STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B056003	A. BUILDING: _____ B. WING _____	06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNFLOWER CARE HOMES LLC- LEGACY	1600 W 15TH AVENUE EMPORIA, KS 66801

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S 000	INITIAL COMMENTS The following citations represent the findings of a Re-Licensure Survey at the above named Home Plus Facility conducted on 06/11/25 and 06/12/25.	S 000		
S5095 SS=D	26-42-201 (d) Functional Capacity Screen Accurate (d) Designated 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: KAR 26-42-201(d) The facility reported a census of 11 residents(R). The sample include three residents. Based on interview and record review the operator failed to ensure designated staff completed one (R3) of three sampled resident's "Functional Capacity Screen" accurately to reflect the resident's functional ability related to management of medications. Findings Included: - R3's medical record revealed she moved into the facility on 08/24/24 with a diagnoses of diabetes type II and Alzheimer's disease. R3's "Functional Capacity Screen" (FCS) dated 08/19/24 identified she was unable to participate	S5095		

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

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S5095	Continued From page 1 in management of her medications and medical treatments. Observation on 06/11/25 at 11:55 AM Certified Medication Aide (CMA) C took R3's Humalog Insulin Kwickpen out of the medication cart, wiped the end with an alcohol pad, put the needle on, and then dialed it to 12 units according to the Medication Administration Record for the ordered dosage. CMA C went to R3's room who said she wanted it in her left arm today and exposed her upper arm. CMA C wiped and area on R3's upper arm with an alcohol pad, removed the needle cover and handed it to R3. R3 took the pen and poked herself in the arm, pushed the plunger without any difficulty, and then handed the pen back to CMA C. Interview on 06/11/25 at 11:30 AM Administrative Licensed Nurse B reported two residents had insulin orders and can self-inject their own insulin. The Certified Medication Aide prepares the pen, dials it to the correct dose, and then hands it to the resident to self-inject. Interview on 06/12/25 at 10:00 AM Administrative Nurse/Operator A confirmed staff should have coded the FCS as a "2", physical assistance needed with management of medications, instead of a "3" unable to participate. The operator failed to ensure designated staff completed R3's FCS accurately to identify her ability to self-inject her insulin and participate in taking her medications after they are prepared by the CMA.	S5095		

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S5105	Continued From page 2	S5105		
S5105 SS=E	26-42-202 (a) Negotiated Service Agreement a) The administrator or operator of each home plus 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 26-42-202(a)(1) The facility reported a census of eleven residents (R). The sample included three residents. Based on interview, and record review for to two (R3 and R5) of three sampled residents, the operator failed to ensure designated staff developed a "Negotiated Service Agreement" based on the resident's "Functional Capacity Screen" and service needs that included a description of services to be provided. Findings included: - R3's medical record revealed she moved into	S5105		

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S5105	Continued From page 3 the facility on 08/24/24 with a diagnoses of Alzheimer's and diabetes type II. R3's "Functional Capacity Screen" (FCS) dated 08/19/24 identified she needed physical assistance with bathing, had impaired cognition and a current problem with wandering. Interview on 06/11/25 at 11:30 AM Administrative Licensed Nurse B reported the 'Negotiated Service Agreement", and "Health Care Service Plan" were combined into one document (NSA/HCSP). R3's NSA/HCSP dated 08/22/24 identified staff would provide supervision and assist with bathing and monitor non-verbal cues for communication. The NSA/HCSP failed to include a description of services related to impaired cognition. Interview on 06/12/25 at 10:02 AM Administrative Nurse/Operator A reviewed R3's NSA/HCSP and confirmed it did not address her cognitive impairment and services staff needed to provide. The operator failed to ensure R3's NSA/HCSP included a description of services related to her cognitive impairment identified on her FCS. - Review of R5's record revealed she moved into the facility on 08/12/24 with diagnosis of dementia. R5's "Functional Capacity Screen" dated 11/02/24 identified she needed physical assistance with all activities of daily living, had impaired cognition and impaired decision making	S5105		

