

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/06/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175221	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/23/2025
NAME OF PROVIDER OR SUPPLIER ADVENA LIVING AT FOUNTAINVIEW			STREET ADDRESS, CITY, STATE, ZIP CODE 601 N ROSE HILL ROAD ROSE HILL, KS 67133		
(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) COMPLETION DATE	
F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey and Complaint Investigation #KS00189612	F 000			
F 645 SS=D	The 2567 was electronically sent on 2/6/25 PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3) (i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires	F 645			

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

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/06/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175221	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/23/2025
NAME OF PROVIDER OR SUPPLIER ADVENA LIVING AT FOUNTAINVIEW			STREET ADDRESS, CITY, STATE, ZIP CODE 601 N ROSE HILL ROAD ROSE HILL, KS 67133		
(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) COMPLETION DATE	
F 645	Continued From page 1 specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i) The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: The facility reported a census of 47 residents with 14 residents sampled. Based on	F 645			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/06/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175221		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/23/2025	
NAME OF PROVIDER OR SUPPLIER ADVENA LIVING AT FOUNTAINVIEW				STREET ADDRESS, CITY, STATE, ZIP CODE 601 N ROSE HILL ROAD ROSE HILL, KS 67133			
(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) COMPLETION DATE
F 645	Continued From page 2 observations, interviews, and record review, the facility failed to ensure that one Resident (R) 6 had a current and valid Preadmission Screening and Annual Resident Review (PASARR). Findings included: - Review of the Electronic Health Record (EHR) for R6 included diagnoses of schizoaffective disorder bipolar type (mental illness is a combination of symptoms of schizophrenia and symptoms of a mood disorder, anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), and depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). The "Annual Minimum Data Set (MDS)" dated 06/21/24, documented a "Brief Interview for Mental Status" (BIMS) score of 15, which indicated intact cognition. The assessment documented R6 had the diagnoses of anxiety, depression, and schizophrenia. Received antipsychotic, antianxiety, hypnotic, anticoagulant, antibiotic, diuretic, and opioid, with indications noted. The 01/09/20 "Care Plan" reviewed 09/24/24, documented R6 took medications and instructed staff to administer and monitor for and/or report possible side effects (unintended effects caused by medication use). Review of the "Certificate of Care Assessment" dated 02/24/20, documented the assessment was good for one year. Observation on 01/23/25 at 10:20 AM revealed			F 645			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/06/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175221	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/23/2025
NAME OF PROVIDER OR SUPPLIER ADVENA LIVING AT FOUNTAINVIEW			STREET ADDRESS, CITY, STATE, ZIP CODE 601 N ROSE HILL ROAD ROSE HILL, KS 67133		
(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) COMPLETION DATE	
F 645	Continued From page 3 R6 seated in her wheelchair in her room. During an interview 01/23/25 at 03:23 PM, Administrative Nurse D confirmed R6 had a "Care Assessment" completed in 2020 and that was the only one completed. Administrative Nurse D stated that the regional director had informed them that this was the only assessment needed, unless a resident was to discharge to the community for greater than six months. The facility's "Preadmission Screening and Annual Resident Review (PASARR)" revised October 2024, documented the purpose of this policy was to ensure that individuals with mental illness and intellectual disabilities receive that care and serviced that they need in the most appropriate setting. The PASARR will be evaluated annually and upon any significant change for those individuals identified.	F 645			
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by:	F 689			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/06/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175221	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/23/2025
NAME OF PROVIDER OR SUPPLIER ADVENA LIVING AT FOUNTAINVIEW			STREET ADDRESS, CITY, STATE, ZIP CODE 601 N ROSE HILL ROAD ROSE HILL, KS 67133		
(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) COMPLETION DATE	
