STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B011004	A. BUILDING: _____ B. WING _____	09/10/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEGACY LIVING OF BAXTER SPRINGS LLC	445 E 10TH ST BAXTER SPGS, KS 66713

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S 000	INITIAL COMMENTS The following citations represent the findings of an initial survey at the above named home plus facility conducted on 8-29-18, 8-30-18, 9-4-18, 9-5-18, 9-6-18, and 9-10-18.	S 000		
S5029 SS=F	26-42-101 (g) Availability of policies and procedures (g) Availability of policies and procedures. Each administrator or operator shall ensure that policies and procedures related to resident services are available to staff at all times and are available to each resident, legal representatives of residents, case managers, and families during normal business hours. A notice of availability shall be posted in a place readily accessible to residents. This REQUIREMENT is not met as evidenced by: KAR 26-42-101(g) The facility reported a census of 8 residents. The sample included 3 residents. The operator failed to post a notice of availability of policies and procedures in a place readily accessible to residents as evidenced by observation and interview and affecting all residents, legal representative of residents, case managers and families. Findings included: - Observation during entrance tour of facility accompanied by Licensed Staff B on 8-29-18 from 12:35 pm to 1:40 pm revealed the facility lacked a posted notice of availability of policies and procedures in a place readily accessible to residents.	S5029		

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

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S5029	Continued From page 1 Interviews on 8-29-18 at 12:35 pm and 3:00 pm during completion of entrance tour checklist with Licensed Staff B confirmed no notice of availability of policies and procedures posted. Stated he/she thought the policies and procedures were on the operator's computer and did not have a printed copy available. For all residents, the operator failed to post a notice of availability of policies and procedures in a place readily accessible to residents.	S5029		
S5050 SS=F	26-42-101 (k) Ombudsman (k) Ombudsman. Each administrator or operator shall ensure the posting of the names, addresses, and telephone numbers of the Kansas department on aging and the office of the long-term care ombudsman with information that these agencies can be contacted to report actual or potential abuse, neglect, or exploitation of residents or to register complaints concerning the operation of the home. The administrator or operator shall ensure that this information is posted in a common area accessible to all residents and the public. This REQUIREMENT is not met as evidenced by: KAR 26-42-101(k) The facility reported a census of 8 residents. The sample included 3 residents. The operator failed to ensure the posting of the name, address, and telephone number of the Kansas Department for Aging and Disability Services and the Office of the Long-Term Care Ombudsman in a common	S5050		

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S5050	Continued From page 2	S5050		

area readily accessible to all residents and the public, with information that this agency could be contacted to report actual or potential abuse, neglect, or exploitation of residents or to register complaints concerning the operation of the home, as evidenced by observations and interviews, for 1 of 1 home plus facility and affecting all residents and the public.

Findings included:

- Observations on 8-29-18 from 12:35 pm to 1:40 pm during a tour of the facility revealed no evidence of the posting of the contact information for the Kansas Department for Aging and Disability Services and the Office of the Long-Term Care Ombudsman in a common area readily accessible to all residents and the public, with information this agency could be contacted to report actual or potential abuse, neglect, or exploitation of residents or to register complaints concerning the operation of the home.

Interviews on 8-29-18 at 12:35 pm and 3:00 pm with Licensed Staff B during tour of facility and completion of entrance tour checklist confirmed the home lacked a poster with contact information for the Kansas Department for Aging and Disability Services and the Office of the Long-Term Care Ombudsman.

The operator failed to ensure the posting of the name, address, and telephone number of the Kansas Department for Aging and Disability Services and the Office of the Long-Term Care Ombudsman in a common area readily accessible to all residents and the public, with information that this agency could be contacted to report actual or potential abuse, neglect, or exploitation of residents or to register complaints

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S5050	Continued From page 3 concerning the operation of the home.	S5050		
S5105 SS=F	26-42-202 (a) Negotiated Service Agreement a) The administrator or operator of each home plus shall ensure the development of a written negotiated service agreement for each resident, based on the resident ' s functional capacity screening, service needs, and preferences, in collaboration with the resident or the resident ' s legal representative, the case manager, and, if agreed to by the resident or the resident ' s legal representative, the resident ' s family. The negotiated service agreement shall provide the following information: (1) A description of the services the resident will receive; (2) identification of the provider of each service; and (3) identification of each party responsible for payment if outside resources provide a service. This REQUIREMENT is not met as evidenced by: KAR 26-42-202(a)(1)(2)(3) The facility reported a census of 8 residents. The sample included 3 residents. The operator failed to 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; and further failed to ensure the negotiated service agreements provide a description of the services the resident will receive, identification of the provider of each service and identification of each party	S5105		

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S5105	Continued From page 4	S5105		

responsible for payment if outside resources provide a service as evidenced by observations, record review and interview for 3 (#508, #509, #510) of 3 sampled residents and affecting all residents.

Findings included:

- Record review for Resident #508 revealed admission on 8-15-18 with diagnoses Dementia with Behavioral Disturbance, Cerebellar Stroke Syndrome, Intracranial Injury and Atrial Fibrillation.

The Functional Capacity Screen (FCS) dated 8-15-18 recorded resident required physical assistance with bathing, dressing, toileting, transfers, walking/mobility and management of medications/treatments; and supervision with eating. Usually continent of bladder. Cognition: problems with short and long term memory, memory/recall and decision-making. No problems with communication. Current problems/risks identified included falls, impaired vision, impaired decision-making and socially inappropriate disruptive behavior. Uses wheelchair and mechanical lift. Comments: Mechanical Soft Diet; Honey Thick Liquids.

The record lacked a written negotiated service agreement and health care service plan.

Observation of resident on 8-29-18 and 8-30-18 revealed resident's room revealed it to be a shared room (no roommate at this time). Resident had hospital bed with bilateral half rails and a Hoyer lift. Video/audio monitor in use. Resident requires two staff for all transfers and uses a wheelchair for mobility. Observed Non-Certified Staff F assisting resident to eat.

