STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175490	A. Building B. Wing	10/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy at Herington	2 E Ash Street Herington, KS 67449

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)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27168 The facility had a census of 31. The sample included 12 residents. Based on record review, interview, and observation the facility failed to provide care for Resident (R)26 and R8 in a manner that protected and promoted resident dignity. This placed the residents at risk for impaired psychosocial well-being. Findings included: - On 10/29/24 at 11:15 AM, observation revealed R26 sat in a wheelchair right outside the medication room, in between the dining room and the common hall. Licensed Nurse (LN) G obtained R26's blood sugar reading using a glucometer (an instrument used to calculate blood glucose) from R26's right index finger. LN G then stated to the resident Your blood sugar reading is 277. Continued observation revealed ten residents were seated in the dining room awaiting lunch to be served, while staff and other residents were in the hallways adjacent to the medication room. Ongoing observation revealed LN G lifted R26's shirt and administered insulin (a hormone that lowers the level of glucose in the blood) shot in the resident's abdomen. On 10/30/24 at 04:00 PM, Administrative Nurse D stated staff should not check residents' blood sugar or give the residents insulin injections in a common area; staff should take the residents to their room or to a private area. The facility's Residents Dignity policy, dated February 2021, documented each resident would be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem. The residents are treated with dignity and respect at all times and their privacy is respected at all times. The facility failed to promote care for R26 in a manner to maintain and enhance dignity and respect placing the resident at risk of impaired psychosocial well-being. 32360 (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175490	A. Building B. Wing	10/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy at Herington	2 E Ash Street Herington, KS 67449

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)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- The Electronic Medical Record (EMR) for R8 recorded diagnoses of cognitive communication deficit (an impairment in organization, sequencing, attention, memory, planning, problem-solving, and safety awareness), a need for assistance with personal care, heart failure, hypertension (high blood pressure), and cardiac arrhythmia (improper beating of the heart, whether irregular, too fast, or too slow). The Significant Change Minimum Data Set (MDS), dated [DATE], documented that R8 had moderately impaired cognition. R8 required partial assistance with upper and lower dressing and showers. R8 required supervision with personal hygiene, mobility, and transfers. R8's Care Plan, dated 08/01/24 and initiated on 06/26/23, documented R8's need for assistance with grooming and personal hygiene and directed staff to encourage care in the morning, afternoon, and at bedtime. On 10/29/24 at 10:32 AM, observation revealed R8's hair was disheveled and greasy. R8 had dried food on her sweatshirt. On 10/29/24 at 03:41 PM, observation revealed that R8's hair was disheveled and greasy. Her chin hair was approximately one-half inch long, and her sweatshirt had dried food on it. On 10/30/24 at 08:29 AM, observation revealed that the front of R8's hair was disheveled, and it was flattened to the back of her head. R8 had chin hair approximately one-half inch long. On 10/3124 at 10:43 AM, Certified Nurse Aide M stated staff should make sure R8's hair was combed before she was brought out of her room. On 10/31/24 at 11:00 AM, Administrative Nurse D stated that staff were to make sure R8's hair was combed and should make sure she was shaved during her showers. The facility's Dignity policy, dated 02/22, documented that each resident should be cared for in a manner that promoted and enhanced his or her sense of well-being, satisfaction with life, and feelings of self-worth and self-esteem. Residents are to be treated with dignity and respect at all times. When assisting with care, residents are supported in exercising their rights and are groomed as they wish to be groomed. The facility failed to promote dignity for R8 when they did not adequately provide grooming assistance before bringing the resident out to the common area. This placed the resident at risk for impaired dignity.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175490	A. Building B. Wing	10/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy at Herington	2 E Ash Street Herington, KS 67449

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)
F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27168 The facility had a census of 31 residents. The sample included 12 residents. Based on observation, interview, and record review, the facility failed to notify the State Long term Care Ombudsman (LTCO) of Resident (R)25's facility-initiated discharge to the hospital. This placed R25 at risk for impaired rights. Findings included: - R25's Electronic Medical Record (EMR) recorded diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion), major depressive disorder (MDD-major mood disorder which causes persistent feelings of sadness), and traumatic subdural hematoma (SDH-serious condition, typically caused by head injury, where blood collects between the skull and the surface of the brain.) R25's Quarterly Minimum Data Set (MDS), dated [DATE] recorded that R25 had a Brief Interview for Mental Status (BIMS) score of 10, which indicated moderately impaired cognition. The MDS recorded R25 required staff assistance with most activities of daily living (ADLs). The MDS recorded the resident received antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality) medication during the observation period. The Care Area Assessment (CAA), dated 06/05/24, recorded R25 had MDD, a craniotomy (an operation in which a small hole is made in the skull or a piece of one from the skull is removed to show part of the brain) on 04/21/24 and was alert and oriented with intermittent confusion. R25 had a history of depression and received medications for the diagnosis that were monitored monthly by the pharmacist. R25's Care Plan, dated 10/29/24 recorded R25 received antipsychotic medication for the diagnosis of MDD, and staff monitored for side effects and effectiveness every shift. The care plan documented a gradual dose reduction (GDR) review would be completed by the pharmacist and physician per facility protocol. The Physician's Order, initial order date 08/29/24, directed the staff to administer Seroquel (antipsychotic) 100 milligrams (mg), twice daily for a diagnosis of MDD. On 06/06/24 at 09:28 AM, the late entry nurse's note, documented on 06/05/24 at 06:20 PM, R25 was observed trying to sharpen a shaving razor with a red door hanger. The Certified Nurse Aide alerted the nurse. The nurse assessed the resident and asked him if he wanted to hurt himself and he stated, Why not. Staff notified the primary care physician and received an order to send the resident to the emergency department for an evaluation. R25 was evaluated at the hospital and returned to the facility at 02:00 AM the hospital documented that the resident stated he did not want to hurt himself he wanted to go home and thought if he went to the hospital, they would discharge him and he would not return to the facility. The facility continued 15-minute checks and continued to seek mental health services and/or acute mental health hospitalization . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175490	A. Building B. Wing	10/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy at Herington	2 E Ash Street Herington, KS 67449

