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Form Approved OMB
No. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
| --- | --- | --- | --- |
| | 175113 | A. Building<br>B. Wing | 03/31/2026 |

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

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES<br>(Each deficiency must be preceded by full regulatory or LSC identifying information) |
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| F 0725<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.<br><br>The facility identified a census of 54 residents. The sample included 14 residents. Based on observation, record review, and interview, the facility failed to ensure there was sufficient nursing staff on the weekends to provide care to each resident's basic and individual needs. Findings included:- A review of the facility's CMS (Centers for Medicare and Medicaid) Payroll-Based Journal (PBJ) Staffing Data Report CASPER Report 1705D for fiscal year (FY) 2026 quarter one data revealed the facility triggered for excessively low weekend staffing.The facility's Facility Assessment, last reviewed on 03/19/26, documented the facility had a capacity of 60 residents. Based on the number of residents and their basic and individual needs the required staffing numbers (optimal/minimum) for each shift on weekdays for day and evening shifts two licensed nurses, two certified medication aides (CMA), and four direct care staff (certified nurse aides); for the night shift: two licensed nurses, two direct care staff. Weekend staffing numbers were two licensed nurses, two certified medication aides (CMA), and four direct care staff; for the night shift: two licensed nurses, two direct care staff. Review of the actual nursing staff working schedules from 10/01/25 to 02/28/26 revealed low weekend staffing (less than the minimum/optimal number of staff per facility assessment) on four of four weekends in October 2025, five of five weekends in November 2025, four of four weekends in December 2025, two of four weekends in January 2026, and four of four weekends in February 2026. On 03/31/26 at 12:51 PM, Licensed Nurse (LN) G stated that typically they try to have two nurses, four nurse aides and two medication aides for each shift on days and evening shift and nights have two nurses and two aides and then on weekends it should be the same. The facility has on-call staff that are called to cover on the weekends. On 03/31/26 at 12:51 PM, Administrative Nurse D stated the facility had an on-call schedule for each weekend and that person would be called if a slot was needed to cover. Administrative Nurse D stated weekends were hard to get staff coverage when there was a call-in and at times management staff would come in to cover if staff were excessively low. Ultimately, each shift for days and evenings and nights should be the same on the weekends as it was during the week. On 03/31/26 at 01:13 PM, Administrative Staff A stated that there was an on-call list for every weekend to call to try to get coverage if there had been call-ins and management staff had to come in to cover at times. The weekends are when there are the most call-ins, and those shifts are hard to get covered but the weekend staffing requirements are the same as during the week and based off what the facility assessment said was the minimal number of staff needed. The facility's Facility Assessment policy, revised July 2024, documented the facility assessment also included a detailed review of the resources available to meet the needs of the resident population. This part of the assessment included: all personnel, including directors, managers, regular employees (full and part-time), contracted staff (full and part-time), and volunteers. There was a breakdown of the training, licensure, education, skill level and measures of competency for all personnel. |

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 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>The facility identified a census of 54 residents. The facility had one kitchen and a dining area. Based on observation, record review, and interviews, the facility failed to follow sanitary dietary standards related to dirty dishes, food storage, and nonworking equipment.Findings included:- During the initial tour on 03/24/26 at 09:10 AM, observation revealed the following:The dietary manager was not wearing a hair net, while in the kitchen area standing by the two-door refrigerator.The floors were sticky and dirty; tiles were missing off the floor next to the dishwasher.There were 17 trays with dried chili, cinnamon rolls and other foods on a tall silver cart, the trays were left from the previous day. The dishwasher sink had standing water. Dietary Staff BB stated the garbage disposal was backed up.The bowls and plates were not stored inverted.The steam table had dried food on the top, and dried food particles of dark brown substance that had run down the front of the table. Underneath the steam