STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175078	A. Building B. Wing	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy at College Hill	5005 E 21st Street North Wichita, KS 67208

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27168 The facility had a census of 66 residents. The sample included 17 residents with one resident reviewed for discharge. Based on observation, record review, and interview, the facility failed to provide Resident (R) 18 with written information regarding the facility bed hold policy when she was transferred to the hospital. This deficient practice placed R18 at risk for not being permitted to return and resume residence in the nursing facility. Findings included: - R18's Electronic Medical Record (EMR) recorded diagnoses of Influenza A (an acute highly contagious viral infection of the nose, throat and lungs that causes the flu), acute respiratory failure (the respiratory system can not maintain normal levels of oxygen and carbon dioxide in the body, the condition is characterized by a relatively sudden onset of symptoms that are usually severe), hypoxia (inadequate supply of oxygen), cerebrovascular accident (CVA - stroke - sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain), dementia (a progressive mental disorder characterized by failing memory and confusion), and diabetes mellitus (DM - when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin). R18's Quarterly Minimum Data Set (MDS), dated [DATE], recorded R18 had moderately impaired cognition. The MDS recorded R18 required moderate to total staff assistance with most activities of daily living (ADL). The Activities of Daily Living Care Area Assessment (CAA), dated [DATE], recorded R18 is dependent on staff for toilet hygiene, all aspects of dressing, all aspects of transfers with total lift, and required substantial to maximal assistance with personal hygiene and shower/bathe self. R 18 is alert and oriented with intermittent confusion noted. R18's Care Plan dated [DATE] recorded R18 had a risk for alteration in oxygen levels due to diagnosis of obstructive sleep apnea (a disorder of sleep characterized by periods without respirations). The staff would check oxygen saturation every shift as ordered and saturation would be greater than 90, if lower than 90 staff were directed to contact the physician The staff would observed for cyanosis (a medical condition characterized by a bluish or purplish discoloration of the skin, lips, and nail beds) and report to the physician as needed. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R18's Care Plan, dated [DATE] documented the resident had an acute infection and was at risk for increased temperature, dehydration, pain, and discomfort. Staff would administer antibiotics as the physician ordered and monitor for effectiveness, monitor temperature, and for dehydration. The Nurse's Note dated [DATE], at 08:50 AM, documented the nurse went to R18's room that morning to obtain vitals. R18 was not responding to the nurse when spoken to, but R18 would open her eyes for a brief second. R18 laid in bed when the nurse came to do vitals and obtain a blood sugar reading. The nurse was told in report R18's temperature was 102.0 degrees Fahrenheit (F) at 06:20 AM and she was administered Tylenol. At 08:00 AM R18's vital signs documented: oxygen saturation was 52 percent (normal ,d+[DATE]%) on room air and 80 percent with oxygen at four liters, temperature was 101.3 degrees F (normal ,d+[DATE] degrees), blood pressure ,d+[DATE] (normal ,d+[DATE]), and blood glucose was 202 (,d+[DATE]), no insulin given at this time. The nurse practitioner was notified, and an order was obtained to send the resident to the hospital, the director of Nursing was notified, and the durable power of attorney was notified. The notes documented the Medication Administration Record (MAR) and bed hold papers were sent with the resident. Continued chart review revealed emergency medical services came to the facility at 08:40 AM and left with the resident to transport to the hospital at 09:00 AM. The Nurses Note dated [DATE] at 04:11 PM, documented the resident was hospitalized . R18's clinical record revealed a copy of the bed hold policy dated [DATE] that lacked a resident or resident representative signature, instead it had a signature of Administrative Nurse E. Administrative Nurse E verified that the resident's representative had not sign the paper and that the facility was unable to provide written evidence upon request. Administrative Nurse E stated they had spoken with the representative to acknowledge her understanding of the facility bed hold policy. On [DATE] at 02:50 PM, Administrative Nurse E verified the facility lacked evidence of a signed bed hold policy notice that had been verbally acknowledged, provided, or signed by the resident's representative when R18 was transferred and admitted to the hospital on [DATE]. The facility's Bed Hold policy dated [DATE], documented residents and/or representatives were informed (in writing) of the facility and state (if applicable) bed-hold policies. 1. All residents/representatives are provided written information regarding the facility and state bed hold policies, which address holding or reserving a resident's bed during periods of absence (hospitalization or therapeutic leave). Residents, regardless of payor source, are provided written notices about these policies at least twice: Notice 1: well in advance of any transfer (such as in the admission packet); and Notice 2: at the time of transfer (or, if the transfer was an emergency, within 24 hours). 2. Reissuance of notice 1 must occur if the bed-hold policy under the state plan of facility policy changes after the notice is issued. 3. Multiple attempts to provide the resident representative with notice 2 staff should be documented in cases where staff were unable to reach and notify the representative timely. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4. The written bed-hold notices provide to the residents/representatives explain in detail. a. The duration of the state bed-hold policy, if any, during which the resident is permitted to return and residence in the facility. b. The reserved bed payment policy as indicated by the state plan (for Medicaid residents); c. The facility policy regarding bed-hold periods. d. The facility per-diem rate required to hold a bed (for non-Medicaid residents). Or to hold a bed beyond the state bed-hold period (for Medicaid resident); and e. The facility return policies. 5. The requirement that the resident be permitted to return to the facility following hospitalization or therapeutic leave applies to all residents regardless of payor source. 6. Residents who seek to return to the facility after a state bed hold period has expired (or when state law does not provide for bed holds) are allowed to return to their previous room if available or immediately to the first available bed in a semi-private room provided that the resident. a. Still required the services provided by the facility; and b. Is eligible for Medicare skilled nursing facility or Medicaid nursing facility services. 7. If the facility determines that a resident cannot return, the facility must comply with the requirements for facility-initiated discharges. The facility failed to provide R18's representative with a copy of the facility bed hold policy when she was transferred to the hospital. This placed the resident at risk for not being permitted to return and resume residence in the nursing facility.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41713 The facility identified a census of 66 residents. The sample included 17 residents, with one Resident (R) 24 reviewed for trauma-informed care (treatment or care directed to prevent re-experiencing or reducing the effects of traumatic events). Based on observation, record review, and interviews, the facility failed to implement a person-centered care plan with individualized interventions to address R24's post-traumatic stress disorder (PTSD - a mental disorder characterized by an acute emotional response to a traumatic event or situation involving severe environmental stress), trauma, triggers, and interventions to prevent re-traumatization. These deficient practices placed R24 at risk for decreased psychosocial well-being and ineffective treatment. Findings included: - R24's Electronic Medical Record (EMR) documented diagnoses of PTSD, major depressive disorder (a major mood disorder that causes persistent feelings of sadness), and traumatic brain injury (TBI - an injury to the brain caused by external forces). R24's Annual Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of six, which indicated severely impaired cognition. R24 displayed the behavior of rejecting care that occurred for one to three days during the look-back period. R24 used a cane to assist with mobility. R24 was independent with his functional abilities and activities of daily living (ADL). R24 had an active diagnosis of PTSD. R24's Cognitive Loss Care Area Assessment (CAA) dated 05/08/24 documented R24 had a cognitive deficit from a history of TBI. He was alert and oriented with confusion noted. R24 had a BIMS score of six out of 15. R24 was able to make his wants and needs known at times. R24 had rejected the offer of showering and changing clothes. R24's Care Plan last revised on 10/23/24, directed staff to administer medications as ordered and to monitor and document side effects. Staff were directed to observe and chart behaviors as necessary and report to the physician. R24's care plan lacked a care area to address his diagnosis of PTSD to direct staff on his triggers or interventions to prevent further re-traumatization. R24's Diagnosis tab of the EMR documented a diagnosis of PTSD with a date of 09/09/22. R24's SS Trauma Admission Assessment v2 dated 02/14/24 asked: Is there a diagnosis of PTSD or trauma-associated event, with the response of no selected. On 02/13/25 at 09:20 AM, R24 walked, using his cane, down the hallway to go outside to smoke. R24 rejected any conversation with this surveyor. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/13/25 at 03:05 PM, Administrative Nurse F stated she expected a resident that had a diagnosis of PTSD would have staff direction on what triggered and the cause of the trauma, as well as interventions in place to alleviate the triggers or re-traumatization. Administrative Nurse F was unaware that R24 failed to have a PTSD care area on his care plan. Administrative Nurse F stated that the management nurses and staff nurses were able to update the care plan as needed. On 02/13/25 at 03:15 PM, Administrative Nurse D stated she was not aware that R24 failed to have a PTSD area on his care plan to address the cause, the triggers, and interventions to prevent further trauma. Administrative Nurse D stated that R24's PTSD should have been addressed at admission or when diagnosed . Administrative Nurse D stated all residents should get the trauma-informed care assessment at admission or with a new diagnosis of PTSD. The Care Plans, Comprehensive Person-Centered policy revised in March 2022 documented that the care plan intervention was derived from a thorough analysis of the information gathered as part of the comprehensive assessment. The comprehensive, person-centered care plan should include measurable objectives and timeframes; and should describe the services that were to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. Assessments of residents were ongoing and care plans were revised as information about the residents and the resident's conditions changed. The facility failed to have a person-centered care plan with individualized interventions to address R24's PTSD triggers and interventions to prevent re-traumatization. These deficient practices placed R24 at risk for decreased psychosocial well-being and ineffective treatment.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27168 The facility had a census of 66 residents. The sample included 17 residents. Based on observation, record review, and interview the facility failed to promote an environment free of hazards for Resident (R)21 who smoked cigarettes but was assessed for supervised safe smoking practices by the facility, however the resident revoked the assessment, and smoked without supervision. This placed the resident at risk for avoidable injuries and fire related hazards Findings included: - R21's diagnoses include cerebral infarction (stroke - sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain), major depressive disorder (major mood disorder that causes persistent feelings of sadness), acute respiratory failure with hypoxia (a condition where there is not enough oxygen in the blood), and pneumonia (a lung infection that causes inflammation and fluid or pus to fill the air sacs of the lungs). R21's Quarterly Minimum Data Set (MDS), dated [DATE], documented the resident had a Brief Interview for Mental Status (BIMS) score of 14 indicating intact cognition. The MDS documented R21 was dependent on staff with activities of daily living (ADL), used a wheelchair for mobility and required staff supervision in the facility. R21's Activities of Daily Living Care Area Assessment (CAA), dated 07/16/24, documented the resident required set up or clean up assistance with oral hygiene, and was dependent on staff for all aspects of toileting, dressing, sit to lying, lying to sitting on side of bed, and all aspects of transfers. The CAA documented the resident was alert and oriented with intermittent confusion noted. R21's Care Plan, dated 02/11/25, directed staff to assist the resident with a two-person mechanical lift to transfer to chair. The care plan recorded R21 was independent with electric wheelchair and does not ambulate. R21 ' s Care Plan for smoking recorded R21 had been sneaking out with independent smokers and was continually educated that she was a supervised smoker. The 08/06/24 updated care plan documented the reside was required to wear a smoking apron when smoking. On 05/26/23 the facility provided the resident with a smoking R21's Smoking policy, dated 05/26/23, the facility provided the resident a smoking policy that documented and allowed time to have questions answered. The care plan documented smoking assessments were to be completed and the residents plan of care would be based on findings of the assessment to ensure that it maintains safety precautions and they are addressed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R21's Smoking Safety Screen, dated 11/25/24, documented the resident did not have any cognitive loss, but had a visual defect and dexterity problems. The assessment documented the resident smoked 5-10 cigarettes a day, during the morning, afternoon, evening, and night. The assessment documented the resident had potential injury from falling asleep while smoking, lacked safety awareness, and had a history of smoking inside the facility. The assessment documented the resident required supervision for safety reasons and was safe to smoke with supervision. R21's Nurses Note dated 01/24/25 at 08:03 AM, documented an aide requested the nurse look at the resident's left waist are. The observation revealed a burn from a cigarette. The nurse notified the Advance Practitioner Registered Nurse across the hall from the resident's room and the APRN ordered the nurse to lace a TAO on the wound and not covered with a bandage. Observation revealed the skin was red around the area with a scab in the middle. The Weekly Skin assessment dated [DATE] documented the resident had a cigarette burn on her left iliac crest (a prominent curved ridge of one that forms the upper border of the ilium, one of the three bones that make up the pelvis), no size documented. Documented the edges are red with a scab in the middle. R21's nurses note dated 01/27/25 at 09:39 PM, (late entry) documented the root cause analysis revealed the resident had a small red area to her left abdomen/iliac crest area that appears to be a burn, The resident is a smoker and had impaired dexterity which caused her to drop the cigarette and ashes at times. R21 is a supervised smoker and would care plan interventions for a smoke apron to be worn while smoking for protection. The resident was educated on wearing a smoke apron and verbalized understanding of the interventions. The nurse applied ointment daily to the area and left the wound open to air, no blisters preset. On 02/11/25 at 03:30 PM, observation revealed the resident in an electric scooter at the end of the 400-hall exiting to the 500 hall to go outside and smoke on the patio with other smokers. The resident was noted to have a protective smoke apron on her lap. On 02/13/25 at 02:20 PM, Administrative Nurse D verified R21 required supervision with smoking. R21 had not require supervision a year and a half ago but stated she still thinks she can smoke independent. Administrative Nurse D verified the residents family or other residents would provide her with the cigarettes to smoke unsupervised. The Smoking Assessment policy, dated September 9, 2023, documented the facility would establish and maintain safe resident tobacco/smoking electronic cigarettes, vape use practices. All residents admitted to the facility property and/or buildings are required to comply with the policy. All employees share the responsibility for enforcing the policy. The policy documented prior to, or upon admission residents shall be informed about any limitations on tobacco use, including designated tobacco/smoking areas. Tobacco/smoking areas would be designated by the Facility and identified by signage. Resident who wish to use tobacco/smoke would be evaluated for safe smoking upon admission and quarterly. Any tobacco use/smoking related privileges, restrictions, and concerns shall be noted on the care plan and determined that the resident cannot do so safely when the available levels of support and supervision. Any resident with restricted tobacco use/smoking/electronic cigarette/vape privileges requiring monitoring shall have direct supervision by a staff member, family member, visitor, or volunteer always while using tobacco/smoking. Tobacco/smoking, including electronic cigarettes/vape material for all residents would be secured by the facility when not in use. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility failed to promote a safe environment for R21 and all the residents residing in the facility. The failure placed the residents at risk for smoke or fire.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27168 The facility had a census of 66 residents. The sample included 17 residents, with one reviewed for dialysis. Based on observation, record review, and interview, the facility failed to provide ongoing care plan communication and documentation of Resident (R) 70, who received dialysis (the process of removing waste products and excess fluid from the body when the kidneys are not able to adequately filter the blood) treatment, including updated care, and services required for R70. This deficient practice placed R70 at risk for inadequate care, complications, and health decline. Findings included: - R70's Electronic Health Record (EHR) documented R70 had a diagnosis of end-stage renal disease (decline in kidney function). R70's Admission Minimum Data Set (MDS), dated [DATE], recorded R70 had a Brief Interview for Mental Status (BIMS) score of 15 which indicated intact cognition. The MDS recorded he required limited assistance of one staff for bed mobility, transfers, and toilet use. The MDS further recorded R70 as continent of urine and recorded the resident received dialysis treatment. R70's Care Plan, dated 12/26/24, documented R70 required supervision or touch assistance with toilet hygiene and required partial to moderate assistance with toilet transfers. The MDS documented R7 was continent during the look-back period. The care plan lacked documentation that R70 received dialysis, what dialysis center he had sessions at, what day and time he went to dialysis, the care of the dialysis site, and special cares for the resident receiving dialysis. The Nurses Notes, dated 11/19/24 documented R70 was admitted to the facility on [DATE] with a diagnosis of renal failure, and end-stage renal disease with urinary retention. The Physician Order, dated 11/18/24 directed staff R70 required dialysis three times a week. The EHR documented R70 was admitted to the hospital on 12/21/24 for osteomyelitis (local or generalized infection of the bone and bone marrow) of his left foot and returned to the facility on [DATE]. The Physician Order, dated 12/29/24, documented the resident received dialysis three times a week. R70's EHR revealed a Dialysis Communication Form, that had completed information from the dialysis center regarding R70's treatment and potential new orders each time R70 had a dialysis appointment. On 02/13/25 at 08:35 AM, R70 sat in a wheelchair in the hall, dressed in sleeper pants and a t-shirt, hair uncombed, and hollered at the staff that they forgot his milk for his cereal when they delivered his room tray. He wheeled down to the dining room got some milk and then returned to his room and ate his breakfast at the bedside table. R70 stated he was going to dialysis at 11:00 AM, and they needed to get his meal delivered earlier than they did this morning. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/13/25 at 11:50 AM, Administrative Nurse D verified R70 received dialysis three times a week on Tuesdays, Thursdays, and Saturdays. Administrative Nurse D verified the facility would send a communication sheet with the resident with each dialysis treatment when he left the facility. Administrative Nurse D verified the resident was admitted to the facility and required dialysis from admission to present. Administrative Nurse D verified R70s care plan lacked documentation that he required dialysis treatment, the days he went to dialysis, the facility he went to for dialysis, and the care of the dialysis site by the nursing staff. Administrative Nurse D verified the care plans were completed by a corporate nurse off-site and they would update in-house as needed. The facility's End Stage Renal Disease (ESRD), Care of a Resident With policy, dated September 2010, documented the facility would be cared for according to the current recognized standard of care. Staff would be trained in the care and special needs of the resident. Education and training of staff include: a. The nature and clinical management of ESRD (including infection prevention and nutritional needs). b. The type of assessment data that is to be gathered about the resident's condition on a daily or per shift basis. c. Signs and symptoms of worsening condition and/or complications of ESRD. d. How to recognize and intervene in medical emergencies such as hemorrhages and septic infections. e. How to recognize and manage equipment failure or complications (according to the type of equipment used in the facility). f. Timing and administration of medications, [particularly those before and after dialysis. g. The care of grafts and fistulas; and h. The handling of waste. Education and training of staff in the care of ESRD/dialysis residents may be managed by the contracted dialysis facility or by a clinician with specialized training in ESRD and dialysis care. Agreements between the facility and the contracted ESRD facility include all aspects of how the resident's care will be managed, including: a. How the care plan will be developed and implemented. b. How the information would be exchanged between the facilities; and c. Responsible for waste handling, sterilization, and disinfection of equipment. 5. The resident's comprehensive plan of care will reflect the resident's needs related to ESRD/dialysis care. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility failed to provide staff with an accurate dialysis care plan communication, with updated care information for R70. This deficient practice placed R70 at risk for unmet needs and care and health decline.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41713 The facility identified a census of 66 residents. The sample included 17 residents, with one Resident (R) 24 reviewed for trauma-informed care (treatment or care directed to prevent re-experiencing or reducing the effects of traumatic events). Based on observation, record review, and interviews, the facility failed to identify trauma-based triggers related to R24's post-traumatic stress disorder (PTSD - a mental disorder characterized by an acute emotional response to a traumatic event or situation involving severe environmental stress). The facility failed to implement individualized interventions to prevent re-traumatization to R24. These deficient practices placed R24 at risk for decreased psychosocial well-being and ineffective treatment. Findings included: - R24's Electronic Medical Record (EMR) documented diagnoses of PTSD, major depressive disorder (a major mood disorder that causes persistent feelings of sadness), and traumatic brain injury (TBI - an injury to the brain caused by external forces). R24's Annual Minimum Data Set (MDS) dated [DATE] documented Brief Interview for Mental Status (BIMS) score of six, which indicated severely impaired cognition. R24 displayed the behavior of rejecting care that occurred for one to three days during the look back period. R24 used a cane to assist with mobility. R24 was independent with his functional abilities and activities of daily living (ADL). R24 had an active diagnosis of PTSD. R24's Cognitive Loss Care Area Assessment (CAA) dated 05/08/24 documented R24 had a cognitive deficit from a history of TBI. He was alert and oriented with confusion noted. R24 had a BIMS score of six of 15. R24 was able to make his wants and needs known at times. R24 had rejected the offer of showering and changing clothes. R24's Care Plan last revised on 10/23/24, directed staff to administer medications as ordered and to monitor and document side effects. Staff were directed to observe and chart behaviors as necessary and report to the physician. R24's care plan lacked a care area to address his diagnosis of PTSD to direct staff on his triggers or interventions to prevent further re-traumatization. R24's Diagnoses tab of the EMR documented a diagnosis of PTSD with a date of 09/09/22. R24's SS Trauma Admission Assessment v2 dated 02/14/24 asked: Is there a diagnosis of PTSD or trauma-associated event, with the response of no selected. On 02/13/25 at 09:20 AM, R24 walked, using his cane, down the hallway to go outside to smoke. R24 rejected any conversation with this surveyor. On 02/13/25 at 03:05 PM, Administrative Nurse F stated she expected a resident that had a diagnosis of PTSD would have staff direction on what triggered and the cause of the trauma, as well as interventions in place to alleviate the triggers or re-traumatization. Administrative Nurse F was unaware that R24 failed to have a PTSD care area on his care plan. Administrative Nurse F stated that the management nurses and staff nurses were able to update the care plan as needed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175078	A. Building B. Wing	02/13/2025

