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	B056003	A. BUILDING: _____ B. WING _____	01/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNFLOWER CARE HOMES LLC- LEGACY	1600 W 15TH AVENUE EMPORIA, KS 66801

(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 Re-Licensure Survey for the above named Home Plus facility conducted on 01/11/24, 01/16/24 and 01/17/24.	S 000		
S 225 SS=D	26-39-102 (a) Admission Policy (a) Each licensee, administrator, or operator shall develop written admission policies regarding the admission of residents. The admission policy shall meet the following requirements: (1) The administrator or operator shall ensure the admission of only those individuals whose physical, mental, and psychosocial needs can be met within the accommodations and services available in the adult care home. (A) Each resident in a nursing facility or nursing facility for mental health shall be admitted under the care of a physician licensed to practice in Kansas. (B) The administrator or operator shall ensure that no children under the age of 16 are admitted to the adult care home. (C) The administrator or operator shall allow the admission of an individual in need of specialized services for mental illness to the adult care home only if accommodations and treatment that will assist that individual to achieve and maintain the highest practicable level of physical, mental, and psychosocial functioning are available. (2) Before admission, the administrator or operator, or the designee, shall inform the prospective resident or the resident ' s legal representative in writing of the rates and charges for the adult care home's services and of the resident's obligations regarding payment. This	S 225		

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

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S 225	Continued From page 1	S 225		

information shall include the refund policy of the adult care home.(3) At the time of admission, the administrator or operator, or the designee, shall execute with the resident or the resident ' s legal representative a written agreement that describes in detail the services and goods the resident will receive and specifies the obligations that the resident has toward the adult care home.
(4) An admission agreement shall not include a general waiver of liability for the health and safety of residents.
(5) Each admission agreement shall be written in clear and unambiguous language and printed clearly in black type that is 12-point type or larger.

This REQUIREMENT is not met as evidenced by:
KAR 26-39-102(a)(3)

The facility reported a census of 11 residents(R) and two residents who received "Day Services". The sample included three residents and four focused record reviews. Based on interview and record review for one (R3) of three sampled residents, the operator failed to execute with the resident or the resident's representative a written admission agreement that described in detail the services the resident would receive and the specifics as to the resident's obligation/liability to the facility at the time of admission.

Findings included:

-R3 moved into the facility on 10/11/23 with

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diagnoses of sacral pressure ulcer stage II, anorexia (lack or loss of appetite), and right shoulder pain.

R3's "Functional Capacity Screen' dated 10/02/23 identified the resident required physical assistance with mobility and bathing and was independent with eating. It lacked information the resident had a sacral wound or wound treatments.

R3's "Negotiated Service Agreement" (NSA) dated 10/02/23 identified Administrative Licensed Nurse A and Administrative Licensed Nurse B were responsible for health care services. It identified staff provided the resident a mechanical soft diet with three meals and snacks served per day. It lacked interventions related to his diagnosis of anorexia. R3 had no control of his bowels and had an indwelling urinary catheter which required assistance of one staff for cares. He also used a wheelchair most of the time.

Review of R3's admission agreement dated 10/02/23 lacked documentation of what level of care the resident was and what the fee would be the resident/legal representative would have to pay. It also failed to have a facility representative signature on the agreement.

Review of the facilities undated "Admission Policy" revealed at the time of admission a written agreement will be executed describing in detail the services and good the resident would receive and specify the obligations of the residents. It will reflect all charges for the covered and non-covered services and who was

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S 225	Continued From page 3 responsible for payment of services. The operator failed to execute a written admission agreement for R3 that included what services he would receive and his obligations to the facility.	S 225		
S 230 SS=D	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)(c) The facility reported a census of 11 residents(R) and two residents who received "Day Services".	S 230		

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S 230	Continued From page 4 The sample included three residents and four focused record reviews. Based on record review and interview the operator failed to ensure designated staff reviewed the facilities advanced directives policy, resident rights, and grievance policy for one (R6) of four focused record reviews Findings Included: - Review of R6's medical record revealed he moved into the facility on 01/05/24 with diagnosis of dementia. R6's paper chart and electronic medical record did not have an admission agreement completed, did not have any information related to advanced directives in his chart or documentation that advanced directives were reviewed with his legal representative. The record also lacked information of providing information to R6's legal representative related to resident rights, grievance policy and procedures for advance medical directives. On 01/16/24 at 04:00 PM Administrative Licensed Nurse B looked through R6's paper chart and confirmed there was no evidence that the facility policies related to advanced directives, resident rights, and the grievance policy were reviewed and provided to the resident's legal representative. The operator failed to ensure designated staff provided R6's legal representative with information regarding advanced directives, resident rights and the facilities grievance policy.	S 230		

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S5080	Continued From page 5	S5080		
S5080 SS=D	26-42-201 (a) (b) Functional Capacity Screen on Admission (a) On or before each individual ' s admission to a home plus, a licensed nurse, a licensed social worker, or the administrator or operator shall conduct a screening to determine the individual ' s functional capacity and shall record all findings on a screening form specified by the department. The administrator or operator may integrate the department ' s screening form into a form developed by the home, which shall include each element and definition specified by the department. (b) A licensed nurse shall assess any resident whose functional capacity screening indicates the need for health care services. This REQUIREMENT is not met as evidenced by: KAR 26-42-201(a) The facility reported a census of 11 residents(R) and two residents who received "Day Services". The sample included three residents and four focused record reviews. Based on interview and record review the operator failed to ensure one (R6) of four focused record reviews, had their admission screening for determination of functional capacity completed on or before moving into the facility. Findings included:	S5080		

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S5080	Continued From page 6 - On 01/11/24 at 02:09 PM Administrative Licensed Nurse A reported there were three residents currently in the facility who currently receive "Respite Care" (provision of services to a resident on an intermittent basis for periods of fewer then 30 days at any one time.). Review of R6's medical record revealed he moved into the facility on 01/09/24 with diagnosis of dementia. Review of R6's paper chart and electronic medical record lacked evidence designated staff completed a "Functional Capacity Screen". On 01/16/24 at 04:02 PM Administrative Licensed Nurse B reported the resident's Functional Capacity Screen was to be completed either before or on day of admission. She acknowledged it had not been completed as the resident's DPOA was supposed to be getting the facility more information. Review of the undated Respite Care policy revealed the facility will ensure all the requirements for admission to the facility will be met. The operator failed to ensure designated staff completed a "Functional Capacity Screen" on or before R6 moved into the facility.	S5080		
S5095 SS=E	26-42-201 (d) Functional Capacity Screen Accurate (d) Designated staff shall ensure that each resident ' s functional capacity at the time of	S5095		

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S5095	Continued From page 7 screening is accurately reflected on that resident ' s screening form. This REQUIREMENT is not met as evidenced by: KAR 26-42-201(d) The facility reported a census of 11 residents(R) and two residents who received "Day Services". The sample included three residents and four focused record reviews. Based on observation, interview, and record review the operator failed to ensure designated staff completed two (R4 and R5) of three sampled resident's "Functional Capacity Screen" accurately to reflect the resident's functional ability. Findings Included: - Review of R4's medical record revealed she moved into the facility on 09/30/23 with diagnoses of diabetes mellitus and hypertension. R4's admission "Functional Capacity Screen" (FCS) dated 09/20/23 revealed the resident was independent with bathing, dressing, toileting, require supervision with transfers and mobility. It also identified she was independent with management of medications and medical treatments. R4's admission Negotiated Service Agreement revealed staff provided stand by assistance with bathing and assistance of one person. For dressing it identified she needed assistance of	S5095		

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S5095	Continued From page 8 one person dressing and encourage her to do as much as she can. For toileting staff to provide stand by assistance of one person. For medications it identified staff will administer medications and failed to include that staff completed the task of monitoring her blood sugars. On 01/16/24 at 11:49 AM the resident reported she could do a lot of things herself but sometimes she needs assistance with getting up in bed, putting on her pants, or getting up from a chair. On 01/16/24 at 12:33 PM Certified Nurse Aide D reported the resident is pretty independent but occasionally needs help getting out of bed or needs assistance with getting on her pants. Some days are better than others but has always needed some kind of assistance with cares. On 01/16/24 at 02:35 PM Certified Medication Aide (CMA) E said R4 sometimes needs help with getting her feet over the side of the bed so she can sit up and will occasionally need an extra boost getting in and out of bed or up from a chair. For her showers we provide stand by assistance, we give her medications and check her blood sugar. The only thing she does on her own related to medications is once we prepare the insulin pen, she can self-inject it. On 01/16/24 at 12:52 PM Administrative Licensed Nurse B reviewed R4's FCS and confirmed it was inaccurate and should match the services the NSA has. She stated if staff are giving any of the medications it should be coded a "2".	S5095		

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S5095	Continued From page 9	S5095		

The operator failed to ensure designated staff completed R4's FCS accurately to reflect her functional ability and need for assistance.