table revealed grease and food residue. Next to the steam table was a stainless-steel counter, the counter had dried food spilled down the side of the counter. Under the counter was brown serving trays with dried white substance covering parts of the trays.Dietary Staff BB stated the ovens on the stove did not work, and staff were using the convection oven to bake their food.The kitchen door was propped open.In the two-door refrigerator in the kitchen prep area, observation revealed a bag of sliced turkey that was opened and undated. The turkey was dripping juices on to the bottom shelves.In a single door white freezer, a box of chocolate chip cookie dough was opened and opened to air.In the double refrigerator in the serving area there was chocolate pudding unlabeled and undated, a bag of canned fruit, and small bowls of fruit that were unlabeled and undated.On 03/31/26 at 07:44 AM, a recheck of the kitchen revealed the ice scoop laid on top of the ice machine, the scoop was not in a container. There was no thermometer in the milk cooler. On 03/23/26 at 09:25 AM, Dietary Staff BB stated all foods should be dated and labeled. She stated the garbage disposal was backed up, and maintenance came in a fixed disposal. Dietary Staff BB stated the steam table, and counters should be cleaned often and after each meal. She stated dishes should be inverted. She stated maintenance had been working on ordering parts and fixing the ovens in the kitchen. Dietary Staff BB stated all dishes should be washed and put away and not left overnight. On 03/31/26 at 08:31 AM, Dietary Staff BB stated maintenance had plunged the garbage disposal and it was now in working order. She stated she would get a thermometer in the milk cooler, and a container for the ice scoop.On 03/23/26 at 12:21 PM, Administrative Staff A was unaware the kitchen was not clean. She stated her expectation was all staff follow policies and procedures. She stated the kitchen had employee turnover in the last six months. The facility's Food Receiving and Storage policy undated documented foods would be received and stored in a manner that complies with safe food handling practices.The facility's Sanitation policy undated documented the food service area shall be maintained in a clean and sanitary manner. |

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| F 0839<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Employ staff that are licensed, certified, or registered in accordance with state laws.<br><br>The facility identified a census of 54 residents. The sample included 14 residents. Based on observation, record review, and interview, the facility failed to ensure Licensed Nurse (LN) on staff had and retained a valid active nursing license. Findings included:- On 03/23/26 the facility report dated 02/17/26 documented Administrative Staff A identified that LN H's nursing license was lapsed since 11/30/25. The facility verified LN H's lapsed nursing license through a search on Nursys (a national database for verification of nurse licensure) website: www.nursys.com and the Kansas State Board of Nursing (KSBN) website at www.kansas.gov/ksbn-verifications/. On 03/23/26 the surveyors conducted a search of the Nursys website and the KSBN and verified that LN H's nursing lapsed on 11/30/25. LN H continued working at the facility with a lapsed license up until 02/17/26.On 03/23/26 at 12:20 PM, Administrative Nurse D stated that human resources (HR) staff were responsible for verifying valid licenses and keeping track of the expiration dates. Administrative Nurse D stated the facility has had some changeover in HR staff recently and it was found that the checking of the nursing licenses and nurse aide registry validations had not been kept up to date.On 03/23/26 at 10:45 AM, Administrative Staff A stated that she had found out after the turnover of three different HR staff in the past six months that nursing license verifications had not been completed for some time. Administrative Staff A stated that Administrative Staff B was now the person that would be responsible for keeping track of licensures and nurse registry verification.The facility's Background Screening Investigations policy dated November 2023 documented for any licensed professional applying for a position that may involve direct contact with residents, his/her respective licensing board is contacted to determine if any sanctions have been assessed against the applicant's license. |