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)
F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/07/24 at 12:41 PM, the nurses' notes documented that R25 was transported to a behavioral health hospital for an inpatient stay and psychiatric evaluation. R25's clinical record lacked documentation staff notified the LTCO of the resident's discharge from the facility. On 10/30/24 at 01:00 PM, Social Services X stated the facility sent a report monthly to the LTCO that included the residents who were discharged home but stated she had never included residents who were discharged to the hospital. Social Service X stated she had been in the position for two years and was not aware she needed to send that information to the LTCO. Upon request, the facility did not provide a policy regarding the discharge of a resident or the Ombudsman notification policy. The facility failed to notify the LTCO of R25's facility-initiated discharge to the hospital. This placed the resident at risk for impaired rights.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175490	A. Building B. Wing	10/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy at Herington	2 E Ash Street Herington, KS 67449

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)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32360 The facility had a census of 31 residents. The sample included 12 residents, with one reviewed for toileting. Based on observation, record review, and interview, The facility failed to revise the care plan to address the toileting needs of one resident, Resident (R) 2. This placed the resident at risk for impaired care due to uncommunicated care needs. Findings included: - The Electronic Medical Record (EMR) for R2 documented diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), pain in the thoracic spine (the middle section of the spine, located between the cervical spine (neck) and the lumbar spine (low back), and hyperthyroidism (a condition characterized by hyperactivity of the thyroid gland). The Annual Minimum Data Set (MDS), dated [DATE], documented R2 had severely impaired cognition. R2 was independent with mobility and ambulation. R2 required supervision with showers, upper and lower body dressing, transfers, toileting, and personal hygiene. The MDS documented R2 was frequently incontinent of bladder and occasionally incontinent of the bowel. R2's Quarterly MDS, dated [DATE], documented R2 had severely impaired cognition. R2 was independent with mobility, toileting, and ambulation. R2 required supervision with showers, upper and lower dressing, transfers, and personal hygiene. The MDS documented R2 was frequently incontinent of bladder and bowel. The Quarterly Bowel and Bladder Assessment, dated 08/08/24, documented R2 had no decline in incontinence and was always incontinent of bowel and frequently incontinent of bladder. R2's Care Plan, dated 08/09/24 and initiated on 11/13/23 documented R2 required one-person assistance with toileting, and directed staff to provide peri-care with every incontinent episode. Staff were to ensure she had an unobstructed path to the bathroom. The care plan lacked direction to staff that R2 required toileting after every meal. On 10/30/24 at 09:20 AM, observation revealed R2 walked with Certified Nurse Aide (CNA) O down the hallway. R2 stated, I have to go to the bathroom, oh, I'm going in my pants! CNA O told R2 staff would change her pants and told her not to worry. CNA O told R2 staff would take her into the shower room and get her cleaned up. R2 told staff she did not think she would have a bowel movement in her pants and asked staff to please get her to a bathroom. On 10/31/24 at 10:43 AM, CNA M stated R2 required assistance with toileting before and after meals. On 10/31/24 at 12:30 PM, Administrative Nurse E stated staff should assist R2 with toileting before and after meals. On 10/31/24 at 3:00 PM, Administrative Nurse D stated staff were aware R2 required toileting assistance before and after meals and confirmed the care plan should reflect that. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175490	A. Building B. Wing	10/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy at Herington	2 E Ash Street Herington, KS 67449

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)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Care Plans-Comprehensive policy, dated 11/10, documented an individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental, and psychological needs was developed for each resident. Care plan interventions were designed after careful consideration of the relationship between the resident's problem areas and concerns. Identifying problem areas and their cases and developing interventions that are targeted and meaningful to the resident are interdisciplinary processes that require careful data gathering, proper sequencing of events, and complex clinical decision-making. The care planning interdisciplinary team was responsible for the review and updating of the care plan if there was a significant change, a desired outcome was not met, a resident was readmitted to the facility from the hospital, and at least quarterly. The facility failed to revise R2's Care Plan with directions to staff on when to assist R2 with her toileting needs. This placed R2 at risk for impaired care due to uncommunicated care needs.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175490	A. Building B. Wing	10/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy at Herington	2 E Ash Street Herington, KS 67449

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)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32360 The facility had a census of 31 residents. The sample included 12 residents, with four reviewed for activities of daily living (ADL). Based on observation, record review, and interview, the facility failed to provide necessary services to maintain good personal hygiene, including bathing and toileting for Resident (R)2. This placed the resident at risk for poor personal hygiene and related complications. Findings included: - The Electronic Medical Record (EMR) for R2 documented diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), pain in the thoracic spine (the middle section of the spine, located between the cervical spine (neck) and the lumbar spine (low back), and hyperthyroidism (a condition characterized by hyperactivity of the thyroid gland). The Annual Minimum Data Set (MDS), dated [DATE], documented R2 had severely impaired cognition. R2 was independent with mobility and ambulation. R2 required supervision with showers, upper and lower body dressing, transfers, toileting, and personal hygiene. The MDS documented R2 was frequently incontinent of bladder and occasionally incontinent of bowel. R2's Quarterly MDS, dated [DATE], documented R2 had severely impaired cognition. R2 was independent with mobility, toileting, and ambulation. R2 required supervision with showers, upper and lower dressing, transfers, and personal hygiene. The MDS documented R2 was frequently incontinent of bladder and bowel. The Quarterly Bowel and Bladder Assessment, dated 08/08/24, documented R2 had no decline in incontinence and was always incontinent of bowel and frequently incontinent of bladder. R2's Care Plan, dated 08/09/24 and initiated on 06/29/23, directed staff to encourage bathing two times per week, inspect her skin during showers, and alert the nurse of any skin issues. The care plan directed staff to reassure R2 that she would not get pneumonia (infection of the lungs) from taking a bath or shower and that staff would try to keep her warm throughout. The update dated 11/13/23 documented R2 required one-person assistance with toileting, and directed staff to provide peri-care with every incontinent episode. Staff were to ensure she had an unobstructed path to the bathroom. The care plan lacked direction to staff that R2 required toileting after every meal. R2's September 2024 Bathing Record and October 2024 Bathing Record, documented R2 requested showers on Wednesday and Saturday dayshift and documented R2 had not received a bath or shower the following days: 09/29/24-10/11/24 (14 days) 10/14/24-10/29/24 (16 days) The EMR documented R2 refused a shower on 10/02/24, 10/05/24, and 10/09/24. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175490	A. Building B. Wing	10/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy at Herington	2 E Ash Street Herington, KS 67449

