STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N040008	A. BUILDING: _____ B. WING _____	R-C 05/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HOMESTEAD OF HALSTEAD	715 W 6TH ST HALSTEAD, KS 67056

(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 a revisit for correction order 18-68 of the above assisted living facility on 5/29/18 and 5/30/18.	{S 000}		
S3082 SS=E	26-41-201 (d) Functional Capacity Screen Accurate d) Designated facility staff shall ensure that each resident ' s functional capacity at the time of screening is accurately reflected on that resident ' s screening form. This REQUIREMENT is not met as evidenced by: KAR 26-41-201(d) The facility reported a census of 23 residents. The sample included 3 residents. Based on record review, observation, and interview for 2 (#1062 and #1061) of 3 residents sampled, the licensed nurse failed to ensure each resident's functional capacity was accurately reflected on that resident's screening form. Findings included: - Record review for resident #1062 revealed an admission date of 12/22/17 with diagnoses of stroke with right side hemiplegia and hemiparesis, above the knee amputation right leg, peripheral vascular disease, and type 2 diabetes mellitus. Functional capacity screen dated 12/26/17 indicated resident was unable to perform walking/mobility, required a wheelchair for mobility, exhibited wandering behavior, and was not cognitively impaired.	S3082		

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
	N040008	A. BUILDING: _____ B. WING _____	R-C 05/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HOMESTEAD OF HALSTEAD	715 W 6TH ST HALSTEAD, KS 67056

(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
S3082	Continued From page 1 Negotiated service agreement/health care service plan dated 12/22/17 documented that resident mobilized self throughout facility in a wheelchair and was alert and oriented to person, place, and time. Negotiated service agreement/health care service plan did not document that resident exhibited wandering behavior. During time in facility on 5/29/18 surveyor observed resident mobilize self independently in wheelchair visiting with staff and other residents. Resident was alert and oriented. During an interview at 12:46 p.m. on 5/29/18, licensed nurse C stated resident was independent with mobility in wheelchair and that he/she assessed resident's ability to ambulate as "unable to perform" on the functional capacity screen. Licensed nurse C stated he/she assessed the resident to have wandering behavior because resident made frequent trips between apartment and commons area. The Functional Capacity Screen Manual defines walking and mobility as "the ability to move between locations in the environment. If resident uses a wheelchair, code for self-sufficiency of the resident." The manual instructs the designated person conducting the screening to code resident as independent with mobility if resident able to mobilize wheelchair without assistance from another person. The Functional Capacity Screen manual instructs the designated person conducting the screening to code wandering behavior if resident exhibits "movement with no identified rational purpose; resident appears oblivious to needs or safety." The licensed nurse failed to ensure resident	S3082		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N040008	A. BUILDING: _____ B. WING _____	R-C 05/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HOMESTEAD OF HALSTEAD	715 W 6TH ST HALSTEAD, KS 67056

(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
S3082	Continued From page 2 #1062's functional capacity was accurately reflected on the resident's screening form. - Record review for resident #1061 revealed an admission date of 3/31/09 with diagnoses of hypertension, chronic kidney disease, and schizo-affective disorder. Functional capacity screen dated 12/19/17 indicated resident required physical assistance with walking/mobility and that resident required a walker for ambulation. Negotiated service agreement/health care service plan dated 12/22/17 lacked a description of services to meet resident's need for physical assistance with walking/mobility. During time in the facility on 5/29/18 surveyor observed resident walking independently with walker. During an interview at 12:51 p.m. on 5/29/18, licensed nurse C stated resident did not require physical assistance with walking but at times required supervision and cueing. The Functional Capacity Screen manual instructs the designated person conducting the screening to code physical assistance needed for walking if resident requires the physical assistance of one or more persons to walk safely and to code as supervision required if resident needs cuing, oversight or encouragement to ambulate. The licensed nurse failed to ensure resident #1061's functional capacity was accurately reflected on the resident's screening form.	S3082		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N040008	A. BUILDING: _____ B. WING _____	R-C 05/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HOMESTEAD OF HALSTEAD	715 W 6TH ST HALSTEAD, KS 67056