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S5105	Continued From page 5 Resident has behaviors of yelling out, restlessness and arguing with staff at times. - Record review for resident #509 revealed admission on 1-13-18 with unknown diagnoses. The Functional Capacity Screen (FCS) dated 1-13-18 recorded resident required physical assistance with bathing, dressing, toileting, transfers, and management of medications/treatments; and supervision with walking/mobility and eating. Incontinent of bladder. . Current problems/risks identified included falls/unsteadiness, impaired vision, impaired hearing, and impaired decision-making. No assistive devices. The record lacked a written negotiated service agreement and health care service plan. Observation of resident on 8-29-18 and 8-30-18 revealed resident to ambulate independently through facility. Enjoys sitting in kitchen. Eats independently. Experienced two falls on 7-9-18 and one fall on 7-22-18 with rib fracture. Intervention was to change footwear from cowboy boots to tennis shoes. No falls since change. Observed resident ambulate with steady gait. Audio monitor in room. - Record review for resident #510 revealed admission on 12-1-17 with diagnosis Epilepsy. The Functional Capacity Screen (FCS) dated 12-1-17 recorded resident required physical assistance with bathing, and management of medications/treatments; independent with dressing, toileting, transfers, eating; and	S5105		

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S5105	Continued From page 6	S5105		

supervision with eating. Occasionally incontinent of bladder. Cognition: problems with long term memory and decision-making. Current problems/risks identified included falls/unsteadiness, impaired decision-making and socially inappropriate disruptive behavior. Uses walker and wheelchair.

The record lacked a written negotiated service agreement and health care service plan.

Observation of resident and room on 8-29-18 revealed resident physically assisted into bed by Non-Certified Staff F. Resident resting in a twin sized bed with fabric-covered side rail on one side of bed (straps extend under mattress and attach to frame on opposite side). The bed lacked a headboard or foot board. Resident stated he/she could get out of the bed, "I can scoot down to the bottom to fall" (indicating he/she could get out of bed at the bottom since there was no footboard). Resident able to request rail to be put down to get out of bed. Audio monitor in use.

Interview on 8-29-18 at 4:35 pm and 5:11 pm with Operator and Licensed Staff B confirmed all resident records lacked a negotiated service agreement and health care service plan. Stated all resident rooms have a baby monitor (audio) so staff can hear if they need assistance.

For residents #508, #509, #510, and affecting all residents, the operator failed to 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 negotiated service agreement shall provide a description of the services the resident will

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S5105	Continued From page 7 receive, identification of the provider of each service and identification of each party responsible for payment if outside resources provide a service.	S5105		
S5155 SS=E	26-42-204 (a) Health Care Services (a) The administrator or operator in each home plus shall ensure that a licensed nurse provides or coordinates the provision of necessary health care services that meet the needs of each resident and are in accordance with the functional capacity screening and the negotiated service agreement. This REQUIREMENT is not met as evidenced by: KAR 26-42-204(a) The facility reported a census of 8 residents. The sample included 3 residents. Based on observation, record review and interview for 2 (#508, #510) of 3 sampled residents, the operator failed to ensure the licensed nurse provides or coordinates the provision of health care services that meet the needs of each resident and are in accordance with the functional capacity screening and the negotiated service agreement. Findings included: - Record review for Resident #508 revealed admission on 8-15-18 with diagnoses Dementia with Behavioral Disturbance, Cerebellar Stroke Syndrome, Intracranial Injury and Atrial	S5155		

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S5155	Continued From page 8 Fibrillation. The Functional Capacity Screen (FCS) dated 8-15-18 recorded resident required physical assistance with bathing, dressing, toileting, transfers, walking/mobility and management of medications/treatments; and supervision with eating. Usually continent of bladder. Cognition: problems with short and long-term memory, memory/recall and decision-making. No problems with communication. Current problems/risks identified included falls, impaired vision, impaired decision-making and socially inappropriate disruptive behavior. Uses wheelchair and mechanical lift. Comments: Mechanical Soft Diet; Honey Thick Liquids. A form labeled "Daily Care Plan" which was kept in a separate notebook and dated 8-16-18 to 8-22-18 stated the following: Mechanical soft diet, Diabetic. Honey to raise blood sugars. 8-22-18 went to emergency room couldn't get blood sugar to stay up. 8-24-18 Returned from emergency room. The record lacked a written negotiated service agreement and health care service plan to address mechanically altered diet and use of a Hoyer lift, 2 staff for transfers, video monitor and siderails on bed. Observation of resident on 8-29-18 and 8-30-18 revealed resident's room revealed it to be a shared room (no roommate at this time). Resident had hospital bed with bilateral half rails and a Hoyer lift. Video/audio monitor in use. Resident requires two staff for all transfers and uses a wheelchair for mobility. Observed Non-Certified Staff F assisting resident to eat. Resident has behaviors of yelling out,	S5155		

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S5155	Continued From page 9	S5155		

restlessness and arguing with staff at times.

Review of "Fiberoptic Endoscopic Evaluation of Swallowing" performed on 7-19-18:
Reason for Referral: To rule out aspiration; to delineate nature/extent/severity of pharyngeal phase dysphagia; and to determine efficacy of potential treatment interventions.
Findings: Mild Oral Phase Dysphagia; Moderate Pharyngeal Phase Dysphagia. No signs observed of esophageal phase dysphagia. Reflux Finding Score: 3 (if greater than 7 = 95% likelihood of laryngopharyngeal reflux.)
Clinical Implications: Patient benefits from: Consuming mechanical soft consistency diet and honey consistency liquids using cyclic ingestion, effortful multiple swallow in upright position as tolerated.
Recommendations: change diet to mechanical soft and honey consistency liquids. Follow up fiberoptic endoscopic evaluation of swallowing in 3 weeks. Reference to New Dining Practice Standards re: patient/caregiver education for informed choice about diet/liquid consistency considerations.

Interview on 8-29-18 at 4:35 pm and 5:11 pm with operator confirmed no negotiated service agreement had been completed and the "Daily Care Plan" was not part of an NSA (Health Care Service Plan)

On 8-30-18 around 10:30 am, Licensed Staff B provided copy of swallow evaluation after contacting previous facility and requesting. Confirmed he/she had not reviewed the evaluation to determine if resident still needed to be on the mechanically altered diet. Further confirmed he/she failed to contact physician with swallow evaluation results to determine if

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S5155	Continued From page 10	S5155		

physician wanted diet to continue. Provided a copy of a form labeled "Daily Care Plan" which identified the diet to be "mechanical soft, diabetic." Confirmed no documentation of the honey thickened liquids. Licensed Staff B stated resident was not receiving a mechanical soft diet because it had been "discontinued" since it was not reordered when the resident returned from a hospital visit. Confirmed he/she did not have documentation of an order to discontinue the mechanically altered diet and had not called the physician to clarify when the resident returned from the hospital on 8-24-18. Further confirmed he/she had not performed a safety assessment for use of siderails for this resident or any other resident utilizing siderail on bed. Further confirmed the siderails and video monitor were not included documented on a health care service plan.

