STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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MONTEREY VILLAGE ASSISTED LIVING	3901 PETERSON ROAD LAWRENCE, KS 66049

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S 000	INITIAL COMMENTS The following represents the findings of a resurvey with attached complaint 196955, 196932, and 196766 at the above-named assisted living facility conducted 08/20/26-08/25/26. The facility reported a census of 30 residents with five included in the sample.	S 000		
S3085 SS=E	26-41-202 (a) Negotiated Service Agreement (a) The administrator or operator of each assisted 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)(1)(2)(3) Based on interview, observation, and record review the facility failed to ensure the Negotiated Service Agreement (NSA) was fully developed based on the resident's Functional Capacity Screen (FCS), service needs, and preferences	S3085		

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

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S3085	Continued From page 1	S3085		

for resident (R)1, R2 and R3 including a description of the services the resident received, the provider of each service, and the responsible party for payment of outside resources.

Findings included:

- Record review for R1 revealed an admission date of 02/09/26 with diagnoses of diabetes mellitus type two, hypothyroidism, and hypertension.

The 02/09/26 Functional Capacity Screen (FCS) identified R1 required supervision with bathing; was independent with dressing, toileting, transfers, and mobility; had no cognitive difficulties; and was at risk of falls.

The 02/09/26 "Negotiated Service Agreement/Health Care Plan" (NSA/HSP) acknowledged facility staff provided stand-by assistance with bathing. R1 could perform dressing, transfers, and toileting. Facility staff provided management of medications. The NSA/HSP noted R1 utilized pharmacy, foot care, and home health services without listing who was responsible for payment and failed to describe services provided for prevention of falls.

On 08/25/26 at 04:35 PM Administrative Nurse E confirmed R1's NSA failed to describe the services provided for prevention of falls and the party responsible for payment of outside resources.

The facility failed to ensure R1's NSA described the services he received, and the provider of the service based on his FCS.

- Record review for R2 revealed an admission

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S3085	Continued From page 2 date of 11/21/24 with a diagnosis of cerebral infarction. The 11/21/25 FCS identified R2 required physical assistance with bathing, mobility, transferring, dressing, toileting, and eating; was unable to perform management of medications and treatments; had impaired vision and hearing; had short-term memory difficulty; and was at risk for falls. The 11/16/25 (most recent) combined NSA/HSP identified staff assisted R2 with bathing, mobility, transferring, dressing, toileting, eating, and management of medications and treatments. The NSA/HSP indicated R2 used pharmacy, foot care agency, home health, and therapy providers. The NSA/HSP failed to describe services provided for prevention of falls and the party responsible for payment of outside resources. Review of nurse note dated 08/17/26 at 01:06 PM revealed the resident fell over while in her wheelchair when attempting to get into facility's transportation vehicle. The note failed to indicate an intervention put into place to prevent reoccurrence. On 08/25/26 at 03:49 PM Certified Nurse Aide (CNA) I stated staff remind R2 to call or assistance, ensure proper footwear, and lock wheelchair brakes when transferring to prevent falls. CNA I stated she was not notified of an intervention to prevent R2 from falling from wheelchair after her 08/17/26 fall. On 08/25/26 at 01:36 PM Administrative Nurse B stated the expectation is for the nurse to document an intervention in the incident report, a nurse's note, and amend the NSA.	S3085		

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S3085	Continued From page 3 On 08/25/26 at 04:35 PM Administrative Nurse E confirmed R2's NSA failed to describe the services provided for prevention of falls and the payer for her outside resources. The facility failed to ensure R2's NSA described the services she received, the provider of the service based on her FCS and needs, and the responsible party for her outside resources. - Record review for R3 revealed an admission date of 05/05/26 with diagnoses of centrilobular emphysema, anxiety, and orthostatic hypotension. The 08/06/26 FCS identified R3 required supervision with bathing, dressing, toileting, transfers, and walking/mobility; was unable to perform management of medications and treatments; was usually able to understand and be understood; and had short-term memory and decision-making cognitive difficulties. R3 was identified at risk of falls and impaired decision making. The 08/06/26 combined NSA/HSP failed to indicate what services and the provider of the service R3 received for cognition difficulties and impaired decision making. The NSA/HSP further failed to indicate what outside resources R3 received for therapy and the party responsible for payment. Review of orders from rehabilitation facility dated 08/06/26 included orders for physical and occupational therapy. Review of "Nurses Notes" pages in the outside provider binder for R3's therapy provider included	S3085		