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| F 0925<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Make sure there is a pest control program to prevent/deal with mice, insects, or other pests.<br><br>The facility had a census of 54 residents. Based on observation, interview, and record review, the facility failed to follow the pest control recommendations. Findings included:- The Pest Control Monthly Report dated 02/24/26 documented recommendations with a high priority related to a hole in the wall under the bathroom sink large enough for rodent entry, and the hole needed to be patched. The recommendations documented the hole in the wall was near the floor.On 03/24/26 at 11:32 AM, an observation of Resident (R) 5's room revealed a hole in the wall underneath his sink.On 03/24/26 at 12:05, Maintenance Supervisor U stated the hole remained in the wall. He stated he did not have time to fix the hole in the wall. Maintenance Supervisor U stated the facility had done a mock survey, and the owners did a walk through, and had given him projects that had a deadline. He stated he had traps set up to catch mice and boxes outside to catch mice. He stated the mice had been less since the traps were set and he had fixed the outside of the building.On 03/31/26 at 12:00, Certified Nurses Aide (CNA) N stated when staff see mice or rodents in R5's room or R18's room the CNA would put that information into Facilities Work order System (TELS). She stated the maintenance person gets this information and takes care of any situation.On 03/31/26 at 12:12, Licensed Nurse (LN) G stated she would call the maintenance supervisor to let them know right away there was a problem.On 03/31/26 at 12:25 PM, Administrative Nurse D stated the facility had a program to ensure all rooms and equipment were kept in good condition. She stated rooms were checked weekly.On 3/31/26 at 02:10 PM, Administrative Staff A stated she expected any recommendations to be followed up on immediately.The facility's Pest Control policy undated documented the facility maintains an on-going pest control program to ensure that the building is kept free of insects and rodents. Garbage and trash are not permitted to accumulate and are removed from the facility daily. Maintenance services assist, when appropriate and necessary, in providing pest control services. |

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| F 0947<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention.<br><br>The facility identified a census of 54 residents. The sample included 14 residents. Based on observation, record review, and interview, the facility failed to ensure nurse aides received the required 12 hours of in-service training. Findings included:- On 03/24/25, the record of the required nurse aide in-service training documentation from the past year was requested. The facility was unable to locate the binder that had the sign-in sheets and the education/training provided to nurse aide staff.On 03/24/26 at 12:41 PM, Administrative Staff A stated she was unable to find the in-service binder and has had some staff turnover in the last year, including the staff responsible for making sure the in-services were completed and documentation maintained. She said the facility will be having a skills fair soon.On 03/31/26 at 12:51 PM, Administrative Nurse D stated the director of nurse aides was responsible for ensuring the nurse aides have completed and maintain the documentation for the required in-services. Administrative Nurse D stated the facility has had staff turnover in that position and some of the required in-service documentation was not completed or retained.The facility's Nurse Aide Qualifications and Training Requirements policy dated 08/10/21 lacked information regarding the nurse aides required yearly 12 hours of in-service training/education. |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 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.<br><br>The facility identified a census of 54 residents. The sample included 14 residents. Based on observation and interviews, the facility failed to provide a clean, home-like environment for the residents who resided in the facility.Findings included:- On 03/23/26 at 08:45 AM, during the facility walk through of the East and West Halls, there was a distinct smell of urine. While doing the walk through, up and down each hall revealed several urinals set on bedside tables and on the floors by the beds, some of the urinals did not have lids. The hall foyer entry into the dining room had a distinct urine smell.An inspection was completed in the facility's laundry service room. Laundry was stacked up, and four large grey tubs of laundry sat in the laundry room. The laundry room was in the hall next to the kitchen foyer entry.The floor in the dining area was sticky and dirty, with multiple dried spills.On 03/31/26 at 12:05 PM, Licensed Nurse (LN) G stated she would have a Certified Nurse's Aides (CNAs) help her look for the source of the smell. She stated she would check all the residents who were incontinent. LN G stated she would also get maintenance and housekeeping involved to find the source.On 03/23/26 at 12:25 PM, Administrative Nurse D started the staff should find the source of the odor. She stated staff can give urinals with a lid, or ensure the urine was dumped more often.On 03/23/26 at 12:12 PM, Administrative Staff A stated her goal for the facility was that there were no foul odors in the building, and policies and procedures would be followed. Administrative Staff A stated the facility did have a person in the facility who urinates in other places than the bathrooms. She stated housekeeping keeps clean as soon as it was seen.The facility's Quality of Life-Home Environment policy undated documented residents were provided with a safe, clean, comfortable and homelike environment and encouraged to use their personal belongings to the extent possible. Staff shall provide person-centered care that emphasizes the residents' comfort, independence and personal needs and preferences. Clean, sanitary and orderly environment; Pleasant, neutral scents. |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.