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)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/29/24 at 12:53 PM, observation revealed R2 had very disheveled hair. On 10/30/24 at 09:20 AM, observation revealed R2 walked with Certified Nurse Aide (CNA) O down the hallway. R2 stated, I have to go to the bathroom, oh, I'm going in my pants! CNA O told R2 staff would change her pants and told her not to worry. CNA O told R2 staff would take her into the shower room and get her cleaned up. R2 told staff she did not think she would have a bowel movement in her pants and asked staff to please get her to a bathroom. On 10/31/24 at 10:43 AM, CNA M stated R2 would tell staff she was cold and didn't want a shower, but staff would continue to ask her. CNA M said that when R2 refused a shower, she would tell the charge nurse. CNA M stated R2 required assistance with toileting before and after meals. On 10/31/24 at 12:30 PM, Administrative Nurse E stated R2 often refused her shower because she got cold very easily. Administrative Nurse E further verified the facility had not offered different types of bathing. On 10/31/24 at 3:00 PM, Administrative Nurse D stated R2 did not like to shower and thought there had been an incident in her life relating to being in water. Administrative Nurse D stated R2 did not like her hair combed and when staff combed her hair, she would often take her hands and mess up her hair. Administrative Nurse D stated staff were aware R2 required toileting assistance before and after meals and the care plan should reflect that. The facility's Activities of Daily Living (ADL), Supporting policy, dated 03/18, documented the residents would be provided with care, treatment, and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs). Residents who are unable to carry out activities of daily living independently would receive the services necessary to maintain good nutrition grooming, and personal and oral hygiene. Residents would receive appropriate support and assistance with bathing, dressing, toileting, and grooming to prevent and/or minimize functional decline. If residents with cognitive impairment resist care, staff would attempt to identify the underlying cause of the problem and not just assume the resident was refusing or declining care. Approaching the resident in a different way or different manner, or just another staff member speaking with the resident may be appropriate. The facility failed to provide cognitively impaired R2 with consistent bathing opportunities and alternatives that incorporated her needs and preferences. The facility further failed to assist R2 with toileting after meals. This placed her at risk for poor hygiene and related complications.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175490	A. Building B. Wing	10/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy at Herington	2 E Ash Street Herington, KS 67449

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)
F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32360 The facility had a census of 31 residents. The sample included 12 residents, with one reviewed for pain. Based on observation, record review, and interview, the facility failed to adequately respond to Resident (R)2's complaints of pain. This placed R2 at risk for unresolved pain and discomfort. Findings included: - The Electronic Medical Record (EMR) for R2 documented diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), pain in the thoracic spine (the middle section of the spine, located between the cervical spine (neck) and the lumbar spine (low back), and hyperthyroidism (a condition characterized by hyperactivity of the thyroid gland). The Quarterly Minimum Data Set (MDS), dated [DATE], documented R2 had severely impaired cognition. R2 required supervision for showers, personal hygiene, upper and lower dressing, and oral hygiene. The MDS documented R2 had no scheduled or as-needed pain medication. R2's Care Plan, dated 08/09/24 and initiated on 06/29/23, directed staff to administer pain medications as ordered, attempt and document any use of non-pharmacological interventions used, evaluate the effectiveness of pain interventions or medications, monitor and document pain level every shift, and notify the physician if interventions are unsuccessful. R2's Pain Assessment, dated 08/08/24, documented R2 complained of mild pain daily and did not receive scheduled or as-needed pain medication. The Physician's Order, dated 10/03/19, directed staff to assess R2's pain every shift, before and after administering pain medication, and document what non-pharmacological interventions were attempted. The Physician's Order, dated 05/26/24, directed staff to administer Tylenol (pain medication), 500 milligrams (mg), by mouth, every four hours, as needed, for pain. The Physician's Order, dated 10/20/24, directed staff to apply Biofreeze (topical pain analgesic), 10%, to R2's back, every eight hours, as needed for pain in the thoracic spine. The Physician's Order, dated 10/25/24, directed staff to administer acetaminophen (pain medication), 650 mg, two tablets, by mouth, three times per day for pain. A review of R2's Medication Administration Record (MAR) for October 2024, documented the scheduled acetaminophen was to be given at 08:00 AM, 02:00 PM, and 08:00 PM. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175490	A. Building B. Wing	10/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy at Herington	2 E Ash Street Herington, KS 67449

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)
F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/30/24 at 07:45 AM, observation revealed Certified Nurse Aide (CNA) N assisted R2 into the dining room for breakfast. R2 stated she did not understand why her back hurt so much when she stood up. Ongoing observation revealed at 08:30 AM, CNA N stood R2 up from the dining table and R2 stated Oh my God, my back hurts so much. CNA N assisted R2 into the commons area and R2 sat down into a chair. Continued observation revealed at 09:20 AM, R2 ambulated down the hall with CNA O and stated again that her back hurt. On 10/30/24 at 09:25 AM, Certified Nurse Aide (CNA) N verified she had not informed the nurse that R2 had complained of back pain. On 10/30/24 at 09:30 AM, Certified Medication Aide (CMA) R stated she was unaware R2 had back pain as staff had not told her. CMA R further stated she had been on vacation for the last two weeks and was unaware R2 had a scheduled pain medication. On 10/30/24 at 09:35 AM, Administrative Nurse E stated the CNA staff should report to the CMA or the nurse when R2 had pain. On 10/30/24 at 10:00 AM, Administrative Nurse D stated R2 had as-needed pain medication and had recently been started on scheduled medication but often refused it. Administrative Nurse D further stated that CNA staff still should report to the charge nurse or CMA that R2 had pain. The facility's Pain-Clinical Protocol, dated 03/18, documented that nursing staff would assess each individual for pain upon admission to the facility, at the quarterly review, whenever there was a significant change in condition, and when there was onset of new pain or worsening of existing pain. The staff and physician would identify the characteristics of pain such as location intensity, frequency, pattern, and severity. The physician would order appropriate non-pharmacologic and medication interventions to address the individual's pain. The facility failed to adequately respond to R2's complaints of pain. This placed R2 at risk for unresolved pain and discomfort.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175490	A. Building B. Wing	10/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy at Herington	2 E Ash Street Herington, KS 67449