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S3085	Continued From page 4 notes from physical therapy assistants and occupational therapy staff for visits made 08/10/26, 08/11/26, 08/18/26, 08/19/26, and 08/24/26. On 08/25/26 at 03:49 PM Certified Medication Aide J stated staff remind R3 frequently about safety and complete frequent checks on her due to her memory issues. On 08/25/26 at 04:35 PM Administrative Nurse E confirmed R3's NSA failed to describe the services provided for cognitive difficulties and outside resources with the party responsible for payment. The facility failed to ensure R3's NSA described the services she received, and the provider of the service based on her FCS, and the party responsible for her outside resources.	S3085		
S3186 SS=E	26-41-205 (b) Administration of Selected Medications (b) Administration of select medications. Any resident who self-administers medication may select some medications to be administered by a licensed nurse or medication aide. The negotiated service agreement shall reflect this service and identify who is responsible for the administration and management of selected medications. This REQUIREMENT is not met as evidenced	S3186		

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S3186	Continued From page 5 by: KAR 26-41-205(b) Based on interview and record review the facility failed to ensure Resident (R) 1 and R3's Negotiated Service Agreements (NSAs) identified who was responsible for the administration and management of select medications. Findings included: - Record review for R1 revealed an admission date of 02/09/26 with diagnoses of diabetes mellitus type two, hypothyroidism, and hypertension. The 02/09/26 Functional Capacity Screen (FCS) identified R1 was unable to perform management of medications. The 02/09/26 Negotiated Service Agreement (NSA) identified facility staff administered R1 his medications. R1's NSA failed to identify who was responsible for the administration of other select medications he administered himself and/or the select medications facility staff administered. The 02/25/23 "Evaluation for Self-Administration of Medications" documented R1 had the ability to administer all types of his ordered medications. The August 2026 "Medication Administration Record" (MAR) documented R1 was able to self-administer unsupervised the following medications: clobetasol cream 0.05%, azelastine hydrochloride nasal spray in both nostrils, Opzelura 1.5% cream to hands, and triamcinolone acetonide 0.1% cream. The MAR	S3186		

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S3186	Continued From page 6 did not indicate who administered Mounjaro insulin. Observation of R1's room on 08/25/26 at 02:02 PM revealed the following medications on his bathroom cabinet: One 454-gram container triamcinolone acetonide 0.1% cream Four 30-gram tubes of pimecrolimus 1% cream One 60-gram tube of clobetasol propionate 0.05% cream One 25 milliliter container of clobetasol propionate 0.05% topical solution Observation of R1's room on 08/25/26 at approximately 02:08 PM revealed the following medications in a three-drawer plastic storage unit on his desk: One 28-gram tube of hydrocortisone cream 1% One bottle 100 liquid gels docusate sodium 100 milligrams (mg) One card 25 tablets bisacodyl 5 mg Observation of R1's room on 08/25/26 at approximately 02:10 PM revealed the following medications in a drawer in cabinet by apartment entrance door: One bottle 40 liquid gels Advil 200 mg One bottle 500 tablets ibuprofen 200 mg One bottle 500 caplets acetaminophen 500 mg Three boxes of 27 lozenges each biotene dry mouth lozenges One 28.3-gram tube Neosporin On 08/25/26 at 03:00 PM Administrative Staff A and Administrative Nurse E confirmed R1 self-administered some of his medications, staff	S3186		

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S3186	Continued From page 7 administered some, and the NSA did not reflect which medications were administered by whom. - Record review for R3 revealed an admission date of 05/05/26 with diagnoses of centrilobular emphysema, anxiety, and orthostatic hypotension. The 08/06/26 FCS identified R3 was unable to perform management of medications. The 08/06/26 Negotiated Service Agreement (NSA) identified facility staff administered R3 her medications. R3's NSA failed to identify who was responsible for the administration of other select medications she administered herself and/or the select medications facility staff administered. R3's record lacked documentation of a medication self-administration evaluation. Observation of R3's room on 08/25/26 at 02:14 PM revealed the following medications in her bathroom: One 100 pads container Tucks medicated pads One four-ounce tube Bengay topical analgesic cream One one-ounce lidocaine 5% cream One box four-suppositories bisacodyl 10 mg One 56-gram tube hydrocortisone cream One 50-gram tube diclofenac sodium 1% cream One 28-gram tube triple antibiotic ointment On 08/25/26 at 03:00 PM Administrative Nurse E confirmed R3 NSA did not reflect which medications were administered by staff or R3 administered to herself.	S3186		

