

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 10/09/2024
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 0553</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Allow resident to participate in the development and implementation of his or her person-centered plan of care.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49634</p> <p>The facility had a census of 55 residents. The sample included 15 residents. Based on observation, record review, and interview, the facility failed to include Resident (R) 50's representative in the development and planning of the resident's care plan, which placed R50 at risk of impaired care and decreased autonomy.</p> <p>Findings Included:</p> <ul style="list-style-type: none"> - R50's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of diabetes mellitus (when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), congestive heart failure (CHF-a condition with low heart output and the body becomes congested with fluid), depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), dysphagia (swallowing difficulty) following cerebral infarction (stroke - the 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), kidney disease (a condition in which the kidneys stop working and are not able to remove waste and extra water from the blood or keep chemicals in balance), urinary retention (lack of ability to urinate and empty the bladder), and aphasia (condition with disordered or absent language function). <p>The Annual Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of zero which indicated severely impaired cognition. The MDS documented R50 was dependent on staff for eating, showering, and personal hygiene.</p> <p>R50's Communications Care Area Assessment (CAA) dated 09/19/24 documented that R50 usually understands others. R50 had minimal difficulty with hearing patterns; R50 can hear if the speaker slows down and has his attention.</p> <p>R50's Care Plan revised 09/18/23, documented R50 has a diagnosis of aphasia and was hard of hearing. R50's plan of care documented that the staff was to announce themselves upon entering his room and to explain to R50 what the staff was doing while in his room and while providing care.</p> <p>R50's EMR documented a care conference on 06/19/24. The EMR lacked documentation R50 or his representative was invited to the care conferences on 03/21/24 and 10/03/24.</p> <p>On 10/07/24 at 07:35 AM R50 lay on his bed. R50 had his head covered up with his blanket.</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 0553</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 10/07/24 at 09:23 AM R50's representative stated she had only been invited to one care plan conference. She stated she desired to attend each care conference.</p> <p>On 10/09/24 at 01:04 PM, Administrative Nurse D stated the Social Service Designee had been scheduling and conducting care conferences. She stated she was unsure how or who was invited to the care conference.</p> <p>The facility's Care Planning Interdisciplinary Team policy documented the facility's care planning and Interdisciplinary Team was responsible for the development of an individualized comprehensive care plan for each resident. The resident, the resident's family, and the resident's legal representative or surrogate are encouraged to participate in the development of and revisions to the resident's care plan. Every effort would be made to schedule care plan meetings and the best time of the day for the resident's family. The mechanics of how the Interdisciplinary Team meets its responsibilities in the development of the interdisciplinary care plan were at the discretion of the Care Planning Committee.</p> <p>The facility failed to include R50's family representative in the development and planning of the resident's care plan placing the resident at risk for impaired care and decreased autonomy.</p>

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49634</p> <p>The facility identified a census of 55 residents. The sample included 15 residents. One resident was sampled for reasonable accommodations of resident needs. Based on observation, record review, and interview, the facility failed to ensure Resident (R)50's call light was within his reach. This deficient practice left R50 vulnerable to unmet care needs due to the inability to call for staff assistance.</p> <p>Findings Included:</p> <ul style="list-style-type: none"> - R50's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of s diabetes mellitus (DM-when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), congestive heart failure (CHF-a condition with low heart output and the body becomes congested with fluid), depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), dysphagia (swallowing difficulty) following cerebral infarction (stroke - the 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), kidney disease (a condition in which the kidneys stop working and are not able to remove waste and extra water from the blood or keep chemicals in balance), urinary retention (lack of ability to urinate and empty the bladder), and aphasia (condition with disordered or absent language function). <p>The Annual Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of zero which indicated severely impaired cognition. The MDS documented R50 was dependent on staff for eating, showering, and personal hygiene.</p> <p>R50's Communications Care Area Assessment (CAA) dated 09/19/24 documented that R50 usually understands others. R50 had minimal difficulty with hearing patterns; R50 can hear if the speaker slows down and has his attention.</p> <p>R50's Care Plan dated 03/25/24 documented R50 was at risk for falls related to confusion, poor communication, and comprehension. R50's plan of care documented staff was to ensure R50's call light was within his reach and encourage him to use the pancake light. R50's plan of care documented that staff were to respond promptly to all requests for assistance.</p> <p>On 10/07/24 at 07:35 AM, R50 lay in his bed, on his back. His call light was on the floor on the right side. The call light was out of R50's reach.</p> <p>On 10/09/24 at 12:14 PM Licensed Nurse (LN)G stated call lights should be within the resident's reach.</p> <p>On 10/09/24 at 12:32 PM, Certified Nurse's Aide (CNA) P stated residents should be able to reach their call light, and staff should let the resident know where the call light was placed.</p> <p>On 10/09/24 at 01:04 PM Administrative Nurse D stated call lights should always be on the resident or beside the resident.</p> <p>(continued on next page)</p>		

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The facility's Accommodation of Needs policy documents the facility's environment and staff behaviors are directed toward assisting the resident in maintaining and/or achieving safe independent functioning, dignity, and well-being.</p> <p>The facility failed to ensure R50's call light was within his reach. This deficient practice left R50 vulnerable to unmet care needs.</p>		