- Review of R5's medical record revealed she moved into the facility on 11/01/21 with diagnoses of Parkinson's disease and Alzheimer's.

R5's most current "Functional Capacity Screen" (FCS) dated 12/1/23 revealed staff coded the resident a "3" (unable to perform any part of the task), for dressing, toileting, and walk/mobility.

R5's "Negotiated Service Agreement" revealed staff were to provide assistance of one staff with dressing, toileting and walk/mobility.

Observation on 01/16/24 at 10:55 AM R4 sat at the table with Certified Nurse Aide (CNA) D assisting her to finish eating breakfast. CNA D had put a piece of pancake on the fork and handed the fork to R4 to finish eating.

On 01/16/24 at 11:19 AM CNA D had assisted the resident from a chair at the table into her wheelchair and then took her over to the recliner in the front room. CNA D told the resident to put her hands on her arms which she did with CNA D's help and then CNA lifted telling the resident to stand up which she did and pivot transferred into the recliner.

On 01/16/24 at 12:28 PM CNA D reported staff help R5 with transfers and help her on and off the toilet. CNA D stated sometimes she is incontinent and sometimes she will use the toilet

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S5095	Continued From page 10 when we set her on it. CNA D reported sometimes R5 can eat on her own and sometimes we must assist her. What she can and cannot do varies day to day. On 01/16/24 at 02:30 PM Certified Medication Aide E reported R5 needs help with all her ADLs. She can hold onto the bar in the bathroom and pull herself up to use the toilet and can occasionally move around a little in her wheelchair. When getting her dressed and undressed she will lift her legs when we ask her to. She needs a lot of assistance but can sometimes help with whatever we are doing. On 01/17/24 at 03:42 PM Administrative Licensed Nurse B stated she coded the ADL areas a "3" because the resident could not do the task herself. After review of the Functional Manual guidelines Administrative Licensed Nurse B acknowledged the coding on the FCS was not accurate. The operator failed to ensure designated staff completed R5's FCS accurately to reflect her functional ability and her need for staff assistance with activities of daily living.	S5095		
S5105 SS=E	26-42-202 (a) Negotiated Service Agreement a) The administrator or operator of each home plus shall ensure the development of a written negotiated service agreement for each resident, based on the resident ' s functional capacity screening, service needs, and preferences, in collaboration with the resident or the resident ' s legal representative, the case manager, and, if agreed to by the resident or the resident ' s legal	S5105		

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S5105	Continued From page 11	S5105		

representative, the resident ' s family. The negotiated service agreement shall provide the following information:
(1) A description of the services the resident will receive;
(2) identification of the provider of each service; and
(3) identification of each party responsible for payment if outside resources provide a service.

This REQUIREMENT is not met as evidenced by:
KAR 26-42-202(a)(1)

The facility reported a census of 11 residents(R) and two residents who received "Day Services". The sample included three residents and four focused record reviews. Based on observation, interview, and record review for three (R3, R4, and R5) of three sampled residents, the operator failed to ensure designated staff developed a "Negotiated Service Agreement" based on the resident's "Functional Capacity Screen" and the resident's service needs that included a description of the services the resident would receive.

Findings included:

- Review of R3's medical record revealed he moved into the facility on 10/11/23 with diagnoses of sacral pressure ulcer stage II, anorexia (lack or loss of appetite), and right shoulder pain.

R3's "Functional Capacity Screen' dated 10/02/23 identified the resident required physical

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S5105	Continued From page 12 assistance with management of medical treatments. R3's "Negotiated Service Agreement" (NSA) dated 10/02/23 failed to address service needs related to medical treatments such as wound treatments to his sacral pressure ulcer. Review of R3's Medication/Treatment Administration Records since admission include skin treatments related to sacral wound as well as treatment for indwelling urinary catheter. Interview on 01/17/24 at 09:19 AM Administrative Licensed Nurse B acknowledged she did not implement measures in R3's NSA related to his need for medical treatments associated with pressure ulcers. Review of the undated "Nursing Functional Capacity Screen and Negotiated Service Agreement with Care Plan Policy" revealed the Negotiated Service Agreement will be developed based upon the residents Functional Capacity Screen. The operator failed to ensure designated staff completed R3's NSA based upon his service needs as identified in his FCS. - Review of R4's medical record revealed she moved into the facility on 09/30/23 with diagnoses of diabetes mellitus and hypertension. R4's admission "Functional Capacity Screen" (FCS) dated 09/20/23 revealed the resident was independent with bathing, dressing, toileting, require supervision with transfers and mobility. It	S5105		

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S5105	Continued From page 13 also identified she was independent with management of medications and medical treatments. R4's admission "Negotiated Service Agreement" (NSA) failed to address services related to medical treatments and failed to include that she used a Ubar attached to the bed as a mobility assistive device. Review of R4's Medication/Treatment Administration Records included staff monitoring her blood sugars since admission and staff also applied topical medication pain treatments for R4. Observation on 01/16/24 the resident had a Ubar on the open side of the bed. R4 stated that she used it to help get sat up on the bed as well as getting in and out of the bed. On 01/16/24 at 12:52 PM Administrative Licensed Nurse B reviewed R4's NSA and confirmed it did not address medical treatments which included staff monitoring R4's blood sugars. Review of the undated "Nursing Functional Capacity Screen and Negotiated Service Agreement with Care Plan Policy" revealed the Negotiated Service Agreement will be developed based upon the residents Functional Capacity Screen. The operator failed to ensure designated staff completed R4's NSA based upon her need for medical treatments as identified in the FCS.	S5105		

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S5105	Continued From page 14 - Review of R5's medical record revealed she moved into the facility on 11/01/21 with diagnoses of Parkinson's disease and Alzheimer's. R5's most current "Functional Capacity Screen" (FCS) dated 12/01/23 revealed she was unable to complete any part of the task related to management of medical treatments. R5's "Negotiated Service Agreement" (NSA) failed to include services related to medical treatments. R5's Medication/Treatment Administration Record since October 2023 included topical estrogen treatments. On 01/18/24 at 03:50 PM Administrative Licensed Nurse B reviewed R5's NSA and acknowledged it did not address medical treatments. Review of the undated "Nursing Functional Capacity Screen and Negotiated Service Agreement with Care Plan Policy" revealed the Negotiated Service Agreement will be developed based upon the residents Functional Capacity Screen. The operator failed to ensure designated staff developed an NSA/HCSP for R4 based upon her service needs identified on the FCS.	S5105		
S5115 SS=D	26-42-202 (c) Admission Negotiated Service Agreement (c) Each administrator or operator shall ensure	S5115		

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SUNFLOWER CARE HOMES LLC- LEGACY	1600 W 15TH AVENUE EMPORIA, KS 66801

(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
S5115	Continued From page 15 the development of an initial negotiated service agreement at admission. This REQUIREMENT is not met as evidenced by: KAR 26-42-202(c) The facility reported a census of 11 residents(R) and two residents who received "Day Services". The sample included three residents and four focused record reviews. Based on interview and record review the operator failed to ensure one (R6) of four focused record reviews had an initial Negotiated Service Agreement" completed at admission. Findings included: - On 01/11/24 at 02:09 PM Administrative Licensed Nurse A reported there were three residents currently in the facility who receive "Respite Care" (provision of services to a resident on an intermittent basis for periods of fewer then 30 days at any one time.). Review of R6's medical record revealed he moved into the facility on 01/09/24 with diagnosis of dementia. Review of R6's paper chart and electronic medical record lacked evidence designated staff completed an initial "Negotiated Service Agreement". On 01/16/24 at 04:02 PM Administrative Licensed Nurse B reported the resident's "Negotiated Service Agreement" was to be	S5115		

