STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N008008	A. BUILDING: _____ B. WING _____	10/05/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD OF AUGUSTA	1611 FAIRWAY AUGUSTA, KS 67010

(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 resurvey of the above assisted living facility on 9/26/16, 9/27/16, 9/28/16, 9/29/16, 10/3/16, 10/4/16, and 10/5/16.	S 000		
S 230 SS=E	26-39-102 (b) (c) Admission Advanced Directives Resident Rights b) At the time of admission, adult care home staff shall inform the resident or the resident ' s legal representative, in writing, of the state statutes related to advance medical directives. (1) If a resident has an advance medical directive currently in effect, the facility shall keep a copy on file in the resident ' s clinical record. (2) The administrator or operator, or the designee, shall ensure the development and implementation of policies and procedures related to advance medical directives. (c) The administrator or operator, or the designee, shall provide a copy of resident rights, the adult care home's policies and procedures for advance medical directives, and the adult care home's grievance policy to each resident or the resident's legal representative before the prospective resident signs any admission agreement. This REQUIREMENT is not met as evidenced by: KAR 26-39-102(b)(1) The facility reported a census of 40 residents. The sample included 4 residents. Based on record review and interview for 2 (#343 and #341) of 4 residents sampled, the operator failed to ensure the resident's clinical record contained a	S 230		

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
	N008008	A. BUILDING: _____ B. WING _____	10/05/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD OF AUGUSTA	1611 FAIRWAY AUGUSTA, KS 67010

(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 230	Continued From page 1 copy of the resident's advance medical directive. Findings included: - Review of the administrative file stored in the operator's office for resident #343 revealed "Advance Directive Acknowledgement" form completed and signed by resident's family member on 5/4/15 that resident had a living will and durable power of attorney for health care decisions. Review of the resident's clinical record revealed the lack of the resident's living will and durable power of attorney for health care decisions. At 10:35 a.m. on 9/29/16 resident care coordinator D confirmed the resident's clinical record lacked these documents. The operator failed to ensure resident #343's clinical record contained a copy of the resident's advance medical directive. - Review of the administrative file stored in the operator's office for resident #341 revealed documentation on the "Advance Directive Acknowledgement" form completed and signed by resident's family member on 6/5/16 that resident had a living will and durable power of attorney for health care decisions. Review of the resident's clinical record revealed the lack of the resident's living will and durable power of attorney for health care decisions. At 10:50 a.m. on 9/29/16 resident care coordinator D confirmed the resident's clinical record lacked these documents.	S 230		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N008008	A. BUILDING: _____ B. WING _____	10/05/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD OF AUGUSTA	1611 FAIRWAY AUGUSTA, KS 67010

(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 230	Continued From page 2 The operator failed to ensure resident #341's clinical record contained a copy of the resident's advance medical directive.	S 230		
S3026 SS=J	26-41-101 (f) (1) Staff Treatment of Residents ANE (f)The administrator or operator shall ensure that all of the following requirements are met: (1) No resident shall be subjected to any of the following: (A) Verbal, mental, sexual, or physical abuse, including corporal punishment and involuntary seclusion; (B) neglect; or (C) exploitation. This REQUIREMENT is not met as evidenced by: KAR 26-41-101(f)(1)(A) The facility reported a census of 40 residents. The sample included 4 residents. Based on record review, interviews, and observations for 1 (#343) of 4 residents sampled, the operator failed to ensure no resident was subjected to abuse when staff members used a tray attached to a Geri-chair (a mobile recliner for an immobile person) and placed resident in a recliner with footrest elevated in order to restrain and keep the resident from getting out of chairs. This failure placed resident #343 in immediate jeopardy for entrapment, harm, injury, or death. Findings included: - Record review for resident #343 revealed an admission date of 5/6/15 and diagnoses of	S3026		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N008008	A. BUILDING: _____ B. WING _____	10/05/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD OF AUGUSTA	1611 FAIRWAY AUGUSTA, KS 67010

(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
S3026	Continued From page 3	S3026		

Alzheimer's disease and anxiety disorder.

The record contained a functional capacity screen dated 12/21/15 that indicated the resident experienced impaired short-term and long-term memory, decision making ability, and memory recall; was at risk for falls; required physical assistance with bathing, dressing, toileting, transferring, mobility, and eating; and required the use of a wheelchair for mobility. The functional capacity screen indicated resident's communication as sometimes understandable and resident sometimes understood verbal communication. The record contained another functional capacity screen dated 12/21/15 marked as a significant change screen and electronically signed by resident care coordinator D 9/13/16. This functional capacity screen contained the same scores as the 12/21/15 screen and did not indicate a change in the resident's functional status.

The record contained a negotiated service agreement/health care service plan dated 12/21/15 that described the services of physical assistance with all activities of daily living. The negotiated service agreement/health care service plan did not include interventions to address the resident's risk for falls. The record did not contain a subsequent negotiated service agreement/health care service plan or an addendum.

The clinical notes contained the following entries:

7/11/16 at 6:53 a.m. licensed nurse B documented resident doing well post-fall (no previous documentation regarding the fall). Resident has been pushing against tables and nearly tipping wheelchair over. Resident has

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N008008	A. BUILDING: _____ B. WING _____	10/05/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD OF AUGUSTA	1611 FAIRWAY AUGUSTA, KS 67010

(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
S3026	Continued From page 4	S3026		

been trying to get out of bed.

8/17/16 at 1:32 p.m. licensed nurse B documented resident unable to sit still, tries to climb over sides of Geri-chair, and getting self out of bed.

9/7/16 at 11:42 a.m. by licensed nurse B that medical care provider here to see resident for continuous behaviors of kicking, slapping, and hitting staff. Received order for Geri-tray for Geri-chair when up due to fall risk. Note: the record lacked documentation of an assessment to show that the tray was not a restraint.

