

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 06/18/2024
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 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42966</p> <p>The facility identified a census of 53 residents. The sample included three residents. Based on observation, record review, and interviews, the facility failed to provide a written notification of transfer to Resident (R) 1 or his representative. This deficient practice had the risk for miscommunication between the facility and resident/representative and possible missed opportunities for healthcare services.</p> <p>Findings included:</p> <p>- R1 admitted to the facility on [DATE], discharged to the hospital on 06/11/24, and readmitted to the facility on [DATE].</p> <p>The Diagnoses tab of R1's Electronic Medical Record (EMR) documented diagnoses for dementia (progressive mental disorder characterized by failing memory, confusion) and bipolar disorder (major mental illness that caused people to have episodes of severe high and low moods).</p> <p>The Admission Minimum Data Set (MDS) dated [DATE], documented R1 had a Brief Interview for Mental Status (BIMS) score of 11 which indicated moderate cognitive impairment. R1 had no behaviors in the assessment period.</p> <p>The Cognitive Loss/Dementia Care Area Assessment (CAA) dated 05/28/24, documented R1 had dementia and a decreased ability to make self-understood.</p> <p>R1's Care Plan, dated 05/22/24, documented R1 had a self-care deficit in bathing, dressing, and eating. The plan directed staff encouraged R1 to participate in planning day-to-day care, encouraged R1 to discuss feelings about self-care deficit, evaluated R1's ability to perform activities of daily living (ADLs), and maintained consistent schedule with R1's daily routine.</p> <p>R1's EMR revealed a Nursing Progress Note on 06/11/24 at 11:30 AM that documented R1 was pacing and showed signs of agitation and anxiety while voicing he would have liked to leave. There were staff placed with R1 immediately for safety concerns. R1 was seen by the provider and an order was given to send to the hospital for increased agitation and aggression. R1's representative was aware, and report was called to the hospital. R1 was transported by Emergency Medical Services (EMS).</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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<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Upon request, the facility provided a Movement Notification to the Contracting Officer Representative form, dated 06/13/24, that documented R1 was admitted to the hospital for behavioral symptoms on 06/11/24 at 11:45 AM. The form documented a bed hold was requested for two days.</p> <p>Upon request, the facility was unable to provide a written notification of transfer for R1's facility-initiated transfer on 06/11/24.</p> <p>On 06/18/24 at 12:16 PM, R1 laid in his bed, facing the wall.</p> <p>On 06/18/24 at 11:51 AM, Administrative Staff B stated when a resident transferred to the hospital, staff called their representative and notified them where the resident was going and why they were transferring. She stated staff did not send a written notification of transfer to the resident or their representative.</p> <p>On 06/18/24 at 12:21 PM, Social Services X stated she did not fill out any forms for transfers including a written notification of transfer.</p> <p>On 06/18/24 at 12:42 PM, Licensed Nurse (LN) G stated he called the resident's family or guardian when a resident was sent to the hospital. He stated he did not fill out or send a written notification of transfer.</p> <p>On 06/20/24 at 11:10 AM, Administrative Nurse D was unavailable for interview.</p> <p>The facility's Transfer or Discharge, Emergency policy, revised October 2021, directed if it become necessary to make an emergency transfer or discharge of a resident to a hospital or other related institution, the facility implemented the following procedures: notification to the resident's physician, notification to the receiving facility, preparation of the resident for transfer, preparation of a transfer form to send with the resident, notification to the representative, assistance in obtaining transportation, and other procedures as necessary. The policy did not address written notification of transfers in facility-initiated transfers.</p> <p>The facility failed to provide a written notification of transfer to R1 or his representative. This deficient practice had the risk for miscommunication between the facility and resident/representative and possible missed opportunities for healthcare services.</p>		