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S5115	Continued From page 16 completed either before or on day of admission. She acknowledged it had not been completed as the resident's DPOA was supposed to be getting the facility more information. Review of the undated Respite Care policy revealed the facility would complete a "Negotiated Service Agreement" prior to services being provided by the facility. The operator failed to ensure designated staff completed a "Negotiated Service Agreement" on or before R6 moved into the facility.	S5115		
S5116 SS=E	26-42-202 (d) NSA revisions (d) Each administrator or operator shall ensure the review and, if necessary, revision of each negotiated service agreement according to the following requirements: (1) At least once every 365 days;(2) following any significant change in condition, as defined in K.A.R. 26-39-100; (3) at least quarterly if the resident receives assistance with eating from a paid nutrition assistant; and (4) if requested by the resident or the resident ' s legal representative, staff, the case manager, or, if agreed to by the resident or the resident ' s legal representative, the resident ' s family. This REQUIREMENT is not met as evidenced by: KAR 26-42-202(d)(2) The facility reported a census of 11 residents(R)	S5116		

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S5116	Continued From page 17	S5116		

and two residents who received "Day Services". The sample included three residents and four focused record reviews. Based on interview and record review, the operator failed to ensure the review and if necessary, the revision of each negotiated service agreement for one (R3) of three sampled residents when the resident had a significant change in condition, as defined in KAR 26-39-100.

Findings Included:

- R3 moved into the facility on 10/11/23 with diagnoses of sacral pressure ulcer stage II, anorexia (lack or loss of appetite), and right shoulder pain.

R3's "Functional Capacity Screen' dated 10/02/23 identified the resident required physical assistance with mobility and bathing and was independent with eating. It lacked information the resident had a sacral wound or wound treatments.

R3's "Negotiated Service Agreement" (NSA) dated 10/02/23 identified Administrative Licensed Nurse A and Administrative Licensed Nurse B were responsible for health care services. It identified he did not receive any home health or therapy services. The NSA had an undated handwritten entry that Physical Therapy had been ordered.

Review of R3's paper and electronic record revealed he started Home Health services on 11/7/23 with a local outside resource for physical therapy and wound care. He then discharged from Home Health and Started Hospice services

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S5116	Continued From page 18 on 12/08/23 with a different company. On 01/04/24 the resident discharged from this Hospice service and started services with a different Hospice company on 01/07/24. On 01/19/24 at 09:19 AM Administrative Licensed Nurse B reported the NSA needed to be revised or an addendum done for any outside services changes, or any assistive device added. Administrative Licensed Nurse acknowledged she should have completed addendums when the resident started Home Health and discontinued Home Health services, and same for when he started and changed Hospice services. Review of the undated "Nursing Functional Capacity Screen and Negotiated Service Agreement with Care Plan Policy" revealed the administrator or operator shall ensure the review and if necessary, revision of the NSA following any significant change in condition, as defined in KAR 26-30-100. The operator failed to ensure designated staff reviewed and revised R3's NSA when he had a change in outside services related to Home Health and Hospice.	S5116		
S5140 SS=E	28-42-203 (b) Adult Day Care Services (b) Adult day care services. Any administrator or operator of a home plus may provide adult day care services to any individual who meets the home ' s admission and retention criteria and receives services less than 24 hours a day if the administrator or operator ensures that all of the following conditions are met:	S5140		

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S5140	Continued From page 19 (1) Written policies are developed and procedures are implemented for the provision of adult day care services. (2) All requirements for admission of a resident to a home plus are met for an individual admitted for adult day care services. (3) At least 60 square feet of common use living, dining, and activity space is available in the home for each resident of the home and each resident receiving adult day care services. (4) The provision of adult day care services does not adversely affect the care and services offered to other residents of the home. This REQUIREMENT is not met as evidenced by: KAR 26-42-203(b) The facility reported a census of 11 residents(R) and two residents who received "Day Services". The sample included three residents and six focused record reviews. Based upon record review and interview the operator provided Day Care services for two (R9 and R10) residents without having a license to do so. Findings included: - Review of the facility License during initial tour on 01/11/23 revealed the facility had a licensed capacity of 12 residents. The license did not include license to have Day Care residents. Review of the "Day Service" Log included two men who had most recently been to the facility for day care services.	S5140		

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S5140	Continued From page 20 On 01/16/24 at 03:43 PM Administrative Licensed Nurse B confirmed R9 and R10 came to the facility periodically for Day Services. - Review of R9's record included an "Admission Agreement Day Services" dated 07/12/22 and signed on 08/07/22. R9's record admission "Functional Capacity Screen" dated 06/06/22 that identified he was independent with all activities of daily living, had impaired cognition, and needed supervision with medication management. On 01/23/24 at 02:19 PM Administrative Licensed Nurse A reported she thought she had applied and filled out the application for Day Care Services. Stated she would check to see about the paperwork in the office. Review of the undated "Adult Day Care" Policy revealed residents would receive services less than 24 hours per day. - Review of R10's medical record included an Admission Agreement titled "Resident and Respite Services" yet his level of care fee is identified as Adult Day Services level one. The agreement is dated 09/18/23. R10's admission Functional Capacity Screen dated 09/18/23 revealed the resident needed physical assistance with bathing, supervision with dressing and toileting and was independent with other activities of daily living. He had impaired cognition and unable to manage medications.	S5140		

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S5140	Continued From page 21 On 01/23/24 at 02:19 PM Administrative Licensed Nurse A reported she thought she had applied and filled out the application for Day Care Services. Stated she would check to see about the paperwork in the office. Review of the undated "Adult Day Care" Policy revealed residents would receive services less than 24 hours per day. The opertor provided Day Care services to two residents without a license to do so.	S5140		
S5141 SS=E	26-42-203 (c) Respite Care Services (c) Respite care services. Any administrator or operator of a home plus may provide respite care services to individuals who meet the home's admission and retention criteria on a short-term basis if the administrator or operator ensures that the following conditions are met: (1) Written policies are developed and procedures are implemented for the provision of respite care services. (2) All the requirements for admission of a resident to a home plus are met for an individual admitted for respite care services. This REQUIREMENT is not met as evidenced by: KAR 26-42-203(c) The facility reported a census of 11 residents(R) and two residents who received "Day Services". The sample included three residents and four focused record reviews. Based on record review and interview the operator failed to ensure	S5141		

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"Respite Care" services did not exceed the 30-day definition for two (R7 and R8) of three residents receiving "Respite Care".

Findings included:

- On 01/11/24 at 02:09 PM Administrative Licensed Nurse A reported there were three residents currently in the facility who received "Respite Care".

By definition "Kansas Administrative Regulations Common to All Adult Care Homes" KAR 26-39-100 (mmm) defined "Respite Care" as the provision of services to a resident on an intermittent basis for periods of fewer than 30 days at any one time.

- Review of R7's medical record revealed she moved into the facility on 12/06/23 for Level three "Respite Care" services. As of 01/17/24, 42 days after her admission she remained in the facility receiving services from facility staff based upon her "Respite Care" admission agreement and level of care payment.

On 01/17/24 at 03:51 PM Administrative Licensed Nurse reported "Respite Care" services are a week-by-week basis and R7 continued on Respite services.

The operator failed to ensure "Respite Care" services were provided according to the definition in the "Kansas Administrative Regulations Common to All Adult Care Homes".

