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S 000	INITIAL COMMENTS The following citations represent the findings of the licensure resurvey for the above named facility conducted on 10/17/24.	S 000		
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: K.A.R. 26-42-201 (a) The facility reported a census of 8 residents. The sample included 3 "Residents'" (R)'s 1, 2, and 3. Based on interview and record review the operator failed to ensure the "Functional Capacity Screen" (FCS) for R2 was performed prior to or at the time of admission. Findings include:	S5080		

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

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S5080	Continued From page 1 - Record review for R2 revealed an admission date of 06/01/24 with diagnoses of Lewy Body dementia and epilepsy. Review of R2's FCS dated 06/02/24 revealed R2 required supervision with bathing and dressing. He lacked the ability to manage his own medications and had impaired short-term memory, long-term memory, memory recall and decision making. He was able to make himself understood and he understood others. He was identified to have impaired vision, hearing, decision making, and wandering. He used a cane or walker assistive device. Interview on 10/17/24 at approximately 04:45PM with Operator A confirmed the FCS for R2 was not done prior to or at the time of admission. The operator failed to ensure the FCS for R2 was performed prior to or at the time of admission.	S5080		
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: K.A.R. 26-42-204 (i) The facility reported a census of 8 residents. The sample included 3 "Residents'" (R)'s 1, 2, and 3. Based on observation, interview and record review the operator failed to provide healthcare services for R3 in accordance with professional	S5171		

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S5171	Continued From page 2	S5171		

standards of practice when the Operator failed to ensure an assessment of R3 was performed to confirm the bed assist device on R3's bed was not a restraint, to determine the purpose of the device, R3's ability to safely use the device, ensure the device was securely attached to the bed posing no risk for entrapment, and provided a description of the device its purpose and any special instructions on use and monitoring in R3's "Negotiated Service Agreement" (NSA).

Findings included:

- Record review for R3 revealed an admission date of 10/14/24 with diagnoses of hip fracture, atrial fibrillation, dementia, and agitation due to dementia.

Review of R3's "Functional Capacity Screen" dated 10/14/24 revealed R3 was unable to perform dressing, bathing, or toileting. He required supervision with transferring and walking/mobility. R3 required supervision with eating. He lacked the ability to manage his own medications/medical treatments and was incontinent. He was marked as cognitively intact and was sometimes able to make himself understood, and he sometimes understood others. He was marked as a fall risk and used a wheelchair mobility device.

Review of R3's combined NSA / "Health Service Plan" (HSP) dated 10/14/24 instructed the facility staff to provide "all assistance" with R3's bathing and toileting. Under section "5 Transfers" "The resident is total dependent and needs total assistance of one certified staff for all transfers. (circle assistive devices used)." "Walker and Bedrail" were circled.

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S5171	Continued From page 3 The NSA lacked a description of the bed assist device, and further lacked its purpose and special instructions on use and monitoring of R3 with the bed assist device. Observation on 10/17/24 at approximately 04:00PM of R3's hospital bed sat against the northeast wall. The bed revealed an inverted "U" shaped tubular device that was slid under the mattress and tied to the bed on the west side of the bed on the east side of the bed. The bed assist device freely raised on the west side of the bed. The device measured approximately 16 inches in height and 18 inches in width with a large open area between the two legs of the inverted "U". Interview on 10/17/24 at approximately 04:45 PM with Operator A confirmed R3's medical record lacked an assessment to confirm the bed assist device on R3's bed was not a restraint, to determine the purpose of the device, R3's ability to safely use the device, ensure the device was securely attached to the bed posing no risk for entrapment, and provided a description of the device its purpose and any special instructions on use and monitoring in R3's NSA. The FDA (food and drug administration) "Bedrails in Assisted Living, Residential Health Care and Home Plus Facilities" recommended the following: Complete an assessment of the resident to confirm that the device is not a restraint. Complete an assessment of the resident to determine the purpose of the device and the resident's ability to safely use the device and	S5171		

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S5171	Continued From page 4 document the findings in the resident's record. Complete an assessment of the device using the recommendations in the FDA guidance to ensure the device is securely attached to the bed or bedframe and poses no risk for entrapment and document the findings in the resident record. If the purpose of the device is to assist the resident with transfers, the FCS should document the resident's functional capacity based on the use of the device and should be listed in the comments section. Include a description of the device, its purpose and special instructions on use and monitoring in the resident's NSA. Document periodic reassessments of the resident's use of the device and their ability to use it safely and reassessment of the safety of the device in the resident's record. The Operator failed to ensure an assessment of R3 was performed to confirm the bed assist device on R3's bed was not a restraint, to determine the purpose of the device, R3's ability to safely use the device, ensure the device was securely attached to the bed posing no risk for entrapment, and provided a description of the device its purpose and any special instructions on use and monitoring in R3's NSA.	S5171		
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,	S5195		

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S5195	Continued From page 5	S5195		

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:
K.A.R. 26-42-206 (f)

The facility reported a census of 8 residents. Based on observation and interview the operator failed to ensure facility staff stored all food under safe and sanitary conditions.

