Kansas State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N008004	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADVENA LIVING AT FOUNTAINVIEW	601 N ROSE HILL ROAD , ROSE HILL, Kansas, 67133

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S0000	INITIAL COMMENTS The following citations represent the findings of the licensure resurvey with attached complaint number 2721425 for the above named facility conducted on 02/25/26 and 02/26/26.	S0000		
S0180 SS = E	Resident Right Medication Self Administration CFR(s): 26-39-103 (q) (q) Self-administration of medication. The administrator shall ensure that each resident in a nursing facility or a nursing facility for mental health is afforded the right to self-administer medications unless the resident's attending physician and the interdisciplinary team have determined that this practice is unsafe. In any assisted living facility, residential health care facility, home plus, or adult day care facility, a resident may self-administer medication if a licensed nurse has determined that the resident can perform this function safely and accurately. This LICENSURE REQUIREMENT is NOT MET as evidenced by: K.A.R. 26-39-103 (q) The facility reported a census of 13 residents. The sample included 3 "Residents'" (R)'s. Based on record review and interview the Administrator failed to ensure that each resident was afforded the right to self-administer their own medications if a licensed nurse determined that the resident could perform the function safely and accurately. Findings included: -Record review for R2 revealed an admission date of 08/01/25 with diagnoses of other amnesia, type two diabetes mellitus, hypertension, venous insufficiency, hyperglycemia, history of falling, other fatigue, and chest pain on breathing. Review of R2's "Functional Capacity Screen" (FCS) dated 10/14/25 revealed R2 was independent with bathing, dressing, toileting, transferring, walking/mobility and	S0180		

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

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S0180 SS = E	Continued from page 1 eating. R2 required supervision with the administration of her medications and medical treatments. R2 was continent and had impaired short-term memory, memory/recall, and decision making. R2 could sometimes make herself understood and she sometimes understood others. R2 was at risk for impaired decision making and inappropriate behavior. R2 used a cane mobility device. Review of R2's combined "Negotiated Service Agreement" (NSA)/"Health Service Plan" (HSP)dated 09/25/25, under the section titled "Medication Management and Medical Treatments Management" identified the facility "Certified Medication Aide" (CMA)/"Licensed Nurse" (LN) were required to administer all of R2's medications and medical treatments. Record review of R2's "Admission Packet" to the facility dated 08/21/25, revealed the following page titled "Medication Administration Addendum" and was signed by R2 on 08/01/25 that revealed the following: It was the policy of the facility that they "administer any and all medications that are prescribed by the physician and from the physician orders, any over the counter medications are included in this". Residents were to bring "any and all" over the counter medications and prescription medications to the CMA's for them to properly store. Review of the untitled document signed by R2 revealed the following: "Policy": to provide the resident information regarding their "Rights". The document lacked the acknowledgement that R2 was afforded the right to self-administer his own medications if a licensed nurse determined that the resident could perform the function safely and accurately. -Record review for R3 revealed an admission date of 01/19/24 with diagnoses of dementia with behavioral disturbances, major depressive disorder, alcohol abuse with unspecified alcohol induced disorder, epilepsy and recurrent seizures, nonrheumatic aortic stenosis and Sialadenitis. Review of R3's FCS dated 10/14/25 revealed R3 required supervision with bathing, eating, and he was independent with dressing, toileting, transferring, and walking/mobility. R3 had impaired short-term memory, long-term memory, memory/recall and decision making. R3 was frequently incontinent and he was able to make himself understood and he understood others. Review of R3's combined NSA/HSP dated 09/25/25 under the section titled "Medication Management and Medical Treatments Management" identified the facility	S0180		

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S0180 SS = E	Continued from page 2 "Certified Medication Aide" (CMA)/"Licensed Nurse" (LN) were required to administer all of R2's medications and medical treatments. Record review of R3's "Admission Packet" to the facility dated 01/29/24, revealed the following page titled "Medication Administration Addendum" and was signed by R3 on 01/19/24 that revealed the following: It was the policy of the facility that they "administer any and all medications that are prescribed by the physician and from the physician orders, any over the counter medications are included in this". Residents were to bring "any and all" over the counter medications and prescription medications to the CMAs for them to properly store. Review of the untitled document signed by R3's "Durable Power of Attorney" (DPOA) revealed the following: "Policy" to provide the resident information regarding their "Rights". The document lacked the acknowledgement that R3 was afforded the right to self-administer his own medications if a licensed nurse determined that the resident could perform the function safely and accurately. Interview on 02/26/25 at approximately 03:30 PM with Administrator A, confirmed the residents in the Assisted Living area of the facility signed the acknowledgement page that confirmed the residents were not allowed to manage their own medications. The Administrator failed to ensure that each resident was afforded the right to self-administer their own medications if a licensed nurse determined that the resident could perform the function safely and accurately.	S0180		
S0225 SS = E	Admission Policy CFR(s): 26-39-102 (a) (a) Each licensee, administrator, or operator shall develop written admission policies regarding the admission of residents. The admission policy shall meet the following requirements: (1) The administrator or operator shall ensure the admission of only those individuals whose physical, mental, and psychosocial needs can be met within the accommodations and services available in the adult care home. (A) Each resident in a nursing facility or nursing facility for mental health shall be admitted under the	S0225		

