimer's disease and diabetes mellitus. The 02/03/26 FCS identified R7 was unable to perform management of medications. R7's record lacked evidence of documentation of a NSA The 03/02/26 signed "Physician Order Sheet" lacked orders R7 could self-inject insulin. R7's record lacked evidence of documentation of an initial assessment before R7 self-injected insulin that determined she could perform self-administration of medications safely and accurately without staff assistance. On 07/29/26 at approximately 02:38 PM Certified Medication Aide (CMA) J stated R7 self-administered her own insulin. On 07/30/26 at 01:57 PM Administrative Staff B confirmed R3 and R7's records lacked evidence of documentation a licensed nurse performed an initial assessment to determine if R3 and R7 could begin self-administering medications safely.	S3175		

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S3175	Continued From page 11 The 06/13/2024 facility's "Resident Self-Management and Storage of Medications" policy documented that any resident who desired to self-manage their medication must be assessed by the Director of Health and Wellness. The Director of Health and Wellness or designee would ensure a physician's order was in place to indicate the resident was able to self-administer medications. The facility failed to ensure a licensed nurse performed an initial assessment to determine if R3 and R7 could begin self-administering medications safely.	S3175		
S3248 SS=F	26-41-102 (d) Staff Qualifications Employee Records (d) The employee records and agency staff records shall contain the following documentation: (1) Evidence of licensure, registration, certification, or a certificate of successful completion of a training course for each employee performing a function that requires specialized education or training; (2) supporting documentation for criminal background checks of facility staff and contract staff, excluding any staff licensed or registered by a state agency, pursuant to K.S.A. 39-970 and amendments thereto; (3) supporting documentation from the Kansas nurse aide registry that the individual does not have a finding of having abused, neglected, or exploited a resident in an adult care home; and (4) supporting documentation that the individual does not have a finding of having abused, neglected, or exploited any resident in an adult	S3248		

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S3248	Continued From page 12 care home, from the nurse aide registry in each state in which the individual has been known to have worked as a certified nurse aide. This REQUIREMENT is not met as evidenced by: KAR 26-41-102 (d) (1) (2) The facility reported a census of 63 residents. Based on interview and record review the facility failed to ensure evidence of certification for three of five sampled staff and criminal background checks for two of five sampled staff were contained in their employee records. Findings included: - Record review for Certified Medication Aide (CMA) E revealed a hire date of 08/13/25. Her record lacked evidence of documentation of certification. Record review for Certified Nurse Aide (CNA) F revealed a hire date of 01/15/2. Her record lacked evidence of documentation of certification. Record review for CNA G revealed a hire date of 03/10/26. Her record lacked evidence of documentation of certification and a criminal background check. Record review for CNA H revealed a hire date of 04/09/26. Her records lacked evidence of documentation of a criminal background check. On 07/29/26 at 02:12 PM Administrative Staff I	S3248			

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S3248	Continued From page 13 confirmed CNA G and CNA H's records lacked evidence of documentation of criminal background checks. On 07/29/26 at 02:27 PM Administrative Staff I confirmed CMA E, CNA F, and CNA G's records lacked evidence of certification documentation. The 06/13/24 facility's "Licensing of Nursing Personnel" policy did not address certification of direct care staff. The facility failed to ensure evidence of certification for three of five sampled staff and criminal background checks for two of five sampled staff were contained in their employee records.	S3248		
S3255 SS=F	26-41-105 (b) Resident Records Confidential (b) Each administrator or operator shall ensure that all information in each resident's record, regardless of the form or storage method for the record, is kept confidential, unless release is required by any of the following: (1) Transfer of the resident to another health care facility; (2) law; (3) third-party payment contract; or (4) the resident or legal representative of the resident. KAR 26-41-105 (b) The facility reported a census of 63 residents with six included in the sample and one focused review. Based on observation, interview, and record review the facility failed to ensure resident's information was kept confidential.	S3255		

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S3255	Continued From page 14 Findings included: - Observation on 07/28/26 at approximately 01:44 PM revealed a "Crisis, Emergency, and Disaster Plan" notebook unsecured in a common area of the building. The notebook had copies of each resident's face sheet inside. On 07/28/26 at approximately 01:44 PM Maintenance Staff C confirmed resident information was not in a secure location. Observation on 07/30/26 at 10:39 AM of a closet in the 100 hall revealed the door to the closet was unlocked and opened freely. Resident records were inside the closet. On 07/30/26 at approximately 10:39 AM Administrative Staff B confirmed resident information was not in a secure location. The 06/13/24 facility's "Confidentiality" policy documented all resident data were kept inaccessible to any individuals not involved in their direct care. The facility failed to ensure residents' information was kept confidential.	S3255		
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	S3280		