For Resident #508, the operator failed to ensure the licensed nurse provided or coordinated the provision of health care services to address the resident's use of siderails, Hoyer lift, video monitoring and mechanically altered diet.

- Record review for resident #510 revealed admission on 12-1-17 with diagnosis Epilepsy.

The Functional Capacity Screen (FCS) dated 12-1-17 recorded resident required physical assistance with bathing, and management of medications/treatments; independent with dressing, toileting, transfers, eating; and supervision with eating. Occasionally incontinent of bladder. Cognition: problems with long term memory and decision-making. Current problems/risks identified included falls/unsteadiness, impaired decision-making and

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S5155	Continued From page 11	S5155		

socially inappropriate disruptive behavior. Uses walker and wheelchair. (Note: The record lacked a written negotiated service agreement)

The record lacked a health care service plan to address resident's risk for seizures and use of a siderail on bed including a safety assessment prior to use.

Observation of resident and room on 8-29-18 revealed resident physically assisted into bed by Non-Certified Staff F. Resident resting in a twin sized bed with fabric-covered side rail on one side of bed (straps extend under mattress and attach to frame on opposite side). The bed lacked a headboard or foot board. Resident stated he/she could get out of the bed, "I can scoot down to the bottom to fall". Resident able to request rail to be put down to get out of bed. Audio monitor in use.

A form labeled "Daily Care Plan" kept in a separate notebook and dated 8-11-18 to 8-17-18 recorded on 8-12-18 "Had a seizure this morning." Initialed by Non-Certified Staff F. The Daily Care Plan listed: Morning meds, afternoon meds, evening meds, wash face, brush teeth, fix hair, lotion feet, put clothes in laundry, make bed, Clorox wipe toilet each use, disinfect wheelchair.

Interviews on 8-30-18 at 12:35 during tour of facility and at 1:26 pm with Licensed Staff B stated resident has seizures, "just about daily" and confirmed no interventions in place to address the seizures. Further confirmed no interventions for use of a siderail. Confirmed he/she failed to perform a safety assessment for use of the siderail.

For Resident #510, the operator failed to ensure a licensed nurse provided or coordinated the

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S5155	Continued From page 12 provision of health care services to address the resident's risk for seizures and use of siderails on bed including a safety assessment prior to use.	S5155		
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 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 8 residents. The sample included 3 residents. Based on record review and interview for 1 (#508) of 1 sampled residents with an order for a mechanically altered diet, the operator failed to ensure the diet shall be prepared according to instructions from a medical care provider or license dietitian. Findings included: - Record review for Resident #508 revealed	S5185		

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admission on 8-15-18 with diagnoses Dementia with Behavioral Disturbance, Cerebellar Stroke Syndrome, Intracranial Injury and Atrial Fibrillation.

The Functional Capacity Screen (FCS) dated 8-15-18 recorded resident required supervision with eating. Comments: Mechanical Soft Diet; Honey Thick Liquids.

A form labeled "Daily Care Plan" which was kept in a separate notebook and dated 8-16-18 to 8-22-18 stated the following: Mechanical soft diet, Diabetic. Honey to raise blood sugars.

Review of "Fiberoptic Endoscopic Evaluation of Swallowing" performed on 7-19-18: Recommendations: change diet to mechanical soft and honey consistency liquids.

On 8-30-18 around 10:30 am, Licensed Staff B provided a copy of swallow evaluation after contacting previous facility and requesting. Confirmed he/she had not reviewed the evaluation to determine if resident still needed to be on the mechanically altered diet. Further confirmed he/she failed to contact physician with swallow evaluation results to determine if physician wanted diet to continue. Provided a copy of a form labeled "Daily Care Plan" which identified the diet to be :mechanical soft diabetic". Confirmed no documentation of the honey thickened liquids.

Interview on 8-29-18 at 9:55 am with operator and Licensed Staff B confirmed Non-Certified Staff H prepared meals at the facility and Resident #508 was only resident in facility that had received a mechanically altered diet when he/she first moved in. Confirmed the facility

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S5185	Continued From page 14 lacked written instructions for preparation and serving of a mechanically altered diet and/or thickened liquids. Interview on 9-6-18 at 10:45 am with operator confirmed the facility lacked policies and procedures for preparation and serving of mechanically altered and/or therapeutic diets. For Resident #508, the operator failed to ensure the mechanically altered diet was prepared according to instructions from a medical care provider or licensed dietitian.	S5185		
S5186 SS=F	26-42-206 (d) Dietary Services Menus (d) The menus shall be planned in advance and in accordance with the dietary guidelines adopted by reference in K.A.R. 26-39-105. This REQUIREMENT is not met as evidenced by: KAR 26-42-206(d) The facility reported a census of 8 residents. The sample included 3 residents. Based on record review and interview for all residents, the operator failed to ensure menus are planned in accordance with the dietary guidelines adopted by reference in KAR 26-39-105. Findings included: - On 8-30-18, operator provided copy of menus used in facility which revealed hand-written menus prepared by the week, Monday through Sunday.	S5186		

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S5186	Continued From page 15 Examples of meals from menus provided: Dinner: Frozen Pizza Dinner: Potato Soup, mozzarella sticks Lunch: Spaghetti and garlic bread Dinner: Sloppy Joes Dinner: 1. Stuffed peppers (left over meatloaf) 2. Chicken nuggets Dinner: 1. Frozen pizza 2. Chicken Enchiladas Lunch: "Marvins" Lunch: 1. Pork loin 2. Pork cutlets Lunch: 1. Spaghetti 2. Pork chops Interview on 8-30-18 at 9:55 am with Operator stated Non-Certified Staff H has begun cooking for facility and writing out weekly menus. Stated "we write (menu) for each week and make a shopping list." Stated Non-Certified Staff H makes out menus "based on the foods they (residents) like." Confirmed the facility staff does not utilize USDA guidelines to make menus from and restated, "we just fix what they like." For all residents, the operator failed to ensure the menus are planned in accordance with the dietary guidelines adopted by reference in KAR 26-39-105.	S5186		
S5205 SS=J	26-42-104 (a) Disaster and Emergency Preparedness a) The administrator or operator of each home plus shall ensure the provision of a sufficient number of staff members to take residents who would require assistance in an emergency or disaster to a secure location. This REQUIREMENT is not met as evidenced by:	S5205		