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Legacy at College Hill	5005 E 21st Street North Wichita, KS 67208

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/13/25 at 03:15 PM, Administrative Nurse D stated she was not aware that R24 failed to have a PTSD area on his care plan to address the cause, the triggers, and interventions to prevent further trauma. Administrative Nurse D stated that R24's PTSD should have been addressed at admission or when diagnosed . Administrative Nurse D stated all residents should get the trauma-informed care assessment at admission or with a new diagnosis of PTSD. The facility failed to provide a policy regarding PTSD care as requested. The facility failed to identify trauma-based triggers related to R24's PTSD. The facility furtherly failed to implement individualized interventions to prevent re-traumatization to R24. These deficient practices placed R24 at risk for decreased psychosocial well-being and ineffective treatment.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41713 The facility identified a census of 66 residents. The sample included 17 residents, with five sample residents reviewed for unnecessary medications. Based on observation, record review, and interview, the facility failed to ensure the Consultant Pharmacist (CP) identified and reported when Resident (R) 25's physician ordered insulin (a hormone that lowers the level of glucose in the blood) administration and finger stick blood sugar (a procedure that measures the level of sugar in a small drop of blood from the fingertip) had not been completed as ordered. This deficient practice placed R25 at risk for unnecessary medication administration and related complications. Findings included: - R25's Electronic Medical Record (EMR) documented diagnoses of hypertension (HTN - elevated blood pressure), hallucinations (sensing things while awake that appear to be real, but the mind created), hemiplegia and hemiparesis (weakness and paralysis on one side of the body), major depressive disorder (major mood disorder that causes persistent feelings of sadness), diabetes mellitus (DM - when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), and anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear). R25's Annual Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 10, which indicated moderately impaired cognition. R25 had impairment of both lower extremities. R25 required a wheelchair to assist with mobility. R25 required maximal to total dependence on staff for his functional abilities and activities of daily living (ADLs). R25 was frequently incontinent of bladder and always incontinent of bowel. R25 took an antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality), antidepressant (a class of medications used to treat mood disorders), anticoagulant (a class of medication used to prevent the blood from clotting), a diuretic(a medication to promote the formation and excretion of urine), an antiplatelet (medication that prevents blood clots by inhibiting the activation and aggregation of platelets), a hypoglycemic (medication used to lower blood sugar levels), and an anticonvulsant (medications used to prevent or control seizures). R25's Psychotropic Drug Use Care Area assessment dated [DATE] documented he received an antidepressant and an antipsychotic medication per orders. R25 had the diagnoses of hallucinations, depression, and anxiety. R25 has had no signs and symptoms of adverse reactions noted and reported. Medication and behavior monitoring was done each shift and was recorded in the EMR. The pharmacist performed reviews quarterly and as needed and recommendations were sent to the prescribing doctor for review. R25's Care Plan last revised on 02/05/25 directed staff to administer medications as directed. Staff were directed to monitor, document, and report to the physician any medication side effects. R25's Order Summary Report documented an order dated 04/18/24 for Humalog (fast-acting insulin)100 units per milliliter (ml) to inject 12 units subcutaneously (SQ - beneath the skin) with meals for DM and notify the physician if the blood sugar was below 60 or higher than 500. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R25's Order Summary Report documented an order dated 04/18/24 for Lantus (long-acting insulin) 100 units per ml to inject 10 units SQ at bedtime for DM. R25's Treatment Administration Record (TAR) reviewed from November 2024 to February 2025 documented blood sugars to be obtained four times a day. A review of R25's November 2024 Medication Administration Record (MAR) and TAR revealed: a lack of staff sign-off on Lantus insulin administration on four of 30 opportunities. The MAR lacked staff sign-off on Humalog insulin on eight of 90 opportunities; the TAR lacked staff sign-off on 12 of 120 blood sugar readings. A review of R25's December 2024 MAR and TAR revealed: a lack of staff sign-off on Lantus insulin administration on two of 31 opportunities. The MAR lacked staff sign-off on Humalog insulin on 12 of 93 opportunities; the TAR lacked staff sign-off on 14 of 124 blood sugar readings. A review of R25's January 2025 MAR and TAR revealed: a lack of staff sign-off on Lantus insulin administration on two of 31 opportunities. The MAR lacked staff sign-off on Humalog insulin on nine of 93 opportunities; the TAR lacked staff sign-off on 11 of 124 blood sugar readings. A review of R25's February 2025 MAR and TAR revealed: a lack of staff sign-off on Lantus insulin administration on two of 16 opportunities. The MAR lacked staff sign-off on Humalog insulin on 48 opportunities; the TAR lacked staff sign-off on six of 64 blood sugar readings. A review of the CP monthly medication regimen review (MRR) from January 2024 to January 2025 revealed the lack of the CP identifying and reporting the missed physician-ordered insulin administrations and blood sugar readings. A review of R25's Progress Notes tab of the EMR from the past year revealed the lack of staff documentation with a reason R25's physician-ordered insulin had not been administered. On 02/13/25 at 09:16 AM, R25 sat in his wheelchair in his room and his supplemental oxygen was on. On 02/13/25 at 03:05 PM, Administrative Nurse F stated she expected the nurses to administer insulin as the physician ordered and staff to obtain blood sugars as well. Administrative Nurse F stated the CP usually did a good job of identifying missed medication administrations. On 02/13/25 at 03:15 PM, Administrative Nurse D stated the CP did monthly MRR and typically identified and reported when medications had not been given. Administrative Nurse D stated she expected the nursing staff to document when and the reason a medication was not administered, especially a dose of insulin. On 02/17/25 at 12:00 PM, Consultant GG was unavailable for an interview by phone. The Pharmacy Services Overview policy last revised in April 2019 documented the CP, in collaboration with the dispensing pharmacy and the facility, oversaw the development of procedures related to pharmacy services including the administration of medications, and the documentation of processes. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility failed to ensure the CP identified and reported when R25's physician-ordered insulin administration and finger stick blood sugar had not been completed as ordered. This deficient practice placed R25 at risk for unnecessary medication administration and related complications.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41713 The facility identified a census of 66 residents. The sample included 17 residents with five sample residents reviewed for unnecessary medications. Based on observation, record review, and interview, the facility failed to ensure facility staff administered Resident (R) 25's physician-ordered insulin (a hormone that lowers the level of glucose in the blood) and obtained finger stick blood sugars (a procedure that measures the level of sugar in a small drop of blood from the fingertip) as ordered. This deficient practice placed R25 at risk for unnecessary medication administration and related complications. Findings included: - R25's Electronic Medical Record (EMR) documented diagnoses of hypertension (HTN - elevated blood pressure), hallucinations (sensing things while awake that appear to be real, but the mind created), hemiplegia and hemiparesis (weakness and paralysis on one side of the body), major depressive disorder (major mood disorder that causes persistent feelings of sadness), diabetes mellitus (DM - when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), and anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear). R25's Annual Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 10, which indicated moderately impaired cognition. R25 had impairment of both lower extremities. R25 required a wheelchair to assist with mobility. R25 required maximal to total dependence on staff for his functional abilities and activities of daily living (ADL). R25 was frequently incontinent of bladder and always incontinent of bowel. R25 took an antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality, antidepressant (a class of drugs used to treat mood disorders), anticoagulant (a class of medication used to prevent the blood from clotting), a diuretic (a medication to promote the formation and excretion of urine), an antiplatelet (medication that prevents blood clots by inhibiting the activation and aggregation of platelets), a hypoglycemic (medication used to lower blood sugar levels), and an anticonvulsant (medications used to prevent or control seizures). R25's Psychotropic Drug Use Care Area assessment dated [DATE] documented he received an antidepressant and an antipsychotic medication per orders. R25 had diagnoses of hallucinations, depression, and anxiety. R25 has had no signs and symptoms of adverse reactions noted and reported. Medication and behavior monitoring was done each shift and was recorded in the EMR. The pharmacist performed reviews quarterly and as needed and recommendations were sent to the prescribing doctor for review. R25's Care Plan last revised on 02/05/25 directed staff to administer medications as directed. Staff was directed to monitor, document, and report to the physician any medication side effects. R25's Order Summary Report documented an order dated 04/18/24 for Humalog (fast-acting insulin)100 units per milliliter (ml) to inject 12 units subcutaneously (SQ- beneath the skin) with meals for DM notify the physician if blood sugar is below 60 or higher than 500. (continued on next page)

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	175078	A. Building B. Wing	02/13/2025