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)
F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 32360 The facility had a census of 31 residents. The sample included 12 residents. Based on observation and interviews, the facility failed to display current daily nursing staff hours. Findings included: - On 10/29/24 and 10/30/24, observation revealed the posted nurse staff hours were dated 10/28/24 and did not display the correct daily nursing staff information. On 10/31/24 at 12:30 PM, Administrative Nurse E stated the night shift nurse was responsible for posting the daily nurse staffing hours and verified the nurse hours for 10/29/24 and 10/30/24 had not been posted. The facility's Posting Direct Care Daily Staffing Numbers policy, dated 07/16, documented the facility would post, daily for each shift, the number of nursing personnel responsible for providing direct care to residents. When computing hours of direct-care staff working split shifts, count only the total number of hours the individual was scheduled to work for the shift information being posted. The facility failed to display current daily nursing hour information as required.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175490	A. Building B. Wing	10/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy at Herington	2 E Ash Street Herington, KS 67449

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)
F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27168 The facility had a census of 31 residents. The sample included 12 residents, with five reviewed for unnecessary medications. Based on observation, interview, and record review, the facility failed to ensure the Consultant Pharmacist (CP) identified and reported the lack of an appropriate indication, or the required physician documentation, for Resident (R) 25's antipsychotic (medications used to treat any major mental disorder characterized by gross impairment in reality) medication. The facility further failed to ensure the CP identified and reported irregularities in R14's blood sugar monitoring. This placed the residents at risk for physical decline, ineffective medication regimen, and side effects from unnecessary medication. Findings included: - R25's Electronic Medical Record (EMR) recorded diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion), major depressive disorder (MDD-major mood disorder which causes persistent feelings of sadness), and traumatic subdural hematoma (SDH-serious condition, typically caused by head injury, where blood collects between the skull and the surface of the brain.) R25's Quarterly Minimum Data Set (MDS), dated [DATE] recorded R25 had a Brief Interview for Mental Status (BIMS) score of 10, which indicated moderately impaired cognition. The MDS recorded R25 required staff assistance with most activities of daily living (ADLs). The MDS recorded the resident received antipsychotic medication during the observation period. The Care Area Assessment (CAA), dated 06/05/24, recorded R25 had MDD, and had a craniotomy (an operation in which a small hole is made in the skull or a piece of one from the skull is removed to show part of the brain) on 04/21/24 and was alert and oriented with intermittent confusion. R25 had a history of depression and received medications for the diagnosis that were monitored monthly by the pharmacist. R25's Care Plan, dated 10/29/24 recorded R25 received antipsychotic medication for the diagnosis of MDD, and staff monitored for side effects and effectiveness every shift. The care plan documented a gradual dose reduction (GDR) review would be completed by the pharmacist and physician per facility protocol. The Physician's Order, initial order date 08/29/24, directed the staff to administer Seroquel (antipsychotic) 100 milligrams (mg), twice daily for a diagnosis of MDD. R25's EMR lacked a documented physician rationale which included unsuccessful attempts for nonpharmacological symptom management and risk versus benefits for the continued Seroquel use. The Consultant Pharmacist's Monthly Medication Review for R25 on 06/20/24, 07/29/24, 08/29/24, and 09/19/24 lacked evidence of a recommendation for an appropriate indication for the continued use of Seroquel. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175490	A. Building B. Wing	10/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy at Herington	2 E Ash Street Herington, KS 67449

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)
F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/30/24 at 08:30 AM, observation revealed the resident sat at the dining room table. Continued observation revealed Certified Medication Aide (CMA) M administered the resident's morning medications which included the Seroquel. On 10/30/24 at 10:10 AM, Administrative Nurse D verified the resident received Seroquel, an antipsychotic medication, with a diagnosis of MMD which was not an approved indication for the medication. Administrative Nurse D verified the physician had been informed of the need for another diagnosis and continues to document MDD. On 10/30/24 at 10:10 AM, Administrative Nurse D verified the resident received Seroquel, an antipsychotic medication, with a diagnosis of MMD which was an inappropriate indication for the medication. Administrative Nurse D stated the pharmacist completed monthly reviews of the facility residents and alerted her of concerns and recommendations. The facility's Pharmacist Services-Role of the Consulting Pharmacist dated 2007, recorded the drug regimen of each resident is reviewed at least once a month by a licensed pharmacist and includes a review of the resident's medical chart. The pharmacist would provide a report of activities, findings, and recommendations to the administrator and the director of nursing on a monthly basis, and render the required services in accordance with local, state, and federal laws, regulations, and guidelines; nursing care center policies and procedures; community standards of practice; and professional standards of practice. The facility failed to ensure the CP identified and reported the inappropriate indication for the continued use of the antipsychotic medication Seroquel. This placed R25 at risk for unnecessary antipsychotic medication with side effects. 32360 - The Electronic Medical Record (EMR) for R14 documented diagnoses of diabetes mellitus (DM-when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), venous insufficiency (poor circulation), hypertension (high blood pressure), and dementia without behavioral disturbance (a progressive mental disorder characterized by failing memory and confusion). The Annual Minimum Data Set (MDS), dated [DATE], documented R14 had severely impaired cognition. R14 was independent with toileting, personal hygiene, mobility, upper and lower dressing, and transfers; R14 did not ambulate. The assessment revealed R14 received hypoglycemic (low blood sugar) medication. The Quarterly MDS, dated [DATE], documented R14 had severely impaired cognition. R14 required supervision for toileting, personal hygiene, upper and lower dressing, and set-up assistance with mobility and transfers. The MDS documented R14 received hypoglycemic medication. R14's Care Plan, dated 08/02/24 and initiated 08/14/23, directed staff to administer diabetic medication as ordered, monitor and obtain blood glucose levels as ordered, and report any signs and symptoms of hypoglycemia and hyperglycemia (high blood sugar). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175490	A. Building B. Wing	10/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy at Herington	2 E Ash Street Herington, KS 67449