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S0225 SS = E	Continued from page 3 care of a physician licensed to practice in Kansas. (B) The administrator or operator shall ensure that no children under the age of 16 are admitted to the adult care home. (C) The administrator or operator shall allow the admission of an individual in need of specialized services for mental illness to the adult care home only if accommodations and treatment that will assist that individual to achieve and maintain the highest practicable level of physical, mental, and psychosocial functioning are available. (2) Before admission, the administrator or operator, or the designee, shall inform the prospective resident or the resident ' s legal representative in writing of the rates and charges for the adult care home's services and of the resident's obligations regarding payment. This information shall include the refund policy of the adult care home.(3) At the time of admission, the administrator or operator, or the designee, shall execute with the resident or the resident ' s legal representative a written agreement that describes in detail the services and goods the resident will receive and specifies the obligations that the resident has toward the adult care home. (4) An admission agreement shall not include a general waiver of liability for the health and safety of residents. (5) Each admission agreement shall be written in clear and unambiguous language and printed clearly in black type that is 12-point type or larger. This LICENSURE REQUIREMENT is NOT MET as evidenced by: K.A.R. 26-39-102 (a) (1) (C) (3) The facility reported a census of 13 residents. The sample included 3 ''Residents'''' (R)'s. Based on record review and interview the administrator failed to ensure at the time of admission executed a written agreement that described in detail the services and goods the resident would receive and specified te obligations that the resident had toward the adult care home for R2 and R3. Findings included: -Record review for Record review for R2 revealed an admission date of	S0225		

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S0225 SS = E	Continued from page 4 08/01/25 with diagnoses of other amnesia, type two diabetes mellitus, hypertension, venous insufficiency, hyperglycemia, history of falling, other fatigue, and chest pain on breathing. Review of R2's "Admission Packet" dated 08/01/25 under the section titled "Services and Accommodations", "C. Personal Service Plan" revealed the following statement: The facility "in its sole discretion, will use a personal service agreement to determine the personal services you require prior to moving in and periodically throughout your residency. The results of the assessments and the cost of providing the personal services will be shared with you and your Responsible Party..." R2's Admission Packet lacked documentation that described in detail the services and goods the resident would receive and specified the obligations that R2 had toward the adult care home. Record review for R3 revealed an admission date of 01/19/24 with diagnoses of dementia with behavioral disturbances, major depressive disorder, alcohol abuse with unspecified alcohol induced disorder, epilepsy and recurrent seizures, nonrheumatic aortic stenosis and Sialadenitis. Review of R3's "Admission Packet" dated 01/19/24, under the section titled "Services and Accommodations", "C. Personal Service Plan" revealed the following statement: The facility "in its sole discretion, will use a personal service agreement to determine the personal services you require prior to moving in and periodically throughout your residency. The results of the assessments and the cost of providing the personal services will be shared with you and your Responsible Party..." R3's Admission Packet lacked documentation that described in detail the services and goods the resident would receive and specified the obligations that R3 had toward the adult care home. Interview on 03/26/26 at approximately 03:30 PM with Administrator A confirmed the Admission Packets for R's 2 and 3 lacked a written agreement that described in detail the services and goods R's 2 and 3 would receive, and specified the obligations that R2 and R3 had toward the adult care home. The administrator failed to ensure at the time of admission executed a written agreement that described	S0225		