The record contained the following written communication from licensed nurse B to the medical care provider:

8/17/16 Resident appears to unable to sit still, trying to climb over side of Geri-chair, getting self out of bed and tearing closet up. Please advise. Medical care provider wrote an order for Depakote sprinkles (mood stabilizer) 125 milligrams by mouth two times a day.

9/7/16 of non-injury fall 9/6/16. Medical care provider documented an order for Geri-tray for chair while up due to fall risk, Benadryl (antihistamine) 25 milligrams every 6 hours as needed, discontinue Depakote, increase Seroquel (antipsychotic) to 100 milligrams by mouth two times a day, and Haldol (antipsychotic) 0.5 milligram by mouth every 4 hours as needed.

At 4:40 p.m. on 9/26/16, observed resident #343 in a Geri-chair with a tray in place in the memory care dining room. Certified employee C was standing by the resident and stated the tray was in place to keep resident from getting out of chair

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N008008	A. BUILDING: _____ B. WING _____	10/05/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD OF AUGUSTA	1611 FAIRWAY AUGUSTA, KS 67010

(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
S3026	Continued From page 5	S3026		

and falling. Certified employee C stated this allowed employees to leave resident (#343) in order to provide care to other residents.

At 4:50 p.m. on 9/26/16, surveyor informed operator, resident care coordinator D, regional director H, and regional nurse J that certified employee C restrained resident #343 in Geri-chair. Regional director H instructed resident care coordinator D to go to the memory care unit and remove the tray from the Geri-chair.

On 9/27/16 at 8:30 a.m. in the memory care dining room observed resident #343 sitting in a Geri-chair pushed up to dining room table. Resident busy moving hands over table. Licensed nurse B went to resident and instructed resident to remove an object from mouth. Certified employee E came to assist nurse to remove a jelly packet from the resident's mouth.

During an interview at 9:05 a.m. on 9/27/16, certified employee E stated resident was sitting in a recliner in the living room since he/she was falling asleep at the table. Certified employee stated resident is very active and at risk for falls. Certified staff E stated he/she checked on (resident) every 30 minutes and when resident was active he/she took resident in Geri-chair to other resident rooms to provide care to those residents.

At 11:20 a.m. on 9/27/16, observed resident #343 in a recliner with the foot rest up in the living room area with other residents and licensed nurse B. Resident #343 moved around in recliner, turned on right side and placed left leg over arm of chair and pushed up on arm of chair with his/her left arm and was almost out of chair. Resident did not attempt to lower footrest of recliner to get out

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N008008	A. BUILDING: _____ B. WING _____	10/05/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD OF AUGUSTA	1611 FAIRWAY AUGUSTA, KS 67010

(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
S3026	Continued From page 6	S3026		

of chair. Licensed nurse B noticed resident getting out of chair and instructed resident to stay in chair. Resident did not respond to the instructions and licensed nurse B went to resident to try to position resident back in chair. Resident care coordinator D arrived and when asked for interventions to keep resident safe and not use a restraint, resident care coordinator D called for a certified employee to come from the assisted living side of facility to sit with resident. Resident continued to attempt to get out of recliner. Resident care coordinator D instructed the certified employee to obtain a gait belt and walk with resident. Observed the resident walk quickly with an unsteady gait down the hall while certified employee held resident's arm and held on to gait belt around resident's waist.

Licensed nurse B provided a written statement on 9/28/16 with documentation " on 9/7/16 began using the tray for resident's Geri-chair " and "if tray is not put on as far as it will go.....resident can still get out of chair."

In a second statement on 9/28/16 licensed nurse B wrote that resident required one-to-one monitoring and when licensed nurse B arrived at work 9/28/16 (6:00 a.m.) resident met him/her at the door to the memory care unit. Licensed nurse B confirmed his/her statement in an interview at 1:00 p.m. on 9/28/16 and explained an employee was not with the resident at 6:00 a.m. on 9/28/16 because the memory care employee was busy getting other residents up for the day and assisted living employees were doing the same on the assisted living side.

At 1:05 p.m. on 9/28/16 operator stated he/she instructed a certified employee working the memory care unit to call the resident's spouse to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N008008	A. BUILDING: _____ B. WING _____	10/05/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD OF AUGUSTA	1611 FAIRWAY AUGUSTA, KS 67010

(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
S3026	Continued From page 7	S3026		

come sit with resident at meal time last evening because resident was agitated and staff had other residents to assist with eating. Operator stated the certified employees on the assisted living side of facility were busy serving evening meal to residents there and could not provide assistance in memory care. Operator confirmed memory care staffing of 2 certified employees or 1 certified employee and licensed nurse B for the 1st shift, 2 certified employees for the 2nd shift, and 1 certified employee for the 3rd shift. Operator stated memory care staff members could call for an employee to come to memory care from the assisted living side of facility if needed. Operator stated 6 residents living in memory care required physical assistance with eating. Review of the resident roster revealed a census of 11 residents living in the memory care unit, 9 residents required toileting assistance, and 4 residents required two-person transfer assistance.

During an interview at 9:35 a.m. on 9/29/16, resident care coordinator D stated he/she was aware staff members used a tray on the Geri-chair when resident was in the chair. Resident care coordinator D stated he/she observed this on 9/8/16 and informed (licensed nurse B and the operator) this was a restraint and to remove the tray. When asked why the tray was still being used, resident care coordinator D stated "Because I did not take it (tray) and place it in my office."

At 11:55 a.m. on 9/29/16, operator stated staff used the tray to keep resident in chair since approximately the beginning of August 2016 and mainly used on 2nd shift. Operator wrote in a statement " I would see the tray on there during second shift and told them to make sure that tray

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N008008	A. BUILDING: _____ B. WING _____	10/05/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD OF AUGUSTA	1611 FAIRWAY AUGUSTA, KS 67010

(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
S3026	Continued From page 8	S3026		

is off, but it would be on the next day." Operator stated a certified employee told him/her the resident needed the tray in place on the Geri-chair in order to keep resident safe. Operator stated he/she instructed licensed nurse B to obtain a medical care provider's order for the device.

