STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N103005	A. BUILDING: _____ B. WING _____	09/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNINGSTAR CARE HOMES OF NEODESHA	400 FIR STREET NEODESHA, KS 66757

(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 the licensure resurvey for the above named facility conducted on 09/18, 09/19, & 09/20/23.	S 000		
S3130 SS=D	26-41-203 (d) Special Care Services (d) Special care. Any administrator or operator of an assisted living facility or residential health care facility may choose to serve residents who do not exceed the facility ' s admission and retention criteria and who have special needs in a special care section of the facility or the entire facility, if the administrator or operator ensures that all of the following conditions are met: (1) Written policies and procedures are developed and are implemented for the operation of the special care section or facility. (2) Admission and discharge criteria are in effect that identify the diagnosis, behavior, or specific clinical needs of the residents to be served. The medical diagnosis, medical care provider ' s progress notes, or both shall justify admission to the special care section or the facility. (3) A written order from a medical care provider is obtained for admission. (4) The functional capacity screening indicates that the resident would benefit from the services and programs offered by the special care section or facility. (5) Before the resident ' s admission to the special care section or facility, the resident or resident's legal representative is informed, in writing, of the available services and programs that are specific to the needs of the resident. (6) Direct care staff are present in the special care section or facility at all times.	S3130		

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
	N103005	A. BUILDING: _____ B. WING _____	09/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNINGSTAR CARE HOMES OF NEODESHA	400 FIR STREET NEODESHA, KS 66757

(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
S3130	Continued From page 1 (7) Before assignment to the special care section or facility, each staff member is provided with a training program related to specific needs of the residents to be served, and evidence of completion of the training is maintained in the employee's personnel records. (8) Living, dining, activity, and recreational areas are provided within the special care section, except when residents are able to access living, dining, activity, and recreational areas in another section of the facility. (9) The control of exits in the special care section is the least restrictive possible for the residents in that section. This REQUIREMENT is not met as evidenced by: K.A.R. 26-41-105 (f)(11) The facility reported a census of 25 residents. The sample included 3 "Residents'" ((R)'s 1, 2, and 3). Based on observation, record review and interview, the operator failed to ensure R3 had a written order from a medical care provider for admission to the specialty unit/memory care unit prior to admission to the specialty unit. The operator further failed to have written policies and procedures developed and implemented for the operation of the specialty unit/memory care unit. Findings included: - Observation on 09/18/23 at 02:35 PM during the facility tour; the doors leading from the	S3130		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N103005	A. BUILDING: _____ B. WING _____	09/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNINGSTAR CARE HOMES OF NEODESHA	400 FIR STREET NEODESHA, KS 66757

(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
S3130	Continued From page 2 assisted living to the specialty/memory care unit are key padded doors that require a code for exit. Operator B confirmed during the tour that the area beyond the doors is the memory care unit. Record review on 09/19/23 for R2 revealed an admission date of 05/03/22 with diagnoses of elevated white blood cell count, hyponatremia, unspecified dementia, major depressive disorder, anxiety disorder, Parkinson's disease, Alzheimer's disease, chronic atrial fibrillation, occlusion and stenosis of right carotid artery and chronic obstructive pulmonary disease. Review of R2 FCS dated 07/20/23 revealed R2 was unable to perform bathing, dressing, he required physical assistance with toileting, transferring and walking/mobility, and supervision with eating. He required supervision with his medications, was frequently incontinent of his bladder, and had impaired short-term memory, impaired long-term memory, impaired memory recall, and impaired decision making. He was usually able to make himself understood and he usually understood others. He used a wheelchair and mechanical lift. Review of R2 NSA dated 08/25/23 identified the following health services to be provided by the facility staff: physical assistance with all personal care, administration of all ordered medications and treatments, 2 persons to assist with bathing twice weekly and as needed, staff to use 2 to 3 people and the mechanical lift for all transfers. R2 had an outside hospice provider identified. Review of R2 HSP instructed facility staff to	S3130		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N103005	A. BUILDING: _____ B. WING _____	09/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNINGSTAR CARE HOMES OF NEODESHA	400 FIR STREET NEODESHA, KS 66757