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S5205	Continued From page 16 KAR 26-42-104(a) The facility reported a census of 8 residents. The sample included 3 residents. Based on observation, record review and interview for 1 (#508) of 3 sampled residents, the operator failed to ensure the provision of a sufficient number of staff on night shift to take residents who would require assistance to a secure location when only one staff was on duty to care for all residents included #508 who required the assistance of 2 staff for transfer. This failure placed the resident in immediate jeopardy for harm, injury, or death. Findings included: - The roster identified all residents with impaired cognition and 1 resident (#508) who required 2 staff for transfers. Interview regarding roster completed by Licensed Staff B on 8-29-18 at 2:35 pm confirmed Resident #508 required two staff to transfer. Resident unable to bear weight and requires use of a Hoyer lift. Confirmed that since resident admission on 8-15-18, "there was one person here" at night. Stated 2 staff were on duty during the day, and only one staff member was scheduled to work the night shift routinely from 11:00 pm until 7:00 am. - Record review for resident #508, admitted on 8-15-18, revealed diagnoses included Dementia with Behavioral Disturbance, Cerebellar Stroke Syndrome, Intracranial Injury and Atrial Fibrillation. The Functional Capacity Screen dated 8-15-18 recorded resident required physical assistance with transfers and walking/mobility. Resident uses wheelchair and mechanical lift. The record lacked a negotiated	S5205		

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S5205	Continued From page 17 service agreement. Observation on 8-30-18 at 10:45 am revealed resident #508 required physical assistance of Licensed Staff B and Certified Staff P to transfer from wheelchair to recliner. Both staff were required to assist the resident with all transfers with use of a Hoyer lift to position properly and safely. Interview on 8-29-18 at 4:30 pm with operator confirmed facility had not conducted a drill that included evacuation of residents with the use of 1 staff member on the night shift to determine if an evacuation could be performed safely and in a timely manner with 1 staff person. Interviews on 9-4-18 at 10:09 am and 12:20 pm, operator confirmed from 9:00 pm until 7:00 am the next day, there was one staff member scheduled to work even after Resident #508 moved in and required two staff to transfer. Stated in the event of an emergency evacuation, Non-Sampled Residents #600 and #601 would not be able to safely evacuate the facility without "full assistance" from staff. For Resident #508 who required 2 staff to transfer, the operator failed to ensure the provision of a sufficient number of staff members to take residents who would require assistance in an emergency or disaster to a secure location during the night shift when only 1 staff member was on duty. This failure placed the resident in immediate jeopardy for harm, injury or death The jeopardy was removed on 8-29-18 when two certified or licensed staff were scheduled on duty at all times.	S5205		

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S5215	Continued From page 18	S5215		
S5215 SS=F	26-42-104 (d) Disaster and Emergency Preparedness Education (d) Each administrator or operator shall ensure disaster and emergency preparedness by ensuring the performance of the following: (1) Orientation of new employees at the time of employment to the home ' s emergency management plan; (2) education of each resident upon admission to the home regarding emergency procedures; (3) quarterly review of the home ' 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 REQUIREMENT is not met as evidenced by: KAR 26-42-104(d) The facility reported a census of 8 residents. The sample included 3 residents. Based on record review and interview for all residents, the operator failed to ensure quarterly review of the home's emergency management plan with employees and residents and an emergency drill that included evacuation of the residents to a secure location. Findings included: - Interview during entrance tour on 8-29-18 at 3:00 pm with Licensed Staff B stated he/she could not locate a copy of the facility emergency management plan and confirmed the facility had	S5215		

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S5215	Continued From page 19 not performed an evacuation. Stated the secure location will be "in the parking lot by the tree". - Interview on 8-29-18 at 4:30 pm, Operator confirmed the facility lacked documentation of an evacuation performed with all residents. Operator unable to provide the Emergency Management Plan, stated it's "on my computer." Further confirmed no documentation of review of the emergency management plan with residents. On 8-30-18 at 1:30 pm, Operator provided copy of staff sign in sheet labeled "Quarterly Emergency Training" performed with 9 staff on 8-22-18. The operator confirmed he/she lacked any further documentation of review and the sign-in sheet lacked an attached agenda stating what information was reviewed. For all residents, the operator failed to ensure disaster and emergency preparedness by ensuring performance of quarterly review of the emergency management plan with residents and staff and performance of an evacuation drill conducted annually with staff and residents to a secure location.	S5215		
S5230 SS=E	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;	S5230		

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S5230	Continued From page 20 (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 26-42-207(c) The facility reported a census of 8 residents. The sample included 3 residents. Based on record review and interview for 2 (#508, #509) of 3 sampled residents and 5 (B, E, F, G, H) of 5 sampled employees, the operator failed to 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. Findings included: - Personnel record review conducted on 8-30-18 at 11:16 am with operator who confirmed the following: Licensed Staff B with date of hire 11-25-17. No documentation of TB skin testing. Certified Staff E with date of hire 1-26-18. No documentation of TB skin testing. Non-Certified Staff F with date of hire 5-19-18. No documentation of TB skin testing. Non-Certified Staff G with date of hire 5-19-18. No documentation of TB skin testing. Non-Certified Staff H with date of hire 11-25-17. No documentation of TB skin testing.	S5230		

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S5230	Continued From page 21 - Resident record review revealed the following: - Record review for Resident #508 with admission on 8-15-18. The record lacked documentation of a 2-Step Tuberculosis Skin Test. Interview on 8-29-18 at 5:10 pm with Licensed Staff B confirmed the record lacked a TB skin test, stating he/she had not performed the test yet. - Record review for resident #509 with admission on 1-13-18. The record contained a 2-step TB skin test which lacked date solution planted and date test read. Results recorded as 0 millimeters of induration and signed by Licensed Staff B. Interview on 8-30-18 1:00 pm with Licensed Staff B reviewed test results and confirmed he/she failed to record the dates on the form. Facility policy for "Infection Control" stated: "F. Tuberculosis Guidelines: The administrator or operator shall insure compliance with the tuberculosis guidelines for adult care homes. Residents and employees shall have a TB test performed within seven days of admission or employment." The policy lacked requirement for a 2 step TB skin test and/or other approved tests and required documentation. For Residents #508, #509, #510 and Staff (B, E, F, G, H), the operator failed to 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.	S5230		