At 12:00 p.m. on 9/27/16 informed operator, resident care coordinator D, regional director H, and regional nurse J the use of a restraint placed resident #343 in immediate jeopardy for entrapment, harm, injury, or death. Requested a written plan to include measures to keep resident (#343) safe without the use of a restraint and education of staff to ensure restraints were not used on any resident.

The operator failed to ensure no resident was subjected to abuse when staff members used a tray attached to a Geri-chair and placed resident in a recliner with footrest elevated in order to restrain and keep resident #343 from getting out of chairs.

The immediate jeopardy corrected with the implementation of the following written plan signed by the executive director (operator) provided on 9/27/16 at approximately 3:15 p.m.

"Homestead of Augusta will achieve and maintain compliance that any chairs provided to residents will not have a tray attached to it to be used as a restrictive device by;

1. Routine monitoring to validate no other restrictive devices are in the facility. The monitoring will be completed by the RCC (resident care coordinator) or designee during rounds.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N008008	A. BUILDING: _____ B. WING _____	10/05/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD OF AUGUSTA	1611 FAIRWAY AUGUSTA, KS 67010

(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
S3026	Continued From page 9 2. If a restraint is identified staff will remove the restraint immediately and report to the ED (executive director) and RCC. 3. An immediate audit was done to ensure no other restraints were in use or were stored in the building, 4. Removing all chairs with trays currently on the property. 5. Phone or fax all vendors providing support furniture that a. We are a non restraint provider and no furniture should be delivered that could be considered a restrictive device. b. All furniture delivered for resident use must be approved by Executive Director or Resident Care Coordinator (RCC) a. Permission received b. Staff training to not use as a restraint at any time c. Care plan updated. To prevent other possible restraints, Homestead of Augusta will; 1. Replace all Geri-chairs with more appropriate mobility devices. All staff will be educated on the identifying restraints and on the State regulations which dictate no restraints are to be used by the facility. The facility education will be completed on 9/27/16. 1st and 2nd shift will be inserviced at 2 P.M., 3rd shift will be inserviced at 10 P.M., by the	S3026		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N008008	A. BUILDING: _____ B. WING _____	10/05/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD OF AUGUSTA	1611 FAIRWAY AUGUSTA, KS 67010

(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
S3026	Continued From page 10	S3026		

Executive Director. Ancillary staff will be inserviced as well as direct staff. The State of Kansas Regulations was printed on Abuse Neglect and Exploitation to explain the statutes. A presentation for the KDADS website was printed to use for education materials for the staff.

The facility Staff education provided on 9/27/16 will discuss what constitutes a restraint:

Examples of restraints or have the potential to be considered a restraint include but are not limited to the following; sheets, furniture, wheel chair behind furniture, bed rails, bed canes, clips from chair to resident, isolating a resident in their room or preventing access outside of a resident's room, a secluded room in the building can all be considered restraints.

Any time a resident tries to move from their chair or bed with a restraint that would inhibit the natural movement of the resident the resident could be cause result in significant injury and/or increase the potential for injury or death.

The plan to keep (resident #343) safe will be:

1. Update assessments and care plan and develop interventions to prevent injury or falls with activities.

2. Collaborate with Hospice to obtain a more appropriate mobility device with no tray.

3. Work with Hospice to provide a volunteer to sit with resident multiple times during the day.

4. Educate staff to contact AL (assisted living) side of building for additional staff support during lunch

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N008008	A. BUILDING: _____ B. WING _____	10/05/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD OF AUGUSTA	1611 FAIRWAY AUGUSTA, KS 67010

(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
S3026	Continued From page 11 breaks and when cares of other residents require staff to be away from common area. 5. Additional staff support would monitor residents for safety and security during times Memory Care staff are busy assisting other residents."	S3026		
S3028 SS=E	26-41-101 (f) (3) Staff Treatment of Residents Reporting (f) (3) Each allegation of abuse, neglect, or exploitation shall be reported to the administrator or operator of the facility as soon as staff is aware of the allegation and to the department within 24 hours. The administrator or operator shall ensure that all of the following requirements are met: (A) An investigation shall be started when the administrator or operator, or the designee, receives notification of an alleged violation. (B) Immediate measures shall be taken to prevent further potential abuse, neglect, or exploitation while the investigation is in progress. (C) Each alleged violation shall be thoroughly investigated within five working days of the initial report. Results of the investigation shall be reported to the administrator or operator. (D) Appropriate corrective action shall be taken if the alleged violation is verified. (E) The department ' s complaint investigation report shall be completed and submitted to the department within five working days of the initial report. (F) A written record shall be maintained of each investigation of reported abuse, neglect, or exploitation.	S3028		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N008008	A. BUILDING: _____ B. WING _____	10/05/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD OF AUGUSTA	1611 FAIRWAY AUGUSTA, KS 67010

(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
S3028	Continued From page 12 This REQUIREMENT is not met as evidenced by: KAR 26-41-101(f)(3) The facility reported a census of 40 residents. The sample included 4 residents. Based on record review and interview for 2 (#343 and #342) of 4 residents sampled, the operator failed to report potential allegations of abuse and neglect to the department within 24 hours and failed to investigate. Findings included: - Record review for resident #343 revealed an admission date of 5/6/15 and diagnoses of Alzheimer's disease and anxiety disorder. The functional capacity screen dated 12/21/15 indicated the resident required physical assistance with toileting, transferring, and mobility; experienced impaired short-term and long-term memory, decision making ability, and memory recall; and was at risk for falls. The record contained a second functional capacity screen dated 12/21/15 and electronically signed by resident care coordinator D on 9/13/16 that scored resident the same as on the 12/21/15 functional capacity screen. The negotiated service agreement/health care service plan (NSA/HCSP) dated 12/21/15 documented staff to assist resident to toilet on a regular basis, assist with transferring, and mobility in wheelchair. The NSA/HCSP documented resident attempted to stand up from wheelchair. NSA/HCSP did not list interventions to reduce resident's risk for falls.	S3028		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N008008	A. BUILDING: _____ B. WING _____	10/05/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD OF AUGUSTA	1611 FAIRWAY AUGUSTA, KS 67010

