STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N040008	A. BUILDING: _____ B. WING _____	10/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HOMESTEAD OF HALSTEAD	715 W 6TH ST HALSTEAD, KS 67056

(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 with complaint investigations 182059, 182110, 184176, 186095, 188725, 188810, and 189874 for the above named Assisted Living Facility conducted on 09/30/24, 10/01/24, and 10/02/24.	S 000		
S3080 SS=D	26-41-201 (a) (b) Functional Capacity Screen on Admission a) On or before each individual ' s admission to an assisted living facility or residential health care facility, 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 facility, 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 26-41-201(a) The facility reported a census of 20 residents(R). The sample included three residents and two focused record reviews. Based on interview and record review the executive director failed to ensure one (R5) of three sampled residents had a "Functional Capacity Screen" completed by designated staff on or before admission to the assisted living facility to determine the resident's	S3080		

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
	N040008	A. BUILDING: _____ B. WING _____	10/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HOMESTEAD OF HALSTEAD	715 W 6TH ST HALSTEAD, KS 67056

(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
S3080	Continued From page 1 functional capacity. Findings included: - Review of R5's medical record revealed she moved into the facility on 08/30/24 with a diagnoses of skin eruptions and osteoarthritis. R5's record included an admission FCS/NSA that included 11 different section to be signed and completed. The admission FCS/NSA had 8 sections the licensed nurse signed and dated on 09/06/24 an three sections the licensed nurse signed and dated on 09/08/24 All 11 sections were signed and dated seven to nine days after R5's admission into the facility. Interview on 10/02/24 at 10:51 AM Executive Director/Licensed Nurse A Looked in R5's electronic record and reported she opened and initiated it on 08/30/24, the day she moved in and thought she had completed it. Executive Director/Licensed Nurse A reviewed signature dates and confirmed they were signed after R5 moved into the facility. The Executive Director failed to ensure designated staff completed an admission Functional Capacity Screen for R5, on or before admission to the facility.	S3080		
S3085 SS=D	26-41-202 (a) Negotiated Service Agreement (a) The administrator or operator of each assisted living facility or residential health care facility 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	S3085		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N040008	A. BUILDING: _____ B. WING _____	10/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HOMESTEAD OF HALSTEAD	715 W 6TH ST HALSTEAD, KS 67056

(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
S3085	Continued From page 2 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 26-41-202(a)(2) The facility reported a census of 20 residents(R). The sample included three residents and two focused record reviews. Based on interview and record review the executive director failed to ensure designated staff completed one (R5) of three sampled residents "Negotiated Service Agreement and Health Care Service Plan" based on their "Functional capacity Screen" to identify who provided outside services for R5. Findings included: - Review of R5's medical record revealed she moved into the facility on 08/30/24 with a diagnoses of skin eruptions and osteoarthritis. R5's record included an admission FCS/NSA completed on 09/08/24 and identified the resident received podiatry, transportation, Lab, and X-ray services from an outside provider but failed to identify who provided the services.	S3085		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N040008	A. BUILDING: _____ B. WING _____	10/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HOMESTEAD OF HALSTEAD	715 W 6TH ST HALSTEAD, KS 67056

(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
S3085	Continued From page 3 Interview on 10/2/24 at 10:51 AM Executive Director A confirmed the FCS/NSA did not identify who provided the outside services. The executive Director failed to ensure designated staff completed R5's FCS/NSA to identify who provided outside services for R5.	S3085		
S3090 SS=D	26-41-202 (c) Admission Negotiated Service Agreement (c) Each administrator or operator shall ensure the development of an initial negotiated service agreement at admission. This REQUIREMENT is not met as evidenced by: KAR 26-41-202(c) The facility reported a census of 20 residents(R). The sample included three residents and two focused record reviews. Based on interview and record review the administrator failed to ensure one (R5) of three sampled residents had an initial "Negotiated Service Agreement" completed at admission. Findings included: - Review of R5's medical record revealed she moved into the facility on 08/30/24 with a diagnoses of skin eruptions and osteoarthritis. R5's record included an admission FCS/NSA that included 11 different section to be signed and	S3090		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N040008	A. BUILDING: _____ B. WING _____	10/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HOMESTEAD OF HALSTEAD	715 W 6TH ST HALSTEAD, KS 67056