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S5250	Continued From page 22	S5250		
S5250 SS=E	26-42-105 (f) (1 - 10) Resident Records Content (f) Each resident record shall contain at least the following: (1) The resident's name; (2) the dates of admission and discharge; (3) the admission agreement and any amendments; (4) the functional capacity screenings; (5) the health care service plan, if applicable; (6) the negotiated service agreement and any revisions; (7) the name, address, and telephone number of the physician and the dentist to be notified in an emergency; (8) the name, address, and telephone number of the legal representative or the individual of the resident's choice to be notified in the event of a significant change in condition; (9) the name, address, and telephone number of the case manager, if applicable; (10) records of medications, biologicals, and treatments administered and each medical care provider ' s order if the facility is managing the resident's medications and medical treatments; and This REQUIREMENT is not met as evidenced by: KAR 26-42-105(f)(5)(6)(10) The facility reported a census of 8 residents. The sample included 3 residents. Based on record review and interview for 3 of 3 sampled residents, the operator failed to ensure each resident record contained the health care service plan, the negotiated service agreement and any revisions;	S5250		

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S5250	Continued From page 23 and records of medications, biologicals and treatments administered and each medical provider's order. Findings included: - Record review for Resident #508 revealed admission on 8-15-18 with diagnoses Dementia with Behavioral Disturbance, Cerebellar Stroke Syndrome, Intracranial Injury and Atrial Fibrillation. The Functional Capacity Screen (FCS) dated 8-15-18 recorded resident required health care services. The record contained a face sheet with physician information, list of diagnoses from previous facility and the FCS. The record lacked the negotiated service agreement, the health care service plan and signed physician orders for admission and medications. - Record review for Resident #509 revealed admission on 1-13-18 with unknown diagnoses. The Functional Capacity Screen (FCS) dated 1-13-18 recorded resident required health care services. The record contained a face sheet with physician information and the FCS. The record lacked the negotiated service agreement, the health care service plan and signed physician orders for admission and medications. - Record review for Resident #510 revealed	S5250		

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S5250	Continued From page 24 admission on 12-1-17 with diagnosis of Epilepsy. The Functional Capacity Screen (FCS) dated 12-1-17 recorded resident required health care services. The record contained the face sheet with physician information. The record lacked a negotiated service agreement and the health care service plan. Interview on 8-29-18 at 4:35 pm with Operator confirmed the negotiated service agreements had not been done for any residents. Interview on 8-30-18 at 10:29 am with Licensed Staff B confirmed Resident #508's chart lacked a Negotiated Service Agreement, Health Care Service Plan, and signed physician orders for admission and medications as applicable. Further confirmed all resident records lacked a negotiated service agreement and health care service plan. For Residents #508, #509, #510 and potentially affecting all residents, the operator failed to ensure the record contained the negotiated service agreement, the health care service plan and signed physician orders for admission and medications.	S5250		
S5251 SS=D	26-42-105 (f) (11) Resident Records Documentation of Incidents (f) (11) documentation of all incidents, symptoms, and other indications of illness or injury including the date, time of occurrence, action taken, and results of the action.	S5251		

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S5251	Continued From page 25 This REQUIREMENT is not met as evidenced by: KAR 26-42-105(f)(11) The facility reported a census of 8 residents. The sample included 3 residents. Based on record review and interview for 1 (#508) of 3 sampled residents, the operator failed to ensure documentation of all incidents, symptoms and other indications or illness or injury including the date, time of occurrence, action taken and results of the action. Findings included: - Record review for Resident #508 revealed admission on 8-15-18 with diagnoses Dementia with Behavioral Disturbance, Cerebellar Stroke Syndrome, Intracranial Injury and Atrial Fibrillation. The Functional Capacity Screen (FCS) dated 8-15-18 recorded resident required physical assistance with bathing, dressing, toileting, transfers, walking/mobility and management of medications/treatments; and supervision with eating. Usually continent of bladder. Cognition: problems with short and long term memory, memory/recall and decision-making. No problems with communication. Current problems/risks identified included falls, impaired vision, impaired decision-making and socially inappropriate disruptive behavior. (Note: The record lacked a negotiated service agreement and health care service plan.) The record lacked any narrative nurse's notes regarding date/time of residents admission to	S5251		

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S5251	Continued From page 26 facility, nursing assessment upon admit, notification of physician of arrival and any notes of regarding resident's condition including an assessment prior to going to the hospital and upon return. The licensed nurse failed to document date/time of resident leaving and returning to facility after the hospital admission. Interviews on 8-29-18 at 10:29 am and 10:50 am with Licensed Staff B provided documentation from hospital and stated resident went to the hospital on 8-22-18 because of low blood sugars. He/she returned to facility on 8-24-18. Confirmed the resident's record lacked documentation of an assessment, date/time resident left and date/time and assessment upon return to the facility including any response to medication changes. For Resident #508, the operator failed to ensure documentation of all incidents, symptoms and other indications of illness including date, time of occurrence, action taken and results of action.	S5251		
S5255 SS=L	26-42-102 (a) Staff Qualifications Sufficent Staff (a) The administrator or operator of each home plus shall ensure the provision of a sufficient number of qualified personnel to provide each resident with services and care in accordance with that resident ' s functional capacity screening, health care service plan, and negotiated service agreement. This REQUIREMENT is not met as evidenced by: KAR 26-42-102(a)	S5255		

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S5255	Continued From page 27 The facility reported a census of 8 residents. The sample included 3 residents. Based on record reviews and interview for all residents, the operator failed to ensure the provision of a sufficient number of qualified personnel to provide each resident with services and care in accordance with that resident's functional capacity screening, health care service plan and negotiated service agreement. The facility direct care staff were employees of a home health agency in a neighboring state. The home health agency was not licensed in Kansas and the staff records revealed 13 of the 18 staff assigned to the facility lacked evidence of licensure or certification in Kansas; the remaining 15 also lacked evidence of licensure or certification in the neighboring state. These non-licensed, non-certified staff provided 24-hour care including hands on assistance with activities of daily living and administration of medications to all residents at the facility. The failure to provide qualified staff placed all residents in jeopardy for harm, injury or death. Findings included: - Observation on 8-29-19 at 12:25 pm upon arrival to facility of Non-Certified Staff F sitting at a table in the dining area feeding a resident. Observations during survey of Non-Certified Staff F and Non-Certified Staff G providing assistance with toileting, dressing, transfers, mobility and eating to residents. - Review of the resident roster revealed a census of 8 residents. All residents identified with impaired cognition and required health care services which included direct care/hands on assistance and medication management. One resident identified as a two-person transfer.	S5255		