(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
S3028	Continued From page 13 The clinical notes contained the following entries of staff finding resident on floor: 12/2/15 at 1:02 p.m. licensed nurse B documented staff found resident on dining room floor at 7:00 p.m. on 12/1/15 with resident unable to verbalize what had occurred and staff reported resident was alone in dining room. 4/19/16 at 3:50 p.m. resident care coordinator documented staff found resident on floor in dining room when staff walked by dining room to answer front door. Resident received a 3 centimeter skin tear to right forearm. Intervention of make sure back of wheelchair is reclined when resident unattended. Review of the incident reports and witness statements revealed staff found resident on dining room floor at 11:20 p.m. on 7/8/16 and on floor of resident's room at 12:15 p.m. on 9/6/16. During an interview at 4:10 p.m. on 9/28/16, operator stated he/she did not report the incidents on 7/8/16 and 9/6/16 to the department. Operator unable to locate documentation of report to the department for the incidents on 12/1/15 and 4/19/16. Contact with the department revealed facility did not report the incidents. For resident #343, the operator failed to report potential allegations of abuse and neglect to the department within 24 hours and failed to investigate. - Record review for resident #342 revealed an admission date of 5/14/14 and diagnoses of	S3028		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N008008	A. BUILDING: _____ B. WING _____	10/05/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD OF AUGUSTA	1611 FAIRWAY AUGUSTA, KS 67010

(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
S3028	Continued From page 14	S3028		

dementia, aphasia, and hypertension.

The record contained a functional capacity screen dated 10/8/15 that indicated the resident experienced impaired short-term and long-term memory, decision making ability, and memory recall; required physical assistance with toileting; and supervision with transferring and walking.

The negotiated service agreement/health care service dated 10/8/15 documented staff to provide physical assistance with toileting and supervision with transferring and walking.

The clinical notes contained the following entries of staff finding resident on floor:

1/13/16 at 12:07 p.m. licensed nurse B documented staff found resident on floor in activity area. Resident received a skin tear to right elbow.

1/19/16 at 11:45 a.m. licensed nurse B documented staff notified him/her at 11:00 p.m. on 1/18/16 that resident was found on floor next to bed. Licensed nurse B documented "Resident is aphasic and it is unknown what happened."

At 4:10 p.m. on 9/28/16, operator unable to locate documentation of report to the department for the incidents on 1/13/16 and 1/18/16.

Contact with the department revealed facility did not report the incidents.

For resident #342, the operator failed to report potential allegations of abuse and neglect to the department within 24 hours and failed to investigate.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N008008	A. BUILDING: _____ B. WING _____	10/05/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD OF AUGUSTA	1611 FAIRWAY AUGUSTA, KS 67010

(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
S3081	Continued From page 15	S3081		
S3081 SS=D	26-41-201 (c) Functional Capacity Screen Reassessment (c) Designated facility staff shall conduct a screening to determine each resident ' s functional capacity 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; and (3) at least quarterly if the resident receives assistance with eating from a paid nutrition assistant. This REQUIREMENT is not met as evidenced by: KAR 26-41-201(c)(1)(2) The facility reported a census of 40 residents. The sample included 4 residents. Based on record review, observations, and interviews for 1 (#342) of 4 residents sampled, the resident care coordinator failed to conduct a screening to determine the resident's functional capacity at least once every 365 days and following a significant change in condition as defined in K.A.R. 26-39-100. Findings included: - Record review for resident #342 revealed an admission date of 5/14/14 and diagnoses of dementia, aphasia, and hypertension. The record contained an admission functional capacity screen dated 5/15/14 and an annual functional capacity screen dated 10/8/15. The record lacked a functional capacity screen	S3081		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N008008	A. BUILDING: _____ B. WING _____	10/05/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD OF AUGUSTA	1611 FAIRWAY AUGUSTA, KS 67010

(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
S3081	Continued From page 16 between 5/15/14 and 10/8/15. The functional capacity screen dated 10/8/15 indicated the resident required supervision with transferring, mobility, and eating. At 12:25 p.m. on 9/26/16 in the memory care unit, observed resident #342 sitting in a Geri-chair (a mobile recliner) at a table in the dining room. Resident made no attempt to feed self. Certified employee E began feeding resident and stated resident would feed self at times but would not eat enough without assistance. Certified employee E stated resident could not walk and required two-person transfer assistance. At 1:30 p.m. on 9/26/16, resident care coordinator D reviewed the resident's functional capacity screen and confirmed the resident had experienced a significant change in physical functioning. Resident care coordinator D confirmed the lack of a functional capacity screen conducted at least every 365 days and with a significant change. The resident care coordinator failed to conduct a screening to determine resident #342's functional capacity at least once every 365 days and following a significant change in condition as defined in K.A.R. 26-39-100.	S3081		
S3085 SS=E	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	S3085		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N008008	A. BUILDING: _____ B. WING _____	10/05/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD OF AUGUSTA	1611 FAIRWAY AUGUSTA, KS 67010

