Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N008010	A. BUILDING: _____ B. WING _____	C 09/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANDOVER COURT ASSISTED LIVING	721 WEST 21ST ST ANDOVER, KS 67002

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S 000	INITIAL COMMENTS The following citations represent the findings of a Health Licensure Resurvey and Complaint survey regarding allegations in the following complaints: 198532, 198285, 198259, 195979, and 195972, conducted on 09/09/26 and 09/10/26. The facility reported a census of 29 residents. The sample included 7 residents.	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	S 190		

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

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S 190	Continued From page 1 because the health or safety of other individuals in the adult care home is endangered. This REQUIREMENT is not met as evidenced by: KAR 26-39-102(e)(2)(A) Admission, Transfer, Discharge Based on record review and interview, the facility failed to ensure the physician documented the rational in the clinical record the involuntary discharge was necessary for the resident's welfare and the residents' needs could not be met by the adult care home for 1 of 7 residents, Resident (R) 1. The failure resulted in R1 receiving an involuntary discharge letter from the facility. R1 diagnoses included major depressive disorder and dementia. The 03/13/25 Functional Capacity Screen revealed R1 had impaired short-term memory, long-term memory, memory/recall, and decision making. R1 was identified at risk for wandering. In the section titled "Comments" it was documented the resident wandered around the building; and did not exit seek. The combined 03/06/25 Negotiated Service Agreement revealed the facility staff were to notify the supervisor of any new or changed behaviors and reassure the resident in times of wandering and to redirect as needed. R1 admitted on 03/14/23 and required facility staff to manage and administer her medications, escort resident to activities daily.	S 190		

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S 190	Continued From page 2 Review of "Progress Notes" revealed the following entries: On 06/09/25 at 04:50 AM an "Incident Note" revealed R1 exited the facility at 6 04:49 AM through the exit door located closest to her room. Staff immediately responded and resident was brought back into the facility at approximately 04:53 AM. Resident was placed on one-on-one care. On 06/09/25 at 06:27 AM revealed a door alarm went off and R1 was escorted back into the facility. On 06/09/25 at 04:03 PM a "Communication Note" revealed the facility nurse and business office manager spoke to R1's Durable Power of Attorney (DPOA) about R1's increased wandering and exit seeking. Due to safety concerns the DPOA was informed of the intent to give R1 a 30 day notice of discharge based on the inability to safely care for R1 and R1 remained on one-on-one care with staff. On 06/10/25 at 10:30 AM R1's DPOA was provided with a 30 day notice of discharge. On 06/11/25 at 08:18 PM a late entry "Order" note revealed the primary care provider wrote an order for discharge to multiple elopement attempts. R1's notes lacked documentation from the provider prior to 06/11/25 substantiating the facility was unable to meet the needs of R1. On 06/13/25 at 03:13 PM a "Move-Out/Discharge" note revealed R1 was discharged to family home.	S 190		

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S 190	Continued From page 3 Review of "Progress" notes dated 12/28/24 to 05/31/25 lacked documentation of R1 having increased exit seeking behaviors, documentation supporting the facility could not meet R1's needs, and substantiation from R1's primary care confirming the facility could not meet R1's needs. Review of the 30-Day Notice of discharge dated 06/13/25 revealed During a recent assessment, it was determined that R1's dementia had made it difficult for the facility to continue to provide on going care and services, and a higher level of care that focused on R1's specific needs would be necessary. A move to an alternate care facility would be required in 30 days ending on 07/09/25. Interview on 09/10/26 at approximately 02:15 PM with Administrator A and Licensed Nurse B confirmed R1's record lacked documentation prior to the time of the 30 day notice of discharge substantiating R1's needs could not be met by the facility. As a result R1 was provided a 30 day notice of discharge.	S 190		
S3200 SS=D	26-41-205 (d) (1-2) Facility Administration of Medications (d) Facility administration of resident ' s medications. If a facility is responsible for the administration of a resident ' s medications, the administrator or operator shall ensure that all medications and biologicals are administered to that resident in accordance with a medical care provider ' s written order, professional standards of practice, and each manufacturer ' s recommendations. The administrator or operator	S3200		

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S3200	Continued From page 4 shall ensure that all of the following are met: (1) Only licensed nurses and medication aides shall administer and manage medications for which the facility has responsibility. (2) Medication aides shall not administer medication through the parenteral route. This REQUIREMENT is not met as evidenced by: K.A.R. 26-41-205 (d) Medication Management Based on record review and interview, the facility failed to administer medications in accordance with Physician's orders and accepted professional standards of practice for one of seven residents reviewed for medication management. From 03/01/26 through 03/20/26 the facility failed to administer Resident (R) 2's ordered medications (17 medications, utilized for various health conditions) within the prescribed administration time frame on 69 occasions. This failure resulted in R2 receiving multiple prescribed medications outside of ordered administration times. R2 diagnoses included anxiety disorder, major depressive disorder, cerebral infarction to unspecified occlusion or stenosis of unspecified cerebral artery, repeated falls, and scoliosis. The 12/26/25 Functional Capacity Screen revealed R2 lacked the ability to manage her own medications and medical treatments. The combined 12/26/25 Negotiated Service Agreement revealed facility staff were instructed to administer medications as ordered after	S3200		

