STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B088002	A. BUILDING: _____ B. WING _____	C 12/14/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD ESTATES HOME PLUS	1140 S PERSHING AVENUE LIBERAL, KS 67901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS The following citations represent the findings of resurvey with complaint investigation #157174 for the above named Home Plus facility conducted on 12/9,10,14/2020.	S 000		
S5116 SS=E	26-42-202 (d) NSA revisions (d) Each administrator or operator shall ensure the review and, if necessary, revision of each negotiated service agreement according to the following requirements: (1) At least once every 365 days;(2) following any significant change in condition, as defined in K.A.R. 26-39-100; (3) at least quarterly if the resident receives assistance with eating from a paid nutrition assistant; and (4) if requested by the resident or the resident ' s legal representative, staff, the case manager, or, if agreed to by the resident or the resident ' s legal representative, the resident ' s family. This REQUIREMENT is not met as evidenced by: KAR 26-42-202 (d)(1)(2) The facility reported a census of 11 residents. The sample included 3 residents and 3 focused record reviews. Based on interview and record review the Operator failed to ensure designated staff reviewed and, if necessary, revised 3 (#129, #131, #130) of 3 residents negotiated service agreements every 365 days or following a significant change in condition, as defined in KAR 26-39-100. Findings included:	S5116		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B088002	A. BUILDING: _____ B. WING _____	C 12/14/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD ESTATES HOME PLUS	1140 S PERSHING AVENUE LIBERAL, KS 67901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5116	Continued From page 1 - Review of resident #129's medical record revealed she moved into the facility on 6-5-2019 with diagnoses of hypertension, coronary artery disease and dementia. Review of the residents functional capacity screen (FCS) dated 6-5-19 revealed the resident required physical assistance with bathing, dressing and toileting, supervision with transfers and had bladder incontinence and cognitive impairment. The resident also could not manage her medications or medical treatments. Review of the FCS dated 6-3-2020 revealed the resident had not changed in her functional abilities. Review of the residents medical record revealed a negotiated service agreement dated 6-5-2019. The negotiated service agreement had no evidence of being reviewed or revised since admission on 6-5-2019 which is greater than 365 days. - Review of resident #130's medical record revealed the resident moved into the facility on 6-22-20 with diagnoses of hypertension, osteoarthritis, and weakness. Review of the resident's medical record revealed a functional capacity screen dated 6-22-20 indicated the resident was unable to manage/complete bathing, dressing and toileting and required physical assistance with transfers and mobility. It also revealed the resident could not manage his/her own medications and treatments. Review of the resident's negotiated service	S5116		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B088002	A. BUILDING: _____ B. WING _____	C 12/14/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD ESTATES HOME PLUS	1140 S PERSHING AVENUE LIBERAL, KS 67901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5116	Continued From page 2	S5116		

agreement dated 6-22-20 identified a local home health agency would provide physical therapy services. The negotiated service agreement failed to be revised when the resident no longer received the physical therapy services or when the resident started to receive skilled nursing services and what for.

During an interview on 12-10-2020 operator A reported the resident did not get physical therapy services but received skilled nursing services from home health.

- Review of resident #131's medical record revealed the resident moved into the facility on 4-5-2019 with diagnoses of multiple scleroses, hypertension and congestive heart failure.

Review of the resident's functional capacity screen (FCS) dated 8-28-19 revealed the resident required physical assistance with toileting and transfers, supervision with bathing and dressing and was independent with walking/mobility. The FCS also revealed the resident had problems with falls/unsteadiness and required supervision with medications and had bladder incontinence.

Review of the resident's FCS dated 4-17-2020 revealed the resident needed physical assistance with all activities of daily living except for eating. It also revealed the resident needed physical assistance with management of medications and medical treatments. This FCS revealed the resident had a significant decline in functional status.