Findings include:

- Observation on 10/17/24 at approximately 09:45AM during the initial facility tour of the white refrigerator with the top freezer that sat on the southwest wall of the kitchen. In the freezer portion there were two-quart size zip lock freezer bags with what appeared to be cookies. The zip lock bags lacked a date of when they were placed in the freezer. On the counter that sat next to the stove on the southeast wall of the kitchen sat a cake pan that contained with what appeared to be a chocolate cake with icing that contained coconut. The cake pan was less then half full of cake. The cake pan was covered with a dish towel and there were flies observed flying in the kitchen.

Observation on 10/17/24 at approximately 11:45 AM during the noon meal the cake was served to residents as part of the noon meal.

Interview on 10/27/24 at approximately with Operator A confirmed all food should be covered

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S5195	Continued From page 6 and dated. Review of the facility provided policy dated 03/11/2019 titled Food Temperature Cooking and Process" revealed; "Store all foods wrapped or in covered containers, store quickly, and avoid overloading your refrigerator because cold air needs room to circulate." The operator failed to ensure facility staff stored all food under safe and sanitary 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: K.A.R. 26-42-104 (d) (3) The home reported a census of 8 residents. Based on interview and record review the	S5215		

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S5215	Continued From page 7 Operator failed to perform a quarterly review of the home's emergency management plan that included fire, flood, severe weather, tornado, explosion, natural gas leak, loss of electrical or water service, missing residents, and any other potential emergency situations, at least quarterly with employees and residents. Findings included: - Record review of the facility provided employee acknowledgement signature sheets revealed the following topics being presented; On 01/12/24 "Policy of Fluid Encouragement." On 01/26/24 "Checklist/Cleaning, Fire/Dangerous weather preparedness, Teamwork, and resident behaviors." On 02/09/24 "Elopement Policy" On 03/08/24 "Gait belt policy/Use of side (bed) rails" On 03/08/24 "Emergency Weather protocol, Labeling/Covering food properly, Food Temperature Logs, Checklist, Residents Clothing." On 03/15/24 "Fire and safety preparedness" On 4/12/24 "Feeding the Resident (dependent eating) On 05/17/24 "Checklist, changes to rooms 2,3, and 6 being sent to hospital, and Chain of Command."	S5215		

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S5215	Continued From page 8 On 05/31/24 "Elopement Triggers and Protocol" Review of the resident sign in sheets revealed the were provided training for the following; On 02/09/24 for Inclement weather protocol. On 05/10/24 for Inclement weather protocol. On 06/07/24 for "Fire and Safety Preparedness." Review of the undat3ed facility policy titled "Disaster and Emergency Preparedness" revealed the following; "d. Disaster and emergency preparedness education to staff and rsidents initially and quarterly and an annual evacuation drill." Interview on 10/17/24 at approximately 04:45 PM with Operator A and Certified Medication Aide B, confirmed the information provided to staff and residents lacked fire, flood, severe weather, tornado, explosion, natural gas leak, loss of electrical or water service, missing residents, and any other potential emergency situations, at least quarterly with employees and residents. The Operator failed to perform a quarterly review of the home's emergency management plan that included fire, flood, severe weather, tornado, explosion, natural gas leak, loss of electrical or water service, missing residents, and any other potential emergency situations, at least quarterly with employees and residents.	S5215		
S5225 SS=F	26-42-207 (a) (b) (1)(2)(3)(4) Infection Control a) The administrator or operator of each home	S5225		

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S5225	Continued From page 9	S5225		

plus shall ensure the provision of a safe, sanitary, and comfortable environment for residents.
(b) Each administrator or operator shall ensure the development of policies and implementation of procedures to prevent the spread of infections. These policies and procedures shall include the following requirements:
(1) Using universal precautions to prevent the spread of blood-borne pathogens;
(2) techniques to ensure that hand hygiene meets professional health care standards;
(3) techniques to ensure that the laundering and handling of soiled and clean linens meet professional health care standards;
(4) providing sanitary conditions for food service;

This REQUIREMENT is not met as evidenced by:
K.A.R. 26-42-207 (a) (3)

The facility reported a census of 8 residents. Based on observation and interview the operator failed to ensure facility staff used techniques to ensure that the handling of soiled lines met professional standards of practice when staff collected several resident dirty/soiled laundry and stacked it together while waiting to be washed.

Findings include:

- Observation on 10/17/24 at approximately 09:30AM with "Certified Nurse Aide" (CNA) G of the home's laundry room revealed the washer and dryer sat on the west wall. On the floor in front of the left side of the washer was a laundry basket with a heaping amount of clothes and bedding.