- Review of R8's medical record revealed he moved into the facility on 11/02/23 for Level one

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S5141	Continued From page 23 "Respite Care" services. As of 01/17/24 R8 continued to receive services from facility staff and had the same "Respite Admission Agreement" with identified "Respite" billing, 76 days after admission into the facility. On 01/17/24 at 03:51 PM Administrative Licensed Nurse reported she thought he had switched from Respite care to long term admission as of 01/01/24, which is still longer than 30 days being on "Respite Care" services. Review of the undated "Respite Care" policy revealed the resident will receive services on a short term basis. The operator failed to ensure "Respite Care" services were provided according to the definition in the "Kansas Administrative Regulations Common to All Adult Care Homes".	S5141		
S5155 SS=G	26-42-204 (a) Health Care Services (a) The administrator or operator in each home plus shall ensure that a licensed nurse provides or coordinates the provision of necessary health care services that meet the needs of each resident and are in accordance with the functional capacity screening and the negotiated service agreement. This REQUIREMENT is not met as evidenced by: KAR 26-42-204(a)	S5155		

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S5155	Continued From page 24 The facility reported a census of 11 residents(R) and two residents who received "Day Services". The sample included three residents and four focused record reviews. Based on observations, interview, and record review the operator failed to ensure a licensed nurse provided and/or coordinated the provision of necessary health care services to meet the needs of one (R3) of three sampled residents regarding the development and worsening of pressure ulcers (localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction). The operator failed to ensure a licensed nurse assessed R3 for wounds upon admission, failed to address the resident's risk for development of pressure ulcers, and failed to develop and implement interventions to promote healing and reduce risk of further pressure ulcer issues. The resident was admitted to the facility with a stage II (partial thickness ulcer involving the outer layer of skin and extending into the next layer of skin resulting in a shallow open wound or a blister containing clear fluid) sacral wound that worsened to a stage III pressure ulcer (ulcer effecting the full thickness of skin extending into the fatty tissue). On 11/07/23 he developed an additional stage III pressure ulcer on his left heel. This failure put R3 at harm for neglect. - Findings included - R3 moved into the facility on 10/11/23 with diagnoses of sacral pressure ulcer stage II, anorexia (lack or loss of appetite), and right shoulder pain.	S5155		

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S5155	Continued From page 25 R3's "Functional Capacity Screen' dated 10/02/23 identified the resident required physical assistance with mobility and bathing and was independent with eating. It lacked information the resident had a sacral wound or wound treatments. R3's "Negotiated Service Agreement" (NSA) dated 10/02/23 identified Administrative Licensed Nurse A and Administrative Licensed Nurse B were responsible for health care services. It identified staff provided the resident a mechanical soft diet with three meals and snacks served per day. It lacked interventions related to his diagnosis of anorexia. R3 had no control of his bowels and had an indwelling urinary catheter which required assistance of one staff for cares. He also used a wheelchair most of the time. Administrative Licensed Nurse B did not "X" dressing changes as a health care service to be provided and had a question mark beside pressure ulcers/wounds as a current/recent problem and risk. The NSA lacked services related to the promotion of healing of his sacral pressure ulcer and lacked services to reduce the risk for development of additional pressure ulcers. R3's "Health Care Service Plan" (HCSP) included a supplement of "Boost" (a nutritional supplement drink) which his family provided, and resident could ask for if he desired it. It identified facility staff would provide two showers per week, assist with dressing upper and lower extremities, and would change incontinent products as needed. The "Health Care Service Plan" failed to include any health care services related to R3's	S5155		

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S5155	Continued From page 26 sacral wound or services related to prevention of additional wounds. Review of the unsigned physician order summary sheet from the discharging rehabilitation facility, identified the resident had a pressure ulcer of sacral region and included wound treatment directions to wash with soap and water, pat dry, apply Calmoseptine (type of barrier ointment), followed by Mepilix bordered dressing (foam dressing) once daily and as needed until resolved. It also identified the resident had a callous (thick or hardened area of skin) to his left heel and to apply Atractain (used to treat dry/rough skin) daily until resolved. The two pressure ulcer treatments he received at the rehab facility were not initiated upon admission to this facility. R3's signed physician's orders dated 10/16/23 included orders for Pressure Ulcer care - wash area with soap and water, rinse, and pat dry. Apply Venelex ointment to open areas, cover with foam and meflix tape every other day and as needed. Review of the October MAR and TAR revealed the signed order for the Venelex to open areas every other day was not applied as ordered. Review of R3's October 2023 Medication Administration Record (MAR) recorded the following medications were initiated on 10/11/23. Mupirocin one thin layer topical in AM to "affected area" daily. The record failed to identify the location of the "affected area". Zinc Oxide one thin layer topical twice a day to "affected area". The record failed to identify the location of the affected area. Venelex one thin layer topical as needed. The	S5155		

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record failed to identify the location of the affected area.
The MAR indicated the Mupirocin and Zinc oxide were applied to "affected area" from 10/12/23 through 10/19/23. The Venelex was never recorded as applied for the month of October. After 10/19/23 the record lacked documentation of any medical treatments for his sacral wound.

R3's October 2023 Treatment Administration Record (TAR)recorded the following:
10/17/23 for pressure ulcer - wash with soap and water, rinse, and pat dry. Apply Venelex ointment to open areas, cover with foam and meflix tape every other day and as needed.
10/17/23 apply calmoseptine or other skin protectant ointment liberally as needed to skin on peri-area and buttocks to provide moisture barrier against incontinent episodes and relieve redness.
The TAR revealed the treatments for the pressure ulcer "as needed" and the skin protectant "as needed" were never administered.

R3's medical record included information he received Home Health and Hospice services through three different outside resources from 11/07/23 to present day which included wound care services.

Review of the skilled nursing notes from an outside resource revealed on 11/07/23 the resident had very limited mobility, rarely ate a complete meal, and could not reposition without sliding against sheets increasing the high risk for pressure ulcers. It identified the resident required frequent repositioning with maximum assistance

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which led to almost constant friction to his skin. Current wounds included: two unhealed pressure ulcers at stage II, one at a stage III and an indwelling catheter related to wounds and incontinence. Pressure ulcer included the following:
Right perineum stage II measured 2 centimeters (cm) x 1.5 cm x 0.1cm
Left perineum stage II measured 1cm in diameter and 0.1 cm in depth
Left heel stage III measured 3 cm x 4 cm no depth described as a full thickness wound with 75-100% necrotic tissue.

The outside provider notes also included the patient and caregivers (facility staff) were instructed on measures to prevent pressure ulcers and to have R3 routinely shift weight every two hours throughout the day, avoid long periods of sitting, and protect heels and bony prominences when sleeping for prolonged periods of time.

Physician's note dated 11/30/23, from the wound care clinic, included orders to obtain a low air loss mattress for bed, use Roho cushion (a specialized pressure reducing cushion) when sitting, apply pressure relieving boot to left lower extremity and use pillows for frequent repositioning every 2 hours from side to side to off-load sacrum pressure.

R3's record included a physician's notification dated 12/05/23 that an air mattress would be set up on 12/06/23. It did not include any information related to obtaining a pressure relieving boot for his left heel.

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SUNFLOWER CARE HOMES LLC- LEGACY	1600 W 15TH AVENUE EMPORIA, KS 66801

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S5155	Continued From page 29 Review of R3's NSA and HCSP, his MAR and TAR, and his "Chart Notes" failed to include directions for staff to reposition the resident every two hours to relieve pressure on boney prominences, instructions for use of a pressure relieving boot or include instructions/direction when R3 received a low air loss mattress. The "Chart Notes" failed to include documentation from the licensed nurse that she had assessed the resident for skin condition issues. Outside resource skilled nursing notes dated 12/06/23 revealed the sacral ulcer deteriorated from a stage II to a stage III and now measured 7.37 cm x 5.37 cm x 0.1cm. R3's left heel pressure ulcer remained a stage III and measured 3.1 cm X 3.5 cm. Observation on 01/17/24 at 07:15 AM, Certified Medication Aide (CMA) C and Certified Nurse Aide (CNA) D went in check R3 for incontinence and change his brief. After staff removed R3's brief observations revealed he had two small red areas on his penis foreskin that CMA C reported were from irritation from his catheter to which she applied Calazime ointment. When staff rolled R3 onto his left side it revealed a stage II pressure ulcer approximately 0.5 cm in diameter and 0.2 cm deep on his coccyx and another pressure ulcer on his right buttock approximately 0.3 cm x 0.2 cm and 0.2cm deep. When staff were finished, they put his left heel protector boot back on. On 01/17/24 at 10:07 AM Administrative Licensed Nurse B and CMA C entered R3's room to change the dressing on his left heel. Administrative Licensed Nurse B removed the	S5155		

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S5155	Continued From page 30	S5155		

current dressing which revealed an oval shaped pressure ulcer that covered the bottom of his left heel and part of the outer side. CMA C got a sterile gauze dressing that had a measurement guide on the packaging. CMA C held the measure guide as Administrative Licensed Nurse B instructed her to, and the pressure ulcer measured 5 cm x 3 cm. The wound bed had dark reddish/gray areas of varying depth and slight bleeding at the top edge of the wound. Administrative Licensed Nurse B cleansed the wound, applied Mupirocin, a non-stick gauze pad, 4x4's and wrapped the site with kling gauze and secured it with tape.

