STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175078	A. Building B. Wing	10/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy at College Hill	5005 E 21st Street North Wichita, KS 67208

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** 31078 The facility had a census of 60 residents with 15 included in the sample. Based on observation, interview, and record review the facility failed to ensure the resident's dignity when facility staff failed to place Resident (R)21's urinary catheter drainage bag in a dignity bag, away from public view. Findings included: - Resident (R) 21's signed History and Physical dated 09/14/21 revealed the following diagnoses: benign prostatic hyperplasia/hypertrophy (BPH, non-cancerous enlargement of the prostate which can lead to interference with urine flow, urinary frequency and urinary tract infections), muscle atrophy (wasting or decrease in size of a part of the body), and progressive neurodegenerative disorder with paraparesis (partial paralysis, usually affecting only the lower extremities). The Annual Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15 indicating intact cognition. The resident required extensive assistance of one staff with transfers, locomotion, toilet use, and bathing. The resident had a foley catheter and was continent of bowel. The Quarterly MDS dated [DATE] revealed a BIMS of 15. The resident required total dependence with toileting, had an indwelling urinary catheter, and was frequently incontinent of bowel. The Urinary Catheter Care Area Assessment (CAA) dated 01/09/21 revealed R21 with indwelling catheter use. R21 had a diagnosis of BPH and was at risk for side effects associated with catheter use. The Care Plan dated 07/27/2021 revealed the resident had an indwelling urinary catheter and noted the resident received preventive antibiotic therapy (Methenamine Hippurate) for urinary tract infection (UTI) prevention related to catheter use. The Care Plan lacked interventions related to use of a dignity bag with R21's urinary catheter drainage bag. Observation on 09/29/21 at 12:27 PM revealed after Certified Nurse Aide (CNA) E provided peri care and toileting assistance to R21, CNA laid R21's urinary catheter bag, that was just on the floor by the toilet and on the foot pad of the lift during transfer and hung it onto the arm rest of the wheelchair above bladder level. The urinary catheter drainage bag did not have a dignity bag observed during the observation and the staff did not attempt to find a dignity bag. (continued on next page)

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
	175078	A. Building B. Wing	10/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy at College Hill	5005 E 21st Street North Wichita, KS 67208

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	Observation on 09/30/21 at 01:40 PM revealed the resident was in the hallway in his wheelchair holding his urinary catheter drainage bag in his hand, trying to hang it on his chair. The resident struggled with the urinary catheter drainage bag and observation revealed no dignity bag on the resident's urinary catheter bag. There were no staff noted in the area to assist the resident. Observation on 10/04/21 at 02:05 PM revealed the resident wheeled himself slowly in the hall. His urinary catheter drainage bag hung on the arm rest of his wheelchair with no dignity bag and was visible to anyone who walked by. There were no staff in hall to assist the resident. Interview on 09/29/21 at 12:00 PM R21 reported he had the catheter for quite a while now and before he came here. He said the staff sometimes put it in a blue bag but said the staff do not want to mess with it, so they do not. He said he did not like it when he has to carry his catheter bag around, but it was hard for him to get it hung right and the staff did not seem to notice. During an interview on 09/29/21 at 12:40 Certified Nurse Aide (CNA) F reported she did not work that hall but if she saw call lights, she comes over to answer them. CNA F said the resident used to have a dignity bag for his urinary catheter bag, but she had not seen it in a long time, so the staff did not use one. During an interview on 09/29/21 at 12:45 PM CNA E reported he had not used a dignity bag on the resident's urinary catheter drainage bag and did not know if he ever had one. He would try to find the residents dignity bag and put his drainage bag in the dignity bag. During an interview on 09/30/21 at 10:00 AM LN G reported all residents with a catheter drainage bag should have a dignity bag to keep it out of sight from the public. Review of the November 2017 facility policy Indwelling Urinary Catheters revealed staff were to cover the resident's urine bag to provide privacy. The facility failed to ensure dignity for R21, when facility staff failed to place the urinary catheter drainage bag into dignity bag, away from public view.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175078	A. Building B. Wing	10/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy at College Hill	5005 E 21st Street North Wichita, KS 67208