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<p>F 0567</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to manage his or her financial affairs.</p> <p>45668</p> <p>The facility identified a census of 55 residents. The facility identified 29 residents with facility-managed trust accounts. Based on observation, record review, and interviews, the facility failed to ensure residents had same-day access to their funds for amounts less than \$100.00. This deficient practice placed 29 residents at risk for decreased psychosocial well-being and impaired rights.</p> <p>Findings Included:</p> <ul style="list-style-type: none"> - A review of the facility's Resident Funds accounts revealed 29 residents had active trust accounts with the facility. <p>On 10/07/24 at 07:05 AM an inspection of the central hallway door revealed a sign that read Bank open 3pm to 5pm on Monday through Fridays.</p> <p>On 10/07/24 at 02:20 PM Resident (R)31 sat outside the business office. R31 reported he was waiting for the bank to open so he could get some money out of his account. He stated he could only access the money from 03:00 PM through 05:00 PM. He stated he could not access money on weekends or after hours.</p> <p>On 10/08/24 at 01:30 PM, Resident Council members R10, R29, and R15 reported the facility's bank was only open on Mondays through Fridays for two hours. R15 stated Administrative Staff B oversaw the money transactions and only worked weekdays. He stated the residents could not access their money outside of the listed hours on the business office door or at all on weekends. R10 stated the facility used to have a cashbox left with the nurses but the facility did away with it a year ago. All three residents stated they wanted access to their money more often than just a few hours a week.</p> <p>On 10/09/24 at 12:02 PM Administrative Staff B stated she was the only staff that could access the resident funds. She stated the facility only allowed residents access to their funds for the listed hours of Monday through Friday between 03:00PMa and 05:00 PM. She stated she could change the hours under certain circumstances, but the funds were only available for limited hours and not every day. She stated the nurses and direct care staff did not have access to give the residents their funds when the facility's bank was closed.</p> <p>A review of the facility's Resident Funds policy (undated) indicated the facility would provide a means to protect the residents' funds. The policy indicated the facility would provide quarterly statements and have access to manage his/her funds in a safe/confidential manner.</p> <p>The facility failed to ensure residents had same-day access to their funds for amounts less than \$100.00. This deficient practice placed 29 residents at risk for decreased psychosocial well-being.</p>		

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<p>F 0576</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Ensure residents have reasonable access to and privacy in their use of communication methods.</p> <p>49634</p> <p>The facility identified a census of 55 residents. The sample included 15 residents. Based on interviews, the facility failed to provide mail delivery on Saturdays.</p> <p>Findings included:</p> <ul style="list-style-type: none"> - On 10/08/24 at 01:22 PM the Resident Council members reported that the facility did not provide mail services for the residents on Saturdays. The council reported the mail was stored over the weekend and distributed the following Monday. They stated that the weekend activity staff that used to pass the mail was no longer working at the facility. On 10/09/24 at 12:32 PM, Certified Nurse Aide (CNA) P stated he was unsure if the mail was passed out to the residents on Saturdays. On 10/09/24 at 01:04 PM Administrative Nurse D stated the mail used to be passed out by the activities staff. She stated that the staff member was no longer with the facility. Administrative D said she was unsure if the residents were getting mail delivered on Saturdays. <p>The facilities did not provide a policy for residents' right to have mail delivery on Saturdays.</p> <p>The facility failed to provide mail delivery on Saturdays.</p>