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(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
S5255	Continued From page 28 Interview on 8-29-18 at 3:00 pm during completion of entrance tour checklist with Licensed Staff B, stated the facility staffing pattern included 8-hour shifts (7:00 am to 3:30 pm, 3:00 pm to 11:30 pm, 11:00 pm to 7:30 am). Licensed Staff B stated on the day shift he/she worked with a CNA (certified nurse aide) or RMA (registered medical assistant). On evening shift, stated there's an "RMA and another helper." Stated for the night shift "there's one person here." Interview on 8-30-18 at 10:55 am with operator stated the first and second residents moved in 12-1-17. On 9-4-18 at 10:09 am operator reviewed August 2018 schedule and confirmed the following: The usual staffing pattern with two staff from 7:00 am until around 9:00 pm. Confirmed one staff scheduled to work overnight. Operator stated he/she worked and stayed overnight at the facility from 12-1-17 until the last resident moved in on 8-15-18 and took the last remaining room. Operator confirmed he/she lacked certification to provide hands-on care and the staff provided from the agency lacked documentation of educational preparation with the exception of Certified Staff D and Certified Staff E who both worked part time due to having full time jobs elsewhere. On 8-30-18, operator provided new hire list which identified 18 facility staff. Thirteen of the eighteen were identified as personnel who provided direct care/hands-on assistance to residents. Review of the Kansas Nurse Aide Registry confirmed these 13 staff were not certified in Kansas. Operator provided written statement, copy of current schedule for August 2018 and copy of	S5255		

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S5255	Continued From page 29 payroll summary from the agency dated June 3, 2018 through June 9, 2018. The payroll summary documented 10 staff, with 9 of the 10 staff whose personnel files lacked certification as a nurse aide in the state of Kansas. The operator confirmed the payroll summary was representative of the facility's staffing pattern. The operator stated the agency providing the staff was from another state. Confirmed he/she was not aware that a home plus facility could employ only Kansas certified staff. For all residents, the operator's failure to provide qualified staff to care for residents and administer medications placed all residents in immediate jeopardy. The jeopardy was removed on 8-29-18 when the operator scheduled 2 certified staff every shift and provided the following written "Plan of Action to Resolve Staffing Issues": 1. (Staffing Agency) have been contracted to staff (facility) with certified staffing. Staffing will consist of 2 CNA's per shift. 2. Job postings have been posted on Facebook and Indeed.com. 3. All non-certified staff will be let go until they become certified. 4. Certified Staff D was brought in to work. 5. Going forward all applicants will be vetted for certifications, background checks, drug tested, and TB testing done once the position has been offered.	S5255		
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		

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S5258	Continued From page 30 (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) The facility reported a census of 8 residents. The sample included 3 residents. Based on record review and interview for all sampled staff (B, E, F, G, H), the operator failed to ensure employee records and agency staff records contained: 1) evidence of licensure, registration, certification or 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 or facility staff and contract staff, excluding any staff licensed or registered by a state agency, pursuant to K.S.A. 39-970 and	S5258		

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S5258	Continued From page 31	S5258		

amendments thereto; 3) supporting documentation from the Kansas nurse aide registry that the individual did not have a finding of having abused, neglected, or exploited a resident in an adult care home; and 4) supporting documentation that the individual did 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 had been known to work as a certified nurse aide.

Findings included:

- On 8-30-18, operator provided list of 18 personnel hired since facility opened. Operator listed 13 of the 18 staff designated as personnel providing direct care/hands-on assistance to resident who are not yet certified and/or licensed.

- Personnel Record Review conducted on 8-30-18 at 11:16 am with operator revealed the following:

Non-Certified Staff H with date of hire: 11-25-17. The record lacked documentation of criminal background check.

Licensed Staff B with date of hire 11-25-17: The record lacked evidence of licensure.

Certified Staff E with date of hire 1-26-18: the record lacked documentation of a criminal background check.

Non-certified staff F with date of hire 5-19-18: The record lacked documentation of criminal background check for Kansas or Missouri. Staff F identified self as Registered Medical Assistant. The record lacked evidence of certification with

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S5258	Continued From page 32 Kansas nurse aide registry. Non-certified Staff G with date of hire 5-19-18. The record lacked documentation of a criminal background check. Interview on 8-30-18 at 11:16 am with operator confirmed the above records for certified and non-certified staff lacked documentation of a criminal background check. Stated all staff with exception of Licensed Staff B worked through an agency out of a neighboring state. Stated he/she did not have an employee file for Licensed Staff B and no copy of licensure verification. The operator failed to ensure the employee records contained evidence of certification for each employee performing a function that required specialized education or training and criminal background check obtained through the department as required by K.S.A. 39-970.	S5258		
S5300 SS=F	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	S5300		

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S5300	Continued From page 33 medication through the parenteral route. This REQUIREMENT is not met as evidenced by: KAR 26-42-205(d)(1) The facility reported a census of 8 residents. The sample included 3 residents. Based on record review and interview for 3 (#508, #509, #510) of 3 sampled residents, the operator failed to ensure all medications and biologicals are administered in accordance with a medical care provider's written order, and professional standards of practice. Only Licensed nurses and medication aides shall administer and manage medications for which the home has responsibility. Findings included: - Record review for Resident #508 revealed admission on 8-15-18 with diagnoses Dementia with Behavioral Disturbance, Cerebellar Stroke Syndrome, Intracranial Injury and Atrial Fibrillation. The Functional Capacity Screen (FCS) dated 8-15-18 recorded resident required physical assistance with management of medications/treatments. (Note: The record lacked a negotiated service agreement/health care service plan). Review of Medication Administration Record (MAR) for August 2018 revealed medications initialed as given by Non-certified Staff F. The record further lacked signed physician orders for all medications.	S5300		