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 0574 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The resident has the right to receive notices in a format and a language he or she understands. 45491 The facility reported a census of 60 with 15 residents included in the sample. Based on observation, interview, and record review the facility failed to ensure staff and residents knew how to contact outside sources for assistance with concerns by the failure to post the State of Kansas Department of Aging and Disability Services (KDADS) Complaint hotline information in the facility. Findings included: - Interview with R30 on 10/05/21 at 08:46 AM revealed he did not know how to contact KDADS or the ombudsman with concerns or where the facility posted the information. Observation on 10/05/21 at 08:53 AM revealed no KDADS complaint hotline information posted in the facility. On 10/05/21 at 08:54 AM Social Services Director (SSD) Q stated the KDADS complaint hotline information should be on the wall but she could not find it. On 10/05/21 at 08:55 AM Administrative Staff A stated the KDADS complaint hotline information had probably not been replaced after the walls were repainted over a year ago. The facility did not provide a policy regarding the posting of contact information for the KDADS complaint hotline as requested on 10/05/21. The facility failed to ensure the staff and residents knew how to contact KDADS with assistance for concerns, by the failure to post the information in the facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175078	A. Building B. Wing	10/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy at College Hill	5005 E 21st Street North Wichita, KS 67208

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** 41302 The facility reported a census of 60 residents with 15 sampled, including three for hospitalization . Based on observation, interview, and record review the facility failed to send a copy of the facility-initiated hospitalization transfer/discharge notice to the representative of the Office of the State Long-Term Care Ombudsman for Resident (R)10, R21, and R50. Findings included: - Review of R10's Minimum Data Set (MDS) tracking form dated [DATE] revealed the resident discharged to the hospital on [DATE] and returned to the facility on [DATE]. Review of R10's Electronic Health Record (EHR) lacked evidence of written notification of the facility-initiated hospitalization transfer/discharge and bed hold to R10's Office of the State Long-Term Care Ombudsman. Observation of [DATE] at 09:00 AM R10 laid in bed covered with blankets and the head of the bed elevated to a sitting position. An interview on [DATE] at 02:05 PM Licensed Nurse (LN) C reported she sent the physician orders, transfer sheet, and nursing notes with the resident when she sent them to the hospital. An interview on [DATE] at 08:00 AM Administrative Nurse B revealed she did not send out the notice of transfer to the Office of the State Long Term Care Ombudsman. An interview on [DATE] at 08:08 AM Administrative Staff D revealed she did not send out notification of transfer to the Office of the State Long Term Care Ombudsman. Interview with Administrative Staff A on [DATE] at 03:36 PM revealed she expected staff to send the logs of hospital transfers to the Office of the State Long Term Care Ombudsman. The [DATE] facility Transfer and/or Discharge Rights and Responsibilities policy documented the facility would send a copy of the notice to the State Long Term Care Ombudsman. The facility failed to send a copy of the notice of facility-initiated hospitalization transfer/discharge to a representative of the Office of the State Long-Term Care Ombudsman when R10 transferred to the hospital. 31078 - Resident (R)21's Annual Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The resident required extensive assistance of one staff with transfers, locomotion, toilet use, and bathing. The resident had a foley catheter and was continent of bowel. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175078	A. Building B. Wing	10/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy at College Hill	5005 E 21st Street North Wichita, KS 67208

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	The Activities of daily living (ADL) Care Area Assessment (CAA) dated [DATE] revealed R21 required assistance with his ADLs due to a diagnosis of multi-system degeneration of the autonomic nervous system and ambulatory dysfunction (a rare neurodegenerative disease that affects the autonomic system functions like respiration, blood pressure and bladder control). The Nurses Progress Notes dated [DATE] at 08:42 PM revealed the resident was unresponsive with no pulse. The staff transferred the resident to the floor, notified 911, and began cardiopulmonary resuscitation (CPR) initiated. Emergency Medical Services (EMS) arrived at 08:05 PM and the resident was responsive and left the facility with EMS at 08:15 PM The Nurses Progress Notes dated [DATE] at 05:00 PM revealed the resident readmitted to the facility from a local hospital. Observation on [DATE] at 02:05 PM revealed the resident wheeled himself slowly in the hall. His urinary catheter bags hung on the arm rest of his wheelchair and not in the dignity bag. There were no staff in hall to assist the resident. During an interview on [DATE] at 02:15 PM Business Office Manager D reported she had not sent any notification to the State Long Term Care Ombudsman when a resident admitted to the hospital. During an interview on [DATE] at 01:30 PM Administrative Nurse B reported she did not know who should have done the Ombudsman notification when a resident transferred to the hospital. On [DATE] at 03:00 PM Administrative Staff A reported she knew a notification was to be sent to the State Ombudsman office when a resident left the facility either discharged or hospitalized and she had a list, but she had not sent anything to the Ombudsman's office. The [DATE] facility Transfer and/or Discharge Rights and Responsibilities policy documented the facility would send a copy of the notice to the State Long Term Care Ombudsman. The facility failed to send a copy of the notice of facility-initiated hospitalization transfer/discharge to a representative of the Office of the State Long-Term Care Ombudsman when R21 transferred to the hospital. - Resident (R)50's Quarterly Minimum Data Set (MDS) dated [DATE] revealed the resident refused the Brief Interview for Mental Status (BIMS). The resident was independent with activities of daily living (ADLs). The resident rejected care on one to three days of the seven-day observation period. The Discharge MDS dated [DATE] revealed the resident admitted to the hospital. The Hospital Records revealed the resident had a cerebrovascular accident (CVA, stroke) and seizures (violent involuntary series of contractions of a group of muscles). He went to the hospital on [DATE] and returned to the facility on [DATE]. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175078	A. Building B. Wing	10/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy at College Hill	5005 E 21st Street North Wichita, KS 67208