On 01/17/24 at 11:58 AM R3 sat in his wheelchair which had a 2-3-inch cushion in it. He had a pressure reduction boot on his left lower extremity. He reported he had difficulty with scooting himself in the bed but could do it if the head of the bed wasn't up too far. He wasn't sure how long he had been wearing the heel boot but thought about two months. R3's family member was in the room and thought he got it just before Christmas. He also had a Low Air Loss mattress that was set to 150. According to documentation in his "chart notes" his bed needed to be set at 141 based upon his weight.

Interview on 01/16/24 at 02:33 PM CMA E reported the resident required two staff for all cares including repositioning in bed and providing incontinent cares. She stated the pressure ulcers on his bottom are no longer covered and the larger one used to be worse than it is now. CMA E stated Hospice does the dressing changes to his left heel and he is to always wear the boot to protect the heel.

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S5155	Continued From page 31 Interview on 01/17/24 at 09:19 AM Administrative Licensed Nurse B acknowledged she did not complete a skin assessment when the resident moved into the facility but thought he moved in with the wound on his bottom and heel. She acknowledged she did not implement measures in R3's NSA or HCSP such as repositioning, offloading his heels, increased protein diet, or other interventions to help promote healing of his pressure ulcers and decrease the risk of development of additional ulcers or further decline of his sacral ulcer. The operator failed to ensure a licensed nurse provided and/or coordinated the necessary health care services to meet the needs for R3 regarding the decline of his sacral pressure ulcer from stage II to a stage III and development of a new stage III left heel ulcer. This placed R3 at harm.	S5155		
S5171 SS=D	26-42-204 (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 26-42-204 (i) The facility reported a census of 11 residents(R) and two residents who received "Day Services". The sample included three residents and four focused record reviews. Based on observation, interview , and record review the operator failed	S5171		

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S5171	Continued From page 32	S5171		

to ensure designated staff assessed one (R4) of three sampled resident's bed assistive devices to ensure that it was secured properly to the bed and safe to use.

Findings included:

- Review of R4's medical record revealed she moved into the facility on 09/30/23 with diagnoses of diabetes mellitus and hypertension.

R4's admission "Functional Capacity Screen" (FCS) dated 09/20/23 revealed the resident was independent with bathing, dressing, toileting, require supervision with transfers and mobility. It also identified she was independent with management of medications and medical treatments.

R4's admission "Negotiated Service Agreement" (NSA) revealed staff provided assistance of one staff with transfers and mobility. It failed to include that R4 used a Ubar as an assistive device.

R4's medical record included a "Bedrail Risk Assessment" dated 10/03/23 that identified the decision had been made for the resident to use a bed rail and it had been checked by Administrative Licensed Nurse B for the resident to use it safely, the rail (Ubar) itself to be safe and for it to be secured properly to the bed. The assessment indicated at the time the bedrail did not move away from the side of the mattress, it was secure, and when in use and was not and entrapment hazard.

On 01/16/24 at 11:47AM the resident sat on the

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S5171	Continued From page 33 side of her bed and there was a Ubar on her left side. R4 stated she used the bar to help her sit up in bed and when she is standing up out of bed. She said she was a little nervous because it will move when she uses it and had fallen when getting out of bed when it moved once. Surveyor checked the Ubar, and the legs were not flat on the floor, it moved out from under the mattress and to the left and right a significant amount to cause R4 concern related to safety. On 01/16/24 at 12:01 PM Administrative Licensed Nurse B reported they have a form they fill out to make sure the Ubar is safe. She stated that included making sure the bar did not move during use, was secure to the bed, and not an entrapment risk. Administrative Licensed Nurse B stated they check the bars when they are put on the bed and do not really check them again unless there is a problem with them. Administrative Licensed Nurse confirmed the Ubar currently was not secure and thought it may be related to the head of the bed being slightly elevated. The operator failed to ensure designated staff assessed the functionality of R4's Ubar to ensure it remained safe for her to used as an assistive device.	S5171		
S5185 SS=D	26-42-206 (a) (b) (c) Dietary Services (a) The administrator or operator of each home plus shall ensure the provision or coordination of dietary services to residents as identified in each resident ' s negotiated service agreement. (b) The supervisory responsibility for dietetic services shall be assigned to one employee.	S5185		

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S5185	Continued From page 34 (c) If a resident ' s negotiated service agreement includes the provision of a therapeutic diet, mechanically altered diet, or thickened consistency of liquids, a medical care provider ' s order shall be on file in the resident ' s clinical record, and the diet or liquids, or both, shall be prepared according to instructions from a medical care provider or licensed dietitian. This REQUIREMENT is not met as evidenced by: KAR 26-42-206 (c) The facility reported a census of 11 residents(R) and two residents who received "Day Services". The sample included three residents and four focused record reviews). Based on observation, interview, and record review the operator failed to ensure one (R5) of one sampled residents record included approved instructions from a medical care provider or licensed dietitian on how to prepare R5's pureed diet. Findings included: - Review of the resident roster provided by Administrative Licensed Nurse B on 01/11/24 revealed R5 received a pureed diet. Review of R5's medical record revealed she moved into the facility on 11/01/21 with diagnoses of Parkinson's disease and Alzheimer's. R5's "Functional Capacity Screen" dated	S5185		

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S5185	Continued From page 35 12/01/23 revealed the resident required physical assistance with eating and had impaired cognition. R5's "Negotiated Service Agreement" dated 12/01/23 identified staff provided the resident a pureed diet with staff assistance. R5's 'Health Care Service Plan" dated 12/01/23 identified staff provided the resident a pureed diet in a divided plate and staff assistance with eating as needed. Observation on 01/16/24 at 10:55 AM R5 sat at the table with Certified Nurse Aide D assisting her to finish eating breakfast that included regular pancakes that were not pureed. Observation on 01/17/24 at 12:30 PM staff had pureed peas, sweet potatoes, and ham for the resident for lunch. On 01/11/24 at 01:32 PM Certified Medication Aide (CMA) C and CMA F reported there were no instructions on how to prepare a pureed diet. Staff just know how to do it because we were trained on it. CMA F reported she eats regular pancakes for breakfast because that is what her family wants her to have and the rest of her food is pureed. They reported the pureed food should be pudding consistency and if needs more liquid we add broth or milk. On 01/11/24 at 01:41 PM Administrative Licensed Nurse A asked CMA C where the directions were for pureed diets were and CMA C told Administrative Licensed Nurse A they did not have any instructions. Administrative Licensed	S5185		

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S5185	Continued From page 36 Nurse A went into the kitchen and stated they are usually kept with the recipes. She looked through three different recipe books and did not find the directions for how to prepare pureed diets. On 01/11/24 at 01:50 PM surveyor looked through R5's paper chart and found instructions for a pureed diet but it was not approved by a medical provider or licensed dietitian. On 01/11/24 at 2:00 PM Administrative Licensed Nurse A provided a pureed diet paper and said their sister house faxed it over. At the bottom of the page identifies it is developed by registered dietitians' nutrition services but is not signed by the resident's medical provider or a licensed dietitian. The operator failed to have instructions for preparing R5's pureed diet that were approved by her medical provider or by a licensed dietitian.	S5185		
S5192 SS=F	26-42-206 (e) Food Preparation (e) Food shall be prepared using safe methods that conserve the nutritive value, flavor, and appearance and shall be served at the proper temperature. (1) Food used by facility staff to serve to the residents, including donated food, shall meet all applicable federal, state, and local laws and regulations.(2) Food in cans that have significant defects, including swelling, leakage, punctures, holes, fractures, pitted rust, or denting severe enough to prevent normal stacking or opening with a manual, wheel-type can opener, shall not be used.	S5192		