(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
{S3085}	Continued From page 3	{S3085}		
{S3085} SS=D	26-41-202 (a) Negotiated Service Agreement (a) The administrator or operator of each assisted living facility or residential health care facility shall ensure the development of a written negotiated service agreement for each resident, based on the resident ' s functional capacity screening, service needs, and preferences, in collaboration with the resident or the resident ' s legal representative, the case manager, and, if agreed to by the resident or the resident ' s legal representative, the resident ' s family. The negotiated service agreement shall provide the following information: (1) A description of the services the resident will receive; (2) identification of the provider of each service; and (3) identification of each party responsible for payment if outside resources provide a service. This REQUIREMENT is not met as evidenced by: KAR 26-41-202(a)(3) The facility reported a census of 23 residents. The sample included 3 residents. Based on record review and interview for 1 (#1060) of 3 residents sampled, the operator failed to ensure the development of a written negotiated service agreement that included the party responsible for payment of the services provided by the outside resource. Findings included: - Record review for resident #1060 revealed an admission date of 9/1/17 with diagnoses of	{S3085}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N040008	A. BUILDING: _____ B. WING _____	R-C 05/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HOMESTEAD OF HALSTEAD	715 W 6TH ST HALSTEAD, KS 67056

(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
{S3085}	Continued From page 4 arteriosclerotic heart disease, osteoarthritis, depression, and dementia. Negotiated service agreement dated 5/2/18 documented the name of hospice providing services of skilled nursing visit 2 times a week and home health aide to assist with bathing 3 times a week. The negotiated service agreement did not list the party responsible for payment of the services provided by hospice. During an interview at 12:36 p.m. on 5/29/18, licensed nurse C confirmed the resident's negotiated service agreement did not specify the party responsible for payment of hospice services. Operator B failed to ensure the resident's negotiated service agreement included the party responsible for payment of services provided by hospice.	{S3085}		
{S3155} SS=E	26-41-204 (a) Health Care Services . (a) The administrator or operator in each assisted living facility or residential health care facility 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:	{S3155}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N040008	A. BUILDING: _____ B. WING _____	R-C 05/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HOMESTEAD OF HALSTEAD	715 W 6TH ST HALSTEAD, KS 67056

(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
{S3155}	Continued From page 5 KAR 26-41-204(a) The facility reported a census of 23 residents. The sample included 3 residents. Based on record review, interview, and observation for 1 (#1060) of 3 residents sampled, the operator failed to ensure the licensed nurse provided or coordinated the provision of necessary health care services that met the needs of the resident related to risk for falls and use of a positioning device in accordance with the resident's functional capacity screen and negotiated service agreement. Based on record review and interview for 1 (#1062) of 3 residents sampled, the operator failed to ensure the licensed nurse provided or coordinated the provision of necessary health care services that met the needs of the resident related to risk for falls in accordance with the resident's functional capacity screen and negotiated service agreement. Based on record review and interview for 1 (#1061) of 3 residents sampled, the operator failed to ensure a licensed nurse provided or coordinated the services of medication management in accordance with the resident's functional capacity screen and negotiated service agreement. Findings included: - Record review on 5/1/18 for resident #1060 revealed an admission date of 9/1/17 with diagnoses of arteriosclerotic heart disease, osteoarthritis, and dementia. Functional capacity screen dated 5/2/18 indicated	{S3155}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N040008	A. BUILDING: _____ B. WING _____	R-C 05/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HOMESTEAD OF HALSTEAD	715 W 6TH ST HALSTEAD, KS 67056

(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
{S3155}	Continued From page 6 resident required physical assistance with bathing and dressing; was independent with toileting, transferring, and mobility with a walker or wheelchair, experienced impaired short-term memory impairment; incontinent of urine; and was at risk for falls. Negotiated service agreement/health care service plan dated 5/2/18 documented the following services: Bathing assistance 3 times a week by an outside resource. Dressing assistance. Toileting: resident independent with toileting and managed incontinence care independently. Supervision of ambulation "when we catch (resident) up and about in (resident's) apartment." The negotiated/health care service plan lacked interventions to address resident's risk for falls as identified in the functional capacity screen. The resident roster indicated resident's bed was equipped with side rails. The negotiated service agreement/health care service plan lacked a description of resident's need for and purpose of side rails. During an interview at 12:36 p.m. on 5/29/18, licensed nurse C stated staff members were to check on resident every time they walked by resident's apartment due to resident's risk for falls. Licensed nurse C provided a "Managed Risk" document completed on 5/29/18 for use of 1/2 side rail device. Licensed nurse C stated and confirmed the negotiated service agreement/health care service plan did not include interventions to address resident's risk for falls and a description of resident's use of side rails as a positioning device.	{S3155}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N040008	A. BUILDING: _____ B. WING _____	R-C 05/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HOMESTEAD OF HALSTEAD	715 W 6TH ST HALSTEAD, KS 67056