F 689	Continued From page 4 The facility had a census of 47 residents and the sample included 14 residents. Based on observation, record review, and interview, the facility failed to ensure a safe environment free from accident hazards for Resident (R) 25 who had a medication located in her room that was not secured. This failure placed the affected residents at risk for preventable accidents and related injuries. Findings included: - During the onsite survey, the surveyors identified a concern regarding the unsecured medications observed in one resident's room during interview. During an observation on 01/21/25 at 11:31 AM, R25 had a 16-ounce, spray wound cleaning medication on her over the bed table. The medication had a warning label "Keep out of reach of children". During an observation on 01/22/25 at 11:07 AM, R25 had a 16-ounce, spray wound cleaning medication on her dresser. The medication had a warning label "Keep out of reach of children". During an interview on 01/22/25 at 11:07 AM, R25's roommate R6 reported she was unsure why the spray bottle was there and that the staff must have forgotten it. During an interview on 01/23/25 at 08:10 AM, Certified Nurse Aide (CNA) N reported that residents should not have medications for wound care in their rooms. During an interview on 01/27/25 at 11:43 AM,	F 689			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/06/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175221	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/23/2025
NAME OF PROVIDER OR SUPPLIER ADVENA LIVING AT FOUNTAINVIEW			STREET ADDRESS, CITY, STATE, ZIP CODE 601 N ROSE HILL ROAD ROSE HILL, KS 67133		
(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) COMPLETION DATE	
F 689	Continued From page 5 License Nurse (LN) I reported she would not think that any wound care medication would be left at the bedside unsecured. During an interview on 01/27/25 at 12:53 PM, Administrative Nurse E reported that the wound cleanser should not be left unattended in any resident room. The facility's "Control of Hazardous Chemicals" policy dated October 2024 documented the facility was committed to eliminating and controlling hazards that could cause injury of illness to our elders. The facility will meet the requirements of safety standards where there are specific rules about hazards or potential hazards in our facility. All substances with warning labels, including but not exclusive to "Keep out of reach of children", will be locked and inaccessible at all times. The facility failed to ensure a safe environment free from accident hazards for R25. This placed the resident at risk for injury and preventable accidents.	F 689			
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced	F 695			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/06/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175221	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/23/2025
NAME OF PROVIDER OR SUPPLIER ADVENA LIVING AT FOUNTAINVIEW			STREET ADDRESS, CITY, STATE, ZIP CODE 601 N ROSE HILL ROAD ROSE HILL, KS 67133		
(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) COMPLETION DATE	
F 695	Continued From page 6 by: The facility reported a census of 47 residents, which included one resident sampled for respiratory care. Based on observation, interview, and record review, the facility failed to provide appropriate respiratory care in maintaining respiratory equipment to prevent the spread of infection, for one Resident (R) 35. The facility failed to ensure safe storage of oxygen nasal cannula and oxygen tubing when not in use to prevent cross contamination and the spread of infection. Finding included: - Review of Resident (R)35's "Physician Orders," dated 01/14/25, revealed diagnoses which included acute respiratory failure with hypoxia (inadequate supply of oxygen). The "Admission Minimum Data Set," (MDS) dated 12/26/24, documented the "Brief Interview for Mental Status" (BIMS) of 15, indicating intact cognition. R35 received oxygen. The "Care Plan," (CP), dated 01/21/25, directed staff to know the resident received oxygen via nasal cannula. The CP lacked direction regarding the maintenance and upkeep of the resident's oxygen supplies such as the storage of oxygen cannulas and tubing when not in use. The "Physician Orders," revealed an order dated 12/20/24, which documented the resident required oxygen at one to two liters via nasal cannula, continuously. An observation on 01/21/25 at 12:43 PM, revealed the resident lying in the bed in his room.	F 695			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/06/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175221	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/23/2025
NAME OF PROVIDER OR SUPPLIER ADVENA LIVING AT FOUNTAINVIEW			STREET ADDRESS, CITY, STATE, ZIP CODE 601 N ROSE HILL ROAD ROSE HILL, KS 67133		
(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) COMPLETION DATE	
F 695	Continued From page 7 The resident's nasal cannula and oxygen tubing laid directly on the floor, next to his bed and without a storage bag present. During an interview on 01/21/25 at 12:48 PM, Certified Nurse Aide O, verified the above findings and stated oxygen tubing and nasal cannulas should be stored in a container when not in use to prevent cross contamination and the spread of infection. During an interview 01/22/25 at 01:18 PM, Administrative Nurse E stated oxygen tubing and nasal cannulas should be stored in a container when not in use to prevent cross contamination and the spread of infection. The facility policy "Policies and Practices-Infection Control," dated 10/2024, lacked address of storage of nasal cannulas and oxygen tubing to prevent cross contamination and the spread of infection. The facility failed to provide appropriate respiratory care for R35, related to storage of oxygen nasal cannula when not in use to prevent cross contamination and the spread of infection.	F 695			