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S5192	Continued From page 37 (3) Food provided by a resident ' s family or friends for individual residents shall not be required to meet federal, state, and local laws and regulations. This REQUIREMENT is not met as evidenced by: KAR 26-42-206 (e) The facility reported a census of 11 residents. Based on record review and interview, the operator failed to have evidence staff checked food temperatures to ensure staff prepared food using safe methods and ensured staff served foods at the proper temperature for all residents in the facility. - During initial tour on 01/21/24 at 01:21 PM food temperature logs on the refrigerator had multiple entries missing. They included the following: February 2023 had missing meals and only had food temperatures for 14 foods/meals out of possible 87. March 2023 had seven days with only a noon meal food temperature and the breakfast meal on the 30th and 31st. April 2023 only had 12 meal food temperatures logged.. May 2023 only had three meal food temperatures logged. June2023 had one meal logged. There were no other food temperature logs on the refirigerator. On 01/11/24 at 03:30 PM Administrative staff A reported there had to be more food temperature	S5192		

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S5192	Continued From page 38 logs and she woudl look and send them to surveyor. On 01/15/24 at 01:43 PM Administrative staff A emailed Surveyor multiple food temperature logs that had written on the top November 2023 and December 2023. The logs had no acutal dates of when the food temperatures were taken and what meal they were for. On 01/17/24 at 04:57 PM Administrative staff A acknowledged the food temperature logs she had emailed did not include the actual dates that the temperatures were taken. The operator failed to ensure staff temped foods as needed for all meals to ensure they were prepared and served at the proper temperatures.	S5192		
S5215 SS=F	26-42-104 (d) Disaster and Emergency Preparedness Education (d) Each administrator or operator shall ensure disaster and emergency preparedness by ensuring the performance of the following: (1) Orientation of new employees at the time of employment to the home ' s emergency management plan; (2) education of each resident upon admission to the home regarding emergency procedures; (3) quarterly review of the home ' s emergency management plan with employees and residents; and (4) an emergency drill, which shall be conducted at least annually with staff and residents. This drill shall include evacuation of the residents to a secure location.	S5215		

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S5215	Continued From page 39 This REQUIREMENT is not met as evidenced by: KAR 26-42-104 (d)(3) The facility reported a census of 11 residents. Based on record review and interview the operator failed to ensure disaster and emergency preparedness by the failure to conduct quarterly reviews of the home's emergency management plan with all residents. Findings included: - Review of the information provided by Administrative Staff A on 01/11/24 for quarterly reviews of the emergency management plan with residents and staff revealed the following: The emergency management plan was reviewed with residents and staff the same days on 11/15/22 and 02/23/23. The reviews conducted on 05/24/23, 09/27/23 and 01/10/24 did not include resident names or information that he emergency management plan was reviewed with residents. On 01/11/24 at 03:00 PM Administrative Staff A read the reviews of the emergency management plan and confirmed the residents were not documented as being included in the last three quarterly reviews. The operator failed to ensure disaster and emergency preparedness by the failure to conduct quarterly reviews of the emergency management plan with all residents.	S5215		

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S5230 SS=F	26-42-207 (b)(5)(6) (c) Infection Control Policies (b)(5) prohibiting any employee with a communicable disease or any infected skin lesions from coming in direct contact with any resident, any resident ' s food, or resident care equipment until the condition is no longer infectious; (6) providing orientation to new employees and employee in-service education at least annually on the control of infections in a health care setting; (c) Each administrator or operator shall ensure the home ' s compliance with the department ' s tuberculosis guidelines for adult care homes adopted by reference in K.A.R. 26-39-105. This REQUIREMENT is not met as evidenced by: K.A.R 26-42-207(c) The facility reported a census of 11 residents(R) and two residents who received "Day Services". The sample included three residents and four focused record reviews and five newly hired staff. Based on interview and record review for one of five newly hired staff, one (R3) of three sampled residents, and three (R6, R7, R8) of four focused record reviews the operator failed to ensure the facility remained in compliance with the department's tuberculosis (TB) guidelines for adult care homes adopted by reference in K.A.R. 26-39-105. Findings included: - Review of the five newly hired employee files	S5230		

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S5230	Continued From page 41 revealed the following irregularities: Certified Medication Aide G hired on 11/28/23 and did not receive a TB symptom screen until 01/12/24, more than seven days after her hire date. Review of the undated "Tuberculosis Guidelines Policy" revealed all employees shall complete the TB Questionnaire within seven days of employment. - R3's moved into the facility on 10/11/23 with diagnoses of sacral pressure ulcer and right shoulder pain. R3's paper medical record and electronic record did not include evidence of a TB symptom screen or a two-step TB skin test. On 01/16/24 at 02:42 PM Administrative Licensed Nurse A reported she did not have additional records for R3 at the main office. On 01/17/24 at 09:19 AM Administrative licensed Nurse B reviewed R3's records and acknowledged she could not find TB screening or testing. - R6 moved into the facility on 01/05/24 with diagnosis of dementia. R6's paper and electronic medical record did not include evidence of a TB symptom screen or a two-step TB skin test. On 01/16/24 at 04:12 PM Administrative Licensed Nurse B reported she had not done	S5230		

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S5230	Continued From page 42 R6's TB skin testing or his TB symptom screen yet. As of 01/17/24 at 02:00 PM Administrative Licensed Nurse B had not completed R6's TB screen or skin testing. - R7 moved into the facility on 12/06/23 with diagnoses of hypertensions and chronic back pain. R7's paper and electronic record did not include evidence of a TB symptom screen or a two-step TB skin test. On 01/17/24 at 03:57 PM Administrative Licensed Nurse B confirmed R7 had not had a TB symptom screen completed or a two-step TB skin test done. - R8 moved into the facility on 11/02/23 with diagnoses of hypertension and anxiety. R8's paper and electronic record did not include evidence of a TB symptom screen or a two-step TB skin test. On 01/17/24 at 03:51 PM Administrative Licensed Nurse B confirmed R8 had not had a TB symptom screen completed or a two-step TB skin test done. Review of the undated "Tuberculosis Guidelines Policy" revealed all residents shall receive a two-step tuberculin skin test and complete the TB Questionnaire within seven days of residency. The operator failed to ensure designated staff completed TB symptom screens and TB skin testing in accordance with TB guidelines to	S5230		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNFLOWER CARE HOMES LLC- LEGACY	1600 W 15TH AVENUE EMPORIA, KS 66801

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5230	Continued From page 43 ensure the facility remained in compliance of infection control guidelines.	S5230		
S5251 SS=E	26-42-105 (f) (11) Resident Records Documentation of Incidents (f) (11) documentation of all incidents, symptoms, and other indications of illness or injury including the date, time of occurrence, action taken, and results of the action. This REQUIREMENT is not met as evidenced by: KAR 26-42-105(f)(11) The facility reported a census of 11 residents(R) and two residents who received "Day Services". The sample included three residents and four focused record reviews. Based on interview and record review the operator failed to ensure the medical record contained documentation of all incidents, symptoms, and other indications of illness or injury including the date and time, action taken, and results of the action for three (R3, R4, and R5) of three sampled residents. Findings included: - Review of R3's medical record revealed he moved into the facility on 10/11/23 with diagnoses of sacral pressure ulcer stage II, anorexia (lack or loss of appetite), and right shoulder pain. R3's "Functional Capacity Screen' dated 10/02/23 identified the resident required physical	S5251		

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assistance with bathing, dressing, toileting, transfers, and mobility. He also had a current risk for falls and was unable to manage his medications.

R3's "Negotiated Service Agreement" (NSA) dated 10/02/23 revealed facility staff provided the resident physical assistance of staff for activities of daily living, they cleaned his room, provided 3 meals per day with snacks, and administered the resident's medications to him.

Review of R3's electronic "Chart Notes" failed to include documentation from the licensed nurse that he had pressure ulcers, that a nurse assessed them, and failed to include documentation that included a description of the wounds, measurements, and effectiveness of current treatment plan.

R3's electronic "Chart Notes" included the following documentation:
11/02/23 - R3 is having some green/yellowish discharge from urethra and head of penis is swollen. Physician notified awaiting return call. The record lacked follow up as to a return call, if there was any type of treatment for signs of infection, or if the discharge and swelling resolved.
11/21/23 Licensed Nurse called PCP and Home Health to see if results for urinalysis were available and they were not.
The record lacked documentation as to a UA being obtained, any symptoms related to why a UA was obtained, and documentation when the UA returned what medical treatment if any was ordered.
12/10/23 resident had a fall at 05:00 AM out of

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bed. EMS called for lift assistance.
The resident lacked follow-up documentation on resident status post fall to rule out latent injuries.