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S0225 SS = E	Continued from page 5 in detail the services and goods the resident would receive and specified the obligations that the resident had toward the adult care home for R2 and R3.	S0225		
S3085 SS = E	Negotiated Service Agreement CFR(s): 26-41-202 (a) (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 LICENSURE REQUIREMENT is NOT MET as evidenced by: K.A.R. 26-41-202 (a) (1) The facility reported a census of 13 residents. The sample included 3 "Residents'" (R)'s 1, 2, and 3. Based on interview and record review the Administrator failed to ensure the development of the written "Negotiated Service Agreement" (NSA) for each resident that was based on the "Functional Capacity Screen" (FCS). Findings included: -Record review for R1 revealed an admission date of 08/19/20 with diagnoses of hypertension, obsessive compulsive disorder, generalized anxiety disorder, bipolar disorder, chronic obstructive pulmonary disease, major depressive disorder, left ventricular failure and Parkinson's disease. Review of R1's FCS dated 10/14/25 revealed R1 was independent with bathing, dressing, toileting, transferring, and walking. R1 lacked the ability to manage her own medications and medical treatments. R1 had impaired short-term memory and memory/recall.	S3085		

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S3085 SS = E	Continued from page 6 Review of R1's combined NSA/"Health Service Plan" (HSP) dated 09/25/25 under the section titled "Cognition /Communication" facility staff were instructed that R1 had "no cognitive impairment", and R1 required the facility "Certified Medication Aide" (CMA)/ "Licensed Nurse" (LN) to administer her medications and medical treatments. On page four of the NSA/HSP there was a list of providers and the services they provided. The last entry in the list was a local Physical Therapy (PT) agency. Interview on 01/26/26 at approximately 03:30 PM with "Registered Nurses"' (RN)'s A and B confirmed R1's FCS was dated 10/14/25, the NSA/HSP was dated 09/25/25, and they continued to confirm R1 was not on physical therapy services. -Record review for R2 revealed an admission date of 08/01/25 with diagnoses of other amnesia, type two diabetes mellitus, hypertension, venous insufficiency, hyperglycemia, history of falling, other fatigue, and chest pain on breathing. Review of R2's FCS dated 10/14/25 revealed R2 was independent with bathing, dressing, toileting, transferring, walking/mobility and eating. R2 required supervision with the administration of her medications and medical treatments. R2 was continent and had impaired short-term memory, memory/recall, and decision making. R2 could sometimes make herself understood and she sometimes understood others. R2 was at risk for impaired decision making and inappropriate behavior. R2 used a cane mobility device. Review of R2's combined NSA/HSP dated 09/25/25 instructed facility staff to provide a sugar free diet. Under the section titled "Cognition/Communication" it was identified that R2 had some cognitive impairment and needs facility staff to offer the resident choices regarding dressing, meals, and provide cues and reminders throughout the day. It was hand written "can get confused on things/where she is". The facility CMA's and LN's were to administer all of R2's medications and perform any medical treatments. Under the section titled 'Behavior Management" it instructed facility staff that R2 had the following behaviors: "pacing, yelling, and cursing". Facility staff were instructed to step out of R2's room and to return to R2's room when she had "calmed down". On page four of the NSA/HSP there was a list of providers and the services they provided. The last entry in the list was a local Physical Therapy (PT) agency. Interview on 01/26/26 at approximately 03:30 PM with	S3085		

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S3085 SS = E	Continued from page 7 "Registered Nurses"' (RN)'s A and B confirmed R1's FCS was dated 10/14/25, the NSA/HSP was dated 09/25/25. -Record review for R3 revealed an admission date of 01/19/24 with diagnoses of dementia with behavioral disturbances, major depressive disorder, alcohol abuse with unspecified alcohol induced disorder, epilepsy and recurrent seizures, nonrheumatic aortic stenosis and Sialadenitis. Review of R3's FCS dated 10/14/25 revealed R3 required supervision with bathing, eating, and he was independent with dressing, toileting, transferring, and walking/mobility. R3 had impaired short-term memory, long-term memory, memory/recall and decision making. R3 was frequently incontinent and he was able to make himself understood and he understood others. R3 was at risk for socially inappropriate disruptive behavior and impaired decision making. Review of R3's combined NSA/HSP dated 09/25/25 instructed facility staff to provide supervision with bathing, dressing, toileting, and provide R3 choices regarding dressing, meals, provide cues and reminders throughout the day. It was handwritten that R3 "can get confused as to where he is". The facility CMA's and LN's would administer all of R3's medications and perform any medical treatments. Under the section titled "Behavior Management" facility staff were instructed to walk away from R3 and get the facility charge nurse when R3 exhibited the behaviors of "Yelling, cursing, or hitting", The combined NSA/HSP further instructed the facility staff to call the charge nurse if R3 attempts to "elope" from the facility. On page four of the NSA/HSP there was a list of providers and the services they provided. The last entry in the list was a local Physical Therapy (PT) agency. Interview on 02/26/26 with RN's A and B confirmed R3's FCS was dated 10/14/25, the NSA/HSP was dated 09/25/25, and they continued to confirm R3 was not on physical therapy services. The Administrator failed to ensure the development of the written NSA for each resident that was based on the FCS.	S3085		
S3280 SS = F	Disaster and Emergency Preparedness CFR(s): 26-41-104 (d) (d) Each administrator or operator shall ensure disaster and emergency preparedness by ensuring the	S3280		

