STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B088002	A. BUILDING: _____ B. WING _____	05/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD ESTATES HOME PLUS	1140 S PERSHING AVENUE LIBERAL, KS 67901

(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 represent the findings of a resurvey for the above named Home Plus facility conducted on 05/07/24.	S 000		
S5085 SS=E	26-42-201 (c) Functional Capacity Screen Reassessment (c) Designated staff shall conduct a screening to determine each resident ' s functional capacity according to the following requirements: (1) At least once every 365 days; (2) following any significant change in condition as defined in K.A.R. 26-39-100; and (3) at least quarterly if the resident receives assistance with eating from a paid nutrition assistant. This REQUIREMENT is not met as evidenced by: 5085 26-42-201(c)(1) The facility reported a census of nine residents. The sample included three residents. Based on interview, and record review the operator failed to ensure designated staff completed a "Functional Capacity Screen" (FCS) for resident (R)101 and R103 once every 365 days. Findings included: - R101's medical record revealed she moved into the facility on 03/06/20. The most recent FCS was completed on 12/28/22. No FCS was completed for 2023.	S5085		

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

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S5085	Continued From page 1 On 05/07/24 at 04:27 PM Administrative Staff A stated review and revision of the FCS was not completed for 2023. Administrative Staff A stated this was a systems problem and has met with the nurse to make sure that all the FCSs were completed at least once every 365 days. The operator failed to ensure designated staff completed a FCS for R103 at least once every 365 days. - R103's medical record revealed she moved into the facility on 06/22/20. The most recent FCS was completed on 12/21/21. No FCS was completed for 2022, and 2023. On 05/07/24 at 05:15 PM Administrative Staff A stated R103's FCS has not been reviewed and revised at least once every 365 days. The operator failed to ensure designated staff completed a FCS for R103 at least once every 365 days.	S5085		
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	S5116		

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S5116	Continued From page 2 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: 5116 26-42-202(d)(1)(2) The facility reported a census of nine residents with three residents included in the sample. Based on interview, and record review the operator failed to ensure the "Negotiated Service Agreement" (NSA) was review and revised as needed at least once every 365 days for residents (R)101 and R103 and failed to revise R102's NSA when she experienced a significant change in condition. Findings included: - Record review for resident (R)101 revealed an admission date of 03/06/20. The most recent NSA was completed on 03/06/20. No NSA was completed for 2021, 2022, 2023 or 2024. On 05/07/24 at 04:27 PM Administrative Staff A stated review and revisions of R101's NSA were missed. Administrative Staff A stated this was a systems problem and has talked with the nurse to make sure that all of the NSAs were completed at least once every 365 days. The operator failed to ensure designated staff revised R101's NSA at least once every 365 days.	S5116		

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S5116	Continued From page 3 - Record review for R102 revealed an admission date of 10/19/23. R102's most current NSA was dated 10/19/23. Review of R102's medical records revealed an order dated 04/29/24 to evaluate and admit to hospice if appropriate. 04/30/24 Nurses note documented, "resident was started on hospice services through Healthwatch Hospice ..." On 05/07/24 at 04:47 AM Administrative Staff A stated R102's NSA was not reviewed and revised when the resident experienced a significant change in condition and started hospice services. The operator failed to ensure designated staff revised the NSA when R102 experienced a significant change in condition. - Record review for R103 revealed an admission date of 06/22/20. R103's most current NSA was dated 06/22/20. On 05/07/24 at 05:15 PM Administrative Staff A stated R103's NSA has not been reviewed and revised at least every 365 days. The operator failed to ensure designated staff revised R101's NSA at least once every 365 days.	S5116		
S5171 SS=D	26-42-204 (i) Health Care Services Standards of Practice (i) All health care services shall be provided to	S5171		

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S5171	Continued From page 4	S5171		

residents by qualified staff in accordance with acceptable standards of practice.