(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 17 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)(1)(2)(3) The facility reported a census of 40 residents. The sample included 4 residents. Based on record review and interview for 2 (#342 and #341) of 4 residents sampled, the operator failed to ensure the development of a written negotiated service agreement for each resident based on the resident's functional capacity screen and service needs that included a description of services to be provided to the resident, identification of the provider of each service, and the identification of the party responsible for payment when services were provided by an outside resource. - Record review for resident #342 revealed an admission date of 5/14/14 and diagnoses of dementia, aphasia, and hypertension. During an interview at 12:25 p.m. on 9/26/16, certified employee E stated a hospice aide came to facility to provide shower assistance for resident.	S3085		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N008008	A. BUILDING: _____ B. WING _____	10/05/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD OF AUGUSTA	1611 FAIRWAY AUGUSTA, KS 67010

(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 18 The record contained a negotiated service agreement/health care service plan (NSA/HCSP) dated 10/8/15 that documented facility staff to provide shower assistance to resident two times a week. The NSA/HCSP lacked a description of hospice services, the name of the hospice and the party responsible for payment of hospice services. At 10:25 a.m. on 9/29/16 resident care coordinator D confirmed resident received hospice services and stated the NSA/HCSP did not document hospice services. The operator failed to ensure the development of a written negotiated service agreement for resident #342 based on the resident's functional capacity screen and service needs that included a description of services to be provided to the resident, identification of the provider of each service, and the identification of the party responsible for payment when services were provided by an outside resource. - Record review for resident #341 revealed an admission date of 6/5/16 and diagnoses of type 2 diabetes mellitus, chronic obstructive pulmonary disease, and anxiety. The functional capacity screen dated 6/6/16 indicated the resident required physical assistance with the management of medications. The negotiated service agreement/health care service plan (NSA/HCSP) dated 6/5/16 documented "Staff will administer medications per doctor's orders. During an interview at 4:40 p.m. on 9/26/16,	S3085		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N008008	A. BUILDING: _____ B. WING _____	10/05/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD OF AUGUSTA	1611 FAIRWAY AUGUSTA, KS 67010

(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 19 certified employee C stated certified medication aides prepared and dialed the dose in resident's insulin pen and resident self-injected insulin. At 10:50 a.m. on 9/29/16 resident care coordinator D stated certified medication aide checked resident's blood sugar level with a glucometer and prepared and dialed insulin pen for resident to self-inject insulin. Resident care coordinator confirmed the NSA/HCSP lacked a description of diabetic management services to be provided for the resident. The operator failed to ensure the development of a written negotiated service agreement for resident #341 based on the resident's functional capacity screen and service needs that included a description of services to be provided to the resident and identification of the provider of each service.	S3085		
S3092 SS=D	26-41-202 (d) Negotiated Service Agreement 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, facility staff, the case manager, or, if agreed to by the resident or the resident ' s legal representative, the resident ' s family.	S3092		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N008008	A. BUILDING: _____ B. WING _____	10/05/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD OF AUGUSTA	1611 FAIRWAY AUGUSTA, KS 67010

(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
S3092	Continued From page 20	S3092		

This REQUIREMENT is not met as evidenced by:
KAR 26-41-202(d)(1)(2)

The facility reported a census of 40 residents. The sample included 4 residents. Based on record review, observations, and interviews for 1 (#342) of 4 residents sampled, the resident care coordinator failed to review and revise the negotiated service agreement at least once every 365 days and following a significant change in condition as defined in K.A.R. 26-39-100.

Findings included:

- Record review for resident #342 revealed an admission date of 5/14/14 and diagnoses of dementia, aphasia, and hypertension.

The record contained an admission negotiated service agreement/health care service plan (NSA/HCSP) 5/15/14 and an annual NSA/HCSP dated 10/8/15. The record lacked a functional capacity screen between 5/15/14 and 10/8/15.

The NSA/HCSP dated 10/8/15 documented resident required supervision with transferring, walking, and eating.

At 12:25 p.m. on 9/26/16 in the memory care unit, observed resident #342 sitting in a Geri-chair (a mobile recliner) at a table in the dining room. Resident made no attempt to feed self. Certified employee E began feeding resident and stated resident would feed self at times but would not eat enough without assistance. Certified employee E stated resident could not walk and required two-person transfer assistance.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N008008	A. BUILDING: _____ B. WING _____	10/05/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD OF AUGUSTA	1611 FAIRWAY AUGUSTA, KS 67010

(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
S3092	Continued From page 21 At 1:30 p.m. on 9/26/16, resident care coordinator D reviewed the resident's NSA/HCSP and stated resident required physical assistance with transferring, mobility, and at times needed assistance with eating. Resident care coordinator D confirmed the resident experienced a significant change in physical functioning. Resident care coordinator D confirmed the lack of an NSA/HCSP reviewed and revised at least every 365 days and with a significant change. The resident care coordinator failed to review and revise the negotiated service agreement at least once every 365 days and following a significant change in condition as defined in K.A.R. 26-39-100.	S3092		
S3155 SS=D	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: KAR 26-41-204(a) The facility reported a census of 40 residents. The sample included 4 residents. Based on record review, observations, and interviews for 1 (#343) of 4 residents sampled, the operator failed	S3155		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N008008	A. BUILDING: _____ B. WING _____	10/05/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD OF AUGUSTA	1611 FAIRWAY AUGUSTA, KS 67010

(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 22	S3155		

to ensure a licensed nurse provided or coordinated the provision of necessary health care services that met the needs of the cognitively impaired resident identified on the functional capacity screen to be at risk for falls.

Findings included:

- Record review for resident #343 revealed an admission date of 5/6/15 and diagnoses of Alzheimer's disease and anxiety disorder.

The record contained a functional capacity screen dated 12/21/15 that indicated the resident experienced impaired short-term and long-term memory, decision making ability, and memory recall, and was at risk for falls.

The record contained a negotiated service agreement/health care service plan dated 12/21/15 that described the services of physical assistance with all activities of daily living. The negotiated service agreement/health care service plan did not include interventions to address the resident's risk for falls.

