STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N078015	A. BUILDING: _____ B. WING _____	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEGEND OF HUTCHINSON	2416 BRENTWOOD STREET HUTCHINSON, KS 67502

(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 180605, 183672, 185288, 187082 for the above named Assisted Living Facility conducted on 12/09/24, 12/10/24, 12/11/24, and 12/12/24.	S 000		
S 115 SS=F	26-39-103 (d) Resident Right Inspection of Records (d) Inspection of records. (1) The administrator or operator shall ensure that each resident or resident's legal representative is afforded the right to inspect records pertaining to the resident. The administrator or operator, or the designee, shall provide a photocopy of the resident's record or requested sections of the resident's record to each resident or resident's legal representative within two working days of the request. If a fee is charged for the copy, the fee shall be reasonable and not exceed actual cost, including staff time. (2) The administrator or operator shall ensure access to each resident ' s records for inspection and photocopying by any representative of the department. This STANDARD is not met as evidenced by: K.A.R. 26-39-103 (d)(2) The facility reported a census of 98 residents. The sample included six residents and two focused record review. Based on interview and record review for all residents, the executive director failed to ensure independent, direct access to each resident's electronic record for	S 115		

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

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S 115	Continued From page 1 inspection by a representative of the department (Kansas Department of Aging and Disabilities) for inspection. Findings included: - The surveyor entered the facility on 12/09/24 at 03:10 PM to conduct a Re-Licensure Survey that included four complaint investigations, with one complaint being anonymous. The surveyor informed Executive Director A of the reason for the visit, and proceeded to conduct the initial tour. Observation during tour revealed a "chart" room in the Assisted Living section with resident paper charts and an office area on the Memory Care Unit that also contained resident paper charts. Interview on 12/10/24 at 11:40 AM Executive Director A stated most of the resident records were paper form. Executive Director A reported the "Medication Administration Record" and "Nursing Notes" are a part of "[NAME]" and if there is anything the surveyor needed they would print it. Surveyor then showed Executive Director A the Regulation K.A.R. 26-39-103 (d)(2) and explained the need to have independent access to records. Executive Director reported she understood, but there was no way to provide the surveyor access to their electronic system. Surveyor then requested a copy of the electronic medical record policy. On 12/10/24 at 12:55 PM surveyor sent a list of 14 residents and requested three months of their MAR's and 12 months of nursing notes. The facility provided the above information as requested by the end on the day on 12/10/24.	S 115		

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S 115	Continued From page 2 Review of the "Electronic Medical Records (EMR) protection, confidentiality, and preservation 10-04-0025P" policy effective 12/04/24 identified the purpose of the policy was to protect resident information from unauthorized access and use. It identified "Authorized Uses" as individuals who have been granted permission to access and input data into the EMR system based on their role within the Organization. It did not identify access for inspection by a representative of the Kansas Department for Aging and Disabilities. For all residents, the executive director failed to provide independent, direct access to each resident's electronic record for inspection by a representative of the department.	S 115		
S3082 SS=E	26-41-201 (d) Functional Capacity Screen Accurate d) Designated facility staff shall ensure that each resident ' s functional capacity at the time of screening is accurately reflected on that resident ' s screening form. This REQUIREMENT is not met as evidenced by: K.A.R 26-41-201(d) The facility reported a census of 98 residents(R). The sample included six residents and two focused record review. Based on observation, interview and record review, the operator failed to ensure designated staff completed two (R4, R5) of six sample residents "Functional Capacity	S3082		

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S3082	Continued From page 3	S3082		

Screen" accurately to reflect their functional ability at that time related to activities of daily living.

Findings Included:

- R4's medical record revealed she moved into the facility on 06/14/19 with diagnosis of glaucoma.

R4's "Functional Capacity Screen" (FCS) dated 10/21/24 identified R4 needed supervision with management of her medications and medical treatments.

R4's "Negotiated Service Agreement/Health Care Service Plan" dated 10/21/24 identified R4's medications were administered by Certified Medication Aides or Licensed Nurses, and she had several medical treatments including eye drops twice a day and occasionally wore an eye patch. It identified medical treatments were performed by qualified staff.