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NAME OF PROVIDER OR SUPPLIER ADDINGTON PLACE OF PRAIRIE VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 2700 SOMERSET DRIVE PRAIRIE VILLAGE, KS 66206		
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S3280	Continued From page 15 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)(3)(4) The facility reported a census of 63 residents. Based on interview and record review the facility failed to provide evidence of documentation that residents and staff received quarterly reviews of the facility's emergency management plan and annual evacuation drills. Findings included: - On 07/28/26 at approximately 01:16 PM quarterly reviews of the facility's emergency management plan and two annual evacuation drills were requested in an email, which the facility failed to provide. On 07/29/26 at 01:18 PM Administrative Staff B confirmed the facility lacked documentation that residents and staff received quarterly reviews of the facility's emergency management plan and annual evacuation drills. On 08/03/26 at 04:32 PM an emergency management plan and evacuation drills policy	S3280		

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S3280	Continued From page 16 was requested, which the facility failed to provide. The facility failed to provide evidence of documentation that residents and staff received quarterly reviews of the facility's emergency management plan and annual evacuation drills.	S3280		
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. (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 63 residents. The facility had a main kitchen where food was stored, prepared, and served and two satellite kitchens where food was stored and served. Based on observation and interview, the facility	S3298		

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S3298	Continued From page 17 failed to ensure designated staff served food at the proper temperature to prevent bacterial growth. Findings included: - Observation on 07/28/26 at approximately 01:53 PM revealed no food temperature log was visible during tour of the main kitchen. Food temperature logs for the main kitchen and two satellite kitchens were requested, which the facility failed to provide. On 07/29/26 at 12:40 PM Administrative Staff B confirmed the facility failed to ensure designated staff served food at the proper temperature to prevent bacterial growth. The facility's revised 11/2025 "Food Deliveries" policy documented hot foods must be above 135 degrees Fahrenheit (F) and cold foods must be less than 41 degrees F. The "Dietary Guidelines for Americans 2005 recommended to make sure food was cooked and held at proper temperatures and to keep cold food cold. Keep food out of the "danger zone" (40 degrees Fahrenheit to 140 degrees Fahrenheit) where bacteria can multiply rapidly. The facility failed to ensure designated staff ensured served food at the proper temperature to prevent bacterial growth.	S3298		
S3299 SS=F	26-41-206 (e) (1) Facility Food Storage (e) Food storage. Facility staff shall store all food under safe and sanitary conditions. (1) Containers of poisonous compounds and	S3299		

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S3299	Continued From page 18 cleaning supplies shall not be stored in the areas used for food storage, preparation, or serving. This REQUIREMENT is not met as evidenced by: KAR 26-41-206(e) The facility reported a census of 63 residents. The facility had a main kitchen where food was stored, prepared, and served and two satellite kitchens where food was stored and served. Based on observation, interview, and record review the facility failed to ensure designated staff stored food items under safe conditions. Findings included: - Observation on 07/28/26 at approximately 01:53 PM of the main kitchen revealed refrigerators and freezers, which stored food for the residents. Review of the main kitchen refrigerator and freezer daily temperature logs from 07/01/26 to 07/28/26 revealed the logs were blank from 07/09/26 to 07/28/26, which was 19 days. Observation on 07/28/26 at approximately 02:04 PM of the first memory care unit satellite kitchen revealed a refrigerator and freezer combo with food inside for the residents. A temperature log was requested, which the facility failed to provide. Observation on 07/28/26 at approximately 02:12 PM of the second memory care unit satellite kitchen revealed a refrigerator and freezer combo with food inside for the residents. A temperature	S3299		

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S3299	Continued From page 19 log was requested, which the facility failed to provide. On 07/29/26 at 12:40 PM Administrative Staff B confirmed the main kitchen's refrigerator and freezer daily temperature logs were blank from 07/09/26 to 07/28/26 and the facility lacked temperature logs for the refrigerators and freezers in the two satellite kitchens. The facility's revised 11/2025 "Food Deliveries" policy documented refrigerated foods should be stored at less than 41 degrees F and frozen foods should be stored at zero degrees or below. The facility failed to ensure designated staff stored food items under safe conditions.	S3299		
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	S3305		