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49634</p> <p>The facility identified a census of 55 residents. The sample included 15 residents with one reviewed for notification of changes. Based on observation, record review, and interviews, the facility failed to notify Resident (R)50's representative of changes related to falls. This deficient practice placed R50 at risk for uninformed treatment or care decisions.</p> <p>Findings included:</p> <ul style="list-style-type: none"> - R50's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of s diabetes mellitus (DM-when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), congestive heart failure (CHF-a condition with low heart output and the body becomes congested with fluid), depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), dysphagia (swallowing difficulty) following cerebral infarction (stroke - the 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), kidney disease (a condition in which the kidneys stop working and are not able to remove waste and extra water from the blood or keep chemicals in balance), urinary retention (lack of ability to urinate and empty the bladder), and aphasia (condition with disordered or absent language function). <p>The Annual Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of zero which indicated severely impaired cognition. The MDS documented R50 was dependent on staff for eating, showering, and personal hygiene.</p> <p>R50's Communications Care Area Assessment (CAA) dated 09/19/24 documented that R50 usually understands others. R50 had minimal difficulty with hearing patterns; R50 can hear if the speaker slows down and has his attention.</p> <p>R50's Care Plan dated 03/25/24 documented R50 was at risk for falls related to confusion, poor communication, and comprehension. R50's plan of care documented staff was to ensure R50's call light was within his reach and encourage him to use the pancake light. R50's plan of care documented that staff were to respond promptly to all requests for assistance.</p> <p>R50's EMR under Nursing Notes dated 06/26/24 documented R50 had a fall with possible injury and was sent to the hospital. The note indicated R50's legal representative was notified.</p> <p>R50's EMR under Nursing Notes dated 10/03/24 documented R50 had a non-injury fall. The EMR lacked documentation R50's representative was notified.</p> <p>R50's EMR under Nursing Notes dated 10/08/24 documented that R50 had a non-injury fall. The EMR lacked documentation R50's representative was notified.</p> <p>On 10/07/24 at 07:35 AM R50 lay on his bed. R50 had his head covered up with his blanket.</p> <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 10/08/24 at 09:42 AM R50 was reclined in his Broda chair (specialized wheelchair with the ability to tilt and recline), in the commons area.</p> <p>On 10/07/24 at 09:23 AM R50's representative stated she had only been notified of one fall.</p> <p>On 10/09/24 at 12:14 PM, Licensed Nurse (LN) G stated the resident's guardian or representative should be called if there were changes in the resident's condition including falls, or anytime the facility had a concern with the resident.</p> <p>On 10/09/24 at 01:37 PM Administrative Nurse D stated she was unsure if the resident's representatives or guardians were always called. Administrative Nurse D stated the legal guardian or representative should be called and informed of any changes in condition.</p> <p>The facility's Change in Residents Condition or Status policy documents that the facility shall promptly notify the resident, his or her attending physician, and representative (sponsor) of changes in the resident's medical and mental condition and or status (changes in level of care, billing/payments, resident rights, etc.).</p> <p>The facility failed to notify R50's representative of changes related to falls. This deficient practice placed R50 at risk for uninformed treatment decisions.</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>45668</p> <p>The facility identified a census of 55 residents. The sample included 15 residents. Based on observation, record review, and interviews, the facility failed to promote a sanitary, homelike environment. This deficient practice had the potential for decreased psychosocial well-being and impaired safety and comfort for the affected residents.</p> <p>Findings Included:</p> <p>- On 10/07/24 at 07:00 AM upon entrance to the facility a strong urine odor was evident in the west and central hallways.</p> <p>On 10/07/24 at 07:03 AM an inspection of the dining hall area revealed multiple food trays with the previous evening's partially eaten taco and sloppy joe meals on a kitchen transport cart. Several flies were observed landing on the food. An inspection of the dining hall revealed flies in the area of the exposed food and trays.</p> <p>On 10/08/24 at 07:05 AM an inspection of the dining hall revealed old food and dirty plates left out from the previous evening's dinner across from the vending machine. Flies were present in the dining room and vending machine area.</p> <p>On 10/08/24 at 09:54 AM an inspection of the dining room revealed dried food particles and residue on the floor throughout the dining room.</p> <p>On 10/08/24 at 10:25 AM Resident (R) 2 slept in her wheelchair in the dining room. Multiple flies continued to land on her as she slept at the table.</p> <p>On 10/08/24 at 12:30 PM, numerous residents swatted flies away from their meals as they ate their meals in the dining room.</p> <p>On 10/08/24 at 01:34 PM, the Resident Council members acknowledged the fly issues. The council stated the facility had issues with flies. The council stated the dining room patio doors were continually left open and food was left out which increased the number of flies in the facility.</p> <p>On 10/10/24 at 01:30 PM Administrative staff A stated the facility was working with a pest control company to eliminate the flies that enter the facility. She stated food should not be left out for long periods of time and that staff were expected to clean. She stated the facility was older and staff was working to improve its condition.</p> <p>The facility's Quality Life-Homelike Environment policy indicates the residents are to be provided with a safe, clean, comfortable, and homelike environment and encouraged to use their personal belongings to the extent possible. The policy noted was expected to provide person-centered care that emphasizes the residents' comfort, independence, and personal needs and preferences.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The facility failed to promote a sanitary, homelike environment. This deficient practice had the potential for decreased psychosocial well-being and impaired safety and comfort for the affected residents.</p>		

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.</p> <p>49634</p> <p>The facility identified a census of 55 residents. The sample included 15 residents. Based on observation, record review, and interviews, the facility failed to implement a system to allow residents and their representatives to file grievances anonymously. This deficient practice placed the residents at risk for decreased psychosocial well-being and unresolved grievances and concerns.</p> <p>Findings Included-</p> <p>- On 10/07/24 at 08:10 AM an inspection of the facility revealed no designated grievance drop boxes or system available in the areas accessible to the residents and visitors of the facility.</p> <p>On 10/08/24 at 01:21 PM, the Resident Council members reported they were not aware that the facility provided a way to complete anonymous grievances. The council reported they must take the grievance to a staff member. The Resident Council stated the staff does help the residents fill out grievances, and the staff would slide the grievance under the door of the administrator's office, or just give the grievance to the administrator.</p> <p>On 10/09/24 at 12:14 PM, Licensed Nurse (LN) G stated the residents give their grievances to any staff member, and staff would ensure the grievance was delivered to the administrator.</p> <p>On 10/09/24 at 01:04 PM, Administrator Nurse D stated the facility did not have an anonymous reporting system for grievances. She stated the residents give their grievances to a staff member or an administrative person.</p> <p>The facility's Grievance, Complaining, and Filing policy documents that residents and their representatives have the right to file grievances, either orally or in writing, to the facility staff or the agency-designated person. The Administrator and staff will make prompt efforts to resolve grievances to the satisfaction of the resident and representative.</p> <p>The facility failed to implement a system to allow residents and/or their representatives to file grievances anonymously within the facility. This deficient practice placed the residents at risk for decreased psychosocial well-being and unresolved grievances.</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide activities to meet all resident's needs.</p> <p>45668</p> <p>The facility identified a census of 55 residents. The sample included 15 residents. Based on observation, record review, and interviews, the facility failed to provide consistent activities for the residents. This deficient practice placed the affected residents at risk for decreased psychosocial well-being, isolation, and boredom.</p> <p>Findings Included:</p> <ul style="list-style-type: none"> - An inspection of the September 2024 activity calendar indicated the residents were to have four scheduled staff-led activities throughout the day for each day. The calendar indicated staff-led activities would be held on or around 08:00 AM-0900 AM, 10:00 AM-11:00 AM, 01:00-02:00 PM, and 06:00-0700 PM with varied events like coffee chat, crafts, social hours, Bingo, and trivia. <p>Observation on 10/08/24 from 07:00 AM through 05:00 PM revealed no staff-led morning or afternoon activities were observed for the residents.</p> <p>Observation on 10/07/24 at 07:00 AM a walkthrough of the facility revealed September 2024 activity calendars still posted through the facility.</p> <p>Observation on 10/08/24 from 07:00 AM through 05:00 PM revealed no staff-led morning or afternoon activities were observed for the residents.</p> <p>On 10/08/24 at 01:34 PM, Resident Council members reported the activities coordinator was let go three weeks ago. The council reported the facility held some groups every now and then, but activities groups were inconsistent. The council reported office staff attempted to hold groups throughout the weekdays, but weekend activities were not often held. The council reported the facility also had a box with coloring pages, games, and crafts the residents could complete on their own over the weekends.</p> <p>On 09/07/24 at 08:45 AM Administrative Nurse D stated the facility's Activity Director was recently let go and didn't currently have anyone to fill the role.</p> <p>On 09/09/24 at 12:15 PM Licensed Nurse (LN) G stated the AC left about three weeks prior. He stated the front office tried to hold staff-led activities, but it was often inconsistent on the weekends. He stated the facility put out coloring pages and games for the residents to engage in as well.</p> <p>The facility's Activities policy revised 10/2022 indicated the facility would provide activities designed to support the needs of each resident's emotional, social, physical, and psycho-social well-being. The policy indicates the facility will employ a qualified staff member to ensure the program meets the required needs of the residents.</p> <p>The facility failed to provide consistent activities for the residents. This deficient practice placed the affected residents at risk for decreased psychosocial well-being, isolation, and boredom.</p>