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	The Nurses Progress Notes dated [DATE] at 08:14 PM revealed at approximately 07:40 PM and the nurse witnessed R50 fall off his chair and rolled onto the ground. R50 had a seizure for two to three minutes and could not answer questions. His Glucose was elevated at 480 milligrams/deciliter (mg/dL) (normal ,d+[DATE] mg/dL). The nurse administered Sliding Scale (insulin dose determined by results of the blood sugar) insulin and called (Emergency Medical Services) EMS. At 08:07 PM EMS transported the resident to the Hospital. Observation on [DATE] at 09:55 AM revealed the resident laid in bed in semi-Fowlers (head elevated part way) position and visiting with a rehabilitation therapist. The resident was weak and talked in a quiet voice. The resident had a gastrostomy tube and received Glucerna 1.5 at 50 milliliters (ml)/hour per enteral tube. During an interview on [DATE] at 02:15 PM Business Office Manager D reported she had not sent any notification to the State Long Term Care Ombudsman when a resident admitted to the hospital. During an interview on [DATE] at 01:30 PM Administrative Nurse B reported she did not know who should have done the Ombudsman notification when a resident transferred to the hospital. On [DATE] at 03:00 PM Administrative Staff A reported she knew a notification was to be sent to the State Ombudsman office when a resident left the facility either discharged or hospitalized and she had a list, but she had not sent anything to the Ombudsman's office. The [DATE] facility Transfer and/or Discharge Rights and Responsibilities policy documented the facility would send a copy of the notice to the State Long Term Care Ombudsman. The facility failed to send a copy of the notice of facility-initiated hospitalization transfer/discharge to a representative of the Office of the State Long-Term Care Ombudsman when R50 transferred to the hospital.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175078	A. Building B. Wing	10/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy at College Hill	5005 E 21st Street North Wichita, KS 67208

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 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31078 The facility had a census of 60 residents with 15 included in the sample. Based on observation, interview, and record review the facility failed to provide Resident (R)21, R50, and R10 or the resident representative with a bed-hold policy upon transfer to a hospital. Findings included: - Resident (R)21's Annual Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The resident required extensive assistance of one staff with transfers, locomotion, toilet use, and bathing. The resident had a foley catheter and was continent of bowel. The Activities of daily living (ADL) Care Area Assessment (CAA) dated [DATE] revealed R21 required assistance with his ADLs due to a diagnosis of multi-system degeneration of the autonomic nervous system and ambulatory dysfunction (a rare neurodegenerative disease that affects the autonomic system functions like respiration, blood pressure and bladder control). The Nurses Progress Notes dated [DATE] at 08:42 PM revealed the resident was unresponsive with no pulse. The staff transferred the resident to the floor, notified 911, and began cardiopulmonary resuscitation (CPR) initiated. Emergency Medical Services (EMS) arrived at 08:05 PM and the resident was responsive and left the facility with EMS at 08:15 PM The Nurses Progress Notes dated [DATE] at 05:00 PM revealed the resident readmitted to the facility from a local hospital. Observation on [DATE] at 02:05 PM revealed the resident wheeled himself slowly in the hall. His urinary catheter bags hung on the arm rest of his wheelchair and not in the dignity bag. There were no staff in hall to assist the resident. On [DATE] at 01:50 PM Licensed Nurse (LN) H reported he did not know what a bed hold policy was. On [DATE] at 02:05 PM LN C reported she never sent a bed hold policy with the resident when a resident transferred out, and did not know what a bed hold policy was. On [DATE] at 02:15 PM Business Office Manager D reported she did not send a bed hold policy when a resident transferred to the hospital. On [DATE] at 01:30 PM Administrative Nurse B reported she did not know who would completed the bed hold policy. On [DATE] at 03:00 PM Administrative Staff A stated she did not know who was responsible for the bed hold policy and did not know it was not competed for residents transferred to the hospital. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175078	A. Building B. Wing	10/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy at College Hill	5005 E 21st Street North Wichita, KS 67208