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)
F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Physician's Order, dated 03/19/24, directed staff to administer Novolog (a rapid-acting insulin that helps lower blood sugar), five units (U), subcutaneous (SQ-beneath the skin), before meals for DM. The order directed staff to notify the physician if R14's blood sugar was below 60 milliliters (ml) per deciliter (dl) or over 350 mm/dl. The order was discontinued on 09/12/24. The Diabetic Monitoring Record, dated August 2024, documented the following days R14's blood sugar was out of parameters and the physician was not notified: 08/05/24 at 05:00 PM-366 mm/dl 08/13/24 at 05:00 PM- 396 mm/dl 08/14/24 at 11:00 AM-370 mm/dl 08/27/24 at 07:00 AM-360 mm/dl 08/30/24 at 11:00 AM-366 mm/dl The Physician's Order, dated 09/12/24, directed staff to administer Novolog, six U SQ, before meals for DM. The order directed staff to notify the physician if R14's blood sugar was below 60 ml/dl or over 350 mm/dl. The Diabetic Monitoring Record, dated September 2024, documented the following days R14's blood sugar was out of parameters and the physician was not notified: 09/13/24 at 07:00 AM-395 mm/dl 09/30/24 at 11:00 AM-388 mm/dl The Diabetic Monitoring Record, dated October 2024, documented the following days R14's blood sugar was out of parameters and the physician was not notified: 10/04/24 at 05:00 PM- lacked documentation R14's blood sugar was obtained as ordered. 10/18/24 at 07:00 AM- 407 mm/dl 10/19/24 at 05:00 PM- lacked documentation R14's blood sugar was obtained as ordered. 10/21/24 at 07:00 AM-413 mm/dd The CP Medication Regimen Review for the months of August and September 2024 lacked evidence the CCP identified and reported the out-of-parameter blood sugars. On 10/30/24 at 07:40 AM, observation revealed Certified Medication Aide (CMA) R administered R14's medication without difficulty. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175490	A. Building B. Wing	10/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy at Herington	2 E Ash Street Herington, KS 67449

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)
F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/30/24 at 09:43 AM, Administrative Nurse E stated she did not know why there were blanks in the blood sugar documentation and said staff should follow the physician's orders. On 10/30/24 at 10:00 AM, Administrative Nurse D stated she thought the order was changed a few months ago to notify the physician if the blood sugar was over 400 ml/dl but verified the order did not get documented in the EMR. Administrative Nurse D said she would contact the physician to get a new order. Administrative Nurse D further stated the CP had not notified her of the errors. The facility's Consultant Pharmacist Services Provider Requirements policy, dated 11/17, documented the Medication Regimen Review (MRR) for each resident was completed at least monthly, or more frequently under certain conditions, incorporating the federally mandated standards of care in addition to other applicable professional standards. The pharmacist communicates to the responsible prescriber, the facility's medical director, and the director of nursing potential or actual problems detected and other findings related to medication therapy orders at least monthly. They communicate recommendations for changes in medication therapy and the monitoring of medication therapy. The facility failed to ensure the CP identified and reported irregularities in R14's blood sugar monitoring. This placed the resident at risk for physical decline, ineffective medication regimen, and side effects from unnecessary medication.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175490	A. Building B. Wing	10/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy at Herington	2 E Ash Street Herington, KS 67449

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)
F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32360 The facility had a census of 31 residents. The sample included 12 residents, with five reviewed for unnecessary medications. Based on observation, record review, and interview, the facility failed to monitor and provide interventions for bowel management for Resident (R) 18 and failed to notify the physician of blood sugars outside of physician-ordered parameters for R14. This placed the residents at risk for physical decline and other related complications. Findings included: - The Electronic Medical Record (ER) for R18 documented diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion) without behavioral disturbance, depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), a need for assistance with personal care, and constipation (difficulty passing stools). The Annual Minimum Data Set (MDS), dated [DATE], documented R18 had severely impaired cognition. R18 required supervision with toileting, upper dressing, and personal hygiene. R18 required set-up assistance with mobility, transfers, and ambulation. The MDS documented R18 was always continent of bowel. The Quarterly MDS, dated [DATE], documented R18 had severely impaired cognition. R18 required supervision with personal hygiene. He was independent with toileting, mobility, transfers, and ambulation. The MDS documented R18 was always continent of bowel. R18's Care Plan, dated 08/01/24, initiated on 02/01/23 documented R18 had impaired cognition and directed staff to cue, orient, and supervise as needed. The update, dated 0508/23, documented R18 was independent with toileting. The update, dated 08/04/23, directed staff to monitor R18 for constipation and administer medication as directed. R18's Quarterly Bowel Assessment, dated 07/24/24, documented R18 had no abnormalities in bowel status and was always continent of bowel. The Physician's Order, dated 04/07/23, directed staff to administer Milk of Magnesia (MOM-a laxative), 1200 milligrams (mg) per milliliters (ml), 30 ml by mouth every 24 hours as needed for constipation. R18's Bowel Monitoring Record, dated July 2024, documented R18 did not have a bowel movement for the following days: 07/03/24-07/11/24 (nine consecutive days) R18's Medication Administration Record, dated July 2024 lacked documentation the staff provided the physician-ordered interventions during the lack of bowel elimination on the above dates. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175490	A. Building B. Wing	10/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy at Herington	2 E Ash Street Herington, KS 67449

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)
F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R18's Bowel Monitoring Record dated August 2024 documented R18 did not have a bowel movement for the following days: 08/05/24-08/10/24 (six consecutive days) 08/18/24-08/21/24 (four consecutive days) R18's Medication Administration Record dated August 2024 lacked documentation the staff provided the physician-ordered interventions during the lack of bowel elimination on the above dates. R18's Bowel Monitoring Record, dated September 2024 and October 2024 documented R18 did not have a bowel movement for the following days: 09/20/24-09/26/24 (seven consecutive days) 09/28/24-10/03/24 (seven consecutive days) 10/05/24-10/08/24 (four consecutive days) 10/21/24-10/31/24 (11 consecutive days) The Medication Administration Record dated September 2024 and October 2024 lacked documentation the staff provided the physician-ordered interventions during the lack of bowel elimination on the above dates. On 10/30/24 at 08:00 AM, observation revealed R18 ambulated with the use of her walker to the entrance door and tried to open it to go outside where a male resident was outside with staff. R18 thought the resident was her husband and wanted to be outside with him. On 10/30/24 at 09:30 AM, Administrative Nurse E stated R18 was independent with toileting and staff asked her if she had a bowel movement. Administrative Nurse E acknowledged R18 was not a good historian due to her cognition and may not remember if she had a bowel movement or not. Administrative Nurse E said staff should have administered the MOM for the extended time periods with no recorded bowel movement. On 10/30/24 at 09:400 AM, Administrative Nurse D verified staff did not provide any interventions to R18 when she did not have a bowel movement. Administrative Nurse D stated R18 was able to take herself to the bathroom but may not remember if she had a bowel movement or not so staff should have completed a bowel assessment on her. On 10/31/24 at 10:43 AM, Certified Nurse Aide (CNA) M stated R18 required assistance with toileting. CNA M said that if R18 had not had a bowel movement, she would tell the nurse. The facility's Standing Order protocol, directed staff to administer MOM 30 ml on day four. If no results on day five, administer bisacodyl (a laxative), 5 mg, and if no results, on day six, administer a Fleets enema (introduction of a solution into the rectum for cleansing or therapeutic purposes), do a bowel assessment. If no results, contact the physician. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175490	A. Building B. Wing	10/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy at Herington	2 E Ash Street Herington, KS 67449