<br><br>The facility identified a census of 54 residents. The sample included 14 residents, with four medication carts and two medication rooms. Based on observation, record review, and interviews, the facility failed to ensure an accurate reconciliation of controlled drugs at the end of daily work shifts.Findings included:- On 03/30/26 at 09:17 AM, a review of the Narcotic Shift Count Sheet on the west hall from 01/01/26 to 03/29/26 (88 days) revealed a missing signature either for the on-coming nurse or the off-going nurse on the following dates (59 days): 01/01/26, 01/02/26, 01/03/26, 01/04/26, 01/05/26, 01/06/26, 01/08/26, 01/12/26, 01/13/26, 01/16/26, 01/17/26, 01/18/26. 01/19/26, 01/20/26, 01/21/26, 01/22/26, 01/23/26, 01/24/26, 01/25/26, 01/27/26, 01/28/26, 01/30/26, 01/31/26, 02/01/26, 02/02/26, 02/05/26, 02/07/26, 02/09/26, 02/10/26, 02/12/26, 02/13/26, 02/15/26, 02/19/26, 02/23/26, 02/24/26, 02/25/26, 02/27/26, 03/01/26, 03/02/26, 03/03/26, 03/08/26, 03/09/26, 03/10/26, 03/11/26, 03/12/26, 03/13/26, 03/15/26, 03/16/26 03/17/26, 03/19/26, 03/20/26. 03/21/26, 03/22/26, 03/23/26, 03/24/26, 03/25/26, 03/27/26, 03/28/26, and 03/29/26. On 03/31/26 at 12:30 PM, Administrative Nurse D stated it was the facility policy and expectation that the narcotic count was reconciled between shift change daily and every shift. The facility's Pharmacy Services Overview policy dated 10/2024 documented the facility would accurately and safely provide or obtain pharmaceutical services, including the provision of routine and emergency medications and biologicals, and the services of a licensed consultant pharmacist. |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 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.<br><br>The facility identified a census of 54 residents. The facility had four medication carts and two medication rooms. Based on observation, record review and interview, the facility failed to ensure that medication carts were not left unlocked and unattended by staff and failed to ensure that medications and stock medication/supplements in a medication room were discarded when expired. Findings included:- On 03/23/26 at 12:09 PM in the west hall, the medication aide medication cart was left unlocked and the keys still in the lock. There were no staff near the medication cart. Administrative Nurse D walked up to the medication cart, locked the cart and removed the keys from the lock then waited for Certified Medication Aide (CMA) R to return to the cart. On 03/30/26 at 09:17 AM the west medication storage room revealed no date on an opened vial of tuberculin (a purified protein derivative used in skin tests to help diagnose tuberculosis [a contagious infection primarily attacking the lungs, though it can affect other organs]) and an outdated eye latanoprost ophthalmic solution (a prescription eye drop used to lower high eye pressure) for Resident (R)19 with an expiration date of 10/15/24. On 03/23/26 at 12:10 PM, Administrative Nurse D stated that the medication carts should never be left unlocked or the keys left in the cart when staff were away from the cart. On 03/23/26 at 12:11 PM, CMA R stated she had stepped away from her medication cart for just a moment to assist another staff member, but she should have locked her cart and removed the keys when she stepped away from the cart. On 03/30/26 at 09:20 AM, Administrative Nurse D stated that Administrative Nurse E was responsible for making sure all medications were sent back to the pharmacy if needed and that there were no outdated medications in the medication room. The facility's Storage of Medications policy, revised October 2021 documented drugs and biologicals used in the facility are stored in locked compartments under proper temperature, light and humidity controls. Discontinued, outdated, or deteriorated drugs or biologicals are returned to the dispensing pharmacy or destroyed. Unlocked medication carts are not left unattended. Medications requiring refrigeration are stored in a refrigerator located in the drug room at the nurses' station or other secured location. Medications are stored separately from food and are labeled accordingly. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide and implement an infection prevention and control program.