The clinical notes contained the following entries:

7/11/16 at 6:53 a.m. licensed nurse B documented resident doing well post-fall (no previous documentation regarding the fall). Resident has been pushing against tables and nearly tipping wheelchair over. Resident has been trying to get out of bed.

8/17/16 at 1:32 p.m. licensed nurse B documented resident unable to sit still, tries to climb over sides of Geri-chair (a mobile recliner), and getting self out of bed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N008008	A. BUILDING: _____ B. WING _____	10/05/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD OF AUGUSTA	1611 FAIRWAY AUGUSTA, KS 67010

(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 23	S3155		

9/7/16 at 11:42 a.m. by licensed nurse B that medical care provider here to see resident for continuous behaviors of kicking, slapping, and hitting staff. Received order for Geri-tray for Geri-chair when up due to fall risk. Note: the record lacked documentation of an assessment to show that the tray was not a restraint. Restraint use is prohibited in a state licensed facility.

The record contained the following written communication from licensed nurse B to the medical care provider:

8/17/16 Resident appears to unable to sit still, trying to climb over side of Geri-chair, getting self out of bed and tearing closet up. Please advise. Medical care provider wrote an order for Depakote sprinkles (mood stabilizer) 125 milligrams by mouth two times a day.

9/7/16 of non-injury fall 9/6/16. Medical care provider documented an order for Geri-tray for chair while up due to fall risk, Benadryl (antihistamine) 25 milligrams every 6 hours as needed, discontinue Depakote, increase Seroquel (antipsychotic) to 100 milligrams by mouth two times a day, and Haldol (antipsychotic) 0.5 milligram by mouth every 4 hours as needed.

At 4:40 p.m. on 9/26/16, observed resident #343 in a Geri-chair with a tray in place in the memory care dining room. Certified employee C was standing by the resident and stated the tray was in place to keep resident from getting out of chair and falling. Certified employee C stated this allowed employees to leave resident (#343) in order to provide care to other residents.

During an interview at 9:05 a.m. on 9/27/16,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N008008	A. BUILDING: _____ B. WING _____	10/05/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD OF AUGUSTA	1611 FAIRWAY AUGUSTA, KS 67010

(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 24	S3155		

certified employee E stated resident was sitting in a recliner in the living room since he/she was falling asleep at the table. Certified employee stated resident is very active and at risk for falls. Certified staff E stated he/she checked on (resident) every 30 minutes and when resident was active he/she took resident in Geri-chair to other resident rooms to provide care to those residents.

At 11:20 a.m. on 9/27/16, observed resident #343 in a recliner with the foot rest up in the living room area with other residents and licensed nurse B. Resident #343 moved around in recliner, turned on right side and placed left leg over arm of chair and pushed up on arm of chair with his/her left arm and was almost out of chair. Resident did not attempt to lower footrest of recliner to get out of chair. Licensed nurse B noticed resident getting out of chair and instructed resident to stay in chair. Resident did not respond to the instructions and licensed nurse B went to resident to try to position resident back in chair. Resident care coordinator D arrived and when asked for interventions to keep resident safe and not use a restraint, resident care coordinator D called for a certified employee to come from the assisted living side of facility to sit with resident. Resident continued to attempt to get out of recliner. Resident care coordinator D instructed the certified employee to obtain a gait belt and walk with resident. Observed the resident walk quickly with an unsteady gait down the hall while certified employee held resident's arm and held on to gait belt around resident's waist.

During an interview at 9:35 a.m. on 9/29/16 resident care coordinator D confirmed the negotiated service agreement/health care service plan dated 12/21/15 lacked interventions related

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N008008	A. BUILDING: _____ B. WING _____	10/05/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD OF AUGUSTA	1611 FAIRWAY AUGUSTA, KS 67010

(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 25 to the resident's risk for falls. The operator failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services that met the needs of cognitively impaired resident #343 identified on the functional capacity screen to be at risk for falls.	S3155		
S3165 SS=E	26-41-204 (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 26-41-204(d) The facility reported a census of 40 residents. The sample included 4 residents. Based on record review and interview for 2 (#343 and #342) of 4 residents sampled, the operator failed to ensure the negotiated service agreement contained the name of the licensed nurse responsible for the implementation and supervision of the health care service plan. Findings included: - Record review for resident #343 revealed an admission date of 5/6/15 and diagnoses of Alzheimer's disease and anxiety disorder. The negotiated service agreement/health care service plan (NSA/HCSP) dated 12/21/15	S3165		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N008008	A. BUILDING: _____ B. WING _____	10/05/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD OF AUGUSTA	1611 FAIRWAY AUGUSTA, KS 67010

(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
S3165	Continued From page 26	S3165		

documented health care services of physical assistance with bathing, dressing, toileting, transferring, mobility, and eating; and management of medications and medical treatments. The NSA/HCSP contained the name of a nurse no longer employed by the facility as the nurse responsible for implementation and supervision of the plan.

At 9:35 a.m. on 9/29/16, resident care coordinator D stated he/she supervised the health care service plan and confirmed the NSA/HCSP lacked his/her name.

The operator failed to ensure the negotiated service agreement for resident #343 contained the name of the licensed nurse responsible for the implementation and supervision of the health care service plan.

- Record review for resident #342 revealed an admission date of 5/14/14 and diagnoses of dementia, aphasia, and hypertension.

The negotiated service agreement/health care service plan (NSA/HCSP) dated 10/8/15 documented health care services of physical assistance with bathing, dressing, and toileting; supervision for transferring, mobility, and eating; and management of medications and medical treatments. The NSA/HCSP contained the name of a nurse no longer employed by the facility as the nurse responsible for implementation and supervision of the plan.