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)
F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility failed to monitor and provide the ordered interventions for bowel management for R18. This placed the resident at risk for impaction and physical decline. - The Electronic Medical Record (EMR) for R14 documented diagnoses of diabetes mellitus (DM-when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), venous insufficiency (poor circulation), hypertension (high blood pressure), and dementia without behavioral disturbance (a progressive mental disorder characterized by failing memory and confusion). The Annual Minimum Data Set (MDS), dated [DATE], documented R14 had severely impaired cognition. R14 was independent with toileting, personal hygiene, mobility, upper and lower dressing, and transfers; R14 did not ambulate. The assessment revealed R14 received hypoglycemic (low blood sugar) medication. The Quarterly MDS, dated [DATE], documented R14 had severely impaired cognition. R14 required supervision for toileting, personal hygiene, upper and lower dressing, and set-up assistance with mobility and transfers. The MDS documented R14 received hypoglycemic medication. R14's Care Plan, dated 08/02/24 and initiated 08/14/23, directed staff to administer diabetic medication as ordered, monitor and obtain blood glucose levels as ordered, and report any signs and symptoms of hypoglycemia and hyperglycemia (high blood sugar). The Physician's Order, dated 03/19/24, directed staff to administer Novolog (a rapid-acting insulin that helps lower blood sugar), five units (U), subcutaneous (SQ-beneath the skin), before meals for DM. The order directed staff to notify the physician if R14's blood sugar was below 60 milliliters (ml) per deciliter (dl) or over 350 mm/dl. The order was discontinued on 09/12/24. The Diabetic Monitoring Record, dated August 2024, documented the following days R14's blood sugar was out of parameters and the physician was not notified: 08/05/24 at 05:00 PM-366 mm/dl 08/13/24 at 05:00 PM- 396 mm/dl 08/14/24 at 11:00 AM-370 mm/dl 08/27/24 at 07:00 AM-360 mm/dl 08/30/24 at 11:00 AM-366 mm/dl The Physician's Order, dated 09/12/24, directed staff to administer Novolog, six U SQ, before meals for DM. The order directed staff to notify the physician if R14's blood sugar was below 60 ml/dl or over 350 mm/dl. The Diabetic Monitoring Record, dated September 2024, documented the following days R14's blood sugar was out of parameters and the physician was not notified: 09/13/24 at 07:00 AM-395 mm/dl (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175490	A. Building B. Wing	10/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy at Herington	2 E Ash Street Herington, KS 67449

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)
F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	09/30/24 at 11:00 AM-388 mm/dl The Diabetic Monitoring Record, dated October 2024, documented the following days R14's blood sugar was out of parameters and the physician was not notified: 10/04/24 at 05:00 PM- lacked documentation R14's blood sugar was obtained as ordered. 10/18/24 at 07:00 AM- 407 mm/dl 10/19/24 at 05:00 PM- lacked documentation R14's blood sugar was obtained as ordered. 10/21/24 at 07:00 AM-413 mm/dd On 10/30/24 at 07:40 AM, observation revealed Certified Medication Aide (CMA) R administered R14's medication without difficulty. On 10/30/24 at 09:43 AM, Administrative Nurse E stated she did not know why there were blanks in the blood sugar documentation and said staff should follow the physician's orders. On 10/30/24 at 10:00 AM, Administrative Nurse D stated she thought the order was changed a few months ago to notify the physician if R14's blood sugar was over 400 ml/dl but verified the order did not get documented in the EMR. Administrative Nurse D said she would contact the physician to get a new order. The facility's Diabetic Care policy, dated 11/20, documented that the provider would order the frequency of glucose monitoring and establish appropriate glycemic targets for individual residents. The policy directed staff to follow the provider's orders for blood glucose monitoring. The facility failed to notify the physician when R14's blood sugar was out of the physician-ordered parameters. This placed the resident at risk for unnecessary medication side effects and other related complications.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175490	A. Building B. Wing	10/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy at Herington	2 E Ash Street Herington, KS 67449

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)
F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27168 The facility had a census of 31 residents. The sample included 12 residents, with five reviewed for unnecessary medications. Based on observations, interviews, and record review, the facility failed to ensure an appropriate indication or a documented physician rationale which included the unsuccessful attempts for nonpharmacological symptom management and risk versus benefits for the continued use of Resident (R)25's antipsychotic (a medication used to treat any major mental disorder characterized by a gross impairment testing) medication. This placed R25 at risk for unintended effects related to psychotropic (alters mood or thought) drug medications. Findings included: - R25's Electronic Medical Record (EMR) recorded diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion), major depressive disorder (MDD-major mood disorder which causes persistent feelings of sadness), and traumatic subdural hematoma (SDH-serious condition, typically caused by head injury, where blood collects between the skull and the surface of the brain.) R25's Quarterly Minimum Data Set (MDS), dated [DATE] recorded R25 had a Brief Interview for Mental Status (BIMS) score of 10, which indicated moderately impaired cognition. The MDS recorded R25 required staff assistance with most activities of daily living (ADLs). The MDS recorded the resident received antipsychotic medication during the observation period. The Care Area Assessment (CAA), dated 06/05/24, recorded R25 had MDD, and had a craniotomy (an operation in which a small hole is made in the skull or a piece of one from the skull is removed to show part of the brain) on 04/21/24 and was alert and oriented with intermittent confusion. R25 had a history of depression and received medications for the diagnosis that were monitored monthly by the pharmacist. R25's Care Plan, dated 10/29/24 recorded R25 received antipsychotic medication for the diagnosis of MDD, and staff monitored for side effects and effectiveness every shift. The care plan documented a gradual dose reduction (GDR) review would be completed by the pharmacist and physician per facility protocol. The Physician's Order, initial order date 08/29/24, directed the staff to administer Seroquel (antipsychotic) 100 milligrams (mg), twice daily for a diagnosis of MDD. R25's EMR lacked a documented physician rationale which included unsuccessful attempts for nonpharmacological symptom management and risk versus benefits for the continued Seroquel use. On 10/30/24 at 08:30 AM, observation revealed the resident sat at the dining room table. Continued observation revealed Certified Medication Aide (CMA) M administered the resident's morning medications which included the Seroquel. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175490	A. Building B. Wing	10/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy at Herington	2 E Ash Street Herington, KS 67449