This REQUIREMENT is not met as evidenced by:
5171
KAR 26-42-204(i)

The facility reported a census of nine residents with three residents included in the sample. Based on observation, interview and record review the operator failed to ensure health care services were provided in accordance with acceptable standards of practice for resident (R)103 by failing to follow facility policy

Findings included:

- Review of R103's medical record revealed she was admitted to the facility on 06/22/20 with a diagnosis of pressure wound.

The 12/21/21 "Functional Capacity Screen" (FCS) documented R103 required physical assistance with transfers, mobility, toileting and was unable to manage her treatments.

The 06/22/20 "Negotiated Service Agreement" (NSA) and "Health Care Service Plan" (HCSP) documented staff provided R103 assistance with toileting, transfers, mobility, and management of treatments.

Review of R103's medical record from admission to 05/07/24 lacked evidence of documentation of skin monitoring and interventions to prevent pressure wounds by licensed facility staff including wound sizes (length, width, and depth), odor, tissue characteristics (including drainage,

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S5171	Continued From page 5 granulation) and any signs of infection. R103's medical record also included a "Pressure Ulcer & Other Skin Ulcer Assessment" form that was not filled out. On 05/07/24 at 03:45 PM "Certified Medication Aide" (CMA) B stated R103 had a pressure wound on her back on her spine that was almost healed. CMA B stated R103 has had this wound for at least a couple of months. On 05/07/24 at 05:15 PM Administrative Staff A stated R103's wound on her spine was almost completely healed. Administrative Staff A stated it was her expectation the nurse assessed and documented on wound care weekly. The operator failed to ensure health care services were provided in accordance with acceptable standards of practice.	S5171		
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. (3) Food provided by a resident ' s family or friends for individual residents shall not be required to meet federal, state, and local laws	S5192		

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S5192	Continued From page 6 and regulations. This REQUIREMENT is not met as evidenced by: 5192 KAR 26-42-206(e) The facility had a census of nine residents. All nine residents ate food prepared in the same kitchen. The operator failed to ensure food items were served at the proper temperature. Findings included: - Review of the March 2024 "Food Temperature Log" revealed missing documentation of food temperatures on the following days: 03/01/24 03/02/24- dinner 03/06/24 03/07/24- dinner 03/08/24- lunch 03/09/24 03/10/24- lunch 03/11/24 - 03/15/24 03/16/24- dinner 03/17/24 03/19/24- dinner 03/20/24 - 03/31/24. No food temperature entries were made for breakfast. Review of the April 2024 "Food Temperature Log" revealed missing documentation of food temperatures on the following days: 04/01/24 - 04/02/24 04/04/24- Dinner 04/05/24- Dinner 04/06/24- Dinner 04/07/24- Lunch 04/08/24- Lunch	S5192		

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S5192	Continued From page 7 04/09/24- Lunch 04/10/24 - 04/15/24 04/16/24- Dinner 04/17/24- Lunch 04/18/24 04/19/24- Lunch 04/20/24 - 04/21/24 04/22/24- Lunch 04/23/24 - 04/24/24 04/25/24- Dinner 04/26/24 - 04/28/24 04/25/24- Dinner 04/26/24 - 04/28/24 04/30/24- Dinner No food temperature entries were made for breakfast. Review of the May 2024 "Food Temperature Log" revealed missing documentation of food temperatures on the following days: 05/02/24- Dinner 05/03/24- Lunch 05/04/24 - 05/07/24 No food temperature entries were made for breakfast. The 08/2015 "Food Temperatures at Serving" policy documented, "Food will be served at the appropriate temperatures to ensure good flavor and to prevent food borne illnesses." According to the Kansas Department of Agriculture "Focus on Food Safety" revised August 2017, hot foods must be maintained at an internal temperature of 135 Fahrenheit (F) or higher and cold foods must be maintained at an internal temperature of 41 F or below. The operator failed to ensure food items were served at the proper temperature.	S5192		