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S5300	Continued From page 34 - Record review for resident #509 revealed admission on 1-13-18 with unknown diagnoses. The Functional Capacity Screen (FCS) dated 1-13-18 recorded resident required physical assistance with management of medications/treatments. (Note: The record lacked a negotiated service agreement/health care service plan). Review of Medication Administration Record (MAR) for August 2018 revealed medications initialed as given by Non-certified Staff F, Non-certified staff J, and Non-certified staff K. The MAR also documented Hydrocodone (narcotic pain reliever) 5/325 mg (milligrams) 1 by mouth every 4-6 hours as needed for pain. The record lacked a physician's order for the Hydrocodone. Interview on 8-30-18 at 1:02 pm with Licensed Staff B identified the above staff initials (for #508 and #509 MARs) and confirmed the medications were administered by staff who were not certified medication aides or licensed nurses. Stated after the Resident #509 fell and went to the emergency room, he/she returned to facility with a filled prescription for the hydrocodone. Confirmed the record lacked a physician's order for the hydrocodone and he/she failed to call the pharmacy for a copy of the emergency room physician's order. - Record review for resident #510 revealed admission on 12-1-17 with diagnosis Epilepsy. The Functional Capacity Screen (FCS) dated	S5300		

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S5300	Continued From page 35 12-1-17 recorded resident required physical assistance with management of medications/treatments. (Note: The record lacked a negotiated service agreement/health care service plan). Review of Medication Administration Record (MAR) for August 2018 revealed medications initialed as given by Non-certified Staff F, Non-certified staff J, and Non-certified staff K. The record lacked signed physician's orders for all medications. The facility lacked policies and procedures for medication administration. Interview on 8-30-18 at 1:26 pm with Licensed Staff B identified the above staff initials and confirmed the medications were administered by staff who were not certified medication aides or licensed nurses. Stated he/she had called the resident's physician and was given the medication orders verbally, did not get the verbal orders signed by the physician. Licensed Staff B confirmed all residents were administered their medications by non-licensed staff who were not certified medication aides. For Resident #508, #509, #510 and affecting all residents, the operator failed to ensure that all medications and biologicals were administered to residents in accordance with a medical care providers written order, and professional standards of practice and administered only by licensed nurses and certified medication aides.	S5300		
S5315 SS=F	26-42-205 (h) Medication Storage (h) Storage. Licensed nurses and medication	S5315		

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S5315	Continued From page 36 aides shall ensure that all medications and biologicals are securely and properly stored in accordance with each manufacturer ' s recommendations or those of the pharmacy provider and with federal and state laws and regulations. (1) Licensed nurses or medication aides shall store non-controlled medications and biologicals managed by the home in a locked medication room, cabinet, or medication cart. Licensed nurses and medication aides shall store controlled medications managed by the home in separately locked compartments within a locked medication room, cabinet, or medication cart. Only licensed nurses and medication aides shall have access to the stored medications and biologicals. (2) Each resident managing and self-administering medication shall store medications in a place that is accessible only to the resident, licensed nurses, and medication aides. (3) Any resident who self-administers medication and is unable to provide proper storage as recommended by the manufacturer or pharmacy provider may request that the medication be stored by the home. (4) A licensed nurse or medication aide shall not administer medication beyond the manufacturer ' s or pharmacy provider ' s recommended date of expiration. This REQUIREMENT is not met as evidenced by: KAR 26-42-205(h) The facility reported a census of 8 residents. The sample included 3 residents. Based on	S5315		

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S5315	Continued From page 37 observation and interview for all staff and residents receiving tuberculosis skin testing, the licensed nurse failed to ensure that all medications and biologicals are securely and properly stored in accordance with each manufacturer's recommendations. Findings included: - Observation on 8-29-18 at 1:40 pm revealed the following: 1 vial of tuberculin skin testing solution 1/4 full. The vial lacked documentation of date opened. Interview on 8-29-18 around 1:44 pm with Licensed Staff B confirmed and removed the opened undated bottle to be discarded. Stated "it's been a while" since last used and "it's only good for 30 days." Confirmed the TB solution was not stored according to manufacturer's recommendation to "discard a penetrated multi-dose vial after 30 days." The facility lacked policies and procedures for medication storage. Licensed nurses failed to ensure all medications and biologicals were properly stored in accordance with the manufacturer's recommendations.	S5315		
S5316 SS=E	26-42-205 (i) Disposition of Medication (i) Accountability and disposition of medications. Licensed nurses and medication aides shall maintain records of the receipt and disposition of all medications managed by the home in sufficient detail for an accurate reconciliation. (1) Records shall be maintained documenting the	S5316		

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S5316	Continued From page 38 destruction of any deteriorated, outdated, or discontinued controlled medications and biologicals according to acceptable standards of practice by one of the following combinations: (A) Two licensed nurses; or (B) a licensed nurse and a licensed pharmacist. (2) Records shall be maintained documenting the destruction of any deteriorated, outdated, or discontinued non-controlled medications and biologicals according to acceptable standards of practice by any of the following combinations: (A) Two licensed nurses; (B) a licensed nurse and a medication aide; (C) a licensed nurse and a licensed pharmacist; or (D) a medication aide and a licensed pharmacist. This REQUIREMENT is not met as evidenced by: KAR 26-42-205(i) The facility reported a census of 8 residents. The sample included 3 residents. Based on observation and interview, the operator failed to ensure licensed nurses and medication aides shall maintain records of the receipt and disposition of all medications managed by the home in sufficient detail for an accurate reconciliation. Findings included: - Observation of medication storage in nurse's office during entrance tour accompanied by	S5316		

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S5316	Continued From page 39 Licensed Staff B on 8-29-18 at 1:40 pm revealed the following: Large drawer file cabinet locked with medications for all residents. Each resident has own section in a drawer. Most medications on bubble-pack cards. Box inside of file with bottles and cards of medications, Licensed Staff B identified as medications to be destroyed: Clearlax 2 26.9 ounce bottles both open with no name on bottle. Resident #603 who discharged to another facility about 2-3 months ago: Bisacodyl 10 mg (milligrams) suppositories filled 4-30-18 and 3-20-18, 58 suppositories in total; ciclopirox topical solution 2 bottle filled on 4-30-18 and 1-24-18; Milk of Magnesia laxative 1 unopened bottle filled on 4-30-18. Resident #604 who passed away in April 2018: Milk of Magnesia, lemon suspension 1 unopened bottle filled 4-9-18. Antacid suspension 1 bottle filled 4-6-18. Cefuroxime 500 mg filled 3-15-18, 8 tablets. Aspirin 81 mg filled 3-15-18, 24 tablets. Clopidogrel 75 mg filled 3-15-18, 24 tablets. Melatonin 3 mg filled 3-1--5-18 23 tablets. Divalproex 125 mg filled 4-6-18, 27 capsules. Clearlax powder filled 3-15-18, 1 bottle. Resident #605 who passed away a week ago: Memantine 5 mg filled 3-15-18, 27 tablets. The box also contained the following over the counter medications to be destroyed which lacked resident names: Aleve 220 mg 25 tablets Niacin 500 mg - 2 open bottles and 1 unopened	S5316		