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R25's Order Summary Report documented an order dated 04/18/24 for Lantus (long-acting insulin) 100 units per ml to inject 10 units SQ at bedtime for DM. R25's Treatment Administration Record (TAR) documented blood sugars to be obtained four times a day. A review of R25's November 2024 Medication Administration Record (MAR) and TAR revealed: a lack of staff sign-off on Lantus insulin administration on four of 30 opportunities. The MAR lacked staff sign-off on Humalog insulin on eight of 90 opportunities; the TAR lacked staff sign-off on 12 of 120 blood sugar readings. A review of R25's December 2024 MAR and TAR revealed: a lack of staff sign-off on Lantus insulin administration on two of 31 opportunities. The MAR lacked staff sign-off on Humalog insulin on 12 of 93 opportunities; the TAR lacked staff sign-off on 14 of 124 blood sugar readings. A review of R25's January 2025 MAR and TAR revealed: a lack of staff sign-off on Lantus insulin administration on two of 31 opportunities. The MAR lacked staff sign-off on Humalog insulin on nine of 93 opportunities; the TAR lacked staff sign-off on 11 of 124 blood sugar readings. A review of R25's February 2025 MAR and TAR revealed: a lack of staff sign-off on Lantus insulin administration on two of 16 opportunities. The MAR lacked staff sign-off on Humalog insulin on 48 opportunities; the TAR lacked staff sign-off on six of 64 blood sugar readings. A review of R25's Progress Notes tab of the EMR from the past six months revealed the lack of staff documentation giving a reason R25's physician-ordered insulin had not been administered. On 02/13/25 at 09:16 AM, R25 sat in his wheelchair in his room and his supplemental oxygen was on. On 02/13/25 at 03:05 PM, Administrative Nurse F stated she expected the nurses to administer insulin as the physician ordered and for staff to obtain blood sugars as well. On 02/13/25 at 03:15 PM, Administrative Nurse D stated she expected the nursing staff to document in the EMR the reason a medication was not administered, especially a dose of insulin. The Administering Medications policy revised in April 2019 documented medications were administered in a safe and timely manner, and as prescribed. Medications were administered in accordance with prescriber orders, including any required time frame. If a drug was withheld, refused, or given other than the scheduled time, the individual administering the medication should initial and circle the MAR space provided for that drug and dose. The facility failed to ensure staff documented and reported when R25's physician-ordered insulin administration and finger stick blood sugar were not completed as ordered. This deficient practice placed R25 at risk for unnecessary medication administration and related complications.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41713 The facility identified a census of 66 residents. The sample included 17 residents with five sample residents reviewed for unnecessary medications. Based on observation, record review, and interview, the facility failed to ensure Resident (R) 25, R38, and R22 had an adequate Centers for Medicare and Medicaid (CMS) approved indication for the use of an antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality) medication. This deficient practice placed R25 at risk for unnecessary medication administration and related complications. Findings included: - R25's Electronic Medical Record (EMR) documented diagnoses of hypertension (HTN - elevated blood pressure), hallucinations (sensing things while awake that appear to be real, but the mind created), hemiplegia and hemiparesis weakness and paralysis on one side of the body), major depressive disorder (major mood disorder that causes persistent feelings of sadness), diabetes mellitus (DM - when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), and anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear). R25's Annual Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 10, which indicated moderately impaired cognition. R25 had impairment of both lower extremities. R25 required a wheelchair to assist with mobility. R25 required maximal to total dependence on staff for his functional abilities and activities of daily living (ADL). R25 was frequently incontinent of bladder and always incontinent of bowel. R25 took an antipsychotic, antidepressant (a class of medications used to treat mood disorders), anticoagulant (a class of medication used to prevent the blood from clotting), a diuretic (a medication to promote the formation and excretion of urine), an antiplatelet (medication that prevents blood clots by inhibiting the activation and aggregation of platelets), a hypoglycemic (medication used to lower blood sugar levels), and an anticonvulsant (medications used to prevent or control seizures). R25's Psychotropic Drug Use Care Area assessment dated [DATE] documented he received an antidepressant and an antipsychotic medication per orders. R25 had diagnoses of hallucinations, depression, and anxiety. R25 has had no signs and symptoms of adverse reactions noted and reported. Medication and behavior monitoring was done each shift and recorded in the EMR. The pharmacist performed reviews quarterly and as needed and recommendations were sent to the prescribing doctor for review. R25's Care Plan last revised on 02/05/25 directed staff to administer medications as directed. Staff were directed to monitor, document, and report to the physician any medication side effects. Staff was directed that the pharmacist and physician would complete a gradual dose reduction (GDR) per facility protocol. R25's Order Summary Report documented a physician's order dated 04/18/24 for Vraylar (an antipsychotic medication) three milligrams (mg) by mouth at bedtime for hallucinations. (continued on next page)

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	175078	A. Building B. Wing	02/13/2025

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A 01/10/24 Consultant Pharmacist (CP) recommendation documented a request for an appropriate indication for the use of Vraylar. No physician response was noted or found. A 05/02/24 physician response to the 04/16/24 CP recommendation for a GDR of Vraylar documented R25 had a history of hallucinations. The resident tolerated the current dosage and a decrease would likely lead to increased signs and symptoms. On 02/13/25 at 09:16 AM, R25 sat in his wheelchair in his room and his supplemental oxygen was on. On 02/13/25 at 03:05 PM, Administrative Nurse F stated that the facility had been working with the physicians on getting the antipsychotic medications out of the facility. Administrative Nurse F stated some of the physicians had been slow about making sure that the antipsychotic medication had an appropriate indication for use and was not prescribed to residents with a dementia diagnosis. On 02/13/25 at 03:15 PM, Administrative Nurse D stated she and the pharmacist had been working with the physicians trying to get the antipsychotic medications out of the building. Administrative Nurse D stated the physicians had not wanted to take some residents off the antipsychotic medications due to good results from them and had not addressed or changed the indication for the use of the medications to an appropriate one. The Psychotropic Medication Use policy dated July 2022 documented that residents would not receive medication that was not clinically indicated to treat a specific condition. The policy lacked information for the CMS appropriate indication for the use of antipsychotics. The facility failed to ensure the physician provided a CMS-approved indication for the use of the antipsychotic medication Vraylar for R25. This deficient practice placed R25 at risk for unnecessary medication administration and related complications. - R38's Electronic Medical Record (EMR) documented diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), dementia (a progressive mental disorder characterized by failing memory and confusion), hemiplegia and hemiparesis (weakness and paralysis on one side of the body), heart failure, and cerebral infarction (stroke - sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain). R38's Significant Change Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of eight, which indicated moderately impaired cognition. R38 displayed a behavior of delusions (untrue persistent belief or perception held by a person although evidence shows it was untrue), verbal behavior directed towards others, and other behavioral symptoms not directed toward others (hitting self, pacing, screaming, and disruptive sounds). R38 had impairment on one side of her upper extremity and both lower extremities. R38 required the use of a wheelchair for mobility. R38 was dependent on staff for all functional abilities except eating. R38 was always incontinent of bladder and bowel. R38 required a mechanically altered diet. R38 took an antipsychotic, a hypnotic (a class of medications used to induce sleep), antianxiety (a class of medications that calm and relax people), and an antidepressant (a class of medication used to treat mood disorders) regularly. R38 was on hospice services. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175078	A. Building B. Wing	02/13/2025