Review of the negotiated service agreement (NSA) dated 8-28-2019 revealed designated staff failed to review/revise the NSA on 4-17-2020 when the resident had a decline in functional

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B088002	A. BUILDING: _____ B. WING _____	C 12/14/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD ESTATES HOME PLUS	1140 S PERSHING AVENUE LIBERAL, KS 67901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5116	Continued From page 3 ability as well as failed to review/revise the NSA within 365 days. During an interview on 12-10-20 at 2:00 PM operator A confirmed the negotiated service agreements needed to be reviewed and revised if necessary every 365 days or when the resident has a significant change. She stated the problem has been trying to get the new nurse trained and having time to work with her on doing negotiated service agreements. The operator failed to ensure designated staff reviewed or revised 3 residents negotiated service agreement every 365 days or when they had a significant change in status.	S5116		
S5161 SS=F	26-42-204 (d) Health Care Services (d) The negotiated service agreement shall contain a description of the health care services to be provided and the name of the licensed nurse responsible for the implementation and supervision of the plan. This REQUIREMENT is not met as evidenced by: KAR 26-42-204 (d) The facility reported a census of 11 residents. The sample included 3 residents and 3 focused record reviews. Based on interview for all residents and record review the operator failed to ensure all resident including 3 (#129, #130, #131) of 3 sampled resident's negotiated service agreements included the name of the licensed nurse responsible for the implementation and supervision of the service plan.	S5161		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B088002	A. BUILDING: _____ B. WING _____	C 12/14/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD ESTATES HOME PLUS	1140 S PERSHING AVENUE LIBERAL, KS 67901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5161	Continued From page 4 Findings included: - Review of resident #128 medical record revealed the resident moved into the facility on 11-26-2018 with diagnoses of hypertension and vascular dementia. Review of the residents medical record revealed a functional capacity screen dated 8-27-2020 which indicated the resident required physical assistance with bathing and toileting, had cognitive impairment and bladder incontinence, and could not manage her own medications. Review of the resident negotiated service agreement dated 8-27-20 revealed licensed nursing staff I (who no longer worked at the facility) was responsible for implementation and supervision of the health care service plan. - Review of resident #130's medical record revealed the resident moved into the facility on 6-22-20 with diagnoses of hypertension, osteoarthritis, and weakness. Review of the resident's medical record revealed a functional capacity screen dated 6-22-20 indicated the resident was unable to manage/complete bathing, dressing and toileting and required physical assistance with transfers and mobility. It also revealed the resident could not manage his/her own medications and treatments. Review of the resident's negotiated service agreement dated 6-22-20 lacked the name of any nurse as responsible for implementation and supervision of the health care service plan.	S5161		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B088002	A. BUILDING: _____ B. WING _____	C 12/14/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD ESTATES HOME PLUS	1140 S PERSHING AVENUE LIBERAL, KS 67901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5161	Continued From page 5 - Review of resident #131's medical record revealed the resident moved into the facility on 4-5-2019 with diagnoses of multiple scleroses, hypertension and congestive heart failure. Review of the resident's medical record revealed a functional capacity screen dated 4-17-2020 revealed the resident needed physical assistance with all activities of daily living except for eating. It also revealed the resident needed physical assistance with management of medications and medical treatments. . Review of the negotiated service agreement dated 8-28-2019 revealed licensed nursing staff I (who no longer worked at the facility) was responsible for implementation and supervision of the health care service plan. During an interview on 10-9-2020 at 10:47 AM Operator A confirmed and stated she knew the licensed nurse responsible for the health care service plan needed to be changed on all of the residents service agreement since licensed nursing staff I is no longer employed at the facility. The operator failed to ensure all resident including 3 (#129, #130, #131) of 3 sampled resident's negotiated service agreements included the name of the current licensed nurse responsible for the implementation and supervision of the service plan.	S5161		
S5185 SS=D	26-42-206 (a) (b) (c) Dietary Services (a) The administrator or operator of each home plus shall ensure the provision or coordination of dietary services to residents as identified in each	S5185		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B088002	A. BUILDING: _____ B. WING _____	C 12/14/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD ESTATES HOME PLUS	1140 S PERSHING AVENUE LIBERAL, KS 67901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5185	Continued From page 6	S5185		

resident ' s negotiated service agreement.
(b) The supervisory responsibility for dietetic services shall be assigned to one employee.
(c) If a resident ' s negotiated service agreement includes the provision of a therapeutic diet, mechanically altered diet, or thickened consistency of liquids, a medical care provider ' s order shall be on file in the resident ' s clinical record, and the diet or liquids, or both, shall be prepared according to instructions from a medical care provider or licensed dietitian.