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S3200	Continued From page 5 attempting non-medical approaches. Staff were instructed to observe for and report to the nurse side effects and effectiveness. R2 admitted on 12/26/25. Facility staff were instructed to administer and manage R2's medications and medical treatments. Review of the 03/01/26 through 03/20/26 Medication Administration Audit Report revealed R2 received 17 ordered medications, and it was documented on the administrations audit report 69 times in twenty days R2 received her medications outside of the ordered time frame. Interview on 9/10/26 at 02:00 PM with Licensed Nurse B confirmed there had been an issue prior with R2's medication administration times. Licensed Nurse B continued to confirm there had been agency staff in the facility and the medication pass times were longer due to the agency staff not being familiar with the residents. Licensed Nurse B confirmed when the concern was brought to her attention she worked to resolve the issue. As a result in 20 days it was documented 69 times R2 did not receive all 17 ordered medications in the prescribed administration time.	S3200		
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 cleaning supplies shall not be stored in the areas used for food storage, preparation, or serving.	S3299		

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S3299	Continued From page 6 This REQUIREMENT is not met as evidenced by: K.A.R. 26-41-206 (e) Dietary Services Based on observation, interview and record review the facility failed to store all food under safe and sanitary conditions. This placed all 29 residents at risk for consuming food that was not appropriately stored under safe and sanitary conditions. Observation on 09/09/26 at approximately 09:00 AM of the facility kitchen refrigerator revealed the following items which lacked a date of being placed in the refrigerator: 1 container of Orange Juice 1 metal pan of gumbo 1 small metal container that contained a purple onion that had been cut 1 small metal container that contained slices of watermelon 1 medium container of macaroni salad 1 metal pan of tacos and beans 1 small metal container of cherry tomatoes 1 large container of iceberg lettuce and cherry tomatoes 2 large bags of shredded cheese that were opened 1 medium metal pan of chicken Observation on 09/09/26 at approximately 09:20 AM of the dry food storage located on the south side of the kitchen revealed a bag of lemons that had small flying bugs flying around the bag and the bag contained one blackened lemon that appeared to have a fuzzy substance covering it.	S3299		

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S3299	Continued From page 7 Observation on 09/09/26 at approximately 09:25 AM of the dry food storage area located on the east side of the kitchen dish area revealed a large plastic container of flour that had flour on top of the lid and on the floor in front of the container. Interview on 09/09/26 at approximately 09:30 with Dietary Supervisor C confirmed the food in the facility refrigerator lacked the dates of when the food was placed in the refrigerator, the bugs flying around the bag of lemons with the one discolored lemon in the bag, and the flour on the floor. The failure placed all 29 residents at risk of being served food that was not stored appropriately under safe and sanitary 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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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:
K.A.R. 26-41-207 (b) (4) Infection Control

Based on observation, interview and record review the facility failed to provide sanitary conditions for the facility food services. This failure placed all 29 Residents' (R)'s at risk.

On 09/10/26 at 01:37 PM the surveyor observed the facility dishwashing room. Under the metal dish counter were two five-gallon containers with small hoses going into each container. The containers were labeled "Dishmachine Rinse Additive All Purpose".

The surveyor reviewed "Dish Machine Temperature Log" which showed facility dishwashing staff were to record the dish machine wash and rinse temperatures the chemical strip for breakfast, lunch and dinner. For the low temperature machine, dishwashing staff were instructed to notify the director if the parts

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per million (PPM) for the sanitizer was less than 50, or if the temperature was less than 120 degrees Fahrenheit (F) or above 150 degrees F.

The surveyor reviewed the August 2026 Dish Machine Log which showed the following:

08/01/26-08/05/26 lacked documentation.

The water temperature was recorded 81 times above 150 degrees F.
The strip column lacked documentation of the PPM and contained the dishwashing staff initials.
The dinner column lacked documentation of the PPM and the wash and rinse temperatures being recorded.

The surveyor reviewed the September 2026 Dish Machine Log which revealed the following:

The water temperature was recorded 46 times above 150 degrees F.
The strip column lacked documentation of the PPM being performed.

The surveyor reviewed the Chemical -Sanitizing Dish Machine (Low Temperature) Policy revised on 02/17/22 which showed the chemical-sanitizing dish machine cleaned and sanitized items at a much lower temperature per specifications on the dish machine. Since different sanitizers required different rinse-water temperatures, it was important to follow manufacturer's guidelines.

Interview on 09/10/26 at 01:56 PM with Administrator A, Licensed Nurse B, and dietary supervisor C, confirmed the facility dish machine was a low temperature chemical sanitizer machine. They continued to confirm the dish

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S3305	Continued From page 10 machine had 2 buckets of a rinse additive, and the dish machine lacked the container of chemical sanitizing agent. Dietary Supervision C confirmed dietary staff do not report to the director if the water temperature is above 150 degrees F. This failure placed all 29 residents at risk of being served food on dishes that had not been properly sanitized.	S3305		