Interview on 12/11/24 at 07:43 AM, Certified Medication Aide G reported she had moved to the memory Unit awhile ago, and facility staff have administered her medications and medical treatments since then.

Interview on 12/11/24 at 12:06 PM Administrative Licensed Nurse B acknowledged if staff were preparing and handing residents their medications it should be coded a "2" for physical assistance.

The executive director failed to ensure designated staff completed R4's FCS accurately

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S3082	Continued From page 4 to reflect R4's functional ability related to medication and medical treatment management. - Review of R5's medical record revealed she moved into the facility on 08/31/23 with a diagnosis of dementia. R5's "Functional Capacity Screen" (FCS) dated 10/08/24 identified she was required supervision with eating, management of medications and management of medical treatments. R5's "Negotiated Service Agreement / Health Care Service Plan" dated 10/08/24 identified she required assistance with opening food packets and containers, and medications were to be administered by Certified Medication Aides or Licensed Nurses. Observation on 12/11/24 at 11:10 AM R5 sat at the lunch table and had a supplement bottle that had been opened by the Certified Medication Aide and given to the resident to finish drinking. Interview on 12/11/24 at 02:52 PM CMA C confirmed R5 received a protein shake that staff have to open for her if she does not eat well. Interview on 12/11/24 at 11:50 AM Licensed Nurse (LN) H reported they code supervision for meals if they eat in the common area where staff can supervise them. She reported if someone needed help with opening packaging, it would be coded a "2" for physical assistance. LN H reported for medications and treatments she was taught if the resident is able to take them on their own once staff prepared them, it should be coded a "1" for supervision.	S3082		

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S3082	Continued From page 5 Interview on 12/11/24 at 12:06 PM Administrative Licensed Nurse B acknowledged if staff prepared and handed residents their medications or medical treatments, it should be coded a two for physical assistance. The executive director failed to ensure designated staff completed R5's FCS accurately to reflect R5's functional ability and need for assistance with eating and management of her medications/medical treatments.	S3082		
S3085 SS=E	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 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:	S3085		

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S3085	Continued From page 6 KAR 26-41-202 (a)(1)(2)(3) The facility reported a census of 98 residents. The sample included six residents and two focused record reviews. Based on interview, and record review the executive director failed to ensure designated staff completed three (R3, R4, R6) of six sampled resident's "Negotiated Service Agreement" based on the "Functional Capacity Screen" (FCS) and service needs and failed to identify services provided. Findings included: - R3's medical record revealed she moved into the facility on 09/25/23 with a diagnosis of dementia. R3's "Functional Capacity Screen" (FCS) dated 10/08/24 she was unable to manage her medical treatments and had impaired communication abilities. R3's "Negotiated Service Agreement/Health care Service Plan" (NSA/HCSP) failed to address service needs related to management of medical treatments and impaired communication. Interview on 12/12/24 at 12:03 PM Licensed Nurse H reviewed R3's FCS and compared it to the NSA/HCSP and confirmed it did not address that staff would administer any medical treatments and did not address services related to her inability to find the right words and express herself. The executive director failed to ensure designated staff completed R3's NSA/HCSP to	S3085		

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S3085	Continued From page 7 identify services as related to needs identified on R3's FCS. - R4's medical record revealed she moved into the facility on 06/14/19 with diagnosis of glaucoma. R4'a "Functional Capacity Screen" (FCS) dated 10/21/24 identified R4 had impaired hearing and problem with wandering. R4's 'Negotiated Service Agreement/Health Care Service Plan" (NSA/HCSP) dated 10/21/24 failed to identify services related to impaired hearing and wandering. Interview on 12/12/24 at 12:25 PM Licensed Nurse H reviewed R4's FCS and NSA/HCSP and acknowledged she had not addressed services related to impaired hearing and wandering in the facility. The executive director failed to ensure designated staff completed R4's NSA/HCSP according to service needs identified on the FCS for impaired hearing and wandering. . - Review of R5's medical record revealed she moved into the facility on 08/31/23 with a diagnosis of dementia. R5's "Functional Capacity Screen" (FCS) dated 10/08/24 identified she needed supervision with medical treatments, had impaired vision, and impaired decision-making ability. R5's "Negotiated Service Agreement / Health Care Service Plan" (NSA/HCSP) dated 10/08/24	S3085		