This REQUIREMENT is not met as evidenced by:
KAR 26-42-206 (c)

The facility reported a census of 11 residents. The sample included 3 residents and 3 focused record reviews. Based on observations, interview and record review the operator failed to ensure 1 (#130) of 1 sampled resident whose negotiated service agreement included the provision of a mechanically altered diet (pureed) was prepared according to instructions from a licensed dietitian.

Findings included:

- Review of resident #130's medical record revealed she admitted to the facility on 5-22-2020 with diagnoses of hypertension, osteoarthritis, and weakness.

Review of the resident's functional capacity screen dated 6-22-20 revealed the resident was independent with eating but unable to prepare her meals.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B088002	A. BUILDING: _____ B. WING _____	C 12/14/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD ESTATES HOME PLUS	1140 S PERSHING AVENUE LIBERAL, KS 67901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5185	Continued From page 7	S5185		

Review of the residents negotiated service agreement dated 6-22-20 revealed the resident needed staff to puree her food for her.

Review of the residents admission physicians orders dated 6-19-2020 included a diet order for regular pureed diet.

Observation on 12-9-2020 at 11:43 PM certified staff B turned on a blender with pork roast in it and confirmed resident #130 needed to have a pureed diet.

On 12-9-2020 at 12:15 PM certified staff B served resident #130 a plate that contained pureed roast pork, and brussel sprouts but the baked beans were regular texture. At 12:28 PM certified staff G served the resident a bowl of mandarin orange slices that were regular consistency. The resident proceeded to eat the oranges without any obvious coughing or other signs of choking.

Observation on 12-10-2020 at 8:03 AM the resident sat at the dining room table eating a whole banana with the peal still on and a container of yogurt with fruit.

During an interview on 12-10-2020 at 11:00 AM operator A stated staff should have pureed the residents mandarin oranges and should have mashed up the residents banana.

Review of the pureed foods instructions provided by Operator A revealed pureed foods do not need chewing, are completely smooth with no lumps. It also noted soft foods like ripe bananas can be mashed with a fork until smooth.