Observation on 01/17/24 at 07:15 AM, Certified Medication Aide (CMA) C and Certified Nurse Aide (CNA) D went in check R3 for incontinence and change his brief. After staff removed R3's brief observations revealed he had two small red areas on his penis foreskin that CMA C reported were from irritation from his catheter to which she applied Calazime ointment. When staff rolled R3 onto his left side it revealed a stage II pressure ulcer approximately 0.5 cm in diameter and 0.2 cm deep on his coccyx and another pressure ulcer on his right buttock approximately 0.3 cm x 0.2 cm and 0.2cm deep. When staff were finished, they put his left heel protector boot back on.

On 01/17/24 at 10:07 AM Administrative Licensed Nurse B and CMA C entered R3's room to change the dressing on his left heel. Administrative Licensed Nurse B removed the current dressing which revealed an oval shaped pressure ulcer that covered the bottom of his left heel and part of the outer side. CMA C got a sterile gauze dressing that had a measurement guide on the packaging. CMA C held the measure guide as Administrative Licensed Nurse B instructed her to, and the pressure ulcer measured 5 cm x 3 cm. The wound bed had dark reddish/gray areas of varying depth and slight bleeding at the top edge of the wound. Administrative Licensed Nurse B cleansed the wound, applied Mupirocin, a non-stick gauze pad, 4x4's and wrapped the site with kling gauze and secured it with tape.

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S5251	Continued From page 46 On 01/17/24 at 09:25 AM Administrative Licensed Nurse B reported she would expect the notes to have documentation basically of when anything different happened, medication changes, and if he had a fall. Administrative Licensed Nurse B reported Hospice and the CMA's do R3's dressing changes and Hospice documents on it in their notes. She acknowledged she did not document on his wounds and did not do follow up documentation on falls. Review of the undated policy "Section 26-42-105 - Resident Records" revealed the record would include documentation of all incidents, symptoms, and other indications of illness or injury including the date, time, action taken, and results of the action. The operator failed to ensure designated included complete documentation related to R3' wounds, falls, and signs of urinary infection. - Review of R4's medical record revealed she moved into the facility on 09/30/23 with diagnoses of diabetes mellitus and hypertension. R4's admission "Functional Capacity Screen" (FCS) dated 09/20/23 revealed the resident was independent with bathing, dressing, toileting, require supervision with transfers and mobility. It also identified she was independent with management of medications and medical treatments. R4's admission "Negotiated Service Agreement" (NSA) dated 09/20/23 directed staff to provide	S5251		

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S5251	Continued From page 47 assistance of one staff with ADL's including stand by assistance with walking and using her front wheeled walker. Review of R4's electronic "Chart Notes" revealed the following: 10/9/23 - 12:59 PM - felt dizzy friend took to Express care. The record lacked documentation of her returning to the facility, any treatment done, and how she felt upon returning. 11/24/23 resident had a fall at 01:59 AM and did not want to go to the emergency room. At 08:19 AM resident called for assist due to unable to apply pressure to left leg without pain at which time EMS was contacted and she went to the emergency room for evaluation. The record lacked documentation that she returned from the hospital and the status of her inability to bear weight without pain. 12/28/23 - new order to decrease Trazadone (antidepressant) to one tablet at night. The record lacked follow up as to how the decrease in medication affected the resident. 01/09/24 at 02:08 AM resident had fallen while getting up out of bed. The record lacked follow up documentation as to the resident's status post fall. On 01/17/24 at 03:32 PM Administrative Licensed Nurse B reported she would expect there to be documentation in the "Chart Notes" whenever something happens, medication changes, outside services change, when they leave the building and if there is a fall. Administrative Licensed Nurse said there were not guidelines for documenting after someone falls but when they fall it is to be documented.	S5251		

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After reviewing R4's "Chart Notes" Administrative Licensed Nurse B reported there should have been documentation when she returned to the facility from the emergency room as well as when she returned from the hospital after having a fracture. She also acknowledged when the trazadone was decreased it could have been followed up for any changes.

Review of the undated policy "Section 26-42-105 - Resident Records" revealed the record would include documentation of all incidents, symptoms, and other indications of illness or injury including the date, time, action taken, and results of the action.

The operator failed to ensure designated included complete documentation related to R4's emergency room visit, hospital stay, decrease in antidepressant, and fall follow up.

- Review of R5's medical record revealed she moved into the facility on 11/01/21 with diagnoses of Parkinson's disease and Alzheimer's.

R5's most current "Functional Capacity Screen" (FCS) dated 12/01/23 revealed she was unable to complete any part of the task related to bathing, dressing, toileting, mobility, and medication management. She also had impaired cognition, needed assistance with eating and had a risk for falls.

R5's "Negotiated Service Agreement" (NSA) dated 12/01/23 directed staff to provide assistance of one with all activities of daily living, included fall interventions, and staff to remind

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S5251	Continued From page 49 and cue resident with daily activities. Review of R5's electronic "Chart Notes' included the following: 07/14/23 - found sitting in front of couch in activity room. The record lacked follow up as to residents status post fall. 07/24/23 - has open ulcer on inside of right buttock 1milimeter in diameter, calmoseptine twice a day and turn/reposition every two ours in bed. The record lacked follow up as to the wound monitoring, or if it healed. 09/11/23 - slid out of recliner in living room. The record lacked documentation of follow up post fall and resident status. 11/11/23 - found on floor in front of bed with abrasion above right eye and large bruise on forehead. The record lacked follow up post fall related to resident status and monitoring of abrasion and forehead injury. 12/07/23 - resident had another fall and the record lacked follow up as to the resident's status post fall. On 01/17/24 at 03:32 PM Administrative Licensed Nurse B reported she would expect there to be documentation in the "Chart Notes" whenever something happens, medication changes, outside services change, when they leave the building and if there is a fall. Administrative Licensed Nurse said there were not guidelines for documenting after someone falls but when they fall it is to be documented. After reviewing R5's "Chart Notes" Administrative Licensed Nurse B reported there could have	S5251		

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S5251	Continued From page 50 been documentation regarding her status post falls and upon her return to the facility related to any possible changes as well as documentation on her wound and it healing. Review of the undated policy "Section 26-42-105 - Resident Records" revealed the record would include documentation of all incidents, symptoms, and other indications of illness or injury including the date, time, action taken, and results of the action. The operator failed to ensure designated included complete documentation related to R5's falls, hospital return and wound management.	S5251		
S5300 SS=E	26-42-205 (d) (1-2) Facility Administration of Medications (d) Home administration of resident ' s medications. If a home is responsible for the administration of a resident ' s medications, the administrator or operator shall ensure that all medications and biologicals are administered to that resident in accordance with a medical care provider ' s written order, professional standards of practice, and each manufacturer ' s recommendations. The administrator or operator shall ensure that all of the following are met: (1) Only licensed nurses and medication aides shall administer and manage medications for which the home has responsibility. (2) Medication aides shall not administer medication through the parenteral route.	S5300		

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S5300	Continued From page 51 This REQUIREMENT is not met as evidenced by: KAR 26-42-205 (d) The facility reported a census of 11 residents(R) and two residents who received "Day Services". The sample included three residents and four focused record reviews. Based on record review and interview the operator failed to ensure staff administered medications according to a Medical Providers written order and professional standards of practice for three (R3, R4, R5) of three sampled residents for whom the facility was responsible for administering medications. Findings included: - Review of R3's medical record revealed he moved into the facility on 10/11/23 with diagnoses of sacral pressure ulcer stage II, anorexia (lack or loss of appetite), and right shoulder pain. R3's "Functional Capacity Screen' dated 10/02/23 identified the resident required physical assistance with management of medications and medical treatments. R3's "Negotiated Service Agreement" (NSA) dated 10/02/23 staff marked medication administration and that facility staff will administer medications for R3. Review of R3's December 2023 Medication Administration Record included for staff to administer the following medications: -Morphine (a narcotic pain medication) 10 milligrams (mg)/ 5 milliliters (ml) administer 5 to	S5300		