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 10/09/2024
NAME OF PROVIDER OR SUPPLIER Legacy on 10th Avenue		STREET ADDRESS, CITY, STATE, ZIP CODE 2015 SE 10th Avenue Topeka, KS 66607	

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<p>F 0680</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure the activities program is directed by a qualified professional.</p> <p>45668</p> <p>The facility identified a census of 55 residents. The sample included 15 residents. Based on observation, record review, and interviews, the facility failed to provide a certified activity professional to direct the activities program in the facility. This deficient practice placed the affected residents at risk for impaired quality of life. (refer to F679)</p> <p>Findings Included:</p> <ul style="list-style-type: none"> - An inspection of the September 2024 activity calendar indicated the residents were to have four scheduled staff-led activities throughout the day for each day. The calendar indicated staff-led activities would be held on or around 08:00 AM-0900 AM, 10:00 AM-11:00 AM, 01:00-02:00 PM, and 06:00-0700 PM with varied events like coffee chat, crafts, social hours, Bingo, and trivia. <p>The facility was unable to provide evidence for an activity coordinator as requested on 10/07/24.</p> <p>Observation on 10/08/24 from 07:00 AM through 05:00 PM revealed no staff-led morning or afternoon activities were observed for the residents.</p> <p>Observation on 10/07/24 at 07:00 AM a walkthrough of the facility revealed September 2024 activity calendars still posted through the facility.</p> <p>Observation on 10/08/24 from 07:00 AM through 05:00 PM revealed no staff-led morning or afternoon activities were observed for the residents.</p> <p>On 10/08/24 at 01:34 PM, Resident Council members reported the activities coordinator was let go three weeks ago. The council reported the facility held some groups every now and then, but activities groups were inconsistent. The council reported office staff attempted to hold groups throughout the weekdays, but weekend activities were not often held. The council reported the facility also had a box with coloring pages, games, and crafts the residents could complete on their own over the weekends.</p> <p>On 09/07/24 at 08:45 AM Administrative Nurse D stated the facility's Activity Director was recently let go and the facility didn't currently have anyone to fill the role.</p> <p>On 09/09/24 at 12:15 PM Licensed Nurse (LN) G stated the Activity Director left about three weeks prior to the survey. He stated the front office tried to organize staff-led activities, but it was often inconsistent on the weekends. He stated the facility put out coloring pages and games for the residents to engage in as well.</p> <p>The facility's Activities policy revised 10/2022 indicated the facility would provide activities designed to support the needs of each resident's emotional, social, physical, and psycho-social well-being. The policy indicates the facility will employ a qualified staff member to ensure the program meets the required needs of the residents.</p> <p>(continued on next page)</p>

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<p>F 0680</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The facility failed to provide a certified activity professional to lead the facility activities program. This deficient practice placed the affected residents at risk for impaired quality of life.</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45668</p> <p>The facility identified a census of 55 residents. The sample included 15 residents with four reviewed for accidents. Based on observation, record review, and interview the facility failed to secure potentially hazardous equipment, oxygen tanks, and chemicals in a safe, locked area, and out of reach of eleven cognitively impaired independently mobile residents. This placed the affected residents at risk for preventable accidents and injuries.</p> <p>Findings Included:</p> <p>- On 10/07/24 at 07:05 AM a walkthrough of the facility was completed and revealed the following:</p> <p>An unsecured oxygen storage room contained 40 pressurized supplemental oxygen cylinders in the storage rack.</p> <p>The central and west hallways revealed unsecured furnace closets. The west hallway also had multiple bottles of bleach wipes stored in a storage room (room [ROOM NUMBER]) with the door propped open. The bottle contained the warning, Keep out of reach of children, hazardous to humans can cause eye irritation, harmful if swallowed.</p> <p>The central hallway revealed an unsecured cleaning closet with two multipurpose floor cleaners. The bottles contained the warning, Keep out of reach of children, hazardous to humans can cause eye irritation, harmful if swallowed.</p> <p>The east hallway revealed an unsecured beauty shop. A bottle of super-strength bleach sat on top of the vanity table. The bottle contained the warning, Keep out of reach of children, hazardous to humans can cause eye irritation, harmful if swallowed. The room also contained an open high-voltage electrical panel.</p> <p>On 10/09/24 at 10:45 AM Licensed Nurse (LN) G stated oxygen should be locked at all times and the facility was working to put an electronic lock on the oxygen storage room.</p> <p>On 10/09/24 at 11:43 AM Administrative Nurse D stated potentially hazardous chemicals and equipment should be secured and locked out of reach from the residents.</p> <p>The facility's Accident- Storage Areas policy revised 10/2024 indicated the facility will ensure the safe storage of potentially hazardous materials. The policy indicated materials and equipment will remain in locked and staff control areas at all times.</p> <p>The facility failed to secure potentially hazardous equipment, oxygen tanks, and chemicals in a safe, locked area, and out of reach of eleven cognitively impaired independently mobile residents. This placed the affected residents at risk for preventable accidents and injuries.</p>		