(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
S3130	Continued From page 3 provide 2 staff for all activity of daily living needs, 2 to 3 staff using a mechanical lift were to lay resident down frequently to prevent skin breakdown. Staff to push wheelchair for resident, qualified facility staff to administer all ordered medications and treatments. Review of the facility provided "Order Sheet" for R2 stated "Transfer patient to Morning Star Neodesha; continue prescribed cares". The document lacked the order to be admitted to a specialty unit. Review of the facility provided policy/procedure titled "Morningstar Care Homes of Neodesha Special Care Section" and dated 09/19/23. Interview with R3 spouse on 09/19/23 at 12:20 PM she stated she and R2 moved from another facility because R3 wheelchair was too wide to fit down the halls safely. She stated they did not look at the rooms at this facility prior to the move in. She stated she has the code to the door, and she takes her husband to the assisted living side for meals and activities. Interview on 09/19/23 at 04:30 PM with LN A and Operator B, they confirmed R2 did not have an order to admit to a specialty/memory care unit, and Operator B further confirmed that the policy provided was dated 09/19/23. The operator failed to ensure R3 had a written order from a medical care provider for admission to the specialty unit/memory care unit prior to admission to the specialty unit. The operator further failed to have written policies and procedures developed and implemented for the	S3130		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N103005	A. BUILDING: _____ B. WING _____	09/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNINGSTAR CARE HOMES OF NEODESHA	400 FIR STREET NEODESHA, KS 66757

(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
S3130	Continued From page 4 operation of the specialty unit/memory care unit.	S3130		
S3211 SS=E	26-41-205 (g) (3) OVER THE COUNTER DRUGS (3) A licensed nurse or medication aide may accept over-the-counter medication only in its original, unbroken manufacturer ' s package. A licensed pharmacist or licensed nurse shall place the full name of the resident on the package. If the original manufacturer ' s package of an over-the-counter medication contains a medication in a container, bottle, or tube that can be removed from the original package, the licensed pharmacist or a licensed nurse shall place the full name of the resident on both the original manufacturer ' s medication package and the medication container. This REQUIREMENT is not met as evidenced by: K.A.R. 26-41-205 (g) (3) The facility reported a census of 25 residents. Based on observation and interview the operator failed to ensure a licensed pharmacist or a "Licensed Nurse" (LN) placed the full name of the resident on "Over-the-Counter" (OTC) medications. Findings included: - Observation on 09/18/23 at 02:40 PM during the initial facility tour of the secured unit, Licensed Nurse A opened the only medication cart on the unit. In the first drawer were the	S3211		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N103005	A. BUILDING: _____ B. WING _____	09/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNINGSTAR CARE HOMES OF NEODESHA	400 FIR STREET NEODESHA, KS 66757

(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
S3211	Continued From page 5 following OTC medication tubes which lacked the full name of the resident: 1 opened tube of Triple Antibiotic Ointment with "Morningstar" written on the tube in black. 1 tube of Double Antibiotic Ointment that lacked the full name of the resident it was for. Interview on 09/18/23 at 02:40 PM with LN A, she confirmed the tube of Triple Antibiotic, and the tube of Double Antibiotic lacked the full name of the resident they were intended for. She further confirmed the facility does not use "stock" medications.	S3211		
S3261 SS=E	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: K.A.R. 26-41-105 (f)(11) The facility reported a census of 25 residents. The sample included 3 "Residents'" ((R)'s 1, 2, and 3). Based on record review and interview, the operator failed to ensure the resident records included documentation of all incidents, symptoms, and other indications of illness and injury including the date, time of occurrence, actions taken, and results of the action for R1,	S3261		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N103005	A. BUILDING: _____ B. WING _____	09/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNINGSTAR CARE HOMES OF NEODESHA	400 FIR STREET NEODESHA, KS 66757

(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 6	S3261		

R2, and R3.

Findings included:

- Record review on 09/19/23 for R1 revealed an admission date of 10/17/2019 with diagnoses of malignant neoplasm of the breast, Type 2 Diabetes, and major depressive disorder.

Review of R1 "Functional Capacity Screen" (FCS) dated 06/06/23 revealed R1 required physical assistance with bathing and dressing. She was independent with toileting, transferring, walking, and eating. She required physical assistance with her medications, she was continent of her bladder, her cognition was intact, she was able to make herself understood and she understood others. She was marked with falls, required a walker and wheelchair mobility devices.