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 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility did not provide a policy regarding a Bed-Hold Policy as requested from Administrative Staff A on [DATE] at 03:00 PM. The facility failed to provide Resident (R) 21 or their representative with a Bed-Hold Policy upon transfer to a hospital. - Resident (R)50's Quarterly Minimum Data Set (MDS) dated [DATE] revealed the resident refused the Brief Interview for Mental Status (BIMS). The resident was independent with activities of daily living (ADLs). The resident rejected care on one to three days of the seven-day observation period. The Discharge MDS dated [DATE] revealed the resident admitted to the hospital. The Hospital Records revealed the resident had a cerebrovascular accident (CVA, stroke) and seizures (violent involuntary series of contractions of a group of muscles). He went to the hospital on [DATE] and returned to the facility on [DATE]. The Nurses Progress Notes dated [DATE] at 08:14 PM revealed at approximately 07:40 PM and the nurse witnessed R50 fall off his chair and rolled onto the ground. R50 had a seizure for two to three minutes and could not answer questions. His Glucose was elevated at 480 milligrams/deciliter (mg/dL) (normal ,d+[DATE] mg/dL). The nurse administered Sliding Scale (insulin dose determined by results of the blood sugar) insulin and called (Emergency Medical Services) EMS. At 8:07 PM EMS transported the resident to the Hospital. Observation on [DATE] at 09:55 AM revealed the resident laid in bed in semi-Fowlers (head elevated part way) position and visiting with a rehabilitation therapist. The resident was weak and talked in a quiet voice. The resident had a gastrostomy tube and received Glucerna 1.5 at 50 milliliters (ml)/hour per enteral tube. On [DATE] at 01:50 PM Licensed Nurse (LN) H reported he did not know what a bed hold policy was. On [DATE] at 02:05 PM LN C reported she never sent a bed hold policy with the resident when a resident transferred out, and did not know what a bed hold policy was. On [DATE] at 02:15 PM Business Office Manager D reported she did not send a bed hold policy when a resident transferred to the hospital. On [DATE] Administrative Nurse B reported she did not know who completed the bed hold policy. On [DATE] at 03:00 PM Administrative Staff A stated she did not know who was responsible for the bed hold policy and did not know it was not competed for residents transferred to the hospital. The facility did not provide a policy regarding a Bed-Hold Policy as requested from Administrative Staff A on [DATE] at 03:00 PM. The facility failed to provide R50 or their representative with a Bed-Hold Policy upon transfer to a hospital. 41302 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175078	A. Building B. Wing	10/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy at College Hill	5005 E 21st Street North Wichita, KS 67208

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 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Review of R10's Minimum Data Set (MDS) tracking form dated [DATE] revealed the resident discharged to the hospital on [DATE] and returned to the facility on [DATE]. Review of R10's Electronic Health Record (EHR) lacked evidence of written notification of the facility-initiated hospitalization transfer/discharge and bed hold to R10 or her representative. On [DATE] at 09:00 AM R10 laid in bed covered with blankets and the head of the bed elevated to a sitting position. On [DATE] at 02:05 PM Licensed Nurse (LN) C reported she sent the physician orders, transfer sheet, and nursing notes with the resident when she sent them to the hospital but did not know what a Bed-Hold policy was. On [DATE] at 08:00 AM Business Office Manager B revealed she did not send the Bed-hold policy when a resident transferred to the hospital. On [DATE] at 03:00 PM Administrative Staff A stated she did not know who was responsible for the bed hold policy and did not know it was not completed for residents transferred to the hospital. The facility failed to provide a policy for bed-holds requested on [DATE] at 03:00 PM. The facility failed to provide a copy of the bed hold policy for R10 or her representative for her [DATE] hospitalization .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175078	A. Building B. Wing	10/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy at College Hill	5005 E 21st Street North Wichita, KS 67208

