STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B049001	A. BUILDING: _____ B. WING _____	04/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOME AGAIN SENIOR LIVING LLC	321 N MAIN STREET HAVILAND, KS 67059

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS The following citations represent the findings of a resurvey with a complaint (#176084) at the above named home plus facility conducted on 04/23/24.	S 000		
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: KAR 26-42-207 (c) The census totaled 9 residents. The sample included 3 residents and review of 5 newly hired employees. Based on record review and interview for 1 sampled Resident (R)1 and 1 newly hired employee (Certified Medication Aide (CMA) C, the facility failed to ensure compliance with the State Agency's tuberculosis (TB) guidelines.	S5230		

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
	B049001	A. BUILDING: _____ B. WING _____	04/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOME AGAIN SENIOR LIVING LLC	321 N MAIN STREET HAVILAND, KS 67059

(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 1 Findings included: - Review of CMA C's employee record revealed they hired onto the facility on 07/13/23. CMA C's first step of TB testing was completed on 07/25/23, 12 days after being hired to the facility. The record lacked evidence of completion of the second step of TB testing upon hire. Interview on 04/23/24 at 12:37 PM with Operator A confirmed the second step of TB testing was not completed upon hire for CMA C and further confirmed the first step was administered late. Interview on 04/23/24 at 01:46 PM with Operator A confirmed a TB questionnaire was not completed upon admission for R1. Facility's "Tuberculosis Testing Policy" (no date) recorded, "All new residents and employees will be skin tested using the two-step method unless documentation is provided to [facility name] of a previous significant reaction. 1. Testing will be performed within seven days of admission or employment. If the first skin test is read as insignificant (induration of less than 10 mm) a repeat skin test will be down in 7 to 30 days." The facility failed to follow the State Agency's tuberculosis guidelines for adult care homes adopted by reference in K.A.R. 26-39-105, which had the potential to affect all residents.	S5230		
S5312 SS=E	26-42-205 (g) (2) Medication Labeling (g) (2) Each prescription medication container shall have a label that was provided by a dispensing pharmacist or affixed to the container	S5312		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B049001	A. BUILDING: _____ B. WING _____	04/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOME AGAIN SENIOR LIVING LLC	321 N MAIN STREET HAVILAND, KS 67059

(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
S5312	Continued From page 2	S5312		

by a dispensing pharmacist in accordance with K.A.R. 68-7-14.

This REQUIREMENT is not met as evidenced by:
KAR 26-42-205 (g) (2)

The facility reported a census of 9 residents and identified 8 residents received facility management of medications. Based on observation, interview and record review, Operator A failed to ensure prescription medication containers were labeled with a prescription label provided by a dispensing pharmacist or affixed to the container by a dispensing pharmacist in accordance with K.A.R. 68-7-14 for 1 sampled resident (R)2 and 1 non-sampled resident (R)4.

Findings included:

- Observation on 04/23/24 at 02:58 PM with Certified Medication Aide (CMA) D of the medication cabinet in the medication room revealed the following insulin injector pens, which were not labeled with resident's name. CMA D identified the insulin injector pens as belonging to R2 and R4. One of the injector pens had a manufacture label of Lantus SoloStar Insulin Glargine Injection Prefilled Pen and the other had a manufacture label of Novolog FlexPen. Neither injector pens had any other identification or pharmacist labeling.

Signed physician orders dated 03/14/24 for R2 recorded, "Basaglar KwikPen Solution Pen-injector, 100 unit/milliliter, 10 units,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B049001	A. BUILDING: _____ B. WING _____	04/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOME AGAIN SENIOR LIVING LLC	321 N MAIN STREET HAVILAND, KS 67059

(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
S5312	Continued From page 3	S5312		

subcutaneous, at bedtime."

Review of R2's current April 2024 Medication Administration Record (MAR) revealed Insulin Glargine Solostar pen-injector had been administered every evening from 04/01/24 through 04/23/24 by certified facility staff.

Signed physician orders dated 02/20/24 for R4 recorded, "NovoLOG Mix 70/30 FlexPen Suspension Pen-injector, 100 units/milliliters, subcutaneous, 18 units before breakfast and 6 units before supper, twice a day."

Review of R4's current April 2024 Medication Administration Record (MAR) revealed NovoLOG Mix 70/30 FlexPen had been administered twice a day from 04/01/24 through 04/23/24 by certified facility staff.

Interview on 04/23/24 at 11:48 AM with CMA D confirmed neither insulin injector pens were labeled.

Facility failed to provide a policy for labeling insulin pens.

Operator A failed to ensure prescription medication containers were labeled with a prescription label provided by a dispensing pharmacist or affixed to the container by a dispensing pharmacist in accordance with K.A.R. 68-7-14 for 1 sampled resident (R)2 and 1 non-sampled resident (R)4.