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R38's Psychotropic Drug Use Care Area Assessment (CAA) dated 01/10/25 documented she received an antipsychotic, a hypnotic, an antianxiety, and an antidepressant medication. R38 had a recent gradual dose reduction on 11/7/24 that was not effective and she was returned to the original dose on 11/19/24. Medication and behavior monitoring was done every shift and recorded in the EMR. Pharmacist reviews were completed monthly and as needed and any recommendations were sent to the prescribing doctor for review. She was recently admitted to hospice for services. R38's Care Plan revised on 01/16/25 directed staff to administer medications as ordered. Staff were directed to monitor, document, and report any side effects of Alzheimer's medications to the physician. R38's Orders tab of the EMR documented an order dated 11/18/24 for risperidone (an antipsychotic medication) 0.5 milligrams (mg) by mouth two times a day related to dementia with psychotic disturbances (a mental health condition characterized by a loss of contact with reality). A 01/10/24 Consultant Pharmacist (CP) recommendation documented R38 received the antipsychotic Risperidone with a listed indication of anxiety. Risperidone was not approved for anxiety and an antipsychotic medication should only be used for the approved diagnoses. The use of an antipsychotic for an inappropriate indication would be considered unnecessary antipsychotic use. If the medication was used for anxiety, then consider discontinuation and starting alternative therapy approved for anxiety. The 01/15/24 physician's response to the CP 01/10/24 recommendation was attempting a gradual dose reduction (GDR) per the psychiatric physician. On 02/13/25 at 10:04 AM, R38 rested in her bed with her supplemental oxygen on. Her call light was within reach and the bed was in a low position. On 02/13/25 at 03:05 PM, Administrative Nurse F stated that the facility had been working with the physicians on getting the antipsychotic medications out of the facility. Administrative Nurse F stated some of the physicians had been slow about making sure that the antipsychotic medication had an appropriate indication for use and was not prescribed to residents with a dementia diagnosis. On 02/13/25 at 03:15 PM, Administrative Nurse D stated she and the pharmacist had been working with the physicians trying to get the antipsychotic medications out of the building. Administrative Nurse D stated the physicians had not wanted to take some residents off the antipsychotic medications due to good results from them. Administrative Nurse D stated the physicians had not addressed or changed the indication for the use of the antipsychotic medications to an appropriate one. The Psychotropic Medication Use policy dated July 2022 documented that residents would not receive medication that were not clinically indicated to treat a specific condition. The policy lacked information for the CMS appropriate indication for the use of antipsychotics. The facility failed to ensure the physician provided a CMS-approved indication for the use of the antipsychotic medication risperidone for R38. This deficient practice placed R38 at risk for unnecessary medication administration and related complications. 32358 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175078	A. Building B. Wing	02/13/2025

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- R22's Electronic Medical Record (EMR) documented R22 had diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion), anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), and psychosis (any major mental disorder characterized by a gross impairment perception). R22's Admission Minimum Data Set (MDS), dated [DATE], documented R22 had a Brief Interview of Mental Status (BIMS) score of four, which indicated severe cognitive impairment. The MDS documented the resident received antipsychotic medications every day during the lookback period. R22's Psychotropic Drug Use Care Area Assessment (CAA), dated 01/27/25, documented R22 had diagnoses of dementia with behaviors, age-related cognitive decline, restlessness, agitation, psychosis, and bipolar disorder (a major mental illness that causes people to have episodes of severe high and low moods). The CAA documented R22 received an antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality) medication. R22's Care Plan, revised 01/23/25, documented R22 had physician orders for routine Seroquel (antipsychotic medication). The plan instructed staff to monitor for medication side effects. The Physician Order, dated 01/23/25, instructed staff to administer R22 Seroquel, 50 milligrams (mg) tablet three times a day for major neurocognitive disorder (a group of mental health conditions that affect a person's ability to think, learn, and remember). The Consultant Pharmacist (CP) had not reviewed R22's medication regimen. R22's clinical record lacked physician documentation which included the rationale and risks versus benefits for R22's continued Seroquel use. On 02/11/25 at 11:40 AM, R22 ambulated back and forth in the 400 hall and attempted to open the exit door, staff intervened and redirected him. On 02/13/25 at 12:17 PM, Administrative Nurse D verified the resident's Seroquel had an inappropriate indication for use. The facility's Psychotropic Medication Use Policy, revised in July 2022, documented psychotropic medication management including indication for use, dose, duration, adequate monitoring for efficacy, and adverse consequences. The facility failed to ensure an appropriate indication for use, or the required physician documentation for R22's Seroquel. This deficient practice placed the resident at risk for unnecessary psychotropic medications.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175078	A. Building B. Wing	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy at College Hill	5005 E 21st Street North Wichita, KS 67208

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27168 The facility had a census of 66 residents. The sample included 17 residents. Based on observation, interview, and record review, the facility failed to discard Resident (R) 10 flex pen, R68 vial of expired insulin (a hormone that lowers the level of glucose in the blood), and further failed to label R36 and R70 insulin flex pens when opened to use and when they expired. This deficient practice placed the affected residents at risk for ineffective medications. Findings included: - On [DATE] at 08:10 AM, observation of the facility's 100 and 300 hall treatment carts revealed the following: -R10's Glargine (long-acting insulin) flex pen, was not labeled with an opened date or expired date. -R68's Levemir (long-acting insulin) vial, was not labeled with an opened date or expired date. -R36's Basaglar (long-acting insulin) flex pen with an opened date of [DATE] and an expiration date of [DATE]. -R70's Glargine flex pen with an opened date of [DATE] and an expiration date of [DATE]. On [DATE] at 08:15 AM, License Nurse (LN) G verified the nurses should discard expired insulin and label and date the insulin flex pens with the date opened. LN G verified the expired dates on the insulin flex pens. On [DATE] at 09:30 AM, Administrative Nurse D verified the nurses should discard the expired insulin and label and date the flex pens with the date opened and the expiration date. Medlineplus.gov directs open, unrefrigerated Lantus (basaglar and glargine) can be used within 28 days; after that time, they must be discarded. Medlinplus.gov documented that Levemir is good for 42 days at room temperature or in the refrigerator then should be discarded. The facility's Medication Labeling and Storage policy, dated February 2023, documented the facility would store all medications and biologicals in locked compartments under proper temperature, humidity, and light controls. The policy documented only authorized personnel would have access to keys. If the facility has discontinued, outdated, or deteriorated medications or biologicals, the dispensing pharmacy is contacted for instructions regarding returning or destroying these items. Multi-dose vials that have been opened and accessed are dated and discarded within 28 days unless the manufacturer specifies a shorter or longer date for the opened vial. If the medication containers have a missing, incomplete, improper, or incorrect label, the facility would contact the dispensing pharmacy for instructions regarding returning or destroying these items. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility failed to discard an expired insulin pen and insulin vial. The facility further failed to date the insulin flex pens when opened and the expiration date, placing the residents at risk for ineffective medication 32358 - On [DATE] at 08:50 AM, the 200-hall treatment cart (R) 37's lispro (fast-acting insulin (a hormone that lowers the level of glucose in the blood) insulin pen (an injection device that you can use to deliver preloaded insulin) lacked an open date. On [DATE] at 08:50 AM, Licensed Nurse (LN) H verified the above finding and stated staff should date an insulin pen when they open it. On [DATE] at 12:15 PM, Administrative Nurse D stated staff should label and date an insulin pen when they open it. The facility's Administrating Medications Policy, revised in [DATE], documented insulin pens were clearly labeled with the resident's name or other identifying information. When opening a multi-dose container, the date opened would be recorded on the container. The facility failed to place an open date on R37's insulin pen. This deficient practice placed R37 at risk of receiving ineffective doses of insulin.