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35556 The facility census totaled 60 residents with 15 included in the sample. Based on observation, interview, and record review the facility failed to develop a person-centered comprehensive care plan to include the use of psychoactive drugs and the specific targeted behaviors staff were to monitor the resident for regarding the psychoactive medications for Resident (R)32. The facility also failed to develop a person-centered comprehensive care plan to address the needs and cares of R55. Findings included: - R32's History and Physical dated 07/19/21 revealed diagnoses of depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness), and dementia (progressive mental disorder characterized by failing memory, confusion.) The Admission Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of three which indicated severe cognitive impairment, and received an antipsychotic and antidepressant daily. The Cognitive Loss/Dementia Care Area Assessment (CAA) dated 07/25/21 revealed R32 triggered due to a diagnosis of unspecified dementia with behavioral disturbance. R32 did not show any behaviors at the time of this assessment. The Psychotropic Drug Use CAA revealed R32 had a diagnosis of unspecified dementia with behavioral disturbances. R32 was at risk for side effects of psychotropic drugs related to the use of Seroquel and Zoloft (antidepressant medication.) The Care Plan dated 07/29/21 revealed R32 had chronic confusion related to unspecified dementia with behavioral disturbances. Interventions included to administer medications as ordered, monitor/document/report side effects and effectiveness. The Care Plan did not include any information on which psychotropic drugs R32 received or what specific targeted behaviors staff monitored R45 for. A review of the Physician Orders included the following: Order dated 07/12/21 for Seroquel 200 milligrams (mg), give one tablet by mouth three times a day for dementia. Order dated 07/12/21 for Depakote 250 mg, give one tablet by mouth three times a day for dementia. Observation on 10/04/21 at 04:15 PM, revealed R32 sat in a chair in the dining room and seemed somewhat sedated or sleepy. R32 got up from his chair and staff assisted R32 to a different chair where he sat down and looked down towards the ground. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175078	A. Building B. Wing	10/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy at College Hill	5005 E 21st Street North Wichita, KS 67208

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 10/05/21 at 09:48 AM, Licensed Nurse (LN) H stated there were no behaviors listed in the care plan to monitor for Seroquel or Depakote for R32. In an interview on 10/05/21 at 09:38 AM, Administrative Nurse B stated there should be specific targeted behaviors to monitor for the use of psychotropic medications. In an interview on 10/05/21 at 01:33 PM, Administrative Staff A stated she expected nursing staff to monitor for specific targeted behaviors for the use of psychotropic medications and be included in the care plan. The facility did not provide a policy regarding Care Plans as requested on 10/04/21 at 04:00 PM to Administrative Staff A. The facility failed to develop a person-centered comprehensive care plan to address the use of psychotropic medications and monitoring of specific targeted behaviors for R32. 31078 - Resident (R)55's signed Physician Orders dated 08/25/21 revealed the following diagnoses: hepatocellular carcinoma (cancer of the liver). Review of the Admission Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 13, indicating intact cognition. The resident required assistance of one staff for daily care. The resident received pain medications on schedule and as needed for occasional pain rated an eight out of 10. The resident received opioids (narcotic pain medication) four days of the seven-day observation period. The resident received oxygen (O2) on continuous basis. Review of the Pain Care Area Assessment (CAA) dated 09/07/21 revealed R55 reported pain at an eight out of 10, during the assessment and stated he had it occasionally. The resident was started on routine pain medications. Review of R55's electronic medical record on 09/30/21 revealed the resident admitted to the facility on [DATE] did not have a Comprehensive Care Plan written, as of 09/30/21 (over a month later). Interview on 09/30/21 at 10:30 AM revealed Administrative Nurse B reported she knew she was behind with her work but had been having to work the floor as a nurse because at times there were not enough nurses and the facility did not have a Director of Nurses (DON). Administrative Nurse B felt like she had to help and the residents were more important to her than paperwork. Interview on 10/04/21 at 04:00 PM Administrative Staff A reported the facility has been short staffed and they tried to fill in with agency nurses but could not always. She knew Administrative Nurse B helped on the floor and helped her with different things, but said with no DON and Administrative Staff A without medical training, there were times she did need help. She did not know Administrative Nurse B was behind in her work though. A request was made on 10/04/21 at 04:00 PM to Administrative staff A for a policy on Care Plans with no policy provided. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175078	A. Building B. Wing	10/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy at College Hill	5005 E 21st Street North Wichita, KS 67208

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility failed to develop a person-centered comprehensive care plan to address the needs and cares of R55.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175078	A. Building B. Wing	10/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy at College Hill	5005 E 21st Street North Wichita, KS 67208