F 730 SS=F	Nurse Aide Perform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced	F 730			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/06/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175221	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/23/2025
NAME OF PROVIDER OR SUPPLIER ADVENA LIVING AT FOUNTAINVIEW			STREET ADDRESS, CITY, STATE, ZIP CODE 601 N ROSE HILL ROAD ROSE HILL, KS 67133		
(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) COMPLETION DATE	
F 730	Continued From page 8 by: The facility reported a census of 47 residents. Based on observation, interview, and record review, the facility failed to conduct annual performance reviews for five of five direct care staff reviewed, to ensure the residents received adequate cares. Findings included: - The facility failed to complete annual performance reviews for the five certified Medication Aide and/or Certified Nurse Aides (CMA/CNA) sampled that were employed by the facility for 12 months or greater as follows: 1. CNA M, hired 6/7/23 2. CNA N hired 4/3/23 3. CNA P hired 1/11/23 4. CNA Q hired 7/21/22 5. CMA S hired 2/22/23 On 1/23/25 at 12:48 PM, Administrative Staff A, confirmed the above findings. She stated she had been employed as administrator of the facility for approximately six weeks and could not explain why the sampled staff lacked annual performance evaluations. Administrative Staff A reported she had reviewed the personnel files and checked with human resources and could not locate performance evaluations for the direct care staff noted above. She agreed staff should have annual evaluations which identify their weaknesses and have an action plan to include training to address those identified areas. The facility lacked a policy to address annual performance evaluations for the direct care staff.	F 730			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/06/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175221	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/23/2025
NAME OF PROVIDER OR SUPPLIER ADVENA LIVING AT FOUNTAINVIEW			STREET ADDRESS, CITY, STATE, ZIP CODE 601 N ROSE HILL ROAD ROSE HILL, KS 67133		
(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) COMPLETION DATE	
F 730	Continued From page 9 The facility failed to conduct annual performance reviews for five direct care staff, to ensure the residents received adequate cares.	F 730			
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced	F 755			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/06/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175221	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/23/2025
NAME OF PROVIDER OR SUPPLIER ADVENA LIVING AT FOUNTAINVIEW			STREET ADDRESS, CITY, STATE, ZIP CODE 601 N ROSE HILL ROAD ROSE HILL, KS 67133		
(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) COMPLETION DATE	
F 755	Continued From page 10 by: The facility identified a census of 47 residents. The sample included 13 residents. Based on observation, record review, and interviews, the facility failed to provide adequate pharmaceutical services to ensure Resident (R) 25 had their prescribed medications available in a timely manner for administration. This deficient practice placed both R25 and R38 at risk of delayed treatment, which could have adverse consequences. Findings included: - R25's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of diabetes mellitus (DM - when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), hyperlipidemia (condition of elevated blood lipid levels), and anemia (inadequate number of healthy red blood cells to carry adequate oxygen to body tissues). The "Annual Minimum Data Set" (MDS) dated 11/05/24 documented a Brief Interview of Mental Status (BIMS) score of 0, which indicated severely impaired cognition. R25's "Care Plan" dated 06/27/24 documented nursing staff would administer medication as ordered, monitor for side effects, and notify the physician as needed. R25's EMR under the "Orders" tab documented the following physician orders: Atorvastatin (HMG-CoA reductase inhibitors -statins) tablet 20 milligrams (mg), give one tablet by mouth at bedtime for high cholesterol dated	F 755			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/06/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175221	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/23/2025
NAME OF PROVIDER OR SUPPLIER ADVENA LIVING AT FOUNTAINVIEW			STREET ADDRESS, CITY, STATE, ZIP CODE 601 N ROSE HILL ROAD ROSE HILL, KS 67133		
(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) COMPLETION DATE	
F 755	Continued From page 11 03//21/24. Review of R25's "Medication Administration Record" (MAR) for January 2025 revealed R25's high cholesterol medication Atorvastatin which was ordered on 03/2/24 was documented as a "9" (not administered) from 01/08/25 through 01/17/25. On 01/21/25 at 01:22 PM, R25 sat in her wheelchair out in the common area. On 01/23/25 at 08:10 AM, Certified Nurse Aide (CMA) R revealed she would inform the nurse if a resident did not have an ordered medication for administration. She stated that she could call the pharmacy if the nurse instructed her to, but that the nurse had to enter it in the electronic medical record. CMA R stated that she made a list daily and went over it with the nurse, she also gave a copy of the list to the ADON. On 01/23/25 at 08:41 AM, Licensed Nurse (LN) G revealed that if a CMA came to her with a missing medication, she would look in the medication room and in the overflow drawer, if she did not find it, she would contact the pharmacy to ensure it had been ordered and would be delivered. On 01/27/25 at 12:53 PM, Administrative Nurse E stated she kept an eye on the missing medications and could not explain why this resident did not have this medication in the middle of the order as the medication was on the pharmacy refill list. The facility's "Pharmacy Services Overview" policy dated October 2024 documented the facility would accurately and safely provide or	F 755			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/06/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175221	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/23/2025