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S3280 SS = F	Continued from page 8 performance of the following: (1) Orientation of new employees at the time of employment to the facility ' s emergency management plan; (2) education of each resident upon admission to the facility regarding emergency procedures; (3) quarterly review of the facility ' s emergency management plan with employees and residents; and (4) an emergency drill, which shall be conducted at least annually with staff and residents. This drill shall include evacuation of the residents to a secure location. This LICENSURE REQUIREMENT is NOT MET as evidenced by: K.A.R. 26-41-104 (d) (3) The facility reported a census of 13 residents. Based on interview and record review the Administrator failed to ensure a quarterly review of the facility's emergency preparedness plan with employees and residents. Findings included: -Review of the facility provided documents titled "Resident Council Notes" revealed the following: On 12/ (no actual date provided)/25 under the section titled "Discuss Safety Drills" it was handwritten "Earthquake" On 01/(no actual date provided)/26 under the section titled "Discuss Safety Drills" it was hand written for inside evacuations the residents were to come to the dining room. On 02/04/26 under the section titled "Discus Safety Drills" it was handwritten "Tornado Drills". Interview on 02/26/26 at approximately 10:15 AM with Activities Director G confirmed she does not include all nine topics of the emergency management plan with all residents quarterly. Interview on 02/26/26 at approximately 03:30 PM with Administrator A confirmed she lacked documentation of the emergency management plan being reviewed with employees quarterly.	S3280		

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S3280 SS = F	Continued from page 9 The Administrator failed to ensure a quarterly review of the facility's emergency preparedness plan with employees and residents.	S3280		
S3310 SS = F	Infection Control Policies CFR(s): 26-41-207 (b) (5-6) (c) (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 LICENSURE REQUIREMENT is NOT MET as evidenced by: K.A.R. 26-41-207 (c) The facility reported a census of 13 residents. The sample included 3 "Residents'" (R)'s and 5 newly hired employees. Based on record review and interview the Administrator failed to ensure the facility's compliance with the department's "Tuberculosis" (TB) guidelines adopted by reference in K.A.R. 26-39-105 for R1, R2, "Certified Medication Aides'" (CMA)'s E and F. Findings included: -Record review for CMA E revealed a hire date of 08/21/24. CMA E's personnel record lacked documentation of the required two step TB skin test being performed within seven days of employment. Record review for CMA F revealed a hire date of 12/17/25. Review of CMA F's personnel record revealed step one of the required TB skin test was administered on 02/20/26 and read negative on 02/22/26. CMA F's personnel record lacked documentation of the required second step of the TB skin test being administered within one to three weeks after the first step read negative. Record review for R1 revealed an admission date of	S3310		

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S3310 SS = F	Continued from page 10 08/19/20 with diagnoses of hypertension, obsessive compulsive disorder, generalized anxiety disorder, bipolar disorder, chronic obstructive pulmonary disease, major depressive disorder, left ventricular failure, and Parkinson's disease. Review of R1's electronic "Medical Record" under the "Forms" tab revealed a TB Symptoms Screen Questionnaire dated 03/01/24. R1's electronic "Medical Record" lacked documentation of the required annual TB Symptom Screen Questionnaire for 2025. Review of R2's electronic "Medical Record" revealed the electronic record lacked documentation of the required TB skin test being administered within 7 days of admission to the facility. Interview on 03/26/26 at approximately 03:30 PM with "Registered Nurses'" (RN)'s B and C, and Administrator A confirmed the personnel file for CMA E lacked the documentation of the required two step TB skin test being administered within seven days of employment, CMA F's personnel record lacked the documentation of the required second step of the required two step TB skin test being administered within one to three weeks of the first step reading negative, the electronic "Medical Record" for R1 lacked documentation of the required annual TB symptom screening questioner being performed for 2025, and R2's electronic "Medical Record" lacked documentation of the required two step TB skin test being administered within seven days of admission to the facility. The Administrator failed to ensure the facility's compliance with the department's TB guidelines adopted by reference in K.A.R. 26-39-105 for R's 1 and 2, and CMA's E and F.	S3310		