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S5195 SS=F	26-42-206 (f) (g) Facility Food Storage (f) Staff shall store all food under safe and sanitary conditions. Containers of poisonous compounds and cleaning supplies shall not be stored in the areas used for food storage, preparation, or serving. (g) Each home shall maintain at least a three-day supply of food to meet the requirements of the planned menus. This REQUIREMENT is not met as evidenced by: 5195 KAR 26-42-206 (f) The facility had a census of nine residents. All nine residents ate food prepared in the same kitchen. The operator failed to ensure food items were stored under safe and sanitary conditions by the failure to ensure foods stored in the refrigerators were kept at 41 degrees Fahrenheit (F) or lower according to Food Safety Guidelines. Findings included: - Observation of the kitchen on 05/07/24 at 10:00 AM revealed there were no refrigerator/freezer logs completed. On 05/07/24 at 10:35 AM Administrative Staff A stated staff did not record refrigerator/freezer temperatures. According to the Kansas Department of Agriculture "Focus on Food Safety" revised August 2017, "Cold foods must be maintained at an internal temperature of 41F or below."	S5195		

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S5195	Continued From page 9 The operator failed to ensure food items were stored under safe and sanitary conditions by failing to document refrigerator/freezer temperatures.	S5195		
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: 5320 KAR 26-42-207(c) The facility reported a census of nine residents. Based on interview and record review for three residents and three new employee records, 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 KAR 26-39-105. Findings included:	S5230		

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S5230	Continued From page 10 - Review of three newly hired staff records revealed the following: Certified Medication Aide (CMA) B's employee record revealed a hire date of 06/12/23. The first step of the two-step TST was administered late on 08/28/23. Certified Nurse Aide (CNA) C's employee record revealed a hire date of 06/29/23. The first step of the two-step TST was administered late on 08/28/23. CNA D's employee record revealed a hire date of 11/12/23. The second step of the two-step TST was administered two days early on 11/17/23 after the first step was read as not positive. On 05/07/24 at 04:13 PM Administrative Staff A acknowledged one of the TB Symptom Screening Questionnaires and one of the two-step TSTs were completed late The June 2013 "Tuberculosis (TB) Guidelines for Adult Care Homes" documented, "Each new ...employee shall have an initial TB symptom screen that includes the components of the TB symptom questionnaire within seven days of ...employment." The operator failed to ensure the facility remained in compliance with the department's tuberculosis guidelines for adult care homes adopted by reference in KAR 26-39-105 regarding newly hired employees. - Resident (R)103 moved into the facility on 06/22/20. R103's medical record revealed an annual	S5230		

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S5230	Continued From page 11 tuberculosis (TB) symptom screening questionnaire was not completed for 2023. The June 2013 "Tuberculosis (TB) Guidelines for Adult Care Homes" documented, "Each resident ...shall have an annual TB symptom screen ..." The operator failed to ensure compliance with the department's TB guidelines for adult care homes adopted by reference to K.A.R. 26-29-105.	S5230		
S5251 SS=D	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: 5251 KAR 26-42-105(f)(11) The facility reported a census of nine residents. The sample included three residents. Based on record review and interview the operator failed to ensure documentation in accordance with accepted professional standards and practices for resident (R)103 concerning a pressure wound. Findings included: - Review of R103's medical record revealed she was admitted to the facility on 06/22/20 with a diagnosis of pressure wound.	S5251		

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S5251	Continued From page 12 The 12/21/21 "Functional Capacity Screen" (FCS) documented R103 required physical assistance with transfers, mobility, toileting and was unable to manage her treatments. The 06/22/20 "Negotiated Service Agreement" (NSA) and "Health Care Service Plan" (HCSP) documented staff provided R103 assistance with toileting, transfers, mobility, and management of treatments. Review of R103's medical records failed to find documentation concerning her pressure wound to include measurements, wound description, treatment, and progression of the wound. On 05/07/24 at 05:15 PM Administrative Staff A stated it was her expectation that nurse documentation of R103's pressure wound include measurements completed weekly. A policy on documentation of pressure wounds was requested on 05/08/24 at 08:49 AM but the operator was not able to provide one. The operator failed to ensure documentation for R103's care was in accordance with accepted professional standards and practices.	S5251		
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 by a dispensing pharmacist in accordance with K.A.R. 68-7-14.	S5312		