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S5225	Continued From page 10 Interview on 10/77/24 with at approximately 09:30AM CNA G confirmed that the bedding and clothing items in the basket belonged to several different residents, she continued to state that the items are separated prior to being washed. Interview on 10/27/24 at approximately 04:45 PM with Operator A confirmed the facility had one hot water heater and it maintains the facility water temperatures between 95- and 120-degrees Fahrenheit. Review of the undated facility provided policy titled "Laundry Procedure" revealed the following; 1. Wash by individual rooms. 6. Do not change any setting on the washer unless it is nice clothing then use cold. 8. Clean Laundry is folded, sorted, or hung on the north side of the room. The operator failed to ensure facility staff used techniques to ensure that the handling of soiled lines met professional standards of practice when staff collected several resident dirty/soiled laundry and stacked it together while waiting to be washed.	S5225		
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	S5230		

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S5230	Continued From page 11 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 8 residents. The sample included 3 "Residents'" (R)'s 1, 2, and 3, and 5 newly hired employees. Based on record review and interview the Operator failed to ensure the home's compliance with the department's "Tuberculosis" (TB) guidelines for adult care homes adopted by reference in K.A.R. 26-39-105, for R's 1 and 2, and newly hired "Certified Nurse Aides'" (CNA)'s C, D, E and newly hired "Registered Nurse" (RN) F. Findings include: - Record review for R1 revealed an admission date of 01/03/24 with a diagnosis of Senile degeneration of the brain. Review of R'1s "Medical Record" revealed a document titled "TB Testing Form" dated 01/03/24. Under the section titled "Test #1" it was dated 01/03/24 and read on 01/05/24. The section titled "Test #2" lacked documentation. Record Review for R2 revealed an admission date of 06/01/24 with diagnoses of Lewy Body dementia and epilepsy.	S5230		

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S5230	Continued From page 12 Review of R2's "Medical Record" revealed a document titled "TB Testing Form" dated 06/29/24. Under the section titled "Test #1" it was dated 06/29/24 and read on 07/01/24. The section titled "Test #2" lacked documentation. Record review for newly hired CNA C revealed she began employment on 02/21/24. The facility provided document dated 02/22/24 titled "TB Testing Form". Under the section titled "Test #1" it was dated 02/22/24 and read on 02/24/24. The section titled "Test #2" lacked documentation. Record review for newly hired CNA D revealed she began employment on 08/15/24. The facility provided document dated 08/27/24 titled "TB Testing Form". Under the section titled "Test #1" it was dated 08/27/24 and read on 08/29/24. The section titled "Test #2" lacked documentation. Record review for newly hired CNA E revealed she began employment on 01/23/24. The facility provided document dated 01/24/24 titled "TB Testing Form". Under the section titled "Test #1" it was dated 01/24/24 and read on 01/26/24. The section titled "Test #2" lacked documentation. Record review for newly hired RN F revealed she began employment on 05/01/24. Her employee record lacked documentation of the required two step TB test. Review of the facility provided undated "Infection Control Policy" revealed; "F. Tuberculosis guidelines: The administrator or operator shall insure compliance with the tuberculosis guidelines for adult care homes. Residents and employees shall have a TB test performed within seven days of admission or employment."	S5230		

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S5230	Continued From page 13 Review of the departments "TB Guidelines for Adult Care Homes" dated 06/2013 revealed the first step of the required TB test was to be administered within seven days of employment/admission. A second TB test shall be administered within one to three weeks after the first negative TB test. Interview on 10/17/24 with Operator A Confirmed the resident records for R's 1 and 2 lacked the required documentation for the second TB test. He further confirmed the employee records for newly hired CNA's C, D, E and newly hired RN F lacked the required documentation for the second TB test. The Operator failed to ensure the home's compliance with the department's TB guidelines for adult care homes adopted by reference in K.A.R. 26-39-105, for R's 1 and 2, and newly hired CNA's C, D, E, and newly hired RN F.	S5230		
S5313 SS=F	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.	S5313		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEGACY LIVING LLC	445 E 10TH ST BAXTER SPGS, KS 66713

(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 14 This REQUIREMENT is not met as evidenced by: K.A.R. 26-42-205 (g) (3) The facility reported a census of 8 residents. Based on observation and interview the operator failed to ensure the licensed nurse or licensed pharmacist placed the full name of the resident on the original manufacturers "Over the Counter" (OTC) medication container. Findings include: - Observation on 10/17/24 at approximately 0940AM of the medication cabinet in the locked facility office revealed the following OTC medication containers that lacked the full name of the resident: 2 bottles of Calcium 600 milligrams 1 bottle of Complete Multivitamin 1 bottle of Low Dose Aspirin 1 box of Tussin Liquid 1 bottle of Tylenol 1 bottle of Colace Interview on 10/17/24 at approximately 04:45PM with Operator A and Certified Medication Aide B confirmed the OTC medications containers should contain the full name of the resident. The operator failed to ensure the licensed nurse or licensed pharmacist placed the full name of the resident on the original manufacturer's "Over the Counter" (OTC) medication container.	S5313		