<br><br>The facility identified a census of 54 residents. The facility identified nine residents on Enhanced Barrier Precautions (EBP-infection control interventions designed to reduce transmission of resistant organisms that employ targeted gown and glove use during high contact care). Based on record review, observations, and interviews, the facility failed to ensure Resident (R)49's, R26's R6, and R30 nebulizer (a device that changes liquid medication into a mist easily inhaled into the lungs) masks were stored in a sanitary manner when not in use. The facility failed to ensure R44's nasal canula was stored in a sanitary manner when not in use. The facility further failed to ensure clean laundry was stored in a sanitary manner. The further failed to ensure the ice scoop was stored in a sanitary manner. The facility failed to ensure hand washing was performed between medication passes and from a dirty environment to a clean environment.Findings included:- On 03/23/26 at 09:10 AM, during the initial walk-through of the facility, R49's nebulizer mask laid next to his oxygen canister. R49's nebulizer mask was not stored in a sanitary container.R26's nebulizer laid on a blue tote by the entrance of her door. R26's nebulizer canister was not contained in a sanitary manner.R6's nebulizer mask laid at the bottom of his bed. R6's nebulizer mask was not contained in a sanitary manner.R30's nebulizer mask laid on his bedside table. R30's nebulizer mask was not contained in a sanitary manner.R44's nasal canula was wrapped around the handle of R44's oxygen canister. R44's nasal canula was not contained in a sanitary manner.The green laundry cart in the 40's Hall was uncovered, with the cover pulled back, and revealed blue chucks, brown blankets and white sheets.In the day room between the East and West Hall, an ice scoop laid on the metal cart next to the blue ice chest. The ice scoop was not contained in a sanitary manner.On 03/24/26 at 11:11 AM, Administrative Staff B prepared R36's medications at the medication cart in the hallway. She took the medication cup with the medications into his room and gave him the medications. Afterward, she brought R36's drinking cup out of his room to fill with ice and placed it on the medication cart. Administrative Staff B did not perform hand hygiene after exiting R36's room and before preparing R48's medications. She prepared R48's medications at the medication cart in the hallway then brought them to R48 in her room. She exited R48's room and did not perform hand hygiene after exiting or before preparing R19's medications. Administrative Staff B prepared R19's medications and administered them in his room. She performed hand hygiene upon exiting R19's room.On 03/24/26 at 11:18 AM, Administrative Staff B prepared R13's medications at the medication cart in the hallway. She gave R13 his medications in his room then exited without performing hand hygiene and before preparing R14's medications. Administrative Nurse B prepared R14's medications at the medication cart in the hallway. She gave R14's medications in her room then exited with the medication cup and threw the cup in the medication cart's trash can which required her to touch the trash can lid. She did not perform hand hygiene after touching the trash can lid or before preparing R6's medications.On 03/24/26 at 11:21 AM, Administrative Nurse B prepared R6's medications at the medication cart in the hallway. She put the medication pills into a pill crusher packet and crushed R6's medications then put them in a medication cup before mixing the crushed medications with pudding. She entered R6's room, touched his blanket, then gave the mixed medications to R6 with a spoon followed with a drink of water. Administrative Nurse B exited R6's room with the medication cup and touched the trash can lid to throw the cup away. She did not perform hand hygiene. She touched the back of her scrub top then pushed the medication cart down the hallway. She grabbed R36's cup from on top of the medication cart and took it to fill with ice. She delivered the cup to R36's room. She did not perform hand hygiene after exiting R36's room. She returned to the medication cart and touched her face. Administrative Nurse B walked towards the dining room and used hand sanitizer. On 03/24/26 at 11:31 AM, Administrative Nurse B grabbed R31's nasal spray out of the cart and prepared his medications into a cup. She donned gloves then administered R31's nasal spray. Administrative Nurse B doffed (removed) her gloves. She did not perform hand hygiene after doffing gloves.On 03/24/26 at 11:44<br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | AM, Administrative Nurse B stated she performed hand hygiene during medication administration after every three medication passes and she washed her hands after four or five medication passes.On 03/31/26 at 11:55: AM, Certified Nurse's Aide (CNA) N stated the facility had plastic bags to put respiratory equipment that was not in use. She stated the green cart with clean laundry