The operator failed to ensure staff provided resident #130 with a purred diet as ordered and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B088002	A. BUILDING: _____ B. WING _____	C 12/14/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD ESTATES HOME PLUS	1140 S PERSHING AVENUE LIBERAL, KS 67901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5185	Continued From page 8 according to dietitian instructions.	S5185		
S5192 SS=F	26-42-206 (e) Food Preparation (e) Food shall be prepared using safe methods that conserve the nutritive value, flavor, and appearance and shall be served at the proper temperature. (1) Food used by facility staff to serve to the residents, including donated food, shall meet all applicable federal, state, and local laws and regulations.(2) Food in cans that have significant defects, including swelling, leakage, punctures, holes, fractures, pitted rust, or denting severe enough to prevent normal stacking or opening with a manual, wheel-type can opener, shall not be used. (3) Food provided by a resident ' s family or friends for individual residents shall not be required to meet federal, state, and local laws and regulations. This REQUIREMENT is not met as evidenced by: KAR 26-42-206(e) The facility reported a census of 11 residents. The operator failed to ensure staff prepared food using safe methods that conserve the nutritive value, flavor and appearance and shall be served at the proper temperature as evidenced by record review and interview for all residents in the facility. Findings included: - Observation during entrance tour on 12-9-2020 at 11:54 AM revealed an open kitchen design with	S5192		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B088002	A. BUILDING: _____ B. WING _____	C 12/14/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD ESTATES HOME PLUS	1140 S PERSHING AVENUE LIBERAL, KS 67901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5192	Continued From page 9 a stove and oven with cabinet area for food prep. Certified staff B was preparing pureed diet for resident #130 and stated that she checked the temperature of the foods before they were served. Staff B looked in the red notebook and there was a food temperature log dated September and October of 2019 but lacked evidence of staff taking temperatures of food thus far for 2020. During an interview on 12-9-20 at 4:20 PM Operator A reported staff should be taking temperatures of food to ensure it is cooked and served at the proper temperature. Review of the policy for food temperature serving provided by the operator revealed all foods will be served at the appropriate temperatures to ensure good flavor and prevent food borne illnesses. All hot foods will be served at a temperature of at least 140 degreed Fahrenheit. For all residents, the operator failed to ensure facility staff used safe methods of cooking to ensure foods were cooked and served at the proper temperature.	S5192		
S5195 SS=F	26-42-206 (f) (g) Facility Food Storage (f) Staff shall store all food under safe and sanitary conditions. Containers of poisonous compounds and cleaning supplies shall not be stored in the areas used for food storage, preparation, or serving. (g) Each home shall maintain at least a three-day supply of food to meet the requirements of the planned menus.	S5195		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B088002	A. BUILDING: _____ B. WING _____	C 12/14/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD ESTATES HOME PLUS	1140 S PERSHING AVENUE LIBERAL, KS 67901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5195	Continued From page 10 This REQUIREMENT is not met as evidenced by: KAR 26-42-206 (f) The facility reported a census of 11 residents. For all residents in the facility, The operator failed to ensure staff stored food under safe and sanitary conditions. Findings included: - During initial tour on 12-9-2020 at 10:15 AM of the kitchen/food storage areas revealed the following: It also contained 8 plastic containers which contained different types of sugar, oatmeal, and pancake mix. There were only 4 of the containers were labeled as to the contents. An inner cereal bag of rice krispies sat on the shelf that was not sealed. A plastic bottle of parmesan cheese in the cabinet that was almost empty that had directions on the label to "refrigerate after opening". The refrigerator contained the following: an opened bottle of liquid with a tea bag in it that was not dated or labeled; a shaker type bottle of reddish liquid that was not dated or labeled and the lid had brownish spillage on it; and a container of cottage cheese without an open date that had a best used by date of 11-25-2020, 14 days past. The freezer had a bag of thawed bacon which was opened, without an open date and was not sealed, an undated opened box of french bread sticks was not sealed, and an undated open box of waffles was not sealed to reduce risk of freezer burn. Surveyor also observed a locked closet that had a 10# bag of potatoes on a plastic pallet	S5195		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B088002	A. BUILDING: _____ B. WING _____	C 12/14/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD ESTATES HOME PLUS	1140 S PERSHING AVENUE LIBERAL, KS 67901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5195	Continued From page 11	S5195		

approximately 2 inches off the floor. The pallet was next to a drain which had the potential to back up and contaminate the potatoes.

During an interview on 12-9-20 at 10:30 AM operator A reported they don't usually date food items in the pantry because they are used so quickly. She also confirmed the opened bag of rice krispies was not sealed and should be in appropriate container.

On 12-9-2020 at 4:20 PM Operator A voiced understanding of concerns related to food storage and stated she had forgotten that the potatoes were even in the closet.

Reference of the Focus on Food Safety dated August 2017 revealed that food must be date marked if prepared on-site, or commercially processed, after the original container is opened and held under refrigeration, potentially hazardous food, ready to eat food, and food that is to be held for more than 24 hours.

According to the FDA Food Code, food must be stored in a clean, dry location where it will not be contaminated, and elevated at least 6 inches off the floor.

Review of the food storage police dated 1-5-2018 revealed when dry foods are transferred to another container after opening, the container ... will be labeled with the name of the item and date the item was transferred.

