STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B099001	A. BUILDING: _____ B. WING _____	07/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HOME, LLC	234 MANOR CIRCLE ALMA, KS 66401

(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 an initial certification survey for the above named Home Plus facility conducted on 07/31/24.	S 000		
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 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 12 residents with three included in the sample. Based on interview and record review the operator failed to ensure the "Negotiated Service Agreements" (NSA) for Residents (R)101 and R102 described the services they received based on their "Functional Capacity Screens" (FCS). Findings included:	S5105		

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

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S5105	Continued From page 1 - Record review for R101 revealed an admission date of 05/15/24 with a diagnosis of dementia and depression. The 05/15/24 FCS identified R101 had impaired vision. The 05/15/24 NSA failed to describe the services she received for impaired vision. Observation on 07/31/24 at 03:58 PM of R101 was in common area without glasses on. Interview of R101 07/31/24 at 04:01 PM revealed the resident forgot to put glasses on. She stated "I need reminded to wear them." Interview on 07/31/24 at 04:12 PM of Certified Medication Aide C revealed the staff needed to remind resident to wear her glasses. - Record review for R102 revealed an admission date of 03/29/24 with a diagnosis of dementia and epilepsy. The 03/29/24 FCS identified R102 had impaired vision. The 03/29/24 NSA failed to describe the services she received for impaired vision. On 07/31/24 at approximately 04:22 PM Administrative Nurse B confirmed R101 and R102's NSA failed to describe the services provided based on their FCS. The operator failed to ensure the NSA for R101 and R102 described the services provided based on their FCS.	S5105		

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S5192	Continued From page 2	S5192		
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 and regulations. This REQUIREMENT is not met as evidenced by: KAR 26-42-206(e) The facility reported a census of 12 residents. Based on record review and interview the operator failed to ensure food was served at the proper temperature. Findings included: Observation on 07/31/24 at 12:11 PM revealed no temperature logs were documented while food was prepared by dietary staff. On 07/31/24 at approximately 12:14 AM Administrative Staff A confirmed the facility had no temperatures of food logged.	S5192		

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S5192	Continued From page 3 On 07/31/24 at approximately 04:40 PM a policy for food handling was requested and the facility failed to provide. The Kansas Department of Agriculture's "Focus on Food Safety" booklet page 14, 18 and 19 documented minimum hot holding temperature is 135 degrees Fahrenheit (F) and maximum cold holding temperature is 41 degrees F. The operator failed to ensure food was served at the proper temperature.	S5192		
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: KAR 26-42-206(f) The facility reported a census of 12 residents. The facility had a main kitchen where food was stored and prepared. Based on observation and interview the operator failed to ensure foods were stored under safe conditions. Findings included: - Observation on 07/31/24 at 12:11 PM revealed	S5195		

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S5195	Continued From page 4	S5195		

three refrigerator spaces and two freezer spaces in the facility's main kitchen which contained food items for all residents. No temperature logs were present.

Freezer space #1 revealed a bag of tater tots which was unsealed.

Refrigerator space #1 revealed the following food items; one bag of english muffins which was undated, a dish of raspberry crisp was unsealed and undated, and one gallon jar of cucumbers and onions which was undated.

The two-door refrigerator contained a zippered bag of cooked bacon which was unsealed.

On 07/31/24 at 12:15 AM Administrative Staff A confirms each food item was unsealed and the expectation was each should have been covered and dated.

On 07/31/24 at 12:15 AM temperature logs for all refrigerator and freezer spaces were requested and the facility failed to provide. Administrative Staff A confirmed there were no temperature logs.

On 07/31/24 at 04:40 PM Administrative Staff A and Administrative Nurse B confirmed the facility did not have a policy regarding food storage or labeling.