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S3305	Continued From page 20 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 (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 reported a census of 63 residents. The facility had a main kitchen where dietary staff prepared food and cleaned/sanitized dishware for all residents in a chemical sanitization dishwasher. Based on observation and interview the facility failed to ensure dietary staff provided sanitary conditions for food service. Findings included: - Observation of the kitchen on 07/28/26 at approximately 01:53 PM revealed three dietary staff in the food preparation area had long hair that was not covered. A chemical sanitization dishwasher was in the kitchen. A chemical test log was requested, which the facility failed to provide. On 07/28/26 at approximately 01:53 PM Maintenance Staff C confirmed three dietary staff	S3305		

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S3305	Continued From page 21 had long hair that was not covered and further confirmed the dishwasher used chemical solutions to sanitize. The undated facility's "Culinary Sanitation Policy" documented hair must be restrained at all times with hairnets or hats. Staff should test sanitizers regularly with test strips to ensure effectiveness and maintain results in a log for all dietary areas. The facility failed to ensure dietary staff provided sanitary conditions for food service.	S3305		
S3310 SS=F	26-41-207 (b) (5-6) (c) Infection Control Policies (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: KAR 26-41-207(c) The facility reported a census of 63 residents with six residents included in the sample and one	S3310		

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S3310	Continued From page 22 focused review. Based on interview and record review the facility failed remain in compliance with the department's tuberculosis (TB) guidelines for adult care homes adopted by reference in KAR 26-39-105 for six current residents and five of five sampled staff. Findings included: - Record review for Resident (R) 1 revealed an admission date of 03/03/22 with diagnoses of dementia and schizoaffective disorder. R1's record lacked evidence of documentation of TB infection testing and an initial and annual TB symptom screen. - Record review for R2 revealed an admission date of 04/01/25 with a diagnosis of Alzheimer's disease. R2's record lacked evidence of documentation of TB infection testing and an initial and annual TB symptom screen. - Record review for R3 revealed an admission date of 03/16/26 with a diagnosis of muscle weakness and falls. R3's record lacked evidence of documentation of TB infection testing and an initial TB symptom screen. - Record review for R5 revealed an admission date of 09/06/24 with diagnoses of muscle weakness and difficulty in walking. R5's record lacked evidence of documentation of TB infection testing and an initial and annual TB symptom screen.	S3310		

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S3310	Continued From page 23 - Record review for R6 revealed an admission date of 04/14/25 with diagnoses of dementia, psychotic disturbance, hearing loss, and bilateral macular degeneration. R6's record lacked evidence of documentation of TB infection testing and an initial and annual TB symptom screen. - Record review for R7 revealed an admission date of 01/03/25 with diagnoses of Alzheimer's disease and diabetes mellitus. R7's record lacked evidence of documentation of TB infection testing and an initial and annual TB symptom screen. On 07/30/26 at approximately 01:57 PM Administrative Staff B confirmed the residents' records lacked evidence of documentation of TB infection testing and initial and annual TB symptom screens. - Review of Certified Medication Aide (CMA) D's employee record revealed a hire date of 12/31/24. Her record lacked evidence of documentation she received TB infection testing and an initial and annual TB symptom screen. Review of CMA E's employee record revealed a hire date of 08/13/25. Her record lacked evidence of documentation she received TB infection testing and an initial TB symptom screen. Review of Certified Nurse Aide (CNA) F's employee record revealed a hire date of 01/15/25. Her record lacked evidence of documentation she received TB infection testing	S3310		

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S3310	Continued From page 24 and an initial and annual TB symptom screen. Review of CNA G's employee record revealed a hire date of 03/10/26. Her record lacked evidence of documentation she received TB infection testing and an initial TB symptom screen. Review of CNA H's employee record revealed a hire date of 03/10/26. Her record lacked evidence of documentation she received TB infection testing and an initial TB symptom screen. On 07/29/26 at approximately 02:03 PM Administrative Staff B confirmed the employees' records lacked evidence of documentation of TB infection testing and initial and annual TB symptom screens. The 06/13/24 facility's "Tuberculosis: Residents" policy documented the community would screen all residents for TB infection and disease and retain documentation in the residents' records. The 06/13/24 facility's "Tuberculosis: Care Staff" policy documented the community would screen all care staff for TB infection and disease per state regulations prior to the start of employment and annually thereafter. The policy did not address TB infection testing of non-care staff. The June 2013 department's "Tuberculosis (TB) Guidelines for Adult Care Homes" documented each new employee, and each new resident should receive a two-step TB skin test and symptom screen questionnaire that included the components of the "Tuberculosis Symptom Screen Questionnaire" within seven days of employment or admission. Each resident and employee should have an annual TB symptom screen that included the components of the	S3310		