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S3186	Continued From page 8 The facility's 06/10/19 "Initial Service Plan" policy documented the service plan would reflect how the resident had medications administered with example of self administration of over-the-counter medications or if a nurse administered insulin. The facility failed to ensure R1 and R3's NSAs identified who was responsible for the administration and management of select medications.	S3186		
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 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.	S3248		

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S3248	Continued From page 9	S3248		

This REQUIREMENT is not met as evidenced by:
KAR 26-41-102(d)(1)

Based on interview and record review the facility failed to ensure evidence of certification for one staff was completed upon performing functions that required specialized training.

Findings included:

- Record review of Unlicensed Staff K's employee record revealed a hire date of 07/17/25.

Upon entrance interview on 08/20/26 at 09:47 AM Administrative Staff A stated each shift included one Certified Nurse Aide (CNA) and one Certified Medication Aide (CMA).

On 08/20/26 at 03:03 PM CMA F stated Unlicensed Staff K was assigned to be the CNA and completed tasks CNAs learn during CNA training for at least 10 shifts.

On 08/24/26 at 01:36 PM Resident (R) 7 stated Unlicensed Staff K assisted her with a shower and did not know what she was doing. R7 requested for Unlicensed Staff K to not help her again.

On 08/24/26 at 01:23 PM R8 stated Unlicensed Staff K helped him don his socks and assisted his wife with showers and toileting.

On 08/25/26 at 11:08 AM CNA H stated

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S3248	Continued From page 10 Unlicensed Staff K was assigned as the CNA and completed all CNA tasks for all residents while she was assigned as staff in another department of the building during the same shifts. On 08/24/26 at 03:45 PM Administrative Staff A confirmed she knew Unlicensed Staff K had completed tasks she should not have. The facility failed to ensure evidence of certification for one staff was completed upon performing functions that required specialized training.	S3248		
S3255 SS=E	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) Based on interview and record review the facility failed to ensure all information for residents who had outside providers were kept confidential. Findings included: - Review of "Resident Roster" provided by facility on 08/20/26 revealed the facility failed to indicate which residents received services from outside providers.	S3255		

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S3255	Continued From page 11 Review of R1, R2, and R3's records revealed all of them received services from outside resources. Observation on 08/20/26 at 09:40 AM revealed an unsecured cabinet in the facility's front entry including medical records for all residents with outside providers. On 08/25/26 at 12:22 PM Administrative Staff A confirmed the cabinet was not secured which includes residents' medical information for those who have outside providers. The facility failed to ensure all information for residents who had outside providers were 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 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.	S3280		

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S3280	Continued From page 12 This REQUIREMENT is not met as evidenced by: KAR 26-41-104(d)(4) Based on record review and interview, the facility failed to ensure disaster and emergency preparedness by ensuring the performance of an emergency drill annually with staff and residents to include an evacuation of the residents to a secure location. Findings included: - On 08/20/26 at 10:20 AM the last two annual evacuation drills of the emergency management plan were requested and a reminder sent via email. On 08/20/26 at 02:55 PM a reminder was given to Administrative Staff A to provide the last two evacuations in which she replied, "I had them, but misplaced them, and need to find them." On 08/25/26 at 10:35 AM evacuation drills were requested for the third time. On 08/25/26 at 02:10 PM a "March In-Service/Staff Meeting" dated 03/18/25 was received with no other evacuations. The facility failed to provide an evacuation drill dated since 03/18/25 which was five months overdue. On 08/25/26 at 07:15 PM Resident (R) 6 and Certified Nurse Aide (CNA) I stated since R6's admission and CNA I's hire, they were never involved in a full evacuation drill.	S3280		

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S3280	Continued From page 13 The facility failed to ensure disaster and emergency preparedness by the failure to ensure the performance of an emergency drill annually with staff and residents to include an evacuation of the residents to a secure location.	S3280		