The August 2017 Kansas Department of Agriculture's "Focus on Food Safety" booklet page 19 documented cold foods must be maintained at an internal temperature of 41 degrees Fahrenheit (F) or below and to cover foods to maintain cold holding temperature. Page 14 had a recommended frozen storage temperature of 0 degrees Fahrenheit. Page 20 of

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S5195	Continued From page 5 the booklet explained that food must be date marked if it is prepared on-site or when opened if commercially processed. The operator failed to ensure foods were stored under safe conditions.	S5195		
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. This REQUIREMENT is not met as evidenced by: KAR 26-42-104(d)(3) The facility reported a census of 12 residents. Based on interview and record review the operator failed to provide quarterly reviews of the facility's emergency management plan with staff and residents. Findings included:	S5215		

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S5215	Continued From page 6 - Review on 07/31/24 at 01:36 PM of the facility's quarterly reviews of the emergency management plan (EMP) with staff revealed the following reviews were completed: 03/27/24 and 07/10/24. The facility failed to provide documentation regarding emergency management plan reviews with staff for the second quarter of 2024. On 07/31/24 at 01:38 PM Administrative Staff A confirmed reviews of the facility's emergency management plan with staff was not conducted quarterly. The facility's "Fire Evacuation Policy and Procedure" revised 06/19/2024 stated "Staff will be required to complete training related to emergency and disaster preparedness upon hire and quarterly." The operator failed to provide quarterly reviews of the facility's emergency management plan with staff for the second quarter of 2024. - Review on 07/31/24 at 01:36 PM of the facility's quarterly reviews of the EMP revealed no quarterly reviews were completed with residents. On 07/31/24 at 04:30 PM Administrative Nurse B confirmed reviews of the facility's emergency management plan with residents were not conducted quarterly. The facility's "Fire Evacuation Policy and Procedure" revised 06/19/2024 stated "Residents will receive orientation to fire evacuation .....this will be reviewed quarterly." The operator failed to provide quarterly reviews of the facility's emergency management plan with	S5215		

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S5215	Continued From page 7 residents.	S5215		
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 facility reported a census of 12 residents with three residents included in the sample. Based on interview and record review of Residents (R) 101, R102, and R103 the operator failed to ensure the facility remained in compliance with the State Agency's tuberculosis (TB) guidelines for adult care homes adopted by reference in KAR 26-39-105. Findings included: - Record review for R101 revealed an admission date of 05/15/24. Her record lacked evidence of documentation of TB symptom screening	S5230		

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S5230	Continued From page 8 completed upon admission. Record review for R102 revealed an admission date of 03/27/24. Her record lacked evidence of documentation of TB symptom screening completed upon admission. Record review for R103 revealed an admission date of 02/29/24. Her record lacked evidence of documentation of TB symptom screening completed upon admission. Interview on 07/31/24 at approximately 01:17 PM Administrative Nurse B confirmed all three residents' records lacked documentation of TB symptom screening completed upon admission. The department's June 2013 "Tuberculosis (TB) Guideline for Adult Care Homes" documented each new resident and employee shall have an initial TB symptom screen that includes the components of the Tuberculosis Symptom Screen Questionnaire. The facility's policy titled "Infection Control Policy and Procedure" dated 08/02/23 stated the "facility will maintain compliance .... with tuberculosis practices for adult care homes." The operator failed to ensure compliance with the State Agency's tuberculosis guidelines for adult care homes adopted by reference in KAR 26-39-105, which had the potential to affect all residents.	S5230		
S5313 SS=E	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	S5313		

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S5313	Continued From page 9 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: KAR 26-42-205(g)(3) The facility reported a census of 12 residents. Based on observation and interview the operator failed to ensure a licensed pharmacist or licensed nurse placed the full names of the residents on the original packages of all over-the-counter (OTC) medications. Findings included: - Observation on 07/31/24 at 12:02 PM revealed Administrative Staff A unlocked and opened the medication closet where the medications for the residents were stored. The following over-the-counter medications were not labeled with residents' full names: One bottle of sulfacetamide sodium 1% solution for resident (R) 102, One tube of hydrocortisone 2.5% cream for R103, One bottle of refresh 1% eye drops for R104, One bottle of fluticasone 50mcg spray for R105	S5313		

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S5313	Continued From page 10 On 07/31/24 at approximately 12:07 PM Administrative Staff A confirmed the OTC medications were not labeled with residents' full names. The operator failed to ensure all OTC medications were labeled with the residents' full names.	S5313		