STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N089042	A. BUILDING: _____ B. WING _____	12/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HOMESTEAD OF AUBURN	280 E VALLEY SPRINGS DR AUBURN, KS 66402

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS The following represent the findings of a resurvey for the above named assisted living facility conducted on 12/23/24, 12/24/24, and 12/26/24.	S 000		
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: KAR 26-41-202(a)(1) (2) The facility reported a census of 29 residents with three residents included in the sample and one focused review. Based on interview, observation, and record review the administrator failed to ensure the Negotiated Service Agreement (NSA) was fully developed based on the resident's Functional Capacity Screen (FCS), service needs, and preferences for resident (R)1, R2, R3	S3085		

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

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S3085	Continued From page 1 and R4 including a description of the services the resident received and the provider of each service. Findings included: - Record review for R1 revealed and admission date of 06/03/24 with diagnoses including chronic venous hypertension, diabetes mellitus type two, and cerebrovascular disease. The 06/03/24 " FCS-NSA - V-11" (the facility's combined Functional Capacity Screen and Negotiated Service Agreement) identified R1 required physical assistance with bathing, dressing, toileting, and transferring and used more than one staff member to complete each task. The FCS-NSA failed to document resident had transfer pole in room. The 12/19/24 "Service Plan" failed to document a transfer pole in place. R1's record lacked documentation of an assessment for the use of a transfer pole. Observation on 12/26/24 at 09:58 AM of R1's room revealed a transfer pole next to R1's bed. On 12/26/24 at approximately 10:02 AM R1 stated she did not use the transfer pole due to no ability to feel legs and stand. She stated two staff assisted her for transfers. On 12/26/24 at approximately 11:47 AM Administrative Nurse C confirmed R1's NSA failed to describe the service of a transfer pole. The administrator failed to ensure R1's NSA described the services she received.	S3085		

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S3085	Continued From page 2 - Record review for R2 revealed an admission date of 06/01/21 with diagnoses including multiple sclerosis, hemiplegia, hemiparesis, cerebral infarction, and polyneuropathy. The 12/18/24 "FCS-NSA - V-11" identified R2 was unable to perform bathing, dressing, toileting, and transfers and staff was responsible for each service. R2 required more than one staff member to complete bathing, dressing, toileting, and transfers. The NSA failed to document service of physical or occupational therapy and provider of service. The 12/19/24 "Service Plan" for R2 failed to document physical or occupational therapy and who provided the service. Review of R2's nurse note by Administrative Nurse C dated 12/18/24 at 12:55 PM documented the resident had refused to get out of bed frequently and a new order for physical and occupational therapy was received. On 12/26/24 at approximately 11:17 AM Administrative Nurse C confirmed R2's NSA failed to describe the services provided for physical and occupational therapy and the provider of the service. The administrator failed to ensure R2's NSA described the services she received, and the provider of the service based on her service needs. - Record review for R3 revealed an admission date of 01/28/20 with diagnoses including vascular dementia, diabetes mellitus type two, polyneuropathy, and Guillain-Barre syndrome.	S3085		

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S3085	Continued From page 3 The 06/29/24 "FCS-NSA - V-11" identified R3 needed physical assistance with bathing and supervision with mobility; was independent with transferring, dressing, toileting, and eating; was at risk for falls and/or unsteadiness; and had impaired decision-making. The FCS-NSA documented R3 had a transfer pole provided by the facility. The FCS-NSA failed to document resident's choice to not sleep in bed and utilize chair instead. The 06/29/24 "Service Plan" (HSP) identified R3 was independent with transfers and mobility, used four wheeled walker for mobility, and needed occasional assistance with toileting from staff. The HSP documented R3 was able to evacuate the facility with only staff cueing and guidance. The HSP for R3 documented a transfer pole was provided by the facility. The HSP failed to describe services provided for prevention of falls after she sustained falls on 04/13/24 and 06/25/24 and resident's choice to sleep in chair instead of bed. Review of R3's nurse note dated 04/13/24 at 09:18 AM revealed the resident attempted to transfer self to chair and found on the floor. The nurse note failed to identify an intervention to prevent future falls. Review of R3's nurse note dated 06/25/24 at 02:27 PM revealed the resident was evacuating the facility on own and hit the curb with wheelchair causing her to fall from wheelchair. The nurse note failed to identify an intervention to prevent future falls or future safe evacuation. Observation on 12/26/24 at 09:38 AM revealed a transfer pole to the left side of R3's bed.	S3085		

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S3085	Continued From page 4 On 12/26/24 at approximately 09:44 AM R3 stated she does not use the transfer pole as she does not sleep in the bed and chose to sleep in the chair. On 12/24/24 at approximately 11:05 AM Administrative Staff A confirmed R3's NSA failed to describe the services provided for prevention of falls after she sustained falls on 04/13/24 and 06/25/24. On 12/26/24 at 11:45 AM Administrative Nurse C confirmed R3 sleeps in chair and the NSA failed to describe the resident's preference. The administrator failed to ensure R3's NSA described the services she received, and the provider of the service based on her FCS, service needs, and preferences. - Record review for R4 revealed an admission date of 12/12/22 with diagnoses including dementia, overactive bladder, anxiety, depression, and pain. The 07/02/24 "FCS-NSA - V-11" identified R4 was independent with bathing, dressing, toileting, transfers, walking/mobility, and eating; required physical assistance with management of medications and treatments; and had decision making difficulties. The FCS-NSA identified that R4 had difficulty with forgetfulness. The FCS-NSA failed to mention R4 prefers to smoke and services related to her smoking. The 07/02/24 "Service Plan" (HSP) identified R4 was provided assistance by staff to find items she had misplaced like her coat.	S3085		

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S3085	Continued From page 5 Record review of "Assisted Living Smoking Assessment" dated 12/12/22 (most recent) identified R4 was unable to identify designated smoking areas, unable to store or maintain smoking materials, and R4 did not smoke currently. The form stated due to answers, staff would be required to provide supervision of R4 to smoke on facility property. Observation on 12/26/24 at 10:25 AM R4 was not wearing a coat and was assisted out the courtyard door by another resident. The outdoor temperature was 41 degrees Farenheit. At 10:33 AM R4 had completed smoking a cigarette and was attempting to enter back into facility. R4 had pushed numbers on keypad three times and attempted to pull on door in between. At 10:36 AM, R4 pushed facility doorbell which no staff responded to. At 10:38 AM R4 successfully remembered entry code and entered facility. On 12/26/24 at 10:28 AM R4 stated she did not remember to take coat outside and finally remembered the code to re-enter the facility. R4 stated she has her own cigarettes and can go outside when she wants to. On 12/26/24 at 11:26 AM Administrative Nurse C stated R4 was forgetful, and staff keeps her cigarettes. She confirmed the NSA failed to state R4's desire to smoke and services provided to R4 to smoke safely. The administrator failed to ensure R3's NSA described the services she received, and the provider of the service based on her FCS, service needs, and preferences.	S3085		

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S3186	Continued From page 6	S3186		
S3186 SS=D	26-41-205 (b) Administration of Selected Medications (b) Administration of select medications. Any resident who self-administers medication may select some medications to be administered by a licensed nurse or medication aide. The negotiated service agreement shall reflect this service and identify who is responsible for the administration and management of selected medications. This REQUIREMENT is not met as evidenced by: KAR 26-41-205(b) The facility reported a census of 29 residents with three included in the sample and one focused record review. Based on observation, interview, and record review the administrator failed to ensure Resident (R) 2's "Negotiated Service Agreement" (NSA) identified who was responsible for the administration and management of select medications. Findings included: - Record review for R2 revealed an admission date of 06/01/21 with diagnoses including multiple sclerosis, hemiplegia, hemiparesis, cerebral infarction, and polyneuropathy. The 12/18/24 "FCS-NSA - V-11" (the facility's combined Functional Capacity Screen and Negotiated Service Agreement) identified R2 was	S3186		

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S3186	Continued From page 7 unable to perform management of medications and staff was responsible for service. The "FCS-NSA" documented that the resident medicated some medications, was capable of recognizing each medication she was currently taking, was capable of identifying reasons for taking medication, R2 stating number of tablets was not applicable, correctly administering eye drops or ointments was not applicable. The "FCS-NSA" stated "all medications administered by med aide." R2's NSA failed to identify who was responsible for the administration of select medications she administered herself and/or the select medications facility staff administered. The 12/19/24 "Service Plan" (HSP) stated all medications were administered by medication aide and "will safely continue to self-administer insulin and tear drops." The HSP documented "Facility RN/LPN/CMA will administer medications and treatments according to physicians orders." The 11/11/24 "Self Medication Administration" documented "not applicable" to correctly administered eye drops or ointments and correctly identified reason taking each medication. The form failed to identify what medications R2 administered to herself and what medications the facility administered. Observation on 12/26/24 at approximately 09:46 AM revealed three medications on R2's bedside table including one bag 25 drops of Halls Cool Berry cough drops, one 75 milliliter bottle Afrin nasal spray, and one 50-gram container of Vicks VapoRub. On 12/26/24 at approximately 09:49 AM R2 stated she self-administered some of her medications including those on her bedside table.	S3186		

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S3186	Continued From page 8 A policy regarding self-administration of medications was requested which the facility failed to provide. The administrator failed to ensure R2's NSA identified who was responsible for the administration and management of select medications.	S3186		
S3227 SS=E	26-41-205 (l) (2) Medication Regimen Review Variance Report (l) (2) The licensed pharmacist or licensed nurse shall notify the medical care provider upon discovery of any variance identified in the medication regimen review that requires immediate action by the medical care provider. The licensed pharmacist shall notify a licensed nurse within 48 hours of any variance identified in the resident ' s regimen review that does not require immediate action by the medical care provider and specify a time within which the licensed nurse must notify the resident ' s medical care provider. The licensed nurse shall seek a response from the medical care provider within five working days of the medical care provider ' s notification of a variance. This REQUIREMENT is not met as evidenced by: KAR 26-41-205(l)(2) The facility reported a census of 29 residents with three residents included in the sample and one focused review. Based on interview and record review the administrator failed to ensure a	S3227		

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S3227	Continued From page 9 licensed nurse notified Resident (R) 2, R3, and R4's medical care provider of variances identified in the medication regimen reviews by the licensed pharmacist and sought a response within five working days. Findings included: - Record review for R2 revealed an admission date of 06/01/21 with diagnoses including multiple sclerosis, hemiplegia, hemiparesis, cerebral infarction, and polyneuropathy. The 01/15/24 "Note to Attending Physician/Prescriber" for R2 documented " ...Singulair 10mg daily ...re-assess the need to continue this medication ...consider a trial change to PRN ..." The form was signed by primary care provider on 04/03/24 and noted by Administrative Nurse C on 04/08/24. On 12/26/24 at approximately 11:15 AM Administrative Nurse C confirmed the 01/15/24 pharmacy review was addressed by provider on 04/03/24, over 2 months late. - Record review for R3 revealed an admission date of 01/28/20 with diagnoses including vascular dementia, diabetes mellitus type two, polyneuropathy, and Guillain-Barre syndrome. The 10/19/23 "Note to Attending Physician/Prescriber" for R3 documented to consider a follow-up basic metabolic profile to determine the continued use of lisinopril. The form was signed by primary care provider on 04/03/24 and noted by Administrative Nurse C on 04/08/24. The 01/15/24 "Note to Attending	S3227		

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S3227	Continued From page 10	S3227		

Physician/Prescriber" for R3 documented to consider ordering vitamin B12 and vitamin D levels with next lab draw. The form was signed by primary care provider on 04/03/24 and noted by Administrative Nurse C on 04/08/24.

On 12/26/24 at approximately 11:15 AM Administrative Nurse C confirmed the 10/19/23 pharmacy review was addressed by provider on 04/03/24 and the 01/15/24 pharmacy review was addressed by the provider on 04/03/24.

- Record review for R4 revealed an admission date of 12/12/22 with diagnoses including dementia, overactive bladder, anxiety, depression, and pain.

The 01/15/24 "Note to Attending Physician/Prescriber" for R4 documented to consider a thyroid stimulating hormone level with next lab draw. The form was signed by primary care provider on 04/03/24 and noted by Administrative Nurse C on 04/08/24.

On 12/26/24 at approximately 12:43 PM Administrative Nurse C confirmed the 01/15/24 pharmacy reviews for all residents were lost and were addressed by provider on 04/03/24.

On 12/26/24 at 12:00 PM a policy regarding medication record reviews was requested which the facility failed to provide.

The administrator failed to ensure a licensed nurse notified R2, R3, and R4's medical care provider of variances identified in the medication regimen reviews by the licensed pharmacist and sought a response within five working days.

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S3298	Continued From page 11	S3298		
S3298 SS=F	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. (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)(2) The facility reported a census of 29 residents. The facility had a main kitchen where food was stored, prepared and served to all residents. Based on interview and observation, the administrator failed to ensure food in cans with significant defects including swelling, leakage, punctures, holes, fractures, pitted rust, or denting severe enough to prevent normal stacking or opening not be used. Findings included: - Observation on 12/23/24 at 03:40 PM of the	S3298		

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S3298	Continued From page 12 kitchen revealed large wooden cabinets along North wall with canned foods which contained two gallon cans of chili beans dented on top and bottom rims, one can of pinto beans dented on top and bottom rims, and one can of pinto beans bulged on top and bottom. On 12/23/24 at approximately 03:42 PM Dietary Staff D confirmed the food cans were dented and/or bulging. On 12/26/24 at 12:00 PM a policy on food storage was requested which the facility failed to provide. The administrator failed to ensure food in cans with significant defects including swelling, leakage, punctures, holes, fractures, pitted rust, or denting severe enough to prevent normal stacking or opening was not used.	S3298		