should be always covered. CNA N stated the ice scoop should have a container to place it in. She stated hands should be washed or sanitized all the time, especially after touching anything dirty.On 03/31/26 at 12:17 PM, Licensed Nurse (LN) G stated respiratory equipment were cleaned and put in a plastic bag when not in use. She stated the green laundry cart was always covered. LN G stated the ice scoop should be placed in the blue hold when staff were finished with it. She stated hands should be washed when walking into a resident's room, leaving a resident's room and anytime hands are soiled.On 03/31/26 at 12:30 PM, Administrative Nurse D stated all respiratory equipment should be placed in a plastic bag when not in use. She stated the green cart that had extra bedding supplies should be covered. Administrative Nurse D stated there was a container by the ice cart that the scoop should be placed in. She stated hands should be washed or sanitized each time staff touch anything dirty, and between residents.The facility's Hand Washing/Hand Hygiene policy undated documented the facility the facility considered hand hygiene the primary means to prevent the spread of infections. All personnel should be trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare-associated infections. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. Hand hygiene products and supplies (sinks, soap, towels, alcohol-based hand rub, etc.) shall be readily accessible and convenient for staff use to encourage compliance with hand hygiene policies.The facility did not provide a policy for clean laundry stored as requested on 03/31/26. |

| 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 03/31/2026 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Legacy on 10th Avenue | 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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| F 0628<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 54 residents. The sample included 14 residents, with one resident reviewed for hospitalization. Based on observation, record review, and interviews, the facility failed to ensure Resident (R) 52 and their representative were provided with a written notification of transfer, which included where, why, and a statement of the right to appeal and the state ombudsman information, upon their transfer to the hospital as soon as practicable.Findings included:- R52's Electronic Medical Record (EMR) recorded a Discharge Minimum Data Set (MDS) dated [DATE], which documented an unplanned discharge to an acute hospital with a return anticipated.The facility provided a Nursing Home to Hospital Transfer Form dated 03/06/26 for R52. The form lacked the transfer location, resident or legal representative was notified of the transfer and the reason for the transfer. The a Nursing Home to Hospital Transfer Form lacked information containing a statement of the resident's appeal rights, including the name, address, and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request, as well as the name, address, and telephone number of the Office of the State Long-Term Care Ombudsman.On 03/31/26 at 12:17 PM, Licensed Nurse (LN) G stated LN G stated she would document in the resident's EMR who was notified of the transfer, where the resident was to be transferred, and the information that was sent with resident regarding their medical condition.On 03/31/26 at AM/PM, Administrative Nurse D stated the facility would not provide written notification if the resident was their legal representative or had a Brief Interview of Mental Status (BIMS) score of 12 or greater which indicated intact cognition.The facility's Transfer or Discharge Notice policy dated 10/2021 documented the facility would provide a resident and/or the resident's representative (sponsor) with a thirty (30)-day written notice of an impending transfer or discharge. If the discharge was due to a medical emergency, the resident would be transferred to an appropriate acute care setting and a determination made regarding the need for a formal notice of discharge. |

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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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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>The facility identified a census of 54 residents. The sample included 14 residents with two residents reviewed for falls. Based on interviews, observation, and record review the facility failed to ensure fall interventions were implemented as care planned for Resident (R) 6 when staff failed to ensure his call light was within reach.Findings included:- R6's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of hemiparesis (muscular weakness of one half of the body), hemiplegia (paralysis of one side of the body), dementia (a progressive mental disorder characterized by failing memory and confusion), and 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).The Quarterly Minimum Data Set (MDS) dated 01/15/25 documented a Brief Interview of Mental Status (BIMS) score of 14 which indicated intact cognition. The MDS documented R6 had one non-injury fall during the observation period. R6's Falls Care Area Assessment (CAA), dated 10/27/25, documented he was at risk for falls related to an unsteady balance, history of falls, and the psychotropic (alters mood or thought) medications ordered.R6's Care Plan, documented the following interventions: 10/06/25: Anticipate and meet his needs; Staff would follow the facility's fall protocol; Staff would educate him, his family and his caregivers about the safety reminders and what to do if a fall occurred.10/17/25: R6 required prompt response to all requests for assistance. 