(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
S3090	Continued From page 4 completed. The admission FCS/NSA had 8 sections the licensed nurse signed and dated on 09/06/24 an three sections the licensed nurse signed and dated on 09/08/24 All 11 sections were signed and dated as complete, seven to nine days after R5's admission into the facility. Interview on 10/02/24 at 10:51 AM Executive Director/Licensed Nurse A Looked in R5's electronic record and reported she opened and initiated it on 08/30/24, the day she moved in and thought she had completed it. Executive Director/Licensed Nurse A reviewed signature dates and confirmed they were signed after R5 moved into the facility. The Executive Director failed to ensure designated staff completed an admission Negotiated Service Agreement for R5, at the time of admission	S3090		
S3156 SS=D	26-41-204 (b) Health Care Services (b) If the functional capacity screening indicates that a resident is in need of health care services, a licensed nurse, in collaboration with the resident, the resident ' s legal representative, the case manager, and, if agreed to by the resident or resident ' s legal representative, the resident ' s family, shall develop a health care service plan to be included as part of the negotiated service agreement. This REQUIREMENT is not met as evidenced by:	S3156		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N040008	A. BUILDING: _____ B. WING _____	10/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HOMESTEAD OF HALSTEAD	715 W 6TH ST HALSTEAD, KS 67056

(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
S3156	Continued From page 5 KAR 26-41-204(b) The facility reported a census of 20 residents (R). The sample included three residents and two focused record reviews. Based on interview and record review the operator failed to ensure designated staff completed a health care service plan for one (R5)of three sampled residents who required health care services. Findings included: - Review of R5's medical record revealed she moved into the facility on 08/30/24 with a diagnoses of skin eruptions and osteoarthritis. R5's record included an admission FCS/NSA identified R5 required supervision with bathing, management of medications and medical treatments. It identified she had a current problem/risk for falls and needed wound care treatments. R5's initial "Health Care Service Plan" was opened on 08/30/24 but did not include any services / interventions the staff were to provide for R5 until 09/08/24. Interview on 10/02/24 at 10:51 AM Executive Director/Licensed Nurse A Looked in R5's electronic record and reported she opened and initiated the service plan on 08/30/24, the day she moved in. Executive Director/Licensed Nurse A confirmed she had not completed the service plan until after R5 was admitted. The executive director failed to ensure designated staff developed a "Health Care Service Plan" at admission to ensure R5's health care needs were met.	S3156		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N040008	A. BUILDING: _____ B. WING _____	10/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HOMESTEAD OF HALSTEAD	715 W 6TH ST HALSTEAD, KS 67056

(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
S3200 SS=E	26-41-205 (d) (1-2) Facility Administration of Medications (d) Facility administration of resident ' s medications. If a facility 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 facility has responsibility. (2) Medication aides shall not administer medication through the parenteral route. This REQUIREMENT is not met as evidenced by: KAR 26-41-205 (d) The facility reported a census of 20 residents (R). The sample included three residents and two focused record reviews. Based on interview and record review the executive director failed to ensure facility staff administered two (R3, R4) of three sampled resident's medications and biologicals in accordance with a medical care providers written order and standards of practice. Findings included: - R3's Electronic Medical Record revealed she moved into the facility on 03/31/22 with diagnoses	S3200		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N040008	A. BUILDING: _____ B. WING _____	10/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HOMESTEAD OF HALSTEAD	715 W 6TH ST HALSTEAD, KS 67056

(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
S3200	Continued From page 7 of dysphagia and myelodysplastic syndrome. R3's FCS/NSA dated 05/15/24 indicated she needed physical assistance with management of medications and staff would administer medications and medical treatments. R3's record included physician order sheets signed on 02/29/24 and 09/19/24 included a physicians order for Miralax Powder by mouth two times a day for constipation. The order had no parameters to hold if having loose stools. Review of R3's progress included notes lacked documentation of facility staff notifying R3's medical provider during the months of August and/or September of 2024, they had routinely held her evening dosage of Miralax due to loose stools. R3's August 2024 Medication Administration Record (MAR) revealed a physician's order for Miralax Powder twice a day for constipation. Facility staff initialed administration of the morning dose 31 out of 31 times and initialed the evening dose only one out of 31 times. The staff documentation coded "na" meaning not administered and lacked documentation as to why staff did not administer the medication. R3's September 2024 MAR included the same physicians order for Miralax Powder and facility staff initialed administration of the morning dose 19 out of 30 times and the evening dose was only initialed as administered two out of thirty times. The facility staff again coded administration as "na" meaning not administered but did not include documentation of why staff did not administer the medication.	S3200		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N040008	A. BUILDING: _____ B. WING _____	10/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HOMESTEAD OF HALSTEAD	715 W 6TH ST HALSTEAD, KS 67056