Review of R1 "Negotiated Service Agreement" dated 06/06/23 identified the following health services to be provided by the facility staff: qualified staff to administer her medications, resident would self-administer her insulin. Facility staff to assist with 1 person with bathing 2 times weekly, and resident to push pendant when assistance is needed for dressing. Resident had an outside provider for therapies.

Review of R1 "Health Service Plan" instructed facility staff to assist R1 with putting on and removing compression stockings. Facility staff to ensure the resident call light was placed in an accessible location in resident bathroom, near her chair and at the bedside to reduce the risk for falls.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N103005	A. BUILDING: _____ B. WING _____	09/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNINGSTAR CARE HOMES OF NEODESHA	400 FIR STREET NEODESHA, KS 66757

(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 7 Review of R1 electronic "Progress Notes" dated 08/20/23 to 09/19/23 and revealed the following entries: 08/24/23 at 01:40 PM "complaint of shoulder pain gave as needed Tylenol, no other concerns to report" The record lacked documentation for: R1 complaining of shoulder pain, who was notified R1 had shoulder pain, and if the Tylenol was effective for the shoulder pain. 08/28/23 at 01:20 PM "Resident compliant of right shoulder pain, no other concerns" The record lacked documentation for action taken to relieve R1 shoulder pain and results of the action to relieve the shoulder pain. 08/31/23 at 12:05 PM "complaint of shoulder pain, gave as needed Tylenol, no other concerns to report" The record lacked documentation for: R1 complaining of shoulder pain, who was notified R1 had shoulder pain, and if the Tylenol was effective for the shoulder pain. Interview on 09/20/23 at 12:30 PM with LN A, she confirmed the resident record lacked the documentation of who had been notified, what the actions were and the results of the actions for R1 shoulder pain. - Record review on 09/19/23 for R2 revealed an	S3261		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N103005	A. BUILDING: _____ B. WING _____	09/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNINGSTAR CARE HOMES OF NEODESHA	400 FIR STREET NEODESHA, KS 66757

(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 8 admission date of 05/03/22 with diagnoses of elevated white blood cell count, hyponatremia, unspecified dementia, major depressive disorder, anxiety disorder, Parkinson's disease, Alzheimer's disease, chronic atrial fibrillation, occlusion and stenosis of right carotid artery and chronic obstructive pulmonary disease. Review of R2 FCS dated 07/20/23 revealed R2 was unable to perform bathing, dressing, he required physical assistance with toileting, transferring and walking/mobility, and supervision with eating. He required supervision with his medications, was frequently incontinent of his bladder, and had impaired short-term memory, impaired long-term memory, impaired memory recall, and impaired decision making. He was usually able to make himself understood and he usually understood others. He used a wheelchair and mechanical lift. Review of R2 NSA dated 08/25/23 identified the following health services to be provided by the facility staff: physical assistance with all personal care, administration of all ordered medications and treatments, 2 persons to assist with bathing twice weekly and as needed, staff to use 2 to 3 people and the mechanical lift for all transfers. R2 had an outside hospice provider identified. Review of R2 HSP instructed facility staff to provide 2 staff for all activity of daily living needs, 2 to 3 staff using a mechanical lift were to lay resident down frequently to prevent skin breakdown. Staff to push wheelchair for resident, qualified facility staff to administer all ordered medications and treatments.	S3261		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N103005	A. BUILDING: _____ B. WING _____	09/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNINGSTAR CARE HOMES OF NEODESHA	400 FIR STREET NEODESHA, KS 66757

(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 Review of R2 electronic "Progress Notes" dated 08/20/23 to 09/19/23 revealed the following entries: 08/22/23 at 09:48 PM "no concerns, resident refused his dinner". The record lacked documentation of actions taken to provide an alternative for a meal. The record lacked documentation of the nurse or provider being notified, and further lacked documentation of follow up with the R2 at a later time. 09/04/23 at 01:26 PM "Staff was rotating R2 in bed, and R2 got mad and punched staff member "Certified Nurse Aide" (CNA) in the head. The record lacked documentation of actions taken to ensure R2 comfort and safety. The record lacked documentation of follow up on R2 after the incident, and further lacked documentation of the incident being reported to the LN or R2 provider. 09/05/23 at 10:39 PM "No other concerns aside from the "PRN" (as needed) given earlier for right shoulder blade discomfort. The record lacked documentation of resident having a complaint for shoulder blade discomfort, who was notified about the discomfort of the right shoulder blade, what was administered for the discomfort and if the medication was effective for the discomfort. 09/07/23 at 09:45 PM "R2 did not roll well and	S3261		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N103005	A. BUILDING: _____ B. WING _____	09/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNINGSTAR CARE HOMES OF NEODESHA	400 FIR STREET NEODESHA, KS 66757

(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	S3261		

when staff tried to assist him, he was swinging at them".