NAME OF PROVIDER OR SUPPLIER ADVENA LIVING AT FOUNTAINVIEW			STREET ADDRESS, CITY, STATE, ZIP CODE 601 N ROSE HILL ROAD ROSE HILL, KS 67133		
(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) COMPLETION DATE	
F 755	Continued From page 12 obtain pharmaceutical services, including provision of routine and emergency medications and biologicals, and the services of a licensed consultant pharmacist. Pharmacy services are available to residents 24 hours a day, seven days a week. The facility failed to provide adequate pharmaceutical services to ensure R25 received her prescribed medication. This deficient practice placed R25 at risk of delayed treatment which could have adverse consequences. - R38's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of diabetes mellitus (DM - when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin) type II, polyneuropathy (neuropathy- weakness, numbness and pain from nerve damage, usually in the hands and feet), and anemia (inadequate number of healthy red blood cells to carry adequate oxygen to body tissues). The "Admission Minimum Data Set" (MDS) dated 04/15/24 documented a Brief Interview of Mental Status (BIMS) score of 14, which indicated intact cognition. R38's "Care Plan" dated 08/15/24 documented nursing staff would administer medication as ordered, monitor for side effects, and notify the physician as needed. R38's EMR under the "Orders" tab revealed the following physician orders: Farxiga (medication used to treat DM) tablet 5 milligrams (mg), give one tablet by mouth daily for DM dated 12/21/24. Gabapentin (medication	F 755			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/06/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175221	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/23/2025
NAME OF PROVIDER OR SUPPLIER ADVENA LIVING AT FOUNTAINVIEW			STREET ADDRESS, CITY, STATE, ZIP CODE 601 N ROSE HILL ROAD ROSE HILL, KS 67133		
(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) COMPLETION DATE	
F 755	Continued From page 13 used to treat nerve pain) tablet 600 mg, give one tablet every six hours for neuropathy dated 11/20/24. Review of R38's "Medication Administration Record" (MAR) for December 2024 documented R38's Gabapentin which was ordered on 11/20/24 was documented as a "9" (not administered) from 12/11/24 through 12/13/24. DM medication Farxiga which was ordered on 12/21/24 was documented as a "9" (not administered) from 12/21/24 through 12/31/24. January 2025 MAR documented R38's DM medication Farxiga which was ordered on 12/21/24 was documented as a "9" (not administered) from 01/01/25 through 01/27/25. On 01/22/25 at 03:01 PM, R38 sat in her wheelchair in the hallway outside of her room. On 01/23/25 at 08:10 AM, Certified Nurse Aide (CMA) R stated she would inform the nurse if a resident did not have an ordered medication for administration. She stated that she could call the pharmacy if the nurse instructed her to, but that the nurse had to enter it in the electronic medical record and fax it to the pharmacy. CMA R stated that she made a list daily and went over it with the nurse, she also gave a copy of the list to the ADON. On 01/23/25 at 08:41 AM, Licensed Nurse (LN) G stated that if a CMA came to her with a missing medication, she would look in the medication room and in the overflow drawer, if she did not find it, she would contact the pharmacy to ensure it had been ordered and would be delivered. On 22/20/24 at 03:30 PM, Administrative Nurse E	F 755			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/06/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175221	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/23/2025
NAME OF PROVIDER OR SUPPLIER ADVENA LIVING AT FOUNTAINVIEW			STREET ADDRESS, CITY, STATE, ZIP CODE 601 N ROSE HILL ROAD ROSE HILL, KS 67133		
(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) COMPLETION DATE	
F 755	Continued From page 14 stated she kept an eye on the missing medications and could not explain why this resident did not have the gabapentin medication in the middle of the order as the medication was on the pharmacy refill list. Administrative Nurse E revealed the Farxiga was being waited on due to the insurance company was refusing to cover the medication. The facility's "Pharmacy Services Overview" policy dated October 2024 documented the facility would accurately and safely provide or obtain pharmaceutical services, including provision of routine and emergency medications and biologicals, and the services of a licensed consultant pharmacist. Pharmacy services are available to residents 24 hours a day, seven days a week. The facility failed to provide adequate pharmaceutical services to ensure R38 received her prescribed medication. This deficient practice placed R25 at risk of delayed treatment which could have adverse consequences.	F 755			