The operator failed to ensure all food items were stored under safe and sanitary conditions.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B088002	A. BUILDING: _____ B. WING _____	C 12/14/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD ESTATES HOME PLUS	1140 S PERSHING AVENUE LIBERAL, KS 67901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5230	Continued From page 12	S5230		
S5230 SS=F	26-42-207 (b)(5)(6) (c) Infection Control Policies (b)(5) prohibiting any employee with a communicable disease or any infected skin lesions from coming in direct contact with any resident, any resident ' s food, or resident care equipment until the condition is no longer infectious; (6) providing orientation to new employees and employee in-service education at least annually on the control of infections in a health care setting; (c) Each administrator or operator shall ensure the home ' s compliance with the department ' s tuberculosis guidelines for adult care homes adopted by reference in K.A.R. 26-39-105. This REQUIREMENT is not met as evidenced by: KAR-42-207 (c) The facility reported a census of 11 residents. The sample included 3 residents and 3 focused record reviews. Based on interview and record review the owner/operator failed to ensure the home maintained compliance with the tuberculosis (TB) guidelines for adult care homes adopted by reference in K.A.R. 26-39-105 for 2 of 5 newly hired employees and 5 (#127, #128, #129, #130) of 6 sampled residents. This failure had the potential to affect all residents in the facility. Findings included: - Review of resident #127's medical record revealed she admitted into the facility on 12-15-2018 with diagnoses of Osteoporosis,	S5230		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B088002	A. BUILDING: _____ B. WING _____	C 12/14/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD ESTATES HOME PLUS	1140 S PERSHING AVENUE LIBERAL, KS 67901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5230	Continued From page 13 myalgia and hypertension. Review of the residents record lacked evidence of staff completing an annual tuberculosis (TB) screening form and/or skin test. - Review of resident #128's medical record revealed the resident admitted to the facility on 11-26-2018 with diagnoses of hypertension and vascular dementia. Review of the resident's record lacked evidence of staff completing an annual TB screening form and/or skin test. - Review of resident # 129's medical record revealed she admitted to the facility on 6-5-2019 with diagnoses of dementia, hypertension and coronary artery disease. Review of the resident's record lacked evidence of staff completing an annual TB screening form and/or skin test. - Review of resident #130's medical record revealed the resident admitted to the facility on 6-22-2020 with diagnoses of hypertension, osteoarthritis, and constipation. Review of the residents included a TB screening form but lacked evidence of a 2 step admission TB skin test. - Review of resident #131's medical record revealed the resident admitted to the facility on 4-5-2019 with diagnoses of multiple sclerosis, pain, hypertension and congestive heart failure. Review of the resident's record lacked evidence of staff completing an annual TB screening form	S5230		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B088002	A. BUILDING: _____ B. WING _____	C 12/14/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD ESTATES HOME PLUS	1140 S PERSHING AVENUE LIBERAL, KS 67901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5230	Continued From page 14 and/or skin test. During an interview on 12-10-2020 at 10:43 AM Operator A reported when Licensed nursing staff I moved licensed nurse J agreed to be the main nurse. Licensed nurse J is new and is learning all the processes that need to be done so that is why TB screening/skin testing has not been completed timely. - Review of certified staff B's record revealed she hired on at the facility on 7-23-2020. The record lacked evidence of TB screening form completed upon hire or a 2-step TB skin test initiated within 7 days of hire. - Review of certified staff C's record revealed she hired on at the facility on 7-22-2020. The record lacked evidence of TB screening form completed upon hire or a 2-step TB skin test initiated within 7 days of hire. During an interview on 12-9-2020 at 12:10 PM when Operator A provided the employee records for review she stated there were 2 employees who did not have their TB skin tests done when they were hired. The operator failed to ensure designated staff maintained compliance with the TB guidelines for adult care homes adopted by reference in K.A.R. 26-39-105.	S5230		