(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
{S3155}	Continued From page 7 The operator failed to ensure the licensed nurse provided or coordinated the provision of necessary health care services that met the needs of resident #1060 related to risk for falls and the use of a positioning device in accordance with the resident's functional capacity screen and negotiated service agreement. - Record review for resident #1062 revealed an admission date of 12/22/17 with diagnoses of stroke with right side hemiplegia and hemiparesis, above the knee amputation right leg, peripheral vascular disease, and type 2 diabetes mellitus. Functional capacity screen dated 12/26/17 indicated resident required physical assistance with bathing and dressing; independent with toileting and transferring; unable to mobilize self; and required a wheelchair for mobility. (Note: during time in facility on 5/29/18 surveyor observed resident mobilize self independently in wheelchair.) The functional capacity screen did not indicate resident was at risk for falls. Negotiated service agreement/health care service plan dated 12/22/17 documented that resident mobilized self throughout facility in a wheelchair, used a transfer pole to transfer self independently in and out of bed, and could independently transfer self to toilet. The nurse's notes contained documentation that resident slid off bed to floor on 1/9/18, fell out of wheelchair on 1/20/18, and fell in bathroom on 4/19/18. The negotiated service agreement/health care service plan lacked revision after each fall to address resident's risk for falls.	{S3155}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N040008	A. BUILDING: _____ B. WING _____	R-C 05/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HOMESTEAD OF HALSTEAD	715 W 6TH ST HALSTEAD, KS 67056

(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
{S3155}	Continued From page 8 During an interview at 12:46 p.m. on 5/29/18, licensed nurse D stated the negotiated service agreement/health care service plan lacked specific interventions related to resident's risk for falls. The operator failed to ensure the licensed nurse provided or coordinated the provision of necessary health care services that met the needs of resident #1062 related to risk for falls. - Record review for resident #1061 revealed an admission date of 3/31/09 with diagnoses of hypertension, chronic kidney disease, and schizo-affective disorder. Functional cpacity screen dated 12/19/17 indicated resident was unable to perform medication management. Negotiated service agreement/health care service plan dated 12/22/17 lacked a description of services for the provider of medication management. During an interview at 12:58 p.m. on 5/29/18, licensed nurse C stated certified medication aides administered medications to the resident. Licensed nurse C stated and confirmed the negotiated service agreement/health care service plan did not specify facility management of medications. The operator failed to ensure the licensed nurse provided or coordinated the provision of necessary health care services that met the needs of resident #1061 related to medication management.	{S3155}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N040008	A. BUILDING: _____ B. WING _____	R-C 05/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HOMESTEAD OF HALSTEAD	715 W 6TH ST HALSTEAD, KS 67056

(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
S3261	Continued From page 9	S3261		
S3261 SS=D	26-41-105 (f) (11) Resident Record 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 This REQUIREMENT is not met as evidenced by: KAR 26-41-105(f)(11) The facility reported a census of 23 residents. The sample included 3 residents. Based on record review and interview for 1 (#1061) of 3 residents sampled, a licensed nurse failed to ensure the resident's record contained documentation of an incident including the date, time of occurrence, action taken, and results of the action. Findings included: - Record review for resident #1061 revealed an admission date of 3/31/09 with diagnoses of hypertension, chronic kidney disease, and schizo-affective disorder. The assessment section of the electronic record listed a wound/skin assessment and reason for assessment as "resident to resident." Surveyor opened the assessment completed by licensed nurse D on 5/21/18 that documented no bruising found on resident. Resident's record lacked documentation of any incident, illness, or injury that would necessitate an assessment of resident for injuries.	S3261		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N040008	A. BUILDING: _____ B. WING _____	R-C 05/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HOMESTEAD OF HALSTEAD	715 W 6TH ST HALSTEAD, KS 67056

(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
S3261	Continued From page 10 During an interview at 12:54 p.m. on 5/29/18, licensed nurse D stated he/she assessed resident (#1061) on 5/21/18 after he/she was notified of a resident-to-resident altercation that occurred after the evening meal on 5/20/18. Licensed nurse D stated resident (#1064) walked up behind resident (#1061), tried to grab the remote control to the television, and a staff member intervened to separate the two residents. Licensed nurse D stated he/she did not document the incident in the resident's record. The licensed nurse failed to ensure the record for resident #1061 contained documentation of an incident including the date, time of occurrence, action taken, and results of the action.	S3261		