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S5105	Continued From page 4 ability. Interview on 06/11/25 at 11:30 AM Administrative Licensed Nurse B reported the 'Negotiated Service Agreement", and "Health Care Service Plan" were combined into one document (NSA/HCSP). Review of R5's NSA/HCSP dated 11/02/24 identified facility staff would provide assistance with activities of daily living but failed to include a description of services related to impaired cognition. Interview on 06/12/25 at 11:22 AM Administrative Nurse/ Operator A reviewed R5's NSA/HCSP and confirmed it did not include a description of services related to impaired cognition. The operator failed to ensure R5's NSA/HCSP identified services to be provided related to impaired cognition.	S5105		
S5251 SS=D	26-42-105 (f) (11) Resident Records Documentation of Incidents (f) (11) documentation of all incidents, symptoms, 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 26-42-105(f)(11)	S5251		

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S5251	Continued From page 5	S5251		

The facility reported a census of 11 residents(R). The sample included three record reviews. Based on interview, and record review the operator failed to ensure the medical record contained documentation of all incidents, symptoms, and other indications of illness or injury including the date and time, action taken, and results of the action for one (R3) of three sampled residents.

Findings included:

- R3's medical record revealed she moved into the facility on 08/24/24 with a diagnoses of Alzheimer's and diabetes type II.

R3's "Functional Capacity Screen" (FCS) dated 08/19/24 identified she needed physical assistance with bathing, had impaired cognition, and could not participate in management of her medications and medical treatments.

Interview on 06/11/25 at 11:30 AM Administrative Licensed Nurse B reported the 'Negotiated Service Agreement", and "Health Care Service Plan" were combined into one document (NSA/HCSP).

R3's NSA/HCSP dated 08/22/24 identified the licensed or certified staff to assist with medications and R3's son would administer insulin when a Licensed Nurse was unavailable.

Review of R3's nursing progress notes revealed the following documentation:
10/14/2024 - 08:00 PM Insulin held due to blood sugar of 69. Staff provided snacks at this time and blood sugar 118. Staff informed the next shift

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S5251	Continued From page 6	S5251		

nurse will continue to monitor it.
The record lacked follow-up and documentation of physician notification the insulin was held.
01/21/25 - insulin held at noon due to blood sugar of 92.
The record lacked follow-up as to physician notification or status after eating noon meal.
03/12/2025 - daughter requested an order for allergy medicine as resident used to take one daily for runny nose. Order obtained and faxed to pharmacy.
The record lacked follow up if the medication was effective in relieving R3's runny nose.
05/12/2025 - Certified Medication Aide (CMA) reported R3's blood sugar was 90 and this nurse (Administrative Licensed Nurse B) instructed CMA to hold insulin.
Record lacked documentation of physician notification of insulin being held.
06/05/2025 - Metformin (antidiabetic agent) decreased due to resident having increase episodes of diarrhea.
The record lacked documentation if the changes in Metformin helped decrease diarrhea.

Interview on 06/12/25 at 10:06 AM Administrative Nurse/Operator A reported she would expect staff to document follow-up on any new orders and would have expected to see documentation that the nurse had contacted the physician whenever the insulin was held.

The operator failed to ensure designated staff documented symptoms and physician notification when she determined the need to hold R3's insulin and follow-up when new medications were initiated.

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S5286	Continued From page 7	S5286		
S5286 SS=D	26-42-205 (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 26-42-205 (b) The facility reported a census of 11 residents. The sample included three residents. Based on observation, interview, and record review the operator failed to ensure one (R3) of three sampled residents "Negotiated Service Agreement" identified qualified staff would prepare and dial R3's insulin pen to the ordered dosages and she would self-inject the insulin. Findings included: - R3's medical record revealed she moved into the facility on 08/24/24 with a diagnoses of Alzheimer's and diabetes type II. R3's "Functional Capacity Screen" (FCS) dated 08/19/24 identified she had impaired cognition and could not participate in management of her medications and medical treatments.	S5286		