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)
F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/30/24 at 10:10 AM, Administrative Nurse D verified the resident received Seroquel, an antipsychotic medication, with a diagnosis of MMD which was not an approved indication for the medication. Administrative Nurse D verified the physician had been informed of the need for another diagnosis and continues to document MDD. The facility's Antipsychotic Medication Use policy, dated December 2016, recorded antipsychotic medication may be considered for residents with dementia but only after medical, physical, functional, psychological, emotional psychiatric, social, and environmental causes of behavioral symptoms have been identified and addressed. The policy documented the residents would only receive antipsychotic medications when necessary to treat specific conditions for which they are indicated and effective. Residents who are admitted from the community or transferred from a hospital and who are already receiving antipsychotic medications will be evaluated for appropriateness and indications for use. The interdisciplinary team would complete a preadmission screening for mentally ill and intellectually disabled individuals if appropriate or use of the antipsychotic medication at the time of admission and or within two weeks at the initial MDS assessment to consider whether or not the medication can be reduced, tapered, or discontinued. In addition to the diagnoses antipsychotic medications would generally only be considered if the following conditions are also met; the behavioral symptoms present a danger to the resident and others and the symptoms are identified as being due to mania or psychosis or behavioral interventions have been attempted and included in the plan of care, except in an emergency. The facility failed to ensure R25 did not receive antipsychotic medication without an appropriate indication or the required physician documentation for its use placing R25 at risk for adverse side effects.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175490	A. Building B. Wing	10/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy at Herington	2 E Ash Street Herington, KS 67449

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)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 27168 The facility had a census of 31 residents. The sample included 12 residents. Based on observation, interview, and record review, the facility failed to label Resident (R)6, R14, and R26s' insulin (a hormone that lowers the level of glucose in the blood) flex pens with opened and discard dates. This deficient practice placed the affected residents at risk for ineffective medications. Findings included: - On 10/29/24 at 09:00 AM, observation of the facility's treatment cart revealed the following: R6's Basaglar (long-acting insulin) flex pen was not labeled with an open or discard date. R14's Lantus (long-acting insulin) flex pen was not labeled with an open or discard date. R26's Basaglar flex pen was not labeled with an open or discard date. On 10/29/24 at 08:35 AM, License Nurse (LN) G verified the nurses should label and date the insulin flex pens with the date opened and the expiration date. On 10/30/24 at 08:30 AM, Administrative Nurse D verified the nurses should label and date the flex pens with the date opened and the expiration date. Medlineplus.gov directs open, unrefrigerated Lantus (basaglar and glargine) can be used within 28 days; after that time, it must be discarded. The facility's Storage of Medication policy, dated November 2020, documented the facility would store all drugs and biologicals in a safe, secure, and orderly manner. The facility would not use discontinued, outdated, or deteriorated drugs or biologicals. All such drugs shall be returned to the dispensing pharmacy or destroyed. The facility failed to date the insulin flex pens with the opened and discard dates placing the residents at risk for ineffective medication.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175490	A. Building B. Wing	10/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy at Herington	2 E Ash Street Herington, KS 67449

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)
F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. 27168 The facility had a census of 31 residents. The sample included 12 residents. Based on observation, record review, and interview, the facility failed to provide the services of a full-time certified dietary manager for the 31 residents who resided in the facility and received their meals from the kitchen. This placed the residents at risk for inadequate nutrition. Findings included: - On 10/29/24 at 08:30 AM, observation revealed dietary staff in the kitchen prepared the breakfast meal. On 10/29/24 at 09:40 AM, Dietary Staff BB verified she was not a certified dietary manager. Dietary Staff BB stated the facility had six residents with mechanical soft diets and three with a pureed diet. On 10/31/24 at 02:00 PM, Administrative Staff A verified Dietary Staff BB, the dietary manager, was not certified. The facility's Dietician policy, dated 10/2017, documented a qualified, competent, and skilled dietician would help oversee the food and nutrition services in the facility. A food and nutrition services manager would oversee the production, storage, and delivery of food. The dietician would work closely with the food and nutrition services manager and clinical staff. The dietician or nutritional professional may be a full-time or part-time consultant or an employee, depending on the current requirements of the facility. These requirements are based on: a.assessments and care plans of resident's nutritional needs; and b. the overall facility assessment of the number, acuity, and diagnosis of the resident population The dietician would have the qualifications, competency, and skills to carry out the functions of the food and nutrition services. If a dietician is not employed full time (35 hours per) a director of food service management would be designated the individual would: a.Be a certified dietary manager; or b.be a certified food service manager; or c.be nationally certified in food service management and safety; or d.have an associate (or higher) degree in food service management or hospitality (must be from an accredited institution and include courses in food service or restaurant management) (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175490	A. Building B. Wing	10/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy at Herington	2 E Ash Street Herington, KS 67449

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)
F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	e.meet any state requirements for food services or dietary manager. The facility failed to employ a full-time certified dietary manager to evaluate residents' nutritional concerns and oversee the ordering, preparing, and storage of food for the 31 residents in the facility. This placed the residents at risk for inadequate nutrition.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175490	A. Building B. Wing	10/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy at Herington	2 E Ash Street Herington, KS 67449