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<p>F 0732</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Post nurse staffing information every day.</p> <p>45668</p> <p>The facility reported a census of 55 residents. The sample included 15 residents. Based on observation, record review and interviews, the facility failed to maintain 18 months of daily posted nurse hours as required.</p> <p>Findings Included:</p> <ul style="list-style-type: none"> - On 10/07/24 at 07:02 AM an inspection of all unit's nursing stations revealed the required daily posted staffing sheets posted on each unit. <p>A review of the facility's Daily Posted Staffing from 05/01/23 to 10/07/24 was completed. The review revealed missing daily posted staffing sheets from 05/01/23 through 11/30/23.</p> <p>On 09/08/24 at 09:01 AM Administrative Nurse D stated she was only able to find the posted staffing sheet from December 2023 to the present due to the previous management team not filing them.</p> <p>A review of the facility's Staffing policy revised 08/2022 indicated that staffing hours must be maintained for facility records for a minimum of 18 months. The policy indicated the records must be made available upon request.</p> <p>The facility failed to retain the daily posted nursing staffing data for the 18 months as required.</p>

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.</p> <p>45668</p> <p>The facility identified a census of 55 residents. The sample included 15 residents with five reviewed for unnecessary medications. Based on observations, interviews, and record review, the facility failed to ensure the Consulting Pharmacist (CP) identified and reported the inappropriate indication or lack of diagnosis for Resident (R)4's Risperdal (antipsychotic medication used to treat major mental conditions that cause a break from reality). This deficient practice placed R4 at risk for unnecessary medications and side effects.</p> <p>Findings Included:</p> <ul style="list-style-type: none"> - The Medical Diagnosis section within R4's Electronic Medical Records (EMR) included diagnoses of altered mental status, epilepsy (brain disorder characterized by repeated seizures), hemiparesis/hemiplegia (weakness and paralysis on one side of the body), 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), and heart failure. <p>R4's Significant Change Minimum Data Set (MDS) completed 09/12/24 noted a Brief Interview for Mental Status (BIMS) score of 14 indicating intact cognition. The MDS indicated bilateral lower extremity impairment. The MDS noted she was dependent on staff assistance for dressing, bed mobility, personal hygiene, bathing, and transfers. The MDS indicated she took antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality) medications on a routine basis. The MDS indicated she had no observed behaviors since her last assessment.</p> <p>R4's Psychotropic Drug Use Care Area Assessment (CAA) completed 10/05/24 indicated she took Risperdal related to her diagnosis of bipolar disorder (a major mental illness that causes people to have episodes of severe high and low moods). The CAA instructed staff to monitor her for side effects related to her medication use.</p> <p>R4's Care Plan initiated 06/19/24 indicated she received psychotropic medications related to her behavioral management. The plan instructed staff to monitor her for adverse effects and behaviors of wandering, aggression, disrobing, delusions (untrue persistent belief or perception held by a person although evidence shows it was untrue), and hallucinations (sensing things while awake that appear to be real, but the mind created).</p> <p>R4's EMR under Physician Orders revealed an active order to administer 0.5 milligrams (mg) of Risperdal at bedtime dated 08/13/24 for antipsychotic.</p> <p>R4's EMR under the Medication Administration Report (MAR) also noted she took the Risperdal medication for antipsychotics.</p> <p>R4's EMR under Miscellaneous revealed a Pharmacy Monthly Medication Review completed on 09/27/24 that indicated R4 readmitted with the medication and reminded the medical provider to attempt a gradual dose reduction (GDR) at least twice within the first year of the medication administration. The Consulting Pharmacist did not identify the inappropriate indication listed for the Risperdal.</p> <p>(continued on next page)</p>		

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 10/07/24 at 11:01 AM, R4 laid in bed on a low air loss mattress.</p> <p>On 10/09/24 at 10:34 AM Licensed Nurse (LN) G stated antipsychotic medication needed to be used for only the approved diagnoses. He stated antipsychotic was not a diagnosis or indication to take a medication.</p> <p>On 10/09/24 at 01:05 AM Administrative Nurse D stated antipsychotic medication needed to be used for only approved diagnoses and indications. She stated antipsychotic was not an acceptable indication for medication use.</p> <p>The facility's Psychotropic Medication Monitoring 09/2024 indicated the facility will make every effort to ensure compliance with state and federal regulations related to the use of psychotropic medications. The policy noted the facility will ensure all medications have the appropriate use and indications, monitoring, and going evaluations for usage.</p> <p>The facility failed to ensure the CP identified and reported the lack of a diagnosis and/or the inappropriate indication for R4 's Risperdal. This deficient practice placed R4 at risk for unnecessary medications and side effects.</p>