The record lacked documentation of actions taken to provide R2 comfort, and further lacked documentation of who was notified of the incident of "swinging at" facility staff.

Interview on 09/20/23 at 12:30 PM with LN A, she confirmed the resident record lacked the documentation of who had been notified, what the actions were and the results of the actions for R2's punching facility staff in the head, swinging at facility staff, R2's refusal of meals, and reporting of R2 right shoulder blade pain.

- Record review on 09/20/23 for R3 revealed an admission date of 02/23/22, with diagnoses of Type 2 diabetes mellitus, glaucoma, essential hypertension, asthma, spinal stenosis, dysphonia, and localized edema.

Record review of R3 FCS dated 06/23/23 revealed he required physical assistance with bathing, dressing, toileting, transferring, walking/mobility, and he was independent with eating. He lacked the ability to manage his own medications, was continent of his bladder, had intact cognition, was able to make himself understood and he understood others. He was marked with falls and used a walker and wheelchair mobility device.

Record review of R3 NSA dated 05/23/23 identified the following health services to be provided by the facility staff; resident to push pendant device to call staff for physical assistance with personal cares. Facility staff to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N103005	A. BUILDING: _____ B. WING _____	09/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNINGSTAR CARE HOMES OF NEODESHA	400 FIR STREET NEODESHA, KS 66757

(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 11	S3261		

provide physical assistance with a shower 2 times a week and as needed. One to two staff members to assist R3 when he used the walker, and one to two staff members to assist when transferring R3 into the wheelchair. R3 able to independently use a urinal and facility staff were to ensure the urinal was emptied and clean. One to two staff members to assist R3 to the toilet. R3 had an outside provider for skilled nursing services.

Record review of R3 HSP instructed facility staff to provide physical assistance with bathing, toileting, mobility and ambulation, dressing, and administer all ordered medications and treatments.

Record review of R3 electronic "Progress Notes" dated 06/21/23 to 09/20/23 revealed the following entries:

08/15/23 at 09:06 "Resident is upset about not having the urinal at his disposal. No other concerns. Wound care done".
08/16/23 at 11:23 AM "Wound care done, upset about urinal issue but in a better mood".

The documentation lacked any mention of there being any incidents with the resident being able to use his urinal. R3 NSA identified the facility staff would empty and clean the urinal. The documentation lacked actions taken for the resident not having his urinal, and further lacked documentation of outcomes for actions taken.

Interview on 09/20/23 at 12:30 PM with LN A, she confirmed the resident record lacked the documentation of who had been notified, what

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N103005	A. BUILDING: _____ B. WING _____	09/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNINGSTAR CARE HOMES OF NEODESHA	400 FIR STREET NEODESHA, KS 66757

(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 12 the actions were and the results of the actions for R3. The operator failed to ensure the resident records included documentation of all incidents, symptoms, and other indications of illness and injury including the date, time of occurrence, actions taken, and results of the action for R1, R2, and R3.	S3261		
S3280 SS=F	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 drill shall include evacuation of the residents to a secure location. This REQUIREMENT is not met as evidenced by: K.A.R. 26-41-104 (d)(3) The facility reported a census of 25 residents.	S3280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N103005	A. BUILDING: _____ B. WING _____	09/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNINGSTAR CARE HOMES OF NEODESHA	400 FIR STREET NEODESHA, KS 66757

(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 13 Based on observation and record review the operator failed to ensure the residents were provided a review of the facility's emergency management plan quarterly. Findings included: - Record review on 09/19/23 of the facility provided "Resident Council" meeting minutes and agenda, revealed the Emergency Management Plan was reviewed on 08/25/22 and on 03/23/23. Interview 09/19/23 at 04:55 PM with Operator B, she confirmed the records lacked documentation for the 4th quarter training for 2022, and for the 2nd quarter training for 2023. The operator failed to ensure the residents were provided a review of the facility's emergency management plan quarterly.	S3280		