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** 35556 The facility census totaled 60 residents with 15 included in the sample. Based on observation, interview, and record review the facility failed to revise the care plan for Resident (R)52 related to nutritional supplementation and treatment of a pressure injury, and R24 related to the use of oxygen. Findings included: - R52's Physician Progress Note dated 09/15/21 revealed the following diagnoses: dementia (progressive mental disorder characterized by failing memory, confusion) and metabolic encephalopathy (a brain disease caused by chemical imbalance in the blood due to an illness or organs that are not working as well as they should). The Significant Change Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of four, which indicated severely impaired cognition. R52 required limited assistance with eating. R52 weighed 108 pounds was 61 inches tall, and experienced weight loss, but was not on a physician prescribed weight-loss program. The Quarterly MDS dated [DATE] revealed a BIMS score of four, which indicated severely impaired cognition. R52 required limited assistance with eating. R52 weighed 108 pounds, was 61 inches tall, and experienced weight loss, but was not on a physician prescribed weight-loss program. The Nutritional Status Care Area Assessment (CAA) dated 07/28/21 revealed R52 recently upgraded to a regular diet with regular texture and thin liquids. R52 had no difficulty noted with eating. The Pressure Ulcer/Injury CAA dated 07/28/21 revealed R52 triggered for pressure ulcer/injury (localized injury to the skin and/or underlying tissue usually over a bony prominence as a result of pressure or pressure in combination with shear) due to periods of incontinence of bowel and bladder, increased weakness, and needed extensive assistance with repositioning. The Care Plan dated 08/03/21 revealed R52 had an alteration in skin related to an open area on her coccyx (small triangular bone at the base of the spine) that was a chronic, unstageable pressure injury. Interventions included for staff to encourage good nutrition and hydration in order to promote healthier skin. Staff would turn and reposition every two hours and as needed (PRN). The licensed nurse would perform a weekly skin assessment. Staff would cleanse the area, pat dry, apply skin prep (a liquid film-forming dressing that, upon application to intact skin, forms a protective film to help reduce friction during removal of tapes) to peri wound (tissue surrounding a wound), apply SilvaKollagen Gel (a silver antimicrobial collagen gel with hydrolyzed collagen which supports autolytic debridement) to wound bed, apply collagen, cover with dry dressing, and change the dressing three times a week. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175078	A. Building B. Wing	10/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy at College Hill	5005 E 21st Street North Wichita, KS 67208

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 Care Plan dated 07/06/21 revealed R52 had a potential for nutritional problem related to needing increased assistance with meals due to dementia. Interventions included for staff to provide R52 Ensure (nutritional supplement drink) three times daily and PRN. There was never a Physician Order for R52 to receive Ensure. The 07/21/21 Social Services Note revealed R52 signed on to hospice care to care for R52's wounds. An order dated 09/12/21 to consult [local wound center] (specialized wound care provider) to evaluate and treat the resident's coccyx wound. Observation on 09/30/21 at 8:38 AM revealed R52 had a breakfast of scrambled eggs, a bowl of oatmeal, French toast, sausage, an 8 oz. cup of orange juice, and an 8 oz. cup of milk. Staff assisted R52 with her meal and she consumed approximately 20 percent of her meal, 75 percent of her orange juice, and no milk. No observation that staff offered R52 a supplement during this meal. Observation on 09/30/21 at 12:12 PM revealed staff assisted R52 with her meal and offered her a lunch that consisted of spinach, beans, cornbread, a cookie, an 8 oz. cup of lemonade, and an 8 oz. cup of water. R52 was not very cooperative and consistently wanted to lean forward in her wheelchair. R52 consumed less than 25 percent of her meal, and approximately 50 percent of her lemonade and water. No observation that staff offered R52 a supplement during this meal. In an interview on 09/30/21 at 09:20 AM Certified Nurse Aide (CNA) O stated R52 was offered Mighty Shakes (nutritional supplement). In an interview on 10/05/21 at 07:30 AM, Licensed Nurse (LN)P stated R52 had not been eating very well. LN P stated if the Registered Dietician recommended Med Pass and weekly weights due to weight loss, staff should have followed up on this recommendation. In an interview on 10/05/21 at 09:28 AM, Administrative Nurse B stated the nurses have the ability to update the care plan themselves but stated the nurses expected her to update it. Administrative Nurse B stated she remembered family brought in the Ensure when R52 first came to the facility but verified there was no order for it and the care plan should have been revised. Administrative Nurse B stated if hospice or [local wound center] treated R52's wounds this should be included in the care plan. In an interview on 10/05/21 at 01:33 PM, Administrative Staff A stated she expected the care plan to include wound care and nutrition interventions and be updated as needed. The facility did not provide a policy related to Care Plans as requested on 10/04/21 at 04:00 PM to Administrative staff A. The facility failed to revise the care plan to include information of wound treatment provided by hospice and [local wound center] and revise nutritional supplementation for R52. - Review of R24's signed Physician Order Set dated 08/02/21 revealed the following diagnosis: pneumonia (inflammation of the lungs). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175078	A. Building B. Wing	10/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy at College Hill	5005 E 21st Street North Wichita, KS 67208