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41037</p> <p>The facility identified a census of 55 residents. The sample included 15 residents with five residents reviewed for unnecessary medications. Based on observation, record review, and interviews, the facility failed to obtain the physician-ordered test to monitor for side effects related to the use of psychotropic (alters mood or thought) medication for Resident (R) 21. The facility also failed to ensure R4 had a Center for Medicare and Medicaid Services (CMS) approved indication or appropriate diagnosis for the use of an antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality). These deficient practices placed the residents at risk for adverse medication effects and unnecessary medications.</p> <p>Findings Included:</p> <ul style="list-style-type: none"> - R21's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), and hypertension (HTN-elevated blood pressure). <p>The Significant Change Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of eight which indicated moderately impaired cognition. The MDS documented R21 received diuretic (a medication to promote the formation and excretion of urine) medication, antidepressant (a class of medications used to treat mood disorders) medication, antianxiety (a class of medications that calm and relax people) medication, and antipsychotic medication during the observation period. The MDS lacked evidence a drug regimen review was completed.</p> <p>The Quarterly MDS dated [DATE] documented a BIMS score of five which indicated severely impaired cognition. The MDS documented that R21 received a hypnotic (a class of medications used to induce sleep), diuretic, antianxiety, and antidepressant medication during the observation period. The MDS lacked evidence a drug regimen review was completed.</p> <p>R21's Psychotropic Drug Use Care Area Assessment (CAA) dated 03/20/24 documented his medication would be addressed on the plan of care.</p> <p>R21's Care Plan dated 10/01/19 documented that staff would administer his medication as ordered and monitor for side effects along for effectiveness.</p> <p>R21's EMR under the Orders tab revealed the following physician order:</p> <p>Electrocardiogram (EKG-records the electrical activity of the heart) every three months (February, May, August, and November) related to psychotropic medication use dated 10/22/22.</p> <p>A review of R21's EMR lacked evidence of EKG results for November 2023 and August 2024. The facility was unable to provide evidence of the above test results.</p> <p>(continued on next page)</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 10/09/24 at 09:04 AM R21 sat in his wheelchair at the dining room table and drank coffee.</p> <p>On 10/09/24 at 01:05 PM, Administrative Nurse D stated she was unable to find results for R21's EKGs. Administrative Nurse D stated she had clarified the physician order, and the EKG order should have been discontinued when R21 was admitted to hospice services.</p> <p>The facility's Psychotropic Medication Monitoring policy last revised 09/2024 documented the facility would use and administer psychotropic medications appropriately working with the interdisciplinary team to ensure the appropriate use, evaluation, and monitoring.</p> <p>The facility failed to obtain physician-ordered EKG testing for R21 to monitor his psychotropic medication use. This deficient practice placed R21 at risk for adverse medication effects and unnecessary medications.</p> <p>45668</p> <p>- The Medical Diagnosis section within R4's Electronic Medical Records (EMR) included diagnoses of altered mental status, epilepsy (brain disorder characterized by repeated seizures), hemiparesis/hemiplegia (weakness and paralysis on one side of the body), 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), and heart failure.</p> <p>R4's Significant Change Minimum Data Set (MDS) completed 09/12/24 noted a Brief Interview for Mental Status (BIMS) score of 14 indicating intact cognition. The MDS indicated bilateral lower extremity impairment. The MDS noted she was dependent on staff assistance for dressing, bed mobility, personal hygiene, bathing, and transfers. The MDS indicated she took antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality) medications on a routine basis. The MDS indicated she had no observed behaviors since her last assessment.</p> <p>R4's Psychotropic Drug Use Care Area Assessment (CAA) completed 10/05/24 indicated she took Risperdal related to her diagnosis of bipolar disorder (a major mental illness that causes people to have episodes of severe high and low moods). The CAA instructed staff to monitor her for side effects related to her medication use.</p> <p>R4's Care Plan initiated 06/19/24 indicated she received psychotropic medications related to her behavioral management. The plan instructed staff to monitor her for adverse effects and behaviors of wandering, aggression, disrobing, delusions (untrue persistent belief or perception held by a person although evidence shows it was untrue), and hallucinations (sensing things while awake that appear to be real, but the mind created).</p> <p>R4's EMR under Physician Orders revealed an active order to administer 0.5 milligrams (mg) of Risperdal at bedtime dated 08/13/24 for antipsychotic.</p> <p>R4's EMR under the Medication Administration Report (MAR) also noted she took the Risperdal medication for antipsychotics.</p> <p>(continued on next page)</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R4's EMR under Miscellaneous revealed a Pharmacy Monthly Medication Review completed on 09/27/24 that indicated R4 readmitted with the medication and reminded the medical provider to attempt a gradual dose reduction (GDR) at least twice within the first year of the medication administration. The Consulting Pharmacist did not identify the inappropriate indication listed for the Risperdal.</p> <p>On 10/07/24 at 11:01 AM, R4 laid in bed on a low air loss mattress.</p> <p>On 10/09/24 at 10:34 AM Licensed Nurse (LN) G stated antipsychotic medication needed to be used for only the approved diagnoses. He stated antipsychotic was not a diagnosis or indication to take a medication.</p> <p>On 10/09/24 at 01:05 AM Administrative Nurse D stated antipsychotic medication needed to be used for only approved diagnoses and indications. She stated antipsychotic was not an acceptable indication for medication use.</p> <p>The facility's Psychotropic Medication Monitoring 09/2024 indicated the facility will make every effort to ensure compliance with state and federal regulations related to the use of psychotropic medications. The policy noted the facility will ensure all medications have the appropriate use and indications, monitoring, and going evaluations for usage.</p> <p>The facility failed to ensure R4 's Risperdal medication had an appropriate CMS-accepted indication for use. This deficient practice placed R4 at risk for unnecessary medications and side effects.</p>		