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S5316	Continued From page 40 bottle Bisacodyl 5 mg tablets Stomach Relief Pink Bismuth tablets 262 mg Beano tablets Vitamin D3 5000 International units Magnesium Laxative caplets 500 mg Mapap (acetaminophen) 325 mg 2 open bottles Stool Softener with stimulant 50/8.6 mg acetaminophen liquid 160 mg/5 milliliter Aspirin 81 mg tablets Glucosamine 1500 mg Interview on 8-29-18 at 1:44 pm with Licensed Staff B confirmed no system in place for medication receipt and destruction. Stated he/she has not destroyed any medications since facility opened and does not have any forms to complete when medications come in from the pharmacy or when medications are returned or destroyed. Stated do not have a disposal system to use yet, may possibly use coffee grounds or kitty litter to discard medications in. The facility lacked policies for medication administration including disposition of medications. The operator failed to ensure licensed nurses and medication aides shall maintain records of the receipt and disposition of all medications managed by the home in sufficient detail for an accurate reconciliation.	S5316		
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	S5325		

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S5325	Continued From page 41 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 8 residents. The sample included 3 residents. The operator failed to ensure 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 as evidenced by record review and interview for 3 (#508, #509, #510) of 3 sampled residents with the potential to affect all residents. Findings included: - Record review for Resident #508 revealed admission on 8-15-18 with diagnoses Dementia with Behavioral Disturbance, Cerebellar Stroke Syndrome, Intracranial Injury and Atrial Fibrillation. The Functional Capacity Screen (FCS) dated 8-15-18 recorded resident required physical assistance with management of medications/treatments. (Note: The record lacked a negotiated service agreement/health care service plan). The record lacked documentation of a medication	S5325		

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S5325	Continued From page 42 regimen review. - Record review for resident #509 revealed admission on 1-13-18 with unknown diagnoses. The Functional Capacity Screen (FCS) dated 1-13-18 recorded resident required physical assistance with management of medications/treatments. (Note: The record lacked a negotiated service agreement/health care service plan). The record lacked documentation of a medication regimen review. - Record review for resident #510 revealed admission on 12-1-17 with diagnosis Epilepsy. The Functional Capacity Screen (FCS) dated 12-1-17 recorded resident required physical assistance with management of medications/treatments. (Note: The record lacked a negotiated service agreement/health care service plan). The record lacked documentation of a medication regimen review. The facility lacked policies and procedures for medication administration including requirement for performance of quarterly medication regimen reviews. Interview on 8-29-18 at 5:23 pm with Licensed Staff B confirmed the records lacked medication regimen reviews. Stated all records lacked reviews because there was no pharmacy consultant.	S5325		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B011004	A. BUILDING: _____ B. WING _____	09/10/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEGACY LIVING OF BAXTER SPRINGS LLC	445 E 10TH ST BAXTER SPGS, KS 66713

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S5325	Continued From page 43 For Residents #508, #509, #510 and affecting all residents, the operator failed to ensure a licensed pharmacist or licensed nurse conducted a medication regimen review at least quarterly for each resident whose medication is managed by the home.	S5325		
S5335 SS=F	28-39-437 Construction (a) Each home-plus facility shall be designed, constructed, equipped, and maintained to protect the health and safety of residents, personnel, and the public. (b) All new construction, renovation, remodeling, and changes in building use in existing buildings shall comply with building and fire codes, ordinances, and regulations enforced by city, county, and state jurisdictions, including the state fire marshal. This REQUIREMENT is not met as evidenced by: KAR 28-39-437(a) The facility reported a census of 8 residents. The sample included 3 residents. Based on observation and interview for all residents, the operator failed to ensure the facility was maintained to protect the health and safety of the residents when chemicals were unsecured throughout the facility. Findings included: - Observation on 8-29-18 during entrance tour from 12:35 pm to 1:40 pm accompanied by Licensed Staff B revealed the following:	S5335		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B011004	A. BUILDING: _____ B. WING _____	09/10/2018

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S5335	Continued From page 44 Unsecured laundry room with wooden shelving which contained 1 gallon of bleach, 1 bottle of Shout cleaner, 1 bottle of Oxi Clean Stain Remover, large bottle of Xtra Laundry Detergent, 1 bottle of Goof Off adhesive remover, Fantastik All Purpose Cleaner, Scent Killer, Pine-Sol Multi-surface Cleaner and Deodorizer, 1 can of Spray Starch, Gonzo Odor Eliminator, 2 bottles of Resolve Spot and Stain Remover, OxiClean, Rug Doctor carpet cleaner, 2 bottles of Shout, 2 cans of Liquid Gold, 6 cans of disinfectant spray and 1 bottle of Grout Sealer. Shower room at back of facility next to outside door with built-in wooden shelving which contained 2 gallons of Fantastik Cleaner, 2 bottles of Basic Toilet Bowl Cleaner, Lysol Disinfectant Spray. Unsecured cabinets under kitchen sink contained 1 gallon of Pine-Sol, 1 can of Lysol Spray, 1 large can of Comet Cleanser, Vanish Mildew , 1 can of Glass Cleaner, 1 bottle of Resolve Cleaner, 1 bottle of Windex, 1 gallon of Cascade Dishwasher Detergent, 1 bottle of Great Value All Purpose Cleaner, 2 cans of Hot Shot Ant and Roach Spray, 1 can of Scotch Guard, 1 can of Raid Flying Insect Spray, Tuff Stuff Multi-purpose Cleaner, 1 bottle of Wrights Brass Polish, Parker and Bailey Kitchen Cabinet Creme, Leather and Vinyl Cleaner, Leather Cream Conditioner, 1 bottle of Soft Scrub and 1 bottle of Bissell Deep Cleaner. The roster identified 8 of 8 residents with impaired cognition. Interview on 8-29-18 from 12:35 pm to 1:40 pm with Licensed Staff B during tour, confirmed the above chemicals were unsecured.	S5335		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B011004	A. BUILDING: _____ B. WING _____	09/10/2018

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S5335	Continued From page 45 For all residents, the operator failed to ensure the facility was maintained to protect the health and safety of the residents when chemicals were unsecured throughout the facility.	S5335		