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 Quarterly Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of three, which indicated severe cognitive impairment. R24 did not receive oxygen therapy. The Significant Change MDS dated [DATE] revealed a BIMS of three which indicated severe cognitive impairment, and R24 received oxygen therapy. The 02/09/21Care Plan lacked interventions related to R24's oxygen use and care. A Physician Order dated 09/20/21 revealed staff were to administer oxygen to R24 at two liter per nasal cannula (a device used to deliver supplemental oxygen or increased airflow to a patient or person in need of respiratory help) continuously as patient allows every shift for pneumonia. An observation on 10/05/21 at 08:59 AM revealed R24's oxygen tubing was draped over the oxygen concentrator, and there was no storage bag available for storing the tubing when not in use. On 10/04/21 at 01:11 PM, Licensed Nurse (LN) C stated R24 was on oxygen as he allowed. LN C stated there should be a large plastic bag where the tubing should be stored when not in use. On 10/05/21 at 09:41 AM, Administrative Nurse B stated she expected oxygen use to be included in R24's care plan. On 10/05/21 at 01:39 PM, Administrative Staff A stated the use of oxygen should be included in the care plan. The facility did not provide a policy related to Care Plans as requested on 10/04/21 at 04:00 PM to Administrative staff A. The facility failed to revise the care plan to include information of oxygen use by R24.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175078	A. Building B. Wing	10/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy at College Hill	5005 E 21st Street North Wichita, KS 67208

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** 41302 The facility reported a census of 60 residents with 15 sampled including four for Activities of Daily Living (ADL). Based on observation, interview, and record review the facility failed to provide ADL assistance to include bathing services to maintain good grooming for Resident (R)29, who required limited assistance with bathing, R21 with assistance to the bathroom in a timely manner to avoid an accident in his clothing, and R50 with timely checks to avoid lying in urine soaked bed linens. Findings Included: - The August 2021 Electronic Health Record (EHR) documented R29 had the following diagnoses: schizophrenia (psychotic disorder characterized by gross distortion of reality, disturbances of language and communication and fragmentation of thought), major depressive disorder (major mood disorder), bipolar (major mental illness that caused people to have episodes of severe high and low moods), dementia (progressive mental disorder characterized by failing memory, confusion), and anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear). The 04/18/21 Annual Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of 11, indicating moderately impaired cognition. R29 required limited assistance of one staff with bathing. The 07/19/21 Quarterly MDS documented a BIMS of 14, indicating intact cognition. R29 required limited assistance of one staff with all ADLs, including bathing. The 04/18/21 ADL Function/Rehabilitation Care Area Assessment (CAA) documented R29 needed supervision and increased assistance from staff for ADLs. The 08/25/21 Care plan documented R29 preferred to take a bath two times a week in the evening on Sunday and Thursday. The September 2021 Electronic Health Record (EHR) lacked documentation of showers for R29. On 09/30/21 at 02:17 PM observed R29 with long fingernails with a dark substance under each of them, and wore a shirt with dribbles of orange, red, and brown substances down the front. R29's face had what appeared to be food substance smeared on her mouth and chin. On 09/30/21 at 02:19 PM R29 revealed she would like to bathe at least twice a week and she understood currently she would have to wait because they had been short of staff. R29 stated that she had not had a bath in a week. R29 stated her nails were longer than she would like, but she knew the girls (staff) were busy. On 09/30/21 at 02:24 PM Certified Medication Aid (CMA) I revealed she was trying to complete her tasks passing medications but would help the floor Certified Nurse Aids (CNA) as soon as she finished. She informed R29 that she would tell the CNA the resident would like a shower. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175078	A. Building B. Wing	10/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy at College Hill	5005 E 21st Street North Wichita, KS 67208