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S3310	Continued From page 25 "Tuberculosis Symptom Screen Questionnaire." The operator failed to ensure the facility remained in compliance with the department's tuberculosis guidelines for adult care homes adopted by reference in KAR 26-39-105.	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: KAR 28-39-254 (a) The facility reported a census of 63 residents with	S3320		

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S3320	Continued From page 26 35 residents living in the assisted living. Based on observation and interview, the facility failed to protect the health and safety of the residents and visitors by ensuring all chemicals were stored within locked areas in the assisted living side of the building. Findings included: - Observation on 07/28/26 at 01:44 PM revealed an unlocked cabinet under the sink in the kitchenette area that contained the following chemicals with labels that read "Keep out of reach of children" : One 32-ounce (oz) spray bottle of EcoLab Grease Express, One spray bottle of odor eliminator. The cabinet also contained one spray bottle with a clear blue liquid inside that lacked a label identifying the contents. On 07/28/26 at approximately 01:44 PM Maintenance Staff C confirmed the cabinet under the sink in the kitchenette area was unlocked with chemicals inside. Observation on 07/28/26 at 01:51 PM revealed an unlocked door with a sign that read "Panel Room #5" with cleaning supplies inside. On 07/28/26 at approximately 01:51 PM Maintenance Staff C confirmed the panel room door was unlocked with chemicals inside. On 08/03/26 at 04:32 PM a chemical storage policy was requested, which the facility failed to provide.	S3320		

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S3320	Continued From page 27 The facility failed to protect the health and safety of the residents and visitors by ensuring all chemicals were stored within locked areas.	S3320		
S3420 SS=E	28-39-256 MECHANICAL REQUIREMENTS (c) Mechanical requirements. (1) Heating, air conditioning, and ventilating systems. (A) The system shall be designed to maintain a year-round indoor temperature range of 70oF or 21oC to 85oF or 26oC. (B) Each apartment or individual living unit shall allow the resident to control the temperature. (2) Plumbing and piping systems. (A) Backflow prevention devices or vacuum breakers shall be installed on fixtures to which hoses or tubing can be attached. (B) Water distribution systems shall be arranged to provide hot water at outlets at all times. The temperature of hot water shall range between 98oF and 120oF at bathing facilities, sinks, and lavatories in resident use areas. (3) Electrical requirements. (A) All spaces occupied by persons or machinery and equipment within the buildings, approaches to buildings, and parking lots shall have adequate lighting. (B) Minimum lighting intensity levels shall be	S3420		

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S3420	Continued From page 28 as required in Table 1. (C) Each corridor and stairway shall remain lighted at all times. (D) Each light in resident use areas shall be equipped with shades, globes, grids, or glass panels. This REQUIREMENT is not met as evidenced by: KAR 28-39-256 (c) (2) (B) The facility reported a census of 63 residents with 35 residing on the assisted living side of the building. Based on observation and interview the facility failed to maintain water temperatures within a safe range between 98 degrees Fahrenheit (F) and 120 degrees F. Findings included: - Review of facility provided map of hot water heaters and room locations revealed 28 of 45 total apartments on the assisted living side of the building were affected by two of five water heaters that had water temperatures set too high. Observations and interviews on 07/30/26 revealed the following: At approximately 10:12 AM Resident (R)5 stated an outside provider came every week to assist her with showering and had to find another location in the building for the shower. She could not use the shower in her apartment because the water was too hot. At approximately 10:48 AM the water temp in	S3420		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046086	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 08/03/2026
NAME OF PROVIDER OR SUPPLIER ADDINGTON PLACE OF PRAIRIE VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 2700 SOMERSET DRIVE PRAIRIE VILLAGE, KS 66206		
(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
S3420	Continued From page 29 R5's apartment bathroom sink was 139.5 degrees F per state surveyor's thermometer and confirmed by Maintenance Staff C with a facility thermometer. At 10:51 AM Maintenance Staff C stated there were five water heaters for the whole building. The water heater in panel room #1 supplied the 100 hall and half of the 200 hall. At 11:01 AM the water temperature in room 225 was 150.1 degrees F in the bathroom sink and 125.1 degrees F in the shower with water running at both locations at the same time. Water temperatures confirmed by Administrative Staff B and Maintenance Staff C. Maintenance Staff C stated the room was supplied by the water heater in panel room #3. On 08/03/26 at 04:32 PM a water temperature policy was requested, which the facility failed to provide. The facility failed to maintain water temperatures within a safe range between 98 degrees Fahrenheit (F) and 120 degrees F.	S3420		