At 10:25 a.m. on 9/29/16, resident care coordinator D stated he/she supervised the health care service plan and stated would make sure his/her name was listed on next NSA/HCSP.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N008008	A. BUILDING: _____ B. WING _____	10/05/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD OF AUGUSTA	1611 FAIRWAY AUGUSTA, KS 67010

(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
S3165	Continued From page 27 The operator failed to ensure the negotiated service agreement for resident #342 contained the name of the licensed nurse responsible for the implementation and supervision of the health care service plan.	S3165		
S3166 SS=E	26-41-204 (e) Delegation of Duties (e) A licensed nurse may delegate nursing procedures not included in the nurse aide or medication aide curriculums to nurse aides or medication aides, respectively, under the Kansas nurse practice act, K.S.A. 65-1124 and amendments thereto. This REQUIREMENT is not met as evidenced by: KAR 26-41-204(e) The facility reported a census of 40 residents. The sample included 4 residents. Based on record review and interview for 3 of 3 certified medication aide employee files reviewed, the licensed nurse failed to delegate glucometer testing of resident blood sugar (a procedure not included in the medication aide curriculum) under the Kansas nurse practice act, K.S.A. 65-1124 and amendments thereto. Findings included: - Review of the employee file for certified medication aides C (hired 8/25/16), F (hired 6/24/16), and G (hired 6/16/16) revealed the lack of documentation of licensed nurse delegation of glucometer testing.	S3166		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N008008	A. BUILDING: _____ B. WING _____	10/05/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD OF AUGUSTA	1611 FAIRWAY AUGUSTA, KS 67010

(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
S3166	Continued From page 28 During a phone interview at 10:40 a.m. on 9/28/16, resident care coordinator D stated he/she did not instruct each certified medication aide and observe each certified medication aide perform glucometer testing to ensure each staff member's competency to perform the procedure. Resident care coordinator D confirmed each certified medication aide performed resident glucometer testing. The licensed nurse failed to delegate glucometer testing of resident blood sugar (a procedure not included in the medication aide curriculum) under the Kansas nurse practice act, K.S.A. 65-1124 and amendments thereto.	S3166		
S3171 SS=D	26-41-204 (i) Health Care Services Standards of Practice (i) All health care services shall be provided to residents by qualified staff in accordance with acceptable standards of practice. This REQUIREMENT is not met as evidenced by: KAR 26-41-204(i) The facility reported a census of 40 residents. The sample included 4 residents. Based on record review, observation, and interviews for 1 (#342) of 4 residents sampled, the operator failed to ensure qualified staff provided health care services in accordance with acceptable standards of practice. Findings included: - Record review for resident #342 revealed an	S3171		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N008008	A. BUILDING: _____ B. WING _____	10/05/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD OF AUGUSTA	1611 FAIRWAY AUGUSTA, KS 67010

(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
S3171	Continued From page 29	S3171		

admission date of 5/14/14 and diagnoses of dementia, aphasia, and hypertension.

The functional capacity screen dated 10/8/15 indicated the resident required supervision with eating and experienced impaired short-term and long-term memory, decision making, and memory recall.

The negotiated service agreement/health care service plan (NSA/HCSP) dated 10/8/15 documented resident required supervision with eating and weight to be monitored monthly. The NSA/HCSP instructed staff to notify resident care coordinator if resident ate less than 50% for 2 consecutive meals.

The clinical notes contained an entry by licensed nurse B at 12:34 p.m. on 7/27/16 that resident is seldom making an effort to feed self and records show a 15 pound weight loss since 6/1/16. Received new order from medical care provider for regular diet mechanical soft consistency.

At 12:25 p.m. on 9/26/16 in the memory care unit, observed resident #342 sitting in a Geri-chair (a mobile recliner) at a table in the dining room. Resident made no attempt to feed self. Certified employee E began feeding resident and stated resident would feed self at times but would not eat enough without assistance.

Review of the monthly weight records for resident #342 revealed the following:
2/1/16 184 pounds
3/1/16 178 pounds
4/1/16 175 pounds
5/1/16 190 pounds
6/1/16 185 pounds
7/1/16 170 pounds

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N008008	A. BUILDING: _____ B. WING _____	10/05/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD OF AUGUSTA	1611 FAIRWAY AUGUSTA, KS 67010

(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
S3171	Continued From page 30 8/1/16 180 pounds 9/1/16 177 pounds The record lacked documentation that resident was weighed again to check accuracy of weight when weight fluctuated with a gain or a loss. During an interview at 10:25 a.m. on 9/29/16, resident care coordinator stated he/she or licensed nurse B monitored weights and facility policy to report to medical care provider a 5 pound weight gain or loss. Resident care coordinator stated resident should have been weighed again in April and July to check for accuracy of weight. The operator failed to ensure qualified staff provided health care services to resident #342 in accordance with acceptable standards of practice.	S3171		
S3202 SS=E	26-41-205 (d) (4) Delegation of Medication Administration (4) Any licensed nurse may delegate nursing procedures not included in the medication aide curriculum to medication aides under the Kansas nurse practice act, K.S.A. 65-1124 and amendments thereto. This REQUIREMENT is not met as evidenced by: KAR 26-41-205(d)(4) The facility reported a census of 40 residents. The sample included 4 residents. Based on record review and interview for 2 of 3 certified medication aide employee files reviewed, the	S3202		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N008008	A. BUILDING: _____ B. WING _____	10/05/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD OF AUGUSTA	1611 FAIRWAY AUGUSTA, KS 67010