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S5300	Continued From page 52 10 mg by mouth as needed (PRN) and then on the bottom said to administer 2.5ml (5 mg) every two hours PRN for moderate to severe pain. The facility staff had initialed administration of Morphine 10mg/5ml solution 33 times with no evidence to show a licensed nurse was contacted prior to administration of the medications and lacked follow up if the medication relieved R3's pain. -Oxycodone (a narcotic pain medication) 5mg tablet PRN to help relieve moderate to severe pain with instructions to give three times a day PRN for break-through pain. Staff administered the Oxycodone seven times with no evidence of nurse notification prior to administration and no follow up if the medication relieved R3's pain. Review of R3's January 2024 Medication Administration Record (MAR) revealed the following: Celebrex was not administered from the 1st to the 3rd due to not available. The resident missed six doses. Vitamin B12 was not administered from the 1st to the 11th due to medication not available. The resident missed 11 doses. Tylenol was not administered on the 2nd and 3rd and then again from the 13th to the 16th due to medication not available. Remeron 15mg did not receive on 15th and 16th due to medication could not be found in cart. The resident's record lacked documentation that the physician was notified that the medications were not available for administration or if family was notified to bring medication into the facility. The January MAR also included staff administered of the following narcotic pain	S5300		

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S5300	Continued From page 53 medications: -Oxycodone 5mg tablets twice for pain without evidence of nurse notification prior to administration and follow up as to effectiveness of the medication. - Morphine 0.5ml (10mg) four times without evidence the licensed nurse was notified prior to administration of the medications and lacked follow up as to effectiveness of the medications. On 01/17/24 at 11:25 AM Certified Medication Aide (CMA) C reported when giving PRN medications staff do not have to call the nurse for things like Tylenol or if the nurse had previously told us to give something whenever a resident asked for it. For narcotics we are supposed to call the nurse and put a note in the MAR and chart notes. CMA C also stated the only PRN medication they are supposed to follow up on for effectiveness is if it says to "follow-up in 30 minutes" on the MAR. CMA C opened R3's MAR and showed where on the as PRN Morphine was the only PRN medication indicated for staff to follow up on. On 01/17/24 at 03:23 PM CMA H reported for PRN medications we just give it to them when they ask for it if they have an order. We document under it why it was given, and we can also follow up on it and say if it was effective or not. CMA H stated they do not need to call the nurse about PRN medications except for the narcotic pain medications. On 01/17/24 at 12:25 PM Administrative Licensed Nurse B reported when CMAs give PRN medications, they can either chart it and put a not in the MAR or put a note in "Chart Note".	S5300		

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S5300	Continued From page 54 She stated they only follow up on specific medications if it is on the MAR to do so otherwise the next shift is supposed to follow up if the medications were effective or not. If a medications is not available staff are supposed to contact the pharmacy and family depending on the medications and let the nurse know. Review of the undated "Nursing Medication Management Policy and Procedures" did not include directions for staff administration of PRN medications or what to do if a medication is not available from family or the pharmacy. The operator failed to ensure CMA's administered PRN medications according to standards of practice and failed to notify physician when ordered medications were not available for administration. - Review of R4's medical record revealed she moved into the facility on 09/30/23 with diagnoses of diabetes mellitus and hypertension. R4's admission "Functional Capacity Screen" (FCS) dated 09/20/23 revealed the resident was independent with management of medications and medical treatments. R4's admission "Negotiated Service Agreement" (NSA) identified facility staff administered the residents medications. Review of R4's December 2023 "Medication Administration Record" revealed staff administered the following as needed (PRN) medications: -Tylenol 500 milligrams (MG) two tablets as	S5300		

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S5300	Continued From page 55	S5300		

needed for pain. The instructions on the MAR identified to administer for general discomfort, pain headache or temperature over 101 degrees. The record indicated staff administered the Tylenol 24 times.
-Cold Relief tablets, two tablets dissolved in water every 4-6 hours PRN four times.
-Dulcolax 30 mg tablet PRN one time.
- Hydrocodone-APAP (a narcotic pain medication) 5-325 mg one time.
-Meclizine 12.5 mg 1 tablet was administered twice.
- Pepto Bismol 30 ml was administered three times.
-Picot 1-2 tabs - use one packet in 1/2 cup of water was administered three times.

Review of the January 2024 MAR revealed the following PRN medications were administered:
- Tylenol 500mg, II tablets five times
-Antacid tablet administered once
-Cold Relief tablets administered twice
-Hydrocodone-APAP administered once
-Picot one packet administered once
- Miralax administered once

PRN medications that were administered by CMA failed to identify they contacted a licensed nurse prior to administration and failed to include follow-up on effectiveness of the medications.

The January 2024 MAR also included directions for staff to administer Insulin Aspart (Fiasp) per sliding scale orders based upon blood sugar readings; less than 99 = o insulin, 100 - 149 give four units, 150-199 give five units, 200-249 give six units, blood sugar greater than 250 give eight units. The medication was to be started on

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01/12/24 and it was not administered until 01/17/24. The blood sugar readings included 12 out of 15 that were over 99 and eight times it was greater than 250. Facility staff documented the administration of sliding scale insulin on 01/17/24 at 09:42 AM for six units and again at 01:29 PM for six units.

On 01/17/24 at 03:00 PM CMA H reported PRN medications we give when the resident asks for them and just call the nurse if it is a narcotic medication. CMA H looked at R4's MAR and thought one of her insulins was going to be discontinued and changed to something else because insurance wasn't going to cover it anymore. She opened the drawer, and it contained a Levemir pen and a Fiasp Aspart pen. She said the Fiasp wasn't here last week, and she did not know when it came in. She stated the only insulin staff are supposed to be giving is the Levemir.

On 01/17/24 at 12:25 PM Administrative Licensed Nurse B reported when CMAs give PRN medications, they can either chart it and put a not in the MAR or put a note in "Chart Note". She stated they only follow up on specific medications if it is on the MAR to do so otherwise the next shift is supposed to follow up if the medications were effective or not. If a medications is not available staff are supposed to contact the pharmacy and family depending on the medications and let the nurse know.

On 01/17/24 at 03:05 PM Administrative Licensed Nurse B stated the resident was going to have some changes to her Levemir insulin due to insurance. However, she did not have any

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	B056003	A. BUILDING: _____ B. WING _____	01/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNFLOWER CARE HOMES LLC- LEGACY	1600 W 15TH AVENUE EMPORIA, KS 66801

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5300	Continued From page 57 new orders for changes including administering Fiasp instead of Novolog insulin for the sliding scale insulin. She stated she would contact the pharmacy and physician to find out why Fiasp was delivered instead of the Novolog incase the physician gave the pharmacy the OK to send it. Review of the undated "Nursing Medication Management Policy and Procedures" did not include directions for staff administration of PRN medications or what to do if a medication is not available from family or the pharmacy. The operator failed to ensure PRN medications were administered according to standards of practice and failed to notify physician when ordered medications were not available for administration, including her sliding scale insulin.	S5300		
S5302 SS=F	26-42-205 (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 26-42-205(d)(4) The facility reported a census of 11 residents(R) and two residents who received "Day Services". Based on interview and record review for three of three newly hired "Certified Medications Aide's"	S5302		

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S5302	Continued From page 58 employee files, the operator failed to ensure the delegated nursing procedure for the dialing of insulin pens for each certified medication under the Kansas nurse practice act, K.S.A. 65-1124 and amendments thereto. Findings included: - Review of the resident roster provided by Administrative Licensed Nurse B revealed one resident received insulin injections. On 01/16/24 at 08:10 AM surveyor requested to review delegation for Certified Medication Aide (CMA) C, CMA G and CMA F, regarding the preparing of insulin pens and dialing them to the ordered administration dosage. On 01/16/24 at 12:26 PM Administrative Licensed Nurse reported via electronic interview that they had just finalized a check off form for a CMA to prepare and dial insulin pens. As of 01/18/24 the facility had not provided evidence of delegation for CMA to prepare and dial insulin pens. Review of the undated policy for "K.A.R 26-42-204(e), 205 (d)(4)" revealed the licensed nurse shall orient and instruct the medication aide in the performance of the nursing task. The medication aide's demonstration of the competency necessary to perform the delegated task shall be documented in writing. The operator failed to ensure the procedure for dialing of insulin pens was delegated to CMA's according to the Kansas nurse practice act,	S5302		

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S5302	Continued From page 59 K.S.A. 65-1124 and amendments thereto.	S5302		