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention	F 880			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/06/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175221	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/23/2025
NAME OF PROVIDER OR SUPPLIER ADVENA LIVING AT FOUNTAINVIEW			STREET ADDRESS, CITY, STATE, ZIP CODE 601 N ROSE HILL ROAD ROSE HILL, KS 67133		
(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) COMPLETION DATE	
F 880	Continued From page 15 and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed	F 880			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/06/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175221	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/23/2025
NAME OF PROVIDER OR SUPPLIER ADVENA LIVING AT FOUNTAINVIEW			STREET ADDRESS, CITY, STATE, ZIP CODE 601 N ROSE HILL ROAD ROSE HILL, KS 67133		
(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) COMPLETION DATE	
F 880	Continued From page 16 by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: The facility identified a census of 47 residents. The facility identified residents on Enhanced Barrier Precautions (EBP-infection control interventions designed to reduce transmission of resistant organisms that employ targeted gown and glove use during high contact care). Based on record review, observations, and interviews, the facility failed to ensure the gait belts were sanitized after each resident's use and further failed to ensure staff followed the protocols when a nurse provided a tube feeding for a resident. These deficient practices placed the residents at risk for infectious diseases. Findings included: - R37's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of dysphagia, gastric ulcer, digestive system surgical aftercare, and gastritis. The "Significant Change Minimum Data Set" (MDS) dated 10/15/24 the staff assessment for	F 880			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/06/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175221	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/23/2025
NAME OF PROVIDER OR SUPPLIER ADVENA LIVING AT FOUNTAINVIEW			STREET ADDRESS, CITY, STATE, ZIP CODE 601 N ROSE HILL ROAD ROSE HILL, KS 67133		
(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) COMPLETION DATE	
F 880	Continued From page 17 mental status documented R37 had long and short-term memory problems and severely impaired cognition. R37 had loss of liquids/solids from mouth, held food in mouth/cheek, coughed or choked when swallowing, and had complaints of difficulty or pain with swallowing. Received 51% or more of calories and 501cc fluid or more per day through tube feeding. R37's "Care Plan" dated 10/01/24 documented nursing staff would administer tube feedings and R37 took nothing by mouth. R37's EMR under the "Orders" tab revealed the following physician orders: Jevity 1.5 bolus 240ml feeding four times daily. Flush with 75ml water before and after feeding for a total of 150ml water flush. On 01/23/25 at 09:49 AM, R37 laid in her bed, covered with a blanket, resting without signs of distress noted. On 01/23/25 at 09:49 AM, Licensed Nurse (LN) G was observed giving R37 her tube feeding without wearing the proper personal protective equipment, she had only gloves in place. On 01/23/25 at 09:49 AM, LN G stated she knew about the enhanced barrier precautions, confirmed she did not, and stated she should have. On 01/27/25 at 12:53 PM, Administrative Nurse E stated she would expect all staff to know and abide by the enhanced barrier precautions protocol. The facility's undated "Enhanced Barrier	F 880			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/06/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175221		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/23/2025	
NAME OF PROVIDER OR SUPPLIER ADVENA LIVING AT FOUNTAINVIEW				STREET ADDRESS, CITY, STATE, ZIP CODE 601 N ROSE HILL ROAD ROSE HILL, KS 67133			
(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) COMPLETION DATE
F 880	Continued From page 18 Precautions (EBP)" policy documented that the facility followed recommendations and guidance from the Centers for Disease Control in order to keep all residents safe from Healthcare Acquired Infections (HAI). On the recommendation and approval of the facility Infection Preventionist in collaboration with the facility's Medical Director, Enhanced Barrier Precautions (EBP) are implemented as one intervention this facility uses to reduce transmission of resistant organisms that employs targeted Personal Protective Equipment (PPE) use during high contact resident care activities. Standard Precautions continue to apply to the care of all residents, regardless of suspected or confirmed infection or colonization status. The required PPE includes but is not limited to gloves and gowns prior to high-contact care activity. Change PPE before caring for another resident. The facility failed to ensure staff followed EBP protocol with tube feedings. This deficient practice placed the residents at risk for infection.			F 880			