(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
S3200	Continued From page 8 Interview on 10/01/24 at 03:06 PM Certified Medication Aide D reported the "na" she documented on the MAR meant the medication was not administered. CMA D reported she thought the electronic record had a place to document in medication progress notes because it wasn't given, but she had not documented in the progress notes. CMA D thought the nurse had told them to "hold" the Miralax because R3 was having diarrhea. CMA D stated it has not resolved as of today. Interview on 10/02/24 at 05:01 PM Executive Director/Licensed Nurse A reported if staff hold a medication, they are to notify her and unless the order has parameters to hold it if having loose stools. Executive Director/Licensed Nurse A reviewed R3's physician orders and confirmed it did not include parameters when facility staff could "hold' the Miralax without physician notification. Executive Director/Licensed Nurse A acknowledged staff should have notified the physician and should have documented in the MAR progress notes why the medication was held. The executive direct/licensed nurse failed to ensure R3's medications for which the facility was responsible for, administered R4's medications according to a physician's written order. - R4's electronic medical record revealed she moved into the facility on 01/14/23 with diagnoses of mild cognitive impairment and psychosis. R4's FCS/NSA revealed she needed physical assistance with management of medications and medical treatments and staff administered three to four medication passes per day.	S3200		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N040008	A. BUILDING: _____ B. WING _____	10/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HOMESTEAD OF HALSTEAD	715 W 6TH ST HALSTEAD, KS 67056

(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
S3200	Continued From page 9	S3200		

R4's signed physician orders dated 04/11/24 included an order to administer Haloperidol (antipsychotic) 0.5 milligrams at bedtime.

R4's electronic record also included signed pharmacy order dated 07/18/24 to increase the Haloperidol to 1 milligram at bedtime.

R4's progress notes from 07/01/24 to 09/30/24 lacked documentation the licensed nurse notified R4's medical provider of holding the Haloperidol or documentation the results of holding the Haloperidol.

R4's August 2024 Medication Administration Record (MAR) included facility staff documented they administered R4's Haloperidol every evening through the 12th. From the 13th to the 31st staff documented they initialed the Haloperidol on the 24th and 25th otherwise they entered "na" meaning they did not administer the medication. The record lacked documentation as to why staff did not administer R4's Haloperidol.

R4's September 2024 MAR included facility staff documented they administered R4's Haloperidol only one time out of thirty with no explanation why staff documented "na" on the MAR.

Interview on 10/01/24 at 03:06 PM Certified Medication Aide D reported the "na" she documented on the MAR meant the medication was not administered. CMA D reported she thought the electronic record had a place to document in the medication progress notes why it wasn't given but she had not documented in the progress notes.

Interview on 10/02/24 at 09:59 AM Executive Director/Licensed Nurse A reported if staff hold a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N040008	A. BUILDING: _____ B. WING _____	10/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HOMESTEAD OF HALSTEAD	715 W 6TH ST HALSTEAD, KS 67056

(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
S3200	Continued From page 10 medication, they are to notify her unless the order has parameters to hold it. Executive Director/Licensed Nurse A reviewed R4's orders and noted there were no parameters to hold the medications and stated she thought the pharmacy did a review and the medication had not been filled. The executive direct/licensed nurse failed to ensure R4's medications for which the facility was responsible for, were administered by facility staff according to a physician's written order.	S3200		
S3211 SS=E	26-41-205 (g) (3) OVER THE COUNTER DRUGS (3) A licensed nurse or medication aide may accept over-the-counter medication only in its original, unbroken manufacturer ' s package. A licensed pharmacist or licensed nurse shall place the full name of the resident on the package. If the original manufacturer ' s package of an over-the-counter medication contains a medication in a container, bottle, or tube that can be removed from the original package, the licensed pharmacist or a licensed nurse shall place the full name of the resident on both the original manufacturer ' s medication package and the medication container. This REQUIREMENT is not met as evidenced by: KAR 26-41-205 (g)(3) The facility reported a census of 20 residents(R). Based on observation and interview, the executive director/licensed nurse failed to ensure	S3211		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N040008	A. BUILDING: _____ B. WING _____	10/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HOMESTEAD OF HALSTEAD	715 W 6TH ST HALSTEAD, KS 67056