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	During an interview on 10/04/21 at 11:20 AM Licensed Nurse (LN) C revealed the CNAs assigned to each hall were expected to complete resident showers. LN C said the staff documented showers given on paper and kept them in a binder, by the residents last name, at the nurses' station. LN C confirmed R29 had a blank sheet in the binder, indicating no showers given. LN C thought the full sheets went to medical records. On 10/05/21 at 01:16 PM Medical Record staff R revealed she did not receive the shower sheets but stated the shower pages used to go to the director of nursing (DON). On 10/05/21 at 12:09 PM Administrative Nurse B stated she did not receive the shower pages and did not know where they went. On 10/05/21 at 03:39 PM Administrative Staff A revealed she expected her staff to complete showers/tub baths as ordered, per the resident choice, but did not know how they were documented. The undated Shower/Tub Bath policy documented staff should document the date, time, and assessment of shower/tub bath in a resident's medical record. The facility failed to provide necessary services to maintain good grooming for personal hygiene for R29 to ensure her comfort. 31078 - Resident (R)21's signed History and Physical dated 09/14/21 revealed the following diagnoses: benign prostatic hyperplasia/hypertrophy (BPH, non-cancerous enlargement of the prostate which can lead to interference with urine flow, urinary frequency and urinary tract infections), muscle atrophy (wasting or decrease in size of a part of the body), and progressive neurodegenerative disorder with paraparesis (partial paralysis, usually affecting only the lower extremities). The Annual Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The resident required extensive assistance of one staff with transfers, locomotion, toilet use, and bathing. The resident had a foley catheter and was continent of bowel. The Quarterly MDS dated [DATE] revealed a BIMS of 15. The resident required extensive assistance of two staff for transfer, locomotion, bathing, and total dependence with toileting. The resident had an indwelling urinary catheter and was frequently incontinent of bowel. The Activities of daily living (ADL) Care Area Assessment (CAA) dated 01/09/21 revealed R21 required assistance with his ADLs due to a diagnosis of multi-system degeneration of the autonomic nervous system and ambulatory dysfunction (a rare neurodegenerative disease that affects the autonomic system functions like respiration, blood pressure and bladder control). The Care Plan dated 01/24/20 revealed the resident had a self-care deficit related to his limited mobility and impairment. He could assist in part of his bathing with extensive assistance of one staff. The resident needed staff supervision with toileting and had an indwelling urinary catheter. The staff encouraged the resident to use the bell to call for assistance. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175078	A. Building B. Wing	10/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy at College Hill	5005 E 21st Street North Wichita, KS 67208

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	Observation on 09/29/21 at 12:00 PM the resident called to the surveyor in the hall to help him. Upon the surveyor entering the room, the resident was notably upset saying he needed help. He reported he had his call light on for over an hour and had to go to bathroom. The surveyor left the room and went to the hall looking for a staff to assist the resident. No staff were on the hall. At 12:15 PM the surveyor saw CNA F in another room on the end of the hall and told her what the resident had said about needing assistance. She reported she was not the aide for this hall but would come over and help. She reported she would find someone to help her with the resident when she finished caring for the resident in the room. At 12:27 PM Certified Nursing Assistant (CNA) E and CNA F arrived to provide care to the resident. The staff brought in a sit to stand mechanical lift to transfer the resident and placed the resident's catheter bag on the footpads of the lift. When the staff lifted the resident with the mechanical lift, there appeared to be a substance which looked like feces on his chair pad and pants. The resident reported to the staff he had called for assistant to go to the bathroom an hour ago. The staff lowered the resident onto the toilet and removed his pants and brief. CNA E tossed the urinary catheter bag from lift to the floor near the side of the toilet. CNA F then wiped and cleaned the feces off of the floor in front of toilet, then cleaned the resident up with wipes, and proceeded to put a clean brief on the resident without changing gloves or performing hand hygiene. CNA F started to remove the resident's pants with feces on them without first taking his shoes off and the resident insisted CNA F remove his shoes before removing the pants and he then asked CNA F to put a pair of shorts on him. CNA F put the shorts on the resident and wore the same gloves throughout cleaning of the feces and subsequently dressing the resident. The resident was then allowed to sit awhile on the toilet and CNA E returned to the room a short time later. CNA E then proceeded to do peri care with wet wipes and then pulled up the brief and pants while the resident stood in the lift. CNA E took the catheter bag from the floor near the toilet with no dignity bag on it and placed it back on the foot pad of the lift to transfer the resident to his wheelchair. The staff laid R21's urinary catheter bag that was just on the floor by the toilet and on the foot pad of the lift, then hung it onto the arm rest of the wheelchair with no dignity bag. CNA E and CNA F did not change their gloves or wash their hands, during the entire observation. Observation on 09/30/21 at 01:40 PM revealed the resident was in the hallway in his wheelchair holding his catheter bag in his hand, trying to hang it on his chair. The resident struggled with the urinary catheter bag. There were no staff noted in the area to assist the resident. Observation on 10/04/21 at 02:05 PM revealed the resident wheeled himself slowly in the hall. His urinary catheter bags hung on the arm rest of his wheelchair and not in the dignity bag. There were no staff in hall to assist the resident. Interview on 09/29