S5258 SS=F	26-42-102 (d) Staff Qualifications Employee Records (d) The employee records and agency staff records shall contain the following information:	S5258		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B088002	A. BUILDING: _____ B. WING _____	C 12/14/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD ESTATES HOME PLUS	1140 S PERSHING AVENUE LIBERAL, KS 67901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5258	Continued From page 15 (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 carehome; 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 work as a certified nurse aide. This REQUIREMENT is not met as evidenced by: KAR-26-42-102 (d)(1) The facility reported a census of 11 residents. Based on interview and record review, the administrator failed to ensure 2 of 5 employee records contained certification verification information upon hire which had the potential to affect all residents in the facility. Findings included: - Review of employee files conducted on 12-9-2020 revealed the following: Certified staff D hired on 3-5-20 and had a	S5258		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B088002	A. BUILDING: _____ B. WING _____	C 12/14/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD ESTATES HOME PLUS	1140 S PERSHING AVENUE LIBERAL, KS 67901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5258	Continued From page 16 certification verification completed on 4-30-2020, more than thirty days after hire date. Certified staff F hired on 10-23-2019 and had a certification verification completed on 11-21-2019, twenty-nine days after hire date. An interview on 12-9-2020 at 12:42 PM Operator A reported she normally prints verification from the registry before she interviews the potential employee. Operator A was not sure why employee D and F did not have theirs done on or before they were hired. The operator failed to ensure employee records contained certification verification information upon hire.	S5258		
S5300 SS=E	26-42-205 (d) (1-2) Facility Administration of Medications (d) Home administration of resident ' s medications. If a home 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 shall ensure that all of the following are met: (1) Only licensed nurses and medication aides shall administer and manage medications for which the home has responsibility. (2) Medication aides shall not administer medication through the parenteral route.	S5300		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B088002	A. BUILDING: _____ B. WING _____	C 12/14/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD ESTATES HOME PLUS	1140 S PERSHING AVENUE LIBERAL, KS 67901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5300	Continued From page 17 This REQUIREMENT is not met as evidenced by: KAR 26-42-205 (d) The facility reported a census of 11 residents. The sample included 3 residents and 3 focused record reviews. Based on interview and record review the Operator failed to ensure designated staff administered medications according to standards of practice for 2 (#128, #130,) of 3 sampled residents. Findings included: - Review of resident #128 medical record revealed the resident moved into the facility on 11-26-2018 with diagnoses of hypertension and vascular dementia. Review of the residents medical record revealed a functional capacity screen dated 8-27-2020 which indicated the resident could not manage her own medications. Review of the resident negotiated service agreement dated 8-27-20 revealed facility staff needed to administer the resident her medications. Review of the physicians orders dated 6/25/2020 included an order for Acetaminophen 500 mg 1-2 tablets every 6 hours as needed (PRN) for pain. Review of the resident's medication administration record (MAR) for December 2020 revealed the staff provided the resident Acetaminophen 500 mg on 12/1,6,7,9/2020. The MAR identified 3 of those times were for right ankle pain and 1 was for right wrist pain. The	S5300		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B088002	A. BUILDING: _____ B. WING _____	C 12/14/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD ESTATES HOME PLUS	1140 S PERSHING AVENUE LIBERAL, KS 67901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5300	Continued From page 18	S5300		