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S3085	Continued From page 8 failed to identify services related to management of medical treatments, impaired vision and impaired decision-making ability. Interview on 12/11/24 at 12:02 PM Licensed Nurse H reviewed the FCS and HCSP/NSA acknowledged she had not addressed services related to impaired vision and decision-making ability or her inability to manage her medical treatment. The executive director failed to ensure designated staff completed R5's NSA/HCSP according to service needs identified on his FCS.	S3085		
S3092 SS=E	26-41-202 (d) Negotiated Service Agreement 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 legal representative, facility 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: KAR 26-41-202 (d)(2)	S3092		

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S3092	Continued From page 9 The facility reported a census of 98 residents(R). The sample included six residents and two focused record review. Based on interview, and record review the operator failed to ensure designated staff reviewed and revised the "Negotiated Service Agreement" for two (R4 and R6) of six sampled residents when the resident had a significant change in status related to therapy services. Findings included: - R4's medical record revealed she moved into the facility on 06/14/19 with diagnosis of glaucoma. R4'a "Functional Capacity Screen" (FCS) dated 10/21/24 identified R4 had impaired hearing and problems with wandering. R4's 'Negotiated Service Agreement/Health Care Service Plan" (NSA/HCSP) dated 10/21/24 failed to identify services related to impaired hearing and wandering. R4's record included an addendum on 09/10/24 to discontinue speech therapy with a local Home Health agency. Interview on 12/12/24 at 12:25 AM Licensed Nurse H looked through R4's chart for an addendum related to therapy services through the Home Health agency. Licensed Nurse H reported she is not getting any therapy services anymore so we should have done an addendum when she started and stopped therapy services. Licensed Nurse H continued to look for an	S3092		

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S3092	Continued From page 10 addendum and was unable to find one. The executive director failed to ensure designated staff reviewed/revised R4's NSA/HCSP when she had a significant change in services.	S3092		
S3175 SS=D	26-41-205 (a) (1) Self Administration of Medication (a) Self-administration of medication. Any resident may self-administer and manage medications independently or by using a medication container or syringe prefilled by a licensed nurse or pharmacist or by a family member or friend providing this service gratuitously, if a licensed nurse has performed an assessment and determined that the resident can perform this function safely and accurately without staff assistance. (1) An assessment shall be completed before the resident initially begins self-administration of medication, if the resident experiences a significant change of condition, and annually. This REQUIREMENT is not met as evidenced by: KAR 26-41-205(a)(1) The facility reported a census of 98 residents (R). The sample included six residents and two focused record reviews. Based on observation, interview, and record review the administrator	S3175		

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S3175	Continued From page 11 failed to ensure a licensed nurse completed an assessment for self-administration of eye drops and nasal spray for one (R6) of six sampled residents prior to her self-administering her eye drops and nasal spray. Findings included: - R4's medial record revealed she moved into the facility on 06/14/19 with diagnosis of glaucoma. R4's "Functional Capacity Screen" (FCS) dated 03/21/24 identified she was needed physical assistance with management of medical treatments. R4's FCS dated 07/15/23 identified she needed physical assistance with management of medical treatments. It included she had orders to administer her own eye drops and the facility reordered them when needed. R4's (NSA/HCSP) dated 07/15/23 failed to include that she self-administered her eye drops. Review of R4's Medication Administration Record (MAR) for July, August, September, and October of 2023 included the following eye drops and nasal spray identified as not administered by the facility" and administered by resident or outside provider: Lantanoprost 0.005% 1 drop in right every other day for glaucoma. Dorzolamide HCL 2% drops 1 dop in right eye twice daily for glaucoma. Prednisolone Aetate 1% drops, 1 drop in right eye every day for glaucoma. Flonase 2 sprays each nostril daily for allergies.	S3175		