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S3211	Continued From page 11 a licensed nurse or pharmacist included the residents full name on all over-the-counter medications, including the original manufacturer's medication package and the medication container/tube. Findings included: - Interview on 10/01/24 at 01:23 PM Certified Medication Aide (CMA) B reported the facility had stock medications they got from he pharmacy to give to someone who did not have their own. CMA B stated they use it when a new resident comes in and doesn't have it or while waiting on family to bring in the resident's own bottle. Observation on 10/01/24 at 01:32 PM Brandi Huerta, CMA B unlocked the medication room and opened the cabinet that contained bottle of Tylenol, Maalox, and Mylanta, each with a pharmacy label entitled "stock". CMA B confirmed that they used the bottles or multi-resident use if they have an order for the medication but not the medication. Interview on 10/01/24 Executive Director/Licensed Nurse A confirmed they did have some "stock" bottles of over-the-counter medications. The executive director failed to ensure a licensed nurse or pharmacist wrote the residents full name on all over-the-counter medications, including the medication package and container.	S3211		
S3261 SS=E	26-41-105 (f) (11) Resident Record Documentation of Incidents (f) (11) documentation of all incidents, symptoms,	S3261		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N040008	A. BUILDING: _____ B. WING _____	10/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HOMESTEAD OF HALSTEAD	715 W 6TH ST HALSTEAD, KS 67056

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S3261	Continued From page 12 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 26-41-105(f)(11) The facility reported a census of 20 residents(R). The sample included three residents and two focused record reviews. Based on interview and record review the operator failed to ensure three (R3, R4, and R5) of three sampled residents records contained documentation of all incidents, symptoms, and other indications of illness or injury, what staff did, and the results of action taken. Findings included: - R3's Electronic Medical Record revealed she moved into the facility on 03/31/22 with diagnoses of dysphagia and myelodysplastic syndrome. Interview on 09/30/21 at 01:10 PM Executive Director/Licensed Nurse A reported the "Functional Capacity Screen" (FCS) and the "Negotiated Service Agreement" (NSA). R3's FCS/NSA dated 05/15/24 indicated she needed physical assistance with bathing, management of medications and medical treatments and had bladder incontinence. It revealed facility staff would provide assistance with showers and administer medications and medical treatments.	S3261		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N040008	A. BUILDING: _____ B. WING _____	10/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HOMESTEAD OF HALSTEAD	715 W 6TH ST HALSTEAD, KS 67056

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S3261	Continued From page 13 Interview on 10/01/24 at 01:14 PM Certified Medication Aide C reported facility staff help with her showers, ensure she wears pullups because she is incontinent, and sometimes we have to help her with dressing but most of the rime she can do that herself. R3's nursing progress notes included the following documentation: 10/17/23 - Resident left community with legal representative to have surgery. 10/18/23 - resident returned from hospital and will have Home Health manage incision and drains. The record lacked documentation related to incisions and overall post surgery status and any treatments provided while recovering. 11/14/23 -Home Health Nurse reported that resident had blisters to right buttocks and redness and foul odor to bilateral groin area and had notified R3's medical provider. New orders received for Nystatin (antifungal) powder twice a day for 14 days and Acyclovir (antiviral) three times a day for seven days. The record lacked follow-up as to the results of the treatment for blisters and groin redness. 11/22/23 - R3 had refused Miralax, and the order changed to as needed instead of scheduled twice daily. 01/08/24 -New order to administer Milk of Magnesia and start Miralax twice a day. The record lacked follow up as to the results of starting Miralax routinely for constipation. 02/15/24 - Resident seen by medical provider with new orders for Acyclovir (antivirus) three times a day for seven days. The record lacked documentation of any symptoms related to the need to start Acyclovir and failed to include results of the medications. 02/28/24 - Received order for Debrox ear drops to R3's left ear twice a day for five days and to	S3261		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N040008	A. BUILDING: _____ B. WING _____	10/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HOMESTEAD OF HALSTEAD	715 W 6TH ST HALSTEAD, KS 67056

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S3261	Continued From page 14	S3261		

flush on the fifth day.
The record lacked documentation of the results of the ear wax removal treatment.

Interview on 10/01/24 at 04:54 PM Executive Director/Licensed Nurse reported she expected to see documentation when there are new orders and what the orders are. She reported the nurses do not really make a progress note on new orders because we let the medical provider know what is going on. We basically only document if it is not working or something is wrong. Executive Director/Licensed Nurse A confirmed the nurse should have documented R3's status when she returned from the hospital about her incisions and the drains.

The Executive director failed to ensure R3's record included documentation of symptoms related to illness and the results of different medications initiated to resolve symptoms.

- R4's electronic medical record revealed she moved into the facility on 01/14/23 with diagnoses of mild cognitive impairment and psychosis.