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S5312	Continued From page 13 This REQUIREMENT is not met as evidenced by: 5312 KAR 26-42-205 (g)(2) The facility reported a census of nine residents. Based on observation, and record review the operator failed to ensure each prescription medication container had a label provided by a dispensing pharmacist affixed to the container. Findings included: - Observation on 05/08/24 at 10:25 AM revealed the facility's medication cart contained the following prescription medications which were not labeled with a resident's full name: Resident (R)104: One tube of Hydrocortisone Cream 1% One inhaler of Albuterol Aero HFA One inhaler of Fluticasone HFA Aero R105: One tube of Procto-Med HC 2.5% R106: One bottle of Ipratropium 0.06% nasal spray The 02/2015 "OTC Medication and Medications Brought to Household by Resident/Family" policy documented, " ...a pharmacist will label the drug as required for prescription drugs." The operator failed to ensure each prescription medication container had a label provided by a dispensing pharmacist affixed to the container.	S5312		

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S5313	Continued From page 14	S5313		
S5313 SS=D	26-42-205 (g) (3) Over the counter medication (g) (3) A licensed nurse or medication aide may accept over-the-counter medication only in its original, unbroken manufacturer ' s package. A licensed pharmacist or licensed nurse shall place the full name of the resident on the package. If the original manufacturer ' s package of an over-the-counter medication contains a medication in a container, bottle, or tube that can be removed from the original package, the licensed pharmacist or a licensed nurse shall place the full name of the resident on both the original manufacturer ' s medication package and the medication container. This REQUIREMENT is not met as evidenced by: 5313 KAR 26-42-205(g)(3) The facility reported a census of nine residents. Based on observation and record review the operator failed to ensure a licensed pharmacist or licensed nurse placed the full name of the resident on the original package of "over-the-counter" medications (OTC). Findings included: - Observation on 05/07/24 at 10:25 AM of the medication cart revealed the following OTC medications that were not labelled with the resident's full name: Resident (R)102: One bottle of Systane Lubricant Eye Drops One bottle of MiraLAX	S5313		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B088002	A. BUILDING: _____ B. WING _____	05/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD ESTATES HOME PLUS	1140 S PERSHING AVENUE LIBERAL, KS 67901

(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
S5313	Continued From page 15 One bottle of Nature's Bounty D3 One bottle of Centrum Silver Men 50+ One bottle of Spring Valley Glucosamine Sulfate Potassium Chloride 1000 mg. One bottle of Nature Made Turmeric The 02/2015 "OTC Medication and Medications Brought to Household by Resident/Family" policy documented, "A licensed nurse will place the name of the resident on the drug container ..." The operator failed to ensure all over-the-counter medications were labeled with the resident's full name.	S5313		
S5325 SS=D	26-42-205 (l) Medication Regimen Review Frequency (l) Medication regimen review. A licensed pharmacist or licensed nurse shall conduct a medication regimen review at least quarterly for each resident whose medication is managed by the home and each time the resident experiences any significant change in condition. This REQUIREMENT is not met as evidenced by: 5325 KAR 26-42-205(l) The facility reported a census of nine residents. Three residents were included in the sample. Based on record review and interview the operator failed to ensure a medication regimen review was completed at least quarterly for	S5325		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B088002	A. BUILDING: _____ B. WING _____	05/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD ESTATES HOME PLUS	1140 S PERSHING AVENUE LIBERAL, KS 67901

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S5325	Continued From page 16 resident (R)103. Findings included: - R103 medical records revealed she admitted to the facility on 06/22/20. The 12/21/21 "Functional Capacity Screen" (FCS) documented R103 was unable to administer her own medications. The 06/22/20 "Negotiated Service Agreement" (NSA) documented staff managed R103's medications. R103's medical records lacked documentation pharmacy reviews were completed for the fourth quarter of 2022 and the first quarter of 2023. On 05/07/24 at 05:15 PM Administrative Staff A stated the registered nurse completed the medication regimen reviews on a quarterly basis, but she was unable to locate the missing quarters for R103. The operator failed to ensure medication regimen review was completed for R103 on a quarterly basis.	S5325		