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S5286	Continued From page 8 Interview on 06/11/25 at 11:30 AM Administrative Licensed Nurse B reported the 'Negotiated Service Agreement", and "Health Care Service Plan" were combined into one document (NSA/HCSP). R3's NSA/HCSP dated 08/22/24 identified R3's son would administer insulin when a Licensed Nurse was unavailable and qualified staff would administer insulin according to physician's orders. It also identified Licensed staff determined resident was unable to self-administer medications. R3's NSA/HCSP did not identify that qualified staff prepared and dialed her insulin pen according to orders and she self-injected the insulin. Review of R3's September 2024 Medication Administration Record identified Humalog Insulin and Tresiba insulin that was initialed by Certified Medication Aides (CMA) and not a licensed Nurse, indicating the CMA prepared and dialed the insulin pen for R3 to self-inject. Observation on 06/11/25 at 11:55 AM Certified Medication Aide (CMA) C took R3's Humalog Insulin Kwickpen out of the medication cart, wiped the end with an alcohol pad, put the needle on, and then dialed it to 12 units according to the Medication Administration Record for the ordered dosage. CMA C went to R3's room who said she wanted it in her left arm today and exposed her upper arm. CMA C wiped and area on R3's upper arm with an alcohol pad, removed the needle cover and handed it to R3. R3 took the pen and poked herself in the arm, pushed the plunger without any difficulty, and then handed the pen back to CMA C.	S5286		

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S5286	Continued From page 9 Interview on 06/12/25 at 10:02 AM Licensed Nurse/Operator A reviewed R3's NSA/HCSP and confirmed it did not identify that qualified staff prepared R3's insulin for her to self-inject. The operator failed to ensure designated staff completed R3's NSA/HCSP to include that she self-injected her insulin and qualified staff administered all other medications.	S5286		
S5300 SS=D	26-42-205 (d) (1-2) Facility Administration of Medications (d) Home administration of resident ' s medications. If a home 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 home has responsibility. (2) Medication aides shall not administer medication through the parenteral route. This REQUIREMENT is not met as evidenced by: KAR 26-42-205 (d) The facility reported a census of 11 residents(R).	S5300		

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S5300	Continued From page 10 The sample included three residents. Based on record review and interview the operator failed to ensure staff administered medications according to standards of practice and a Medical Providers written order for one (R3) of three sampled residents for whom the facility was responsible for administering medications. Findings included: - R3's medical record revealed she moved into the facility on 08/24/24 with a diagnoses of Alzheimer's and diabetes type II. R3's "Functional Capacity Screen" (FCS) dated 08/19/24 identified she had impaired cognition and could not participate in management of her medications and medical treatments. Interview on 06/11/25 at 11:30 AM Administrative Licensed Nurse B reported the 'Negotiated Service Agreement", and "Health Care Service Plan" were combined into one document (NSA/HCSP). R3's NSA/HCSP dated 08/22/24 identified R3's son would administer insulin when a Licensed Nurse was unavailable and qualified staff would administer insulin according to physician's orders. Review of R3's September 2024 Medication Administration Record (MAR) identified staff failed to administer R3's Humalog Insulin seven out of 30 times before breakfast, 18 times out of 30 before lunch, and 12 times out of 30 before supper. It also indicated staff failed to administer R3's Tresiba Insulin 14 out of 30 times in the	S5300		

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S5300	Continued From page 11 evening. The MAR "note" indicated not to administer per nurse on duty. Review of R3's April 2025 Medication Administration Record (MAR) revealed facility staff did not administer R3's Humalog Insulin two out of 30 times before breakfast, nine out of 30 times before lunch and eight times before supper. Staff also failed to administer her Tresiba Insulin 14 out of 30 times in the evening. The "notes" on the MAR indicated the insulin was held "per Nurse"' for low blood sugar. Review of R3's May 2025 Medication Administration Record (MAR) revealed facility staff failed to administer R3's Humalog seven out of 31 times before lunch and 10 out of 31 times before supper. Staff also failed to administer R3's Tresiba Insulin eight out of 16 times in the evening. The "notes" on the MAR indicated the insulin was held "per nurse" for low blood sugar. Review of R3's record lacked a medical providers order on when to hold R3's insulin and failed to include documentation that the medical provider was notified each time the licensed nurse directed certified staff to hold R3's insulin. Interview on 06/12/25 at 10:05 AM Administrative Nurse/Operator A confirmed they did not have a medical providers order for insulin to be held based on R3's blood sugars. The operator failed to ensure staff notified R3's medical provider when the licensed nurse determined a need to hold R3's insulin based upon her blood sugar and obtain an order to hold it.	S5300		

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