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S3175	Continued From page 12 Review of R4's record lacked an assessment to identify she was able to safely and accurately self administer her eye drops or her nasal spray. Interview on 12/11/24 at 03:20 PM Administrative Licensed Nurse B reported she could not find an assessment for R4 to self administer any of her medications. Administrative Licensed Nurse B acknowledged an assessment should have been completed before R4 was allowed to self administer any of her medications, including her eye drops and nasal spray. Review of the "Self-Administration of Medications" policy dated 07/01/21 revealed an assessmenet to self-administer medications shall be conducted by a lcensed nurse using the Self-Medication Assessment. The assessment should be completed when the resident moves in and before beginning to self-adminsiter medications. The executive director failed to ensure a Licensed Nurse assessed R4 for ability to safely and accurately self-administer her eye drops and nasal spray.	S3175		
S3298 SS=E	26-41-206 (d) Food Preparation (d) Food preparation. 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.	S3298		

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S3298	Continued From page 13 (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 26-41-206(d) The facility reported a census of 98 residents. Based on observation, interview, and record review the executive director failed to ensure facility staff on the "Memory Care" unit, monitored food temperatures after they were delivred to the unit, to ensure food was served at the proper temperature. Findings included: - Observations during initial tour of the Memory Care Unit on 12/09/24 at 04:33 PM surveyor asked Certified Medication Aide (CMA) C if they checked the temperature of the food that dietary staff brought to the unit before staff served it. CMA C reported they used to check it but one of the cooks had told them a few months ago they no longer needed to check the temperature of the food since it was checked in the main kitchen. During this same conversation CMA D confirmed they had not been taking food	S3298		

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S3298	Continued From page 14 temperatures because they were told they no longer needed to. Interview on 12/09/24 at approximately 04:45 PM dietary staff E looked on the clipboard where food temperatures were kept and stated Memory Care should have their own notebook and check the temperature of the foods before serving to make sure they are at the right temperatures. Interview on 12/10/24 at 10:32 AM Administrative Dietary Staff F acknowledged the memory care staff should have been taking the temperature of the foods prior to serving them to make sure they had maintained the proper serving temperature since the food is transported from the main kitchen to the memory care unit. The executive director failed to ensure dietary staff monitored food cooking and serving temperatures to ensure it was prepared and served at the proper temperature.	S3298		
S3310 SS=E	26-41-207 (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; and (c) Each administrator or operator shall ensure the facility ' s compliance with the department ' s tuberculosis guidelines for adult care homes	S3310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N078015	A. BUILDING: _____ B. WING _____	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEGEND OF HUTCHINSON	2416 BRENTWOOD STREET HUTCHINSON, KS 67502

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S3310	Continued From page 15 adopted by reference in K.A.R. 26-39-105 This REQUIREMENT is not met as evidenced by: K.A.R 26-41-207(c) The facility reported a census of 98 residents (R). The sample included six residents plus two focused resident reviews. Based on interview and record review for one (R5) of six sampled residents the operator failed to ensure the facility remained in compliance with the department's TB guidelines for adult care homes adopted by reference in K.A.R. 26-39-105. Findings included: - Review of R5's resident record revealed she moved into the facility on 08/31/23 and lacked evidence she received a TB symptom screen within seven days of admitting to the facility or annually according to TB guidelines. She also received her first TB skin test on 09/22/23, more than seven days after admission. Interview on 12/11/24 at 01:18 PM Administrative Licensed Nurse B looked through R5's record and confirmed there was not evidence of completing an admission TB symptom screen or an annual TB symptom screen. Review of the "TB Testing of Residents' policy dated 09/08/12 revealed the required TB testing shall include the two-step TB skin test or blood testing. Residents shall receive a symptom	S3310		

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S3310	Continued From page 16 screen review annually. Review of the departments "Tuberculosis (TB) Guidelines for Adult Care Homes" June 2013 revealed each new resident shall have an initial TB symptom screen that included the components of the "Tuberculosis Symptom Screen Questionnaire" within seven days of residency and shall receive a two-step TB skin test within seven days of residency. The executive director failed to ensure the facility remained in compliance with the department's tuberculosis guidelines for adult care homes adopted by reference in K.A.R. 26-39-105 by failing initiate TB symptom screens and two-step skin testing for one of six residents within seven days of admission and failed to complete an annual TB symptom screen thereafter.	S3310		