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<p>F 0838</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45668</p> <p>The facility identified a census of 55 residents. The sample included 15 residents. Based on interviews and record reviews, the facility failed to conduct a thorough facility-wide assessment to determine the resources necessary to care for residents competently during both day-to-day operations and emergencies. This placed all residents in the facility at risk for unidentified care needs and inadequate care.</p> <p>Findings Included:</p> <p>- On 10/08/24 at 08:00 AM an inspection of the Facility assessment dated [DATE] provided by the facility revealed the following:</p> <p>The assessment lacked information stating the specific staffing needed for each unit including nights and weekends and lacked the number of Registered Nurses (RN), Licensed Nurses (LPN/LVN), Certified Medication Aides (CMA), and Certified Nurse Aides (CNA) needed for each unit.</p> <p>The assessment lacked an informed contingency plan for events that did not require activation of the facility's emergency plan but had the potential to impact resident care.</p> <p>The assessment lacked a plan to maximize recruitment and retention of direct care staff.</p> <p>On 10/09/24 at 01:20 PM Administrative Staff A noted she reviewed the updated requirements from the Centers for Medicare and Medicaid Services (CMS) related to facility assessments but some of the information may not be attached to the facility's documentation.</p> <p>The facility's Facility Assessment policy revised 07/2024 indicated the assessment will be completed annually to provide a detailed review of the services, care, equipment, and staffing needs related to patient care.</p> <p>The facility failed to conduct a thorough facility-wide assessment to determine what resources were necessary to care for residents competently during both day-to-day operations and emergencies. This placed all residents in the facility at risk for unidentified care needs and inadequate care.</p>		

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<p>F 0849</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49634</p> <p>The facility identified a census of 55 residents. The sample included 15 residents with three residents reviewed for hospice (a type of health care that focuses on the terminally ill patient's pain and symptoms and attending to their emotional and spiritual needs at the end of life) services. Based on observation, record review, and interview, the facility failed to ensure a collaborated plan of care, which coordinated care and services provided by the facility with the care and services provided by hospice, was developed and available for Resident (R)51. This deficient practice created a risk for missed or delayed services and impaired care for R51.</p> <p>Findings Included:</p> <ul style="list-style-type: none"> - R51's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of diabetes mellitus (when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), atrial fibrillation (rapid, irregular heartbeat), cirrhosis (chronic degenerative disease of the liver), chronic obstructive pulmonary disease (COPD- a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), hypertension (HTN-elevated blood pressure), dysphagia (swallowing difficulty), and congestive heart failure (CHF-a condition with low heart output and the body becomes congested with fluid). <p>The Quarterly Minimum Data Set (MDS) dated [DATE] documented that R51 had a Brief Interview for Mental Status (BIMS) score of 13, which indicated cognitively intact cognition. The MDS documented that R51 had impairment on one side of his body. The MDS documented that R51 received hospice services during the observation period.</p> <p>R51's Functional Abilities Care Area Assessment (CAA) dated 06/18/24 documented R51 had a recent hospital stay. R51 was now admitted to hospice. The CAA documented R50 has had a recent decline due to his heart disease.</p> <p>R51's Care Plan dated 06/17/24 documented R51 had a terminal prognosis related to end-stage heart failure. R51's dignity and autonomy would be maintained at the highest level through the review date. R51's plan of care documented staff was to adjust the provision of activities of daily living (ADLS) to compensate for the resident's changing abilities. R51's plan of care documented that staff were to encourage participation to the extent the resident wished to participate, observe R51 closely for signs of pain, administer pain medications as ordered, and notify the physician immediately if there was breakthrough pain. The plan lacked information regarding the frequency of hospice staff visits and the medications, equipment, and supplies covered and provided by hospice.</p> <p>A review of the hospice-provided communication binder revealed that R51 was admitted to hospice services on 06/14/24.</p> <p>On 10/07/24 at 08:25 AM, R51 sat in his doorway in his wheelchair. His head was laid on his lap.</p> <p>On 10/08/24 at 10:21 AM R51 was in his wheelchair waiting to go outside to smoke.</p> <p>(continued on next page)</p>		

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 10/09/2024
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.			
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<p>F 0849</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 10/09/24 at 12:32 PM, Certified Nursing Aide (CNA)P stated the hospice provider would let the staff know when the hospice staff would return. CNA P was unsure what hospice provided for R51, he stated he was sure he could find the information in the Kardex (a nursing tool that gives a brief overview of the care needs of each resident).</p> <p>On 10/09/24 at 01:05 PM Administrated Nurse D stated the facility should have collaborated R51's care with hospice and the medication, supplies, and when the hospice staff would be in the facility should be care planned.</p> <p>The facility's Hospice Program policy documented hospice services were available to residents at the end of life. The facility had an agreement in place with at least one hospice provider to ensure that residents who wish to participate in a hospice program may do so.</p> <p>The facility failed to ensure collaboration between the facility and the hospice provider for R51's end-of-life care. This deficient practice created a risk for missed or delayed services and impaired care for R51.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>49634</p> <p>The facility identified a census of 55 residents. The facility failed to ensure staff performed adequate hand hygiene, ensure respiratory equipment was stored in a sanitary manner, and further failed to ensure linens were stored in a sanitary manner. These deficient practices placed the residents at risk for infectious diseases.</p> <p>Findings included:</p> <ul style="list-style-type: none"> - An initial walkthrough of the facility was completed on 10/07/24 at 07:34 AM. R30's nebulizer mask laid directly on his bedside table. The mask was not in a sanitary container. <p>On 10/07/24 at 07:54 AM during the initial tour, a high-back wheelchair in the south hallway revealed unbagged oxygen tubing coiled around the back arm of the wheelchair.</p> <p>On 10/07/24 at 01:34 PM, an inspection of the west hall revealed a storage room with clean linen next to a soiled linen bin. The clean linen cover was left open next to the soiled bin.</p> <p>On 10/08/24 at 09:16 AM Certified Nurse's Aide (CNA) M and CNA O donned gloves, without performing hand hygiene first. CNA M pushed R50 into his room, and the CNAs used a Hoyer (total body mechanical lift) to place R50 in bed. CNA M held R50's suprapubic catheter (urinary bladder catheter inserted through the abdomen into the bladder) tubing during the transfer. CNA M and CNA O rolled R50 left to right removing the sling from underneath the resident. CNA M checked R50's brief and placed the call light within the resident's reach. CNA O and CNA M removed their gloves and placed the gloves in a trash container. Booth CNA O and CNA M did not perform hand hygiene after removing the gloves or upon leaving the resident's room.</p> <p>On 10/09/24 at 12:14 PM, Licensed Nurse (LN) G stated nebulizer mask and oxygen tubing should be placed in a bag and dated when not in use. He stated hand hygiene should be performed when entering or existing resident rooms, and always after resident care. LN G stated he was unsure how laundry was stored.</p> <p>On 10/09/24 at 12:32 PM, CNA P stated nebulizers and oxygen should be stored in a bag when not in use. He stated staff should wash their hands all the time, before going into residents' rooms and leaving the residents' room, going to the bathroom, and after residents' care. CNA P stated dirty and clean laundry should not be stored together.</p> <p>On 10/09/24 at 01:04 PM, Administrative Nurse D stated clean laundry should always be covered. She stated all respiratory equipment should be bagged if not in use, the nebulizer mask was to be rinsed after each use and nasal cannulas were changed weekly. Administrative nurse D stated that staff should do hand hygiene before entering a resident's room, during a resident's care, leaving a resident's room, and any time their hands are soiled.</p> <p>The facility's Hand Hygiene policy documented the facility considers hand hygiene the primary means to prevent the spread of infections. All personnel shall be trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare-associated infections.</p> <p>(continued on next page)</p>

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NAME OF PROVIDER OR SUPPLIER Legacy on 10th Avenue		STREET ADDRESS, CITY, STATE, ZIP CODE 2015 SE 10th Avenue Topeka, KS 66607	

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The facility's Nebulizer Treatment policy was implemented to ensure the safe and effective delivery of medication or moisture to the trachea, bronchi, and/or lungs. Upon provider order, nebulizer treatments will be administered by nursing staff as directed using proper technique and universal precautions.</p> <p>The facility failed to ensure staff performed adequate hand hygiene, ensure respiratory equipment was stored in a sanitary manner, and further failed to ensure linens were stored in a sanitary manner. These deficient practices placed the residents at risk for infectious diseases.</p>

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<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Make sure there is a pest control program to prevent/deal with mice, insects, or other pests.</p> <p>45668</p> <p>The facility identified a census of 55 residents. The sample included 15 residents. Based on record reviews, interviews, and observations, the facility failed to provide effective pest control to ensure the facility was free from pests. This placed the residents at increased risk for impaired comfort and disease.</p> <p>Findings Included:</p> <p>- A review of the facility's pest control Service Inspection Report revealed an inspection was completed on 10/07/24 at 09:00 AM and indicated Dietary Staff BB reported no pest concerns. The report noted fly bait traps were placed around the dining and vending machine areas.</p> <p>Observation on 10/07/24 at 07:00 AM of the dining hall area revealed multiple food trays with the previous evening's exposed and partially eaten taco and sloppy joe meals on a kitchen transport cart. There were several flies observed landing on the food. Further observation of the dining hall revealed flies in the area of the exposed food and trays.</p> <p>Observation on 10/08/24 at 07:05 AM of the dining hall revealed old food and dirty plates left out from the previous evening's dinner across from the vending machine. There were more flies present in the dining room and vending machine area.</p> <p>Observation on 10/08/24 at 10:25 AM revealed Resident (R)2 slept in her wheelchair in the dining room. Multiple flies landed on her as she slept at the table.</p> <p>Observation on 10/08/24 at 11:50 AM revealed R2 slept at the dining room table. At 12:05 PM R2's food sat in front of her on the table as she slept. Her food remained on the table uncovered until Licensed Nurse (LN) G entered the dining hall at 12:21 PM and woke her up. Multiple flies landed on and around her plate as she slept. LN G cued R2 and assisted her with her meal set-up.</p> <p>Observation on 10/08/24 at 12:30 PM revealed numerous residents swatted flies away from their meals as they ate their meals in the dining room.</p> <p>During an interview on 10/09/24 at 12:02 PM, Dietary Staff BB stated old food and dirty dishes should never be left out overnight. She stated the trash should be stored in closed containers and dishes should be washed. but said the trash area had no place to dispose of the old food and used dishes.</p> <p>During an interview on 10/09/24 at 01:05 PM Administrative Nurse D stated food and dirty dishes should never be left out after meals. She stated staff were expected to throw out the old food and rinse the dishes off before putting them in the turn-in bin.</p> <p>The facility did not provide a policy for pest control.</p> <p>The facility failed to provide effective pest control to ensure the facility was free from pests. This placed the residents at increased risk for impaired comfort and disease.</p>		