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	175078	A. Building B. Wing	02/13/2025

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32358 The facility had a census of 66 residents. The sample included 17 residents. Based on observation, record review, and interview, the facility failed to store, prepare, distribute, and serve food by professional standards for food service safety in one kitchen. This deficient practice placed the residents who received their meals from the facility's kitchens at risk for foodborne illness. Findings included: - On [DATE] at 08:20 AM, the kitchen, revealed the following: The walk-in refrigerator had a box of uncovered bacon and a box of roasted turkey breast on a shelf above a box of bulk pork sausage. Dietary Manager (DM) BB verified the finding and stated staff should cover food items before placing them in the refrigerator. DM BB stated staff should store thawing meat on the bottom shelf and discard the box of bacon in the trash. The outside of the ice machine, located outside the kitchen near the window to the kitchen where dirty dishes were placed, had numerous different-sized streaks of a whitish substance, and the drainage pipe, extending through the kitchen wall underneath the dishwasher, touched the floor drainage area. On [DATE] at 01:00 PM, the follow-up to Kitchen revealed the following: 1) An area, approximately four to five inches (in) located above the mopboard underneath the three sinks had a missing tile. 2) An area with missing tile, on the floor, approximately two feet (ft) by one and a half ft, underneath the three-sink area. 3) The pipes located underneath the three sinks, approximately five to six ft long, had numerous different-sized areas with a grayish-black substance. 4) The open small storage closet had peeling sheetrock underneath the bottom shelf around the top of the mopboard. 5) An area with missing tile, approximately two and a half ft by one and a half ft underneath the dishwasher, where the clean dishes come out. 6) The parts-per-million sanitizer (ppm) test strips expired [DATE]. 7) The ceiling vent had a grayish fuzzy substance on it. 8) The ceiling lights had numerous different-sized black specks in them. 9) The window above the steam table had numerous different-sized streaks of grayish substance. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 2:00 PM, DM BB verified the above issues and stated she had only been employed at the facility for two weeks and was working with staff on the above issues. The facility's Sanitization Policy, revised in [DATE], documented that all kitchens, kitchen areas, and dining areas would be kept clean, and free from garbage and debris. The policy documented dishwashing machines would be operated to manufacture instructions for heat and chemical sanitization. The chemical solution would be maintained at the correct sanitization. The facility's Food Receiving Storage Policy, revised in [DATE], documented all food stored in the refrigerator or freezer would be covered, labeled, and dated. Uncooked and raw animal products and fish would be stored separately in drip-proof containers, and below fruits, vegetables, and other ready-to-eat foods to prevent meat juices from dripping onto these foods. The facility failed to store, prepare, distribute, and serve food by professional standards for food service safety for the 65 residents who received their meals from the facility's kitchen. This deficient practice placed the 65 residents at risk for foodborne illness.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41713 The facility identified a census of 66 residents. The sample included 17 residents, with two sampled residents reviewed for hospice care. Based on observation, record review, and interview, the facility failed to ensure there was a collaboration of care between Resident (R) 38's hospice provider and the facility. This deficient practice placed R38 at risk of inadequate end-of-life care. Findings included: - R38's Electronic Medical Record (EMR) documented diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), dementia (a progressive mental disorder characterized by failing memory and confusion), hemiplegia and hemiparesis (weakness and paralysis on one side of the body), heart failure, and cerebral infarction (stroke - sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain). R38's Significant Change Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of eight, which indicated moderately impaired cognition. R38 displayed a behavior of delusions (untrue persistent belief or perception held by a person although evidence shows it was untrue), verbal behavior directed towards others, and other behavioral symptoms not directed toward others (hitting self, pacing, screaming, and disruptive sounds). R38 had impairment on one side of her upper extremity and both lower extremities. R38 required the use of a wheelchair for mobility. R38 was dependent on staff for all functional abilities except eating. R38 was always incontinent of bladder and bowel. R38 required a mechanically altered diet. R38 took an antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality), a hypnotic (a class of medications used to induce sleep), antianxiety (a class of medications that calm and relax people), and an antidepressant (a class of medication used to treat mood disorders) regularly. R38 was on hospice services. R38's Psychotropic Drug Use Care Area Assessment (CAA) dated 01/10/25 documented she received an antipsychotic, hypnotic, antianxiety, and antidepressant medication. R38 had a recent gradual dose reduction on 11/7/24 that was not effective and was returned to the original dose on 11/19/24. Medication and behavior monitoring was done every shift and recorded in the EMR. Pharmacist reviews were completed monthly and as needed and any recommendations were sent to the prescribing doctor for review. R38 was recently admitted to hospice for services. R38's Care Plan, last revised on 01/16/25, directed staff to administer medications as directed. Staff were directed that R38's comfort would be maintained through the end-of-life or the next review date. Staff were directed that the hospice interdisciplinary team (IDT) was to provide services based on R38's identified needs. Staff were directed that hospice was to provide medications, equipment, and supplies due to R38's terminal diagnosis. Staff were directed to notify hospice of changes in R38's condition. (continued on next page)

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	175078	A. Building B. Wing	02/13/2025

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R38's Care Plan lacked staff direction on how to contact R38's hospice provider; the provided medical supplies, durable medical equipment, and medications provided by hospice. And a schedule of when and how often hospice staff would make visits. R38's Orders tab in the EMR documented a physician's order dated 01/03/25: May admit to hospice 01/03/25. A review of R38's hospice provider book revealed the lack of a hospice plan of care for the resident, that included a list of medications, supplies and other services provided by hospice. On 02/13/25 at 10:04 AM, R38 rested in her bed with her supplemental oxygen on. Her call light was within reach and the bed was in a low position. On 02/13/25 at 03:05 PM, Administrative Nurse F stated that R38's hospice book should have the hospice plan of care, the list of medications provided, the hospice staff names, and when they would make visits. Administrative Nurse F stated that R38 had only been on hospice for a short time. On 02/13/25 at 03:15 PM, Administrative Nurse D stated any resident who received hospice services should have the hospice plan of care in their hospice book. Administrative Nurse D stated that most of the facility staff knew what services or supplies hospice provided. Administrative Nurse D stated she would expect R38's or any other resident's care plan to reflect how to contact the hospice provider. Administrative Nurse D stated that R38's hospice provider book should have all the information about when the hospice nurse, nurse aide, and other staff would make visits. Administrative Nurse D stated it would make sense for R38's care plan to reflect all the hospice information, the supplies provided, and hospice staff visits so new and current staff had direction. The facility's Hospice Program policy last revised in July 2017 documented in general, it was the responsibility of the hospice to manage the resident's care as it related to the terminal illness and related conditions, including- determining the appropriate hospice plan of care; changing the level of services provided when deemed appropriate; providing medical direction, nursing and clinical management of the terminal illness; providing spiritual, bereavement and or psychosocial counseling and social services as needed; and providing medical supplies, durable medical equipment, and medications necessary for the palliation of pain and symptoms. In general, it was the responsibility of the facility to meet the resident's personal care and nursing needs in coordination with the hospice representative and ensure that the level of care provided was appropriately based on the individual resident's needs. Coordinated care plans for residents receiving hospice services would include the most recent hospice plan of care as well as the care and services provided by the facility to maintain the resident's highest practicable physical, mental, and psychosocial well-being. The facility failed to ensure a collaboration of care between R38's hospice provider and the facility. This deficient practice placed R38 at risk of inadequate end-of-life care.