Interview on 09/30/21 at 01:10 PM Executive Director/Licensed Nurse A reported the "Functional Capacity Screen" (FCS) and the "Negotiated Service Agreement" (NSA).

R4's FCS/NSA revealed she needed physical assistance with bathing, dressing, toileting, management of medications and medical treatments and had problems with falls and bladder incontinence. It indicated facility staff would assist with personal care and management of medications.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N040008	A. BUILDING: _____ B. WING _____	10/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HOMESTEAD OF HALSTEAD	715 W 6TH ST HALSTEAD, KS 67056

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S3261	Continued From page 15 09/29/23 - Received new order for Fluticasone (steroid) nasal spay for allergic rhinitis (inflammation of inner lining of nose) and received an injection in her left knee for pain. The order included instructions to monitor for sigs of infection including swelling and increased pain. The record lacked follow up on the results of initiating the nasal spray or results of the injection to help relieve pain to R3's left knee. 11/27/23 -Resident received steroid injection to her right knee. The record lacked documentation on the results of the steroid injection. 02/06/24 - Received new orders for Miralax daily and to hold if having loose stools. The record lacked follow up on the results of starting the Miralax. 02/15/24 - New orders for Meloxicam (nonsteroidal anti-inflammatory analgesic). The record lacked follow up on the results of starting the Meloxicam. 04/01/24 - Received signed order for Haloperidol (antipsychotic) at bedtime. The record lacked documentation of symptoms that would require need to initiating an antipsychotic medication and lacked documentation of the results of the medication. 04/08/24 - Received new order for Tramadol (Analgesic Opioid) for Osteoarthritis pain. The record lacked documentation of the results of the Tramadol. 04/11/24 - Behaviors observed. Behavior easily redirected. The record lacked documentation of what the behaviors were and if the resident continued to have behaviors. 07/08/24 - Resident has been having delusions and received new orders to increase Haloperidol to 1 milligram twice a day. The record lacked follow up on the results of	S3261		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N040008	A. BUILDING: _____ B. WING _____	10/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HOMESTEAD OF HALSTEAD	715 W 6TH ST HALSTEAD, KS 67056

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S3261	Continued From page 16	S3261		

increasing R4's Haloperidol.
08/15/24 - New order to start Cymbalta (antidepressant), Tylenol Arthritis every 8 hours, and received a steroid injection to her left knee. The record lacked documentation of any symptoms for starting the Cymbalta and lacked follow-up on the steroid injection for pain.

Interview on 10/02/24 at 10:34 AM Executive Director/Licensed Nurse A reported the medical provider is in the facility every two weeks and we communicate with her at that time. She reported they do not usually document follow-up in the nurse's notes.

The executive director failed to ensure designated staff documented all symptoms and other indications of illness or injury, actions taken and results of the action.

- R5's medical record revealed she moved into the facility on 08/30/24 with diagnoses of skin eruptions and osteoarthritis.

R5's FCS/NSA signed and dated 09/06/24 identified R5 needed supervision with management of medical treatments and facility staff would provide first aid and skin monitoring.

Review of R5's admission orders from local hospital dated 8/19/24 included documentation resident seen for leg suture removal from a wound that showed significant necrosis. R5 completed antibiotic therapy and plan to initiate wound care.

Review of physician progress note dated 09/05/24 included orders for Align dressing changes with a foam dressing to be changed Tuesday, Thursday and Saturday with showers.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N040008	A. BUILDING: _____ B. WING _____	10/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HOMESTEAD OF HALSTEAD	715 W 6TH ST HALSTEAD, KS 67056

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S3261	Continued From page 17 Remove the dressing prior to showers and then once completed pat area dry with gauze dressing and apply new foam dressing. Review of R5's electronic Treatment Administration Record (TAR) lacked documentation of completing wound care. Observation on 10/01/24 at 09:58 AM R5 sat in her recliner with her pant leg up exposing the wound on her shin. The wound bed was raised and uneven with yellowish eschar in approximately 20% of the wound bed. The wound is irregular in shape and had dark red edging. The surrounding skin is dry and tight with slight redness. The area on the back of her leg was discolored with staples intact. Licensed Nurse (LN) E asked R5 about pain and she stated it was about the same for both. LN E put a non-stick gauze on R5's calf wound and then put a boarder foam gauze on the shin wound. LN D then took wide tape and secured the non-stick dressing to her leg. Interview on 10/02/24 at 12:42 PM Executive Licensed Nurse A reported the facility staff do the treatments after her showers and should have the treatments on the TAR.	S3261		