12/15/25: Be sure R6's call light was within reach and encourage him to use it for assistance as needed; Staff to ensure R 6's chair was reclined when he was not eating. 03/04/26: Staff was to ensure right lateral support was in place.R6?s EMR revealed a Fall Note dated 03/04/26 at 10:11 AM which documented a dietary staff member witnessed R6 fall over the side of his wheelchair to the floor. R6 received skin tears on his left knee, right ankle and left thumb.R6's EMR revealed a Fall Risk Assessment dated 03/04/26, which documented R6 was a high fall risk.On 03/24/26 at 01:22 PM, R6 sat reclined in his Broda chair (specialized wheelchair with the ability to tilt and recline), in his room. R6's call light laid behind his bed and was not within his reach. On 03/31 at 11:22 AM, R6 laid reclined in his Broda chair. R6's call light was behind the bed and not in his reach.On 03/31/26 at 11:55 AM, Certified Nurse Aide (CNA) N stated everyone had access to the resident's care plans. CNA N stated a residents fall intervention could be found on their care plans. CNA N stated a residents call light should be within their reach when they are in their rooms.On 03/31/26 at 12:17 PM, Licensed Nurse (LN) G stated the residents fall interventions could be found on their care plan which everyone had access too. LN G stated R6's call light should be within reach of every resident.On 03/31/26 at 12:30 PM, Administrative Nurse D stated she expected the call light to be within R6's reach to prevent falls. The facility's Managing Falls and Fall Risk policy, dated 10/2021 documented based on previous evaluations and current data, the staff would identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. |

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| Legacy on 10th Avenue | 2015 SE 10th Avenue<br>Topeka, KS 66607 |

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| F 0883<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement policies and procedures for flu and pneumonia vaccinations.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 54 residents. The sample included 14 residents with five reviewed for immunization status. Based on record reviews and interviews, the facility failed to offer or obtain informed declinations, consent, or a physician-documented contraindication for the influenza (highly contagious viral infection that attacks the lungs, nose, and throat and can be deadly in high-risk groups) vaccination for Resident (R) 26 and R8. The facility also failed to offer or obtain informed declinations, consent, or a physician-documented contraindication for the Pneumococcal Conjugate Vaccine (PCV20- vaccination for bacterial infections), pneumococcal (type of bacterial infection) for R8.Findings included:- 1. On 03/30/26, R26's clinical record revealed he was admitted on [DATE]. The EMR under the Immunization tab lacked documentation the influenza vaccination was offered or declined and lacked documentation of a historical administration or physician-documented contraindication. The facility was unable to provide a declination for the annual influenza vaccination.2. On 03/30/26, R8's clinical record revealed he was admitted on [DATE]. The EMR under the Immunization tab lacked documentation the influenza vaccination or PCV20 vaccination was offered or declined and lacked documentation of a historical administration or physician-documented contraindication. The facility was unable to provide a declination for the annual influenza vaccination or the PCV 20.On 03/31/26 at 12:17 PM, Licensed Nurse (LN) G stated she was not responsible for tracking resident immunization history or administration of the vaccinations.On 03/31/26 at 12:30 PM, Administrative Nurse D stated she was unable to locate the consent or declination forms for R26 and R8's immunizations. Administrative Nurse D stated the infection preventionist was responsible for tracking and documenting the residents' immunizations. The facility's Influenza Vaccine policy dated 10/2021 documented all residents and employees who have no medical contraindications to the vaccine will be offered the influenza vaccine annually to encourage and promote the benefits associated with vaccinations against influenza.The facility shall provide pertinent information about the significant risks and benefits of vaccines to staff and residents (or residents' legal representatives); for example, risk factors that have been identified for specific age groups or individuals with risk factors such as allergies or pregnancy.The facility's Pneumococcal Vaccine policy dated 10/2021 documented all residents will be offered pneumococcal vaccines to aid in preventing pneumonia/pneumococcal infections. |

