

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175113	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/23/2024
NAME OF PROVIDER OR SUPPLIER Legacy on 10th Avenue		STREET ADDRESS, CITY, STATE, ZIP CODE 2015 SE 10th Avenue Topeka, KS 66607	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>39752</p> <p>The facility identified a census of 54 residents. Based on observation, record review and interview the facility failed to ensure an accurate and consistent reconciliation of all controlled substances on the medication carts. This placed the residents at risk for misappropriation and ineffective medication regimens.</p> <p>Findings included:</p> <p>- A review of the facility's Licensed Nurse: As Needed (PRN) Narcotic Count Sheet dated April 2024 revealed that 17 out of 88 opportunities the narcotic reconciliation was not performed on Medication Cart A and 52 out of 88 opportunities the reconciliation was not completed on Medication Cart B.</p> <p>A review of the facility's Scheduled Narcot [sic] Count Sheet dated April 2024 revealed 34 opportunities out of 132 opportunities the narcotic reconciliation was not completed on Medication Cart C, and 22 opportunities out of 132 opportunities a reconciliation was not completed on Medication Cart D.</p> <p>Review of the facility's Shift to Shift Sheet Med Count East/West Station two pages, ranging in dates from 04/08/24 through 04/23/24, had the following dates documented with only one signature representing staff completing the narcotic reconciliation for the entire day: 04/12/24, 04/14/24, 04/17/24, and 04/18/24. There was no reconciliation documentation for 04/10/24, 04/13/24, 04/16/24, or 04/21/24 indicating oncoming or off-going shifts reconciled the number of cards located in the narcotic medication lock box on Medication Cart A.</p> <p>Review of the facility's Shift to Shift Sheet Med Count East/West Station four pages, ranging in date from 04/08/24 to 04/23/24, had the following dates which documented only one staff signature for reconciliation for the entire day: 04/10/24, 04/11/24, 04/12/24, 04/13/24, 04/14/24, 04/18/24, and 04/19/24.</p> <p>Review of the facility's Shift to Shift Med Count [NAME] Sheets three pages, ranging in dates from 04/01/24 to 04/23/24, recorded the following dates had only one staff signature for reconciliation for the entire day: 04/03/24, 04/06/24, 04/07/24, 04/08/24, 04/13/24, 04/14/24, 04/16/24, 04/17/24, 04/18/24, 04/20/24, and 04/21/24. There were no signatures or indications that oncoming or off-going shifts documented the number of cards located in the narcotic medication lock box on Medication Cart C.</p> <p>(continued on next page)</p>

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of the facility's Shift to Shift Sheet Med Count East/West Sheets which consisted of three pages, ranging in dates from 04/10/24 to 04/23/24, had only one staff signature for reconciliation for the entire day: 04/18/24, 04/20/24, and 04/21/24. On 04/13/24 and 04/14/24 there were no signatures or indications that oncoming or off-going shifts documented the number of cards located in the narcotic medication lock box on Medication Cart D.</p> <p>On 04/23/24 at 02:25 PM Certified Medication Aide (CMA) R stated that she counted the cart with the staff that was on shift before CMA R took over Medication Cart C and accepted the keys. CMA R further stated staff had been trained recently and was told to count at shift change, this meant the number of carts and the number of pills per card.</p> <p>On 04/23/24 at 02:30 PM, Licensed Nurse (LN) H stated that she did not sign both signature sheets, she only signed the sheets for counting the number of cards located in the cart and signed off on that sheet. LN H stated she never signed the Scheduled Narcot Count Sheet or the Licensed Nurse: PRN Narcotic Count Sheet.</p> <p>On 04/23/24 at 02:33 PM, CMA S stated he had received training for signing the narcotic count sheets when taking over his medication cart and when going off shift. When CMA S was asked if the narcotic count sheet should have already had his signature or initials, CMA S stated that it should, and he must have forgotten and observation revealed he proceeded to sign the oncoming shift opportunity and the off-going shift opportunity at that time. When CMA S was asked if that was appropriate, he stated he did it that way, so he did not forget to sign it when he got done. CMA S then stated that practice was not the appropriate way to perform the narcotic counts.</p> <p>On 04/23/24 at 02:35 PM LN G stated staff were supposed to count the narcotics at the beginning and end of shift change and then sign the log sheets.</p> <p>On 04/23/24 at 03:02 PM Administrative Nurse D stated that she expected the staff to count the number of cards and the pills on the cards and sign both pages in the narcotic count books. Administrative Nurse D stated staff were not to sign the sheets for the beginning and the end of the shift at once, but separately when staff counted coming on and then counted going off. Administrative D revealed she had just done training with staff for signing for the controlled medications when the staff took over the medication cart. Administrative Nurse D stated that the staff needed more demonstration training on counting the narcotics and that she and Administrative Nurse E would have to do that soon.</p> <p>The facility's Controlled Substance policy revised in October 2021 documented that only authorized licensed nursing and/or pharmacy personnel have access to controlled drugs maintained on the premises. The document directed staff that at the end of the shift worked the controlled medications were counted and the LN or CMA coming on duty and the LN or CMA going off duty determined the count together.</p> <p>Based on observation, record review and interview the facility failed to ensure an accurate and consistent reconciliation of all controlled substances on the medication carts. This placed the residents at risk for misappropriation and ineffective medication regimens.</p>		