MAR lacked evidence of staff checking with the resident to identify if the Acetaminophen was effective or not.

- Review of resident #130's medical record revealed the resident moved into the facility on 6-22-20 with diagnoses of hypertension, osteoarthritis, and weakness.

Review of the resident's medical record revealed a functional capacity screen dated 6-22-20 indicated the resident could not manage his/her own medications and treatments.

Review of the resident's negotiated service agreement dated 6-22-20 revealed facility staff would administer the resident her medications.

Review of the physicians orders dated 6-19-2020 included an order for Aleve 220 mg. every 8 hours as needed (PRN) for pain.

Review of the November 2020 medication administration record (MAR) revealed the staff administered the resident Aleve on 11/3,10, 11, 14, 25,26/2020. The MAR revealed staff failed to document administration on the back of the MAR as to the time and reason of administration for the 10th, 14th, and 25th. Staff also failed to follow-up for effectiveness of pain medication given.

Review of the December 2020 MAR revealed the resident received Aleve 220 mg on 12/1,4/2020 but staff failed to follow-up on effectiveness of pain medication.

During an interview on 12-10-2020 at 11:35 AM certified staff B reported that after she gives the resident a PRN medications the resident will let me know if it doesn't work. Staff B stated she did

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B088002	A. BUILDING: _____ B. WING _____	C 12/14/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD ESTATES HOME PLUS	1140 S PERSHING AVENUE LIBERAL, KS 67901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5300	Continued From page 19 not follow-up with the resident for the effectiveness of the medications and did not write on the MAR or nurses note if it was effective or not. During an interview on 12-10-2020 at 10:48 AM operator A stated the staff should follow-up for effectiveness if they give a PRN medication. The Operator failed to ensure designated staff administered medications according to standards of practice for 2 (#128, #130,) of 3 sampled residents related to the follow-up for effectiveness of PRN medications.	S5300		
S5325 SS=F	26-42-205 (l) Medication Regimen Review Frequency (l) Medication regimen review. A licensed pharmacist or licensed nurse shall conduct a medication regimen review at least quarterly for each resident whose medication is managed by the home and each time the resident experiences any significant change in condition. This REQUIREMENT is not met as evidenced by: KAR 26-42-205(l) The facility reported a census of 11 residents. The sample included 3 residents and 3 focused record review. Based on record review and interview for all residents and for 3 (#128, #130, #131) of 3 sampled residents, the administrator failed to ensure a licensed pharmacist or	S5325		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B088002	A. BUILDING: _____ B. WING _____	C 12/14/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD ESTATES HOME PLUS	1140 S PERSHING AVENUE LIBERAL, KS 67901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5325	Continued From page 20	S5325		

licensed nurse conducted a medication regimen review at least quarterly for each resident whose medication was managed by the facility staff.

Findings included:

-- Review of resident #128 medical record revealed the resident moved into the facility on 11-26-2018 with diagnoses of hypertension and vascular dementia.

Review of the residents medical record revealed a functional capacity screen dated 8-27-2020 which indicated the resident could not manage her own medications.

Review of the resident negotiated service agreement dated 8-27-20 revealed the facility staff administered the resident her medications.

The residents record lacked evidence of medication reviews since April of 2020.

- Review of resident #130's medical record revealed the resident moved into the facility on 6-22-20 with diagnoses of hypertension, osteoarthritis, and weakness.

Review of the resident's medical record revealed a functional capacity screen dated 6-22-20 indicated the resident could not manage his/her own medications and treatments.

Review of the resident's negotiated service agreement dated 6-22-20 revealed staff would administer the resident her medications and she preferred them to be crushed in applesauce.

The residents record lacked evidence of a medication regimen review since admission to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B088002	A. BUILDING: _____ B. WING _____	C 12/14/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD ESTATES HOME PLUS	1140 S PERSHING AVENUE LIBERAL, KS 67901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5325	Continued From page 21 the facility. - Review of resident #131's medical record revealed the resident moved into the facility on 4-5-2019 with diagnoses of multiple scleroses, hypertension and congestive heart failure. Review of the resident's medical record revealed a functional capacity screen dated 4-17-2020 revealed the resident needed physical assistance with management of medications and medical treatments. . Review of the negotiated service agreement dated 8-28-2019 revealed staff would administer medications on the MAR and there was a list of medication in her room she self-administered. The residents record lacked evidence of a medication regimen review since June of 2020. During an interview on 10-9-2020 at 3:00 PM Operator A reported the facility had a change in licensed nurses and the third quarter medication reviews for all residents had not been completed. Review of the facilities medication regimen review policy dated 2-2015 revealed the consultant pharmacist will perform a drug regimen review on each resident at least quarterly. The operator failed to ensure designated staff conducted a medication regimen review at least quarterly for all residents and for 3 (#904, #014, #924) of 3 residents.	S5325		