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	175078	A. Building B. Wing	02/13/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 27168 The facility had a census of 66 residents. The sample included 17 residents. Based on observation, record review, and interview, the facility failed to implement a water management program for Legionella disease (Legionella is a bacterium spread through mist, such as from air-conditioning units for large buildings. Adults over the age of 50 and people with weak immune systems, chronic lung disease, or heavy tobacco use are most at risk of developing a pneumonia caused by legionella). The facility failed to implement acceptable infection control practices when staff failed to properly store Resident (R) 48 and R60's oxygen tubing and nasal cannula (a device used to deliver supplemental oxygen or increased airflow to a person in need of respiratory help) in a sanitary manner. This deficient practice placed the residents in the facility at risk for infectious diseases. Findings Included: - On 02/11/25 at 03:35 PM, observation revealed R60 had an unbagged oxygen tubing and nasal cannula that was attached to the oxygen canister. The tubing and nasal cannula laid in the seat of the wheelchair. The wheelchair was located in the hall outside of the resident's room with residents and staff walking up and down the hall. On 02/13/25 at 12:25 PM, observation revealed R48 unbagged oxygen tubing and nasal cannula that was attached to the oxygen canister. The tubing and nasal cannula laid in the seat of the wheelchair in the resident's room, while staff walked in and out of the R48's room. On 02/13/25 at 09:30 AM, Administrative Nurse D stated the oxygen tubing and cannulas should be stored in a bag when not in use. On 02/13/25 at 02:30 PM, Administrative Staff A stated the last maintenance supervisor was no longer with the facility and the facility was unable to locate or retrieve the information regarding the legionella water testing or water management regarding, if or when it had been completed and the testing results. Administrative Staff A had the information material for the water management process however lacked documentation the process was completed. Upon request, the facility failed to provide a policy related to the sanitary storage of oxygen or catheter tubing. The facility's Water Management policy dated October 2022, documented that the facility handles and maintains its water supply in accordance with recommendations from the Center for Disease Control, (CDC), The American Society of Heating, Refrigerating and Air-Conditioning Engineers (ASHRAE0, Environmental Protection Agency (EPA), and Food and Drug Administration (FDA). Guidelines. 1. The facility would demonstrate its measures to minimize the risk of Legionella and other opportunistic pathogens in the building water system through a documented water management program. The facility's approach to controlling waterborne microorganisms will be consistent with nationally accepted standards of the CDC, ASHRAE, and the EPA. (continued on next page)

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	175078	A. Building B. Wing	02/13/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	2. Facilities hot water distribution systems serving resident care areas would be continuously recirculated. 3. Facilities would complete an assessment of the water system annually. a. Assessment data would identify where Legionella and other opportunistic waterborne pathogens could grow and spread. b. Assessment would include interventions performed by the facility if risk is identified to prevent the growth of opportunistic waterborne pathogens as well as how the facility would monitor them. 4. Facilities would contact the state's public health authority in the event of a suspected or confirmed case of healthcare acquired legionellosis, or another waterborne pathogen. 5. Facilities would follow CDC guidelines in the collection of cultures in the event it is recommended by the state's public health authority in response to potential/confirmed outbreaks of legionella or other opportunistic waterborne pathogens. 6. Facilities would follow the state's local health authority recommendations in response to outbreaks which may include re-mediating the pathogen reservoir and adjusting control measures as necessary. The facility failed to store R48's and R60's oxygen tubing and nasal cannula in a sanitary manner. The facility further failed to implement a water management program to test and manage waterborne pathogens placing the residents who reside in the facility at risk of contracting Legionella pneumonia.

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	175078	A. Building B. Wing	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. 27168 The facility had a census of 66 residents. The sample included 17 residents, with five residents reviewed for immunizations, Resident (R) 24, R25, R29, R33, and R37, to include pneumococcal (a disease that refers to a range of illnesses that affect various parts of the body and are caused by infection) vaccinations. Based on record review and interviews, the facility failed to offer, or obtain an informed declination, or a physician documented contraindication for the pneumococcal PCV20 vaccination per the latest guidance from the Centers for Disease Control and Prevention (CDC). This deficient practice placed the residents at risk for pneumococcal infection and related complications. Findings included: - Review of R24, R25, R29, R33, and R37 clinical medical records lacked evidence the facility or the resident representative received or signed a consent or informed declination for the pneumococcal vaccine PCV20. On 02/13/25 at 01:30 PM, Administrative Nurse E stated residents are offered the pneumonia vaccines on admission and as indicated. Administrative Nurse E said the facility would send out the CDC vaccination sheets, and the resident or the resident's representative would consent or deny receiving the vaccinations. Administrative Nurse E verified that every resident in the building had not been reviewed to determine if they were eligible to receive the PVC20 vaccination or not. Administrative Nurse E stated the facility relied on the medical director or clinic physician's office to determine who was eligible for what vaccinations but lacked a definitive system in place to determine who was eligible, when they were eligible, if they had been offered or declined the vaccinations, or had received the vaccinations. On 02/13/25 at 2:35 PM, Administrative Nurse D verified the facility lacked a system in place to identify which residents were eligible for which pneumococcal vaccination. Administrative Nurse D Stated they have the pharmacy alert the facility and then the facility would notify the provider and the provider would give the facility an order to give the resident the immunizations. Administrative Nurse D verified after she looked at a few of the resident's immunization records/flow sheets she verified they do not have a system in place to identify who needed what pneumonia vaccine or if they are eligible and if so for which one. (continued on next page)

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	175078	A. Building B. Wing	02/13/2025

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's Pneumococcal Vaccine policy dated, October 2023 documented all residents were offered pneumococcal vaccines to aid in the prevention of pneumonia/pneumococcal infections. Prior to or upon admission, residents are assessed for eligibility to receive the pneumococcal vaccine series, and when indicated, are offered the vaccine series within thirty days of admission to the facility unless medically contraindicated or the resident has completed the current recommended vaccine series. Assessment of pneumococcal vaccination status were conducted within five working days of the resident's admission if not conducted prior to admission. Before receiving a pneumococcal vaccine, the resident or legal representative receives information and education regarding the benefits and potential side effects of the pneumococcal vaccine. Provision of such education is documented in the resident's medical record. Pneumococcal vaccines are administered to residents per the facilities physician approved pneumococcal vaccination protocol. Residents/representatives have the right to refuse vaccinations. If refused, appropriate information is documented in the resident's medical record indicating the date of refusal of the pneumococcal vaccine. Administration of the pneumococcal vaccines was made in accordance with the current Centers for Disease Control and Prevention (CDC) recommendations at the time of the vaccination. The facility failed to offer the PCV20 pneumococcal vaccination for the residents. This deficient practice placed the residents at risk of acquiring, spreading, and experiencing complications from pneumonia.

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	175078	A. Building B. Wing	02/13/2025

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 32358 The facility had a census of 66 residents. The sample included 17 residents. Based on observation, record review, and interview the facility failed to provide a safe, functional, sanitary, and comfortable environment for residents who ate in the main dining room and resided in the 400 hall. This deficient practice placed the residents who ate in the main dining room at risk for impaired health and well-being; and the residents who resided in the 400 hall at risk for falls. Findings included: - On 02/11/25 at 11:29 AM, in the dining room and the 400 hall revealed the following issues: 1) The floor, approximately 18 inches (in) wide by five feet (ft) long, half an inch deep, located in front of the shower room on the 400 hall, had missing flooring down to concrete. The main dining room had the following: 1) The four floor vents with grayish-black fuzzy substance. 2) The two window air conditioners had the same substance. 3) The windows all around the dining room had numerous different-sized streaks of grayish-black areas on them. 4) Below the window air conditioner had approximately five ft by three in, of missing mopboard on the left side of the floor air vents and approximately three ft by three, missing mopboard on the right side of the floor air vent. 5) The area located below the shelf where the iced tea was kept had approximately one ft by three ft mopboard sticking out from the wall. 02/13/25 at 02:30 PM, Administrating Staff A verified the above issues in the dining room and the 400 hall and stated the facility had no maintenance staff at this time, so he was responsible for fixing the environmental issues. Administrating Staff A stated if staff had an environmental concern, they would place it in the Technology Enhanced Learning System (TELS) system (a web-based technology designed to tackle the day-to-day challenges of building operations) on the computer. The facility's Quality of Life-Homelike Environment Policy, revised May 2017, documented the facility staff and management should maximize, to the extent possible, the characteristics of the facility that reflect a personalized homelike setting. These characteristics include a clean, sanitary, and orderly environment. The facility failed to provide a sanitary environment in the main dining room and the 400 halls. This deficient practice placed the residents who ate in the main dining room at risk for impaired health and well-being. And the residents who resided on the 400 hall were at risk for falling.