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<p>F 0625</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42966</p> <p>The facility identified a census of 53 residents. The sample included three residents. Based on observation, record review, and interviews, the facility failed to provide a bed hold policy notice to Resident (R) 1 or his representative when he was transferred to the hospital. This deficient practice had the risk of impaired ability to return to the facility and to the previous room for R1.</p> <p>Findings included:</p> <p>- R1 admitted to the facility on [DATE], discharged to the hospital on 06/11/24, and readmitted to the facility on [DATE].</p> <p>The Diagnoses tab of R1's Electronic Medical Record (EMR) documented diagnoses for dementia (progressive mental disorder characterized by failing memory, confusion) and bipolar disorder (major mental illness that caused people to have episodes of severe high and low moods).</p> <p>The Admission Minimum Data Set (MDS) dated [DATE], documented R1 had a Brief Interview for Mental Status (BIMS) score of 11 which indicated moderate cognitive impairment. R1 had no behaviors in the assessment period.</p> <p>The Cognitive Loss/Dementia Care Area Assessment (CAA) dated 05/28/24, documented R1 had dementia and a decreased ability to make self-understood.</p> <p>R1's Care Plan, dated 05/22/24, documented R1 had a self-care deficit in bathing, dressing, and eating. The plan directed staff encouraged R1 to participate in planning day-to-day care, encouraged R1 to discuss feelings about self-care deficit, evaluated R1's ability to perform activities of daily living (ADLs), and maintained consistent schedule with R1's daily routine.</p> <p>R1's EMR revealed a Nursing Progress Note on 06/11/24 at 11:30 AM that documented R1 was pacing and showed signs of agitation and anxiety while voicing he would have liked to leave. There were staff placed with R1 immediately for safety concerns. R1 was seen by the provider and an order was given to send to the hospital for increased agitation and aggression. R1's representative was aware, and report was called to the hospital. R1 was transported by Emergency Medical Services (EMS).</p> <p>Upon request, the facility provided a Movement Notification to the Contracting Officer Representative form, dated 06/13/24, that documented R1 was admitted to the hospital for behavioral symptoms on 06/11/24 at 11:45 AM. The form documented a bed hold was requested for two days.</p> <p>Upon request, the facility was unable to provide a bed hold notice to R1 or his representative for R1's facility-initiated transfer on 06/11/24.</p> <p>On 06/18/24 at 12:16 PM, R1 laid in his bed, facing the wall.</p> <p>(continued on next page)</p>

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<p>F 0625</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 06/18/24 at 11:51 AM, Administrative Staff B stated when a resident transferred to the hospital, staff called their representative and notified them where the resident was going and why they were transferring.</p> <p>On 06/18/24 at 12:19 PM, Administrative Staff A stated the Movement Notification to the Contracting Officer Representative form was the form used for bed hold notice. She stated the form was sent to the hospital within 4 hours.</p> <p>On 06/18/24 at 12:21 PM, Social Services X stated she did not fill out any forms for transfers, but she knew there was a movement form that was sent to the hospital that the facility completed if the resident was admitted .</p> <p>On 06/18/24 at 12:42 PM, Licensed Nurse (LN) G stated he called the resident's family or guardian when a resident was sent to the hospital. He stated a bed hold policy was supposed to be filled out but that probably did not happen as much as it should. LN G stated every resident sent out, received a bed hold notice and generally the social worker sent the notice to the family.</p> <p>On 06/20/24 at 11:10 AM, Administrative Nurse D was unavailable for interview.</p> <p>The facility's Bed-Holds and Returns policy, revised October 2021, directed that prior to or at the time of the resident's transfer, the facility gave written information to the resident and their representative that explained in detail: the rights and limitations of the resident regarding bed-holds, the reserve bed payment policy as indicated by the state plan, the facility per diem required to hold a bed, the details of the transfer, and a copy of the bed hold agreement.</p> <p>The facility failed to provide a bed hold policy notice to R1 or his representative when he was transferred to the hospital. This deficient practice had the risk of impaired ability to return to the facility and to the previous room for R1.</p>		