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)
F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 27168 The facility had a census of 31 residents. The sample included 12 residents. Based on observation, record review, and interview, the facility failed to correctly prepare a pureed diet for three residents that retained both nutritive value and palatability. This placed the affected residents at risk for impaired nutrition or decreased quality of life. Findings included: - On 10/30/24 at 10:00 AM, observation revealed the lunch meal included cheesy macaroni hamburger helper, carrots, pears, and garlic bread. On 10/30/24 at 10:30 AM, observation revealed Dietary Staff (DS) CC prepared three pureed diets. DS CC placed three servings of cheesy macaroni hamburger helper in the Robot-coup blender (a food processor) and added four ounces of beef base. DS CC blended the macaroni to a thin consistency and emptied the blended food into a metal pan and placed the pan into the hot water well in the hot holding cart. Observation revealed DS CC then placed three - four-ounce servings of pears in the Robot coup, with four squirts of simply thick easy mix and blended the food to a pureed texture. DS CC emptied the pureed pears into three bowls, covered them with aluminum foil, and placed them on a serving tray. Observation revealed DS CC then placed three -four-ounce servings of carrots in the Robo-t coup blender including the butter juice from the cooked carrots and blended the food to a pureed texture. DS CC emptied the pureed carrots into a metal pan and placed the pan in the hot water well in the hot holding cart. On 10/31/24 at 11:00 AM, DS BB verified DS CC did not provide the pureed diet residents with the same nutritional diet as the other residents. DS BB verified DS CC did not puree rolls or a biscuit with added milk to the pureed texture and stated DS CC was nervous and just forgot to do that. The facility's Pureed Diet policy, dated January 2014, documented a pureed diet is designed for individuals with moderate to severe dysphagia, and for individuals with poor dentition, minimal or no ability to chew. The general diet or other appropriate diet is modified in consistency by pureeing foods to a smooth consistency. Some foods may need to be thickened after they are pureed to achieve desired consistency. Add the number of pureed diets plus one to the food processor, and give a quick start. If bread/dinner rolls/crackers are on the menu for the general diet, this can be added to the meat or vegetable. If general diets get butter on their bread or roll, add butter to the bread/roll. Puree until proper final consistency is reached the food should be pudding consistency and not run when plated. Cover, label with serving size, and place in appropriate hot or cold areas. The facility failed to provide food prepared by methods that conserve nutritive value and flavor while preparing a pureed diet for three residents. This placed the affected residents at risk for impaired nutrition.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175490	A. Building B. Wing	10/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy at Herington	2 E Ash Street Herington, KS 67449

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)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 27168 The facility had a census of 31 residents. The facility had one kitchen. Based on observation, interview, and record review the facility failed to prepare, store, distribute, and serve food under sanitary conditions for the residents in the facility, who receive their meals from the kitchen. This deficient practice placed the residents of the facility at risk for food-borne illness. Findings included: - On 10/29/24 at 8:45 AM, during the initial tour, observation revealed a one three foot by six-inch air vent grill located above the North door entrance to the kitchen was covered with a brownish grease/sticky substance and a gray fuzzy substance blowing directly on the food preparation area. Continued observation revealed two florescent light fixtures, approximately six inches by two feet located in the exhaust hood above the stovetop. One of the florescent covers was missing and exposed the florescent bulb and the other cover was partially affixed to the light fixture. On 10/29/24 at 09:15 AM, observation revealed nine ceiling-mounted fluorescent light fixtures approximately 10 inches by three feet located on the ceiling. The fixtures had metal pull chains affixed to the fixtures with a brownish-gray fuzzy substance affixed to the chains, the fixtures were located directly above the food preparation area and the dishwashing area. On 10/31/24 at 12:10 PM, Maintenance Staff U verified the dirty register grill, and the dirty overhead fluorescent light pull chains and verified the fluorescent bulb located in the stove hood was not encapsulated and should have a cover on the fixture. Maintenance Staff U verified the cover on the other fluorescent light was partially coming off the fixture. The facility's Sanitization policy, dated October 2008, stated the food service area should be maintained in a clean and sanitary manner. All kitchen areas and dining areas should be kept clean, free from litter and rubbish, and protected from rodents, roaches, flies, and other insects. Utensils, counters, shelves, and equipment shall be kept clean and maintained in good repair and shall be free from breaks, corrosion, open seams, cracks, and chipped areas that may affect their use or proper cleaning. Kitchen and dining room surfaces not in contact with food shall be cleaned on a regular schedule and frequently enough to prevent the accumulation of grime. The food service manager would be responsible for scheduling staff for regular cleaning of kitchen and dining areas. The facility failed to prepare, store, distribute, and serve food under sanitary conditions for the 31 residents in the facility, who received their meals from the kitchen. This deficient practice placed the residents of the facility at risk for food-borne illness.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175490	A. Building B. Wing	10/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy at Herington	2 E Ash Street Herington, KS 67449

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)
F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. 32360 The facility had a census of 31 residents. Based on interviews and record review, the facility failed to submit complete and accurate staffing information through Payroll-Based Journaling (PBJ) as required. This deficient practice placed the residents at risk for unidentified and ongoing inadequate nurse staffing. Findings included: - The PBJ report provided by the Centers for Medicare & Medicaid Services (CMS) for Fiscal Year (FY) 2023 Quarter (Q) 4 indicated no licensed nurse coverage on eight days. The PBJ for FY 2024 Q4 recorded no licensed nurse coverage on the following dates: 07/29/23, 07/30/23, 09/09/23, 09/10/3, 09/11/23, 09/2/23, 09/28/23, and 09/29/23. The PBJ report provided by CMS for FY 2024 Q3 indicated no licensed nurse coverage on eight days. The PBJ for FY 2024 Q3 recorded no licensed nurse coverage on the following dates: 05/12/24, 05/13/24, 05/15/24, 05/16/24, 05/17/24, 05/18/24, 05/19/24, and 05/22/24. The PBJ report provided by CMS for FY 2024 Q1 indicated no licensed nurse coverage on six days. The PBJ for FY 2024 Q1 recorded no licensed nurse coverage on the following days: 10/01/24, 10/05/24, 10/06/24, 10/07/24, 10/09/24, and 10/12/24. A review of the facility licensed nurse payroll data for the dates listed above revealed a licensed nurse was on duty for 24 hours a day seven days a week. On 10/29/24 at 09:00 AM, Administrative Staff A stated that there was maybe a time when someone was not sending in the correct information and verified the above dates as being reported incorrectly. Administrative Staff A stated that there was always a licensed nurse in the building and that there were more registered nurses than there used to be. The facility's Reporting Direct Care Staffing Information) Payroll-Based Journal) policy, dated 08/2022, documented that direct care staffing information was reported electronically to CMS through the Payroll-Based Journal system. The category of work for each person on the direct care staff (including, but not limited to, whether the individual was a registered nurse, licensed practical nurse, certified nursing assistant, therapist, or other type of medical personnel as specified by CMS. Direct care staffing information included staff hired directly by the facility, those hired through an agency, and contract employees. The information on direct care staff turnover and tenure, and the hours of care provided by each category of staff per resident per day (including, but not limited to, start date, end date (as applicable), and hours worked for each individual). The facility failed to submit accurate PBJ data which placed the residents at risk for unidentified and ongoing inadequate staffing.