(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
S3202	Continued From page 31 licensed nurse failed to delegate preparation and dialing the dose on an insulin pen (a procedure not included in the medication aide curriculum) under the Kansas nurse practice act, K.S.A. 65-1124 and amendments thereto. Findings included: - Review of the employee file for certified medication aides F (hired 6/24/16) and G (hired 6/16/16) revealed the lack of documentation of licensed nurse delegation of preparation and dialing the dose on an insulin pen. During a phone interview at 10:40 a.m. on 9/28/16, resident care coordinator D stated he she did not instruct each certified medication aide and observe each certified medication aide prepare and dial the dose on an insulin pen to ensure each staff member's competency to perform the procedure. Resident care coordinator D confirmed each certified medication aide performed this procedure for residents self-injecting insulin with an insulin pen prepared by a certified medication aide. The licensed nurse failed to delegate preparation and dialing the dose on an insulin pen (a procedure not included in the medication aide curriculum) under the Kansas nurse practice act, K.S.A. 65-1124 and amendments thereto.	S3202		
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	S3261		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N008008	A. BUILDING: _____ B. WING _____	10/05/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD OF AUGUSTA	1611 FAIRWAY AUGUSTA, KS 67010

(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 32	S3261		

This REQUIREMENT is not met as evidenced by:
KAR 26-41-105(f)(11)

The facility reported a census of 40 residents. The sample included 4 residents. Based on record review and interview for 1 (#343) of 4 residents sampled, the operator failed to ensure the resident's record contained documentation of all incidents and other indications of injury including the date, time of occurrence, action taken, and results of the action

Findings included:

- Record review for resident #343 revealed an admission date of 5/6/15 and diagnoses of Alzheimer's disease and anxiety disorder.

Review of the incident reports and witness statements revealed staff found resident #343 on dining room floor at 11:20 p.m. on 7/8/16 and on floor of resident's room at 12:15 p.m. on 9/6/16.

The resident's clinical record lacked documentation of these incidents including the date, time of occurrence, action taken, and results of the action.

During an interview at 11:00 a.m. on 9/28/16 resident's spouse stated that resident injured (his/her) toe last evening.

At 1:00 p.m. on 9/28/16 licensed nurse B confirmed resident had somehow injured a toe on left foot. Licensed nurse B stated she had

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N008008	A. BUILDING: _____ B. WING _____	10/05/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD OF AUGUSTA	1611 FAIRWAY AUGUSTA, KS 67010

(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 33 contacted medical care provider who told (him/her) to contact hospice nurse. Review of the resident's clinical notes on 9/28/16 and 9/29/16 revealed the lack of an entry regarding the injured toe including the date, time of occurrence, action taken, and results of the action. During an interview at 9:35 a.m. on 9/29/16 resident care coordinator D confirmed the resident's clinical record lacked documentation of all incidents and indications of injury including the date, time of occurrence, action taken, and results of the action. The operator failed to ensure resident #343's record contained documentation of all incidents and other indications of injury including the date, time of occurrence, action taken, and results of the action	S3261		
S3280 SS=E	26-41-104 (d) Disaster and Emergency Preparedness (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 facility ' s emergency management plan; (2) education of each resident upon admission to the facility regarding emergency procedures; (3) quarterly review of the facility ' s emergency management plan with employees and residents; and (4) an emergency drill, which shall be conducted at least annually with staff and residents. This	S3280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N008008	A. BUILDING: _____ B. WING _____	10/05/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD OF AUGUSTA	1611 FAIRWAY AUGUSTA, KS 67010

(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
S3280	Continued From page 34 drill shall include evacuation of the residents to a secure location. This REQUIREMENT is not met as evidenced by: KAR 26-41-104(d)(3) The facility reported a census of 40 residents. The sample included 4 residents. Based on interview and record review for all residents, the operator failed to ensure disaster and emergency preparedness by ensuring a quarterly review of the emergency management plan with residents. Findings included: - At 10:55 a.m. on 9/26/16, operator provided documentation of a review of the emergency management plan with residents dated 3/9/15 and stated there were no other reviews documented. Operator stated he/she started employment as operator at facility on 5/1/16 and he/she had not conducted a review with residents. The operator failed to ensure disaster and emergency preparedness by ensuring a quarterly review of the emergency management plan with residents.	S3280		
S3320 SS=D	28-39-254 CONSTRUCTION (a) The assisted living facility or residential health care facility shall be designed, constructed, equipped and maintained to protect the health and safety of residents, personnel and the public.	S3320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N008008	A. BUILDING: _____ B. WING _____	10/05/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD OF AUGUSTA	1611 FAIRWAY AUGUSTA, KS 67010

(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
S3320	Continued From page 35 (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. (c) New construction, modifications and equipment shall conform to the following codes and standards: (1) Title III of the Americans with disabilities act, 42 U.S.C. 12181, effective as of January 26, 1992; and (2) "Food Service Sanitation Manual," health, education, and welfare (HEW) publication no. FDA 78-2081, as in effect on July 1, 1981. This REQUIREMENT is not met as evidenced by: KAR 28-39-254(a) The facility reported a census of 40 residents. The sample included 4 residents. Based on observation and interview for 1 (#344) non-sampled resident, the operator failed to ensure cleaning chemicals were stored in a locked cabinet. Findings included: - During tour of the dining room in the memory care unit at 9:50 a.m. on 9/26/16, observed an unlocked cabinet under the sink in the drink preparation area. Observed a liquid in a plastic spray bottle labeled "Bleach H20" and liquid in a plastic spray bottle with manufacturer label of Vindicator disinfectant. Operator stated the	S3320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N008008	A. BUILDING: _____ B. WING _____	10/05/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD OF AUGUSTA	1611 FAIRWAY AUGUSTA, KS 67010

(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
S3320	Continued From page 36 cabinet should be locked. Operator removed the bottles and placed them in a locked area in the locked kitchen. At 11:15 a.m. on 9/29/16 observed resident #344 ambulating in memory care dining room. No employees or other residents in dining room. Observed resident opening trash can and readjusting liner and moving hand over front of cabinets as if he/she were dusting. Resident tried to open the cabinets below the drink prep area but cabinets were locked. The resident roster indicated resident #344 experienced impaired cognition. The operator failed to ensure cleaning chemicals were stored in a locked cabinet.	S3320		