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| F 0582<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Many | Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.<br><br>The facility identified a census of 54. The sample included 14 residents with four residents reviewed for beneficiary notification. Based on record review and interviews, the facility failed to provide the correct Form CMS 10055- Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage (SNF ABN) to Resident (R) 56 and R57 and/or their representative.Findings included:- Upon request of the Medicare Liability Notice, CMS 101123- Notice of Medicare Non-Coverage (NOMNC) and SNF ABN for R56, the facility provided a NOMNC and an ABN for R56. The NOMNC documented R56's covered services ended on 11/19/25 and R56 and/or his representative received the NOMNC and ABN on 11/17/25. The ABN form provided by the facility was not the most current version of the CMS-10055.Upon request of the Medicare Liability Notice, CMS 101123- Notice of Medicare Non-Coverage (NOMNC) and SNF ABN for R57, the facility provided a NOMNC and an ABN for R57. The NOMNC documented R57's covered services ended on 11/04/25 and R57 and/or his representative received the NOMNC and ABN on 11/02/25. The ABN form provided by the facility was not the most current version of the CMS-10055.On 03/31/24 at 12:45 PM, Social Services Staff X stated she obtained and used ABN forms from the facility's master list of forms. Social Services Staff X stated sometimes she used ABN forms insurance companies provided to her. Social Services Staff X stated she did not realize the ABN form lacked an identification number.On 03/31/26 at 01:13 PM, Administrative Staff A stated she was not aware that Social Services Staff X had issued the wrong ABN form.The facility did not provide a policy on beneficiary notice. |

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| F 0732<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Many | Post nurse staffing information every day.<br><br>The facility identified a census of 54 residents. The sample included 12 residents. Based on observation, record review, and interview, the facility failed to ensure that daily posted nurse staffing information was retained for the required amount of time. The facility also failed to ensure that daily nurse staffing information was posted for each day. Findings included:- Upon review of the requested past 18 months of posted staffing information on 03/24/26, the facility lacked posted staffing information from 08/01/25 through 11/14/25. Additional missing daily posted staffing information for the following days: 11/16/25, 12/21/25, 12/29/25, 01/04/26, 01/07/26, 01/11/26, 01/15/26, 1/27, 01/29/26, 02/10/26, 02/14/26 to 02/16/26, and 02/19/26 to 02/22/26, 2/24/26, 02/25/26, 02/26/26, 02/28/26, and 03/15/26.On 03/24/26 at 01:49 PM, observation revealed the daily posted staffing information sheet was dated 03/23/26.On 03/31/26 at 12:10 PM, Licensed Nurse (LN) G stated that Administrative Staff B was responsible for posting the daily staffing sheets during the week, and on weekends the sheets would be prefilled with the information and posted by the charge nurse and adjusted if needed.On 03/31/26 at 12:51 PM, Administrative Nurse D stated that Administrative Staff B was in charge of posting the daily staffing information and retaining the sheets. On the weekends, the sheets were prefilled and updated as needed if staffing changes had been made, and the charge nurse was responsible for the posting of the sheet on the weekends.On 03/31/26 at 01:13 PM, Administrative Staff A stated that there had been a changeover of the staff that was responsible for maintaining the daily posted staffing sheets and she had not been able to find all of them from the past 18 months. Administrative Staff A stated that right now Administrative Staff B is responsible for ensuring that the daily posted staffing information was posted during the week and the charge nurse was on the weekends. The facility's Posted Direct Care Daily Staffing Numbers policy dated October 2021, documented: Within two (2) hours of the beginning of each shift, the number of Licensed Nurses (RNs, LPNs, and LVNs) and the number of unlicensed nursing personnel (CNAs) directly responsible for resident care will be posted in a prominent location (accessible to residents and visitors) and in a clear and readable format. Records of staffing information for each shift will be kept for a minimum of eighteen (18) months or as required by state law (whichever is greater). |