STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N056012	A. BUILDING: _____ B. WING _____	06/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD OF EMPORIA	1200 W 12TH AVENUE EMPORIA, KS 66801

(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 for the above named Assisted Living conducted on 06/09/25.	S 000		
S3092 SS=D	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) The facility reported a census of 26 residents(R). The sample included three residents. Based on interview, and record review the executive director failed to ensure designated staff reviewed and revised the "Negotiated Service Agreement" for one (R5) of three sampled residents when the resident had a significant change in service needs related to skilled therapy.	S3092		

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
	N056012	A. BUILDING: _____ B. WING _____	06/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD OF EMPORIA	1200 W 12TH AVENUE EMPORIA, KS 66801

(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
S3092	Continued From page 1 Findings included: - Review of R5's medical record revealed she moved into the Assisted Living on 03/08/24 with diagnoses of low back pain and muscle weakness. Interview on 06/09/25 at 10:39 AM Administrative Nurse B reported the "Functional Capacity Screen" and the "Negotiated Service Agreement"(FCS/NSA) were combined as one document. R5's record included the following FCS/NSAs: 03/08/24 - Identified she used services with a local Home Health Company and was independent with activities of daily living except for bathing. 04/12/24 - identified the same functional needs and the same local Home Health company. 11/13/24 - identified the same functional needs but identified she now received Hospice services. 05/12/25 identified she was independent with activities of daily living except for bathing but was at risk for falls/unsteadiness. It indicated she received services from the same local Hospice company. R5's medical record also included documentation in Nurse's Progress Notes: 05/09/24 -new orders for physical and occupational therapy through local Home Health. 08/27/24 - R5 refusing to participate in physical or occupational therapy and will be discharged. 08/30/24 - Resident admitted to Hospice services.	S3092		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N056012	A. BUILDING: _____ B. WING _____	06/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD OF EMPORIA	1200 W 12TH AVENUE EMPORIA, KS 66801

(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
S3092	Continued From page 2 R5's record lacked review and revision to her FCS/NSA to identify that she had discontinued services with Home Health and started on Hospice services. Interview on 06/09/25 at 03:59 PM Administrative Nurse looked in R5's record and confirmed she had not completed a review/revision of R5's FCS/NSA when she stopped Home Health Services and started Hospice. The executive director failed to ensure designated staff reviewed and revised R5's FCS/NSA as needed when she discontinued Home Health services and started Hospice services.	S3092		
S3310 SS=D	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 adopted by reference in K.A.R. 26-39-105	S3310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N056012	A. BUILDING: _____ B. WING _____	06/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD OF EMPORIA	1200 W 12TH AVENUE EMPORIA, KS 66801

(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
S3310	Continued From page 3 This REQUIREMENT is not met as evidenced by: K.A.R 26-41-207(c) The facility reported a census of 26 residents (R). The sample for infection control included three residents and five newly hired staff. Based on interview and record review for one (R$) of three sampled residents, the executive director 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 R4's medical record revealed she moved into the assisted living on 02/14/24 with diagnosis of type II diabetes mellitus. R4's record include a TB symptom screen completed on 02/14/24 and that she had been administered a TB skin test on 02/14/24 and 02/28/24 and both were negative with 0 induration. However, the record did not include the date staff read the TB skin tests. Interview on 06/09/25 at 01:00 PM Administrative Nurse B thought the date it was read would be on the February Medication Administration Record (MAR) and when she looked it was not initialed as being read. Administrative Nurse B confirmed the documentation should have included a date it was read. Review of the "Tuberculosis (TB) Guidelines for Adult Care Homes" June, 2013 included the required documentation in resident's clinical	S3310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N056012	A. BUILDING: _____ B. WING _____	06/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD OF EMPORIA	1200 W 12TH AVENUE EMPORIA, KS 66801

(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
S3310	Continued From page 4 record for the two-step TB needed to included name and address of entity where testing took place, date each test was administered, and date each test was read... The executive director failed to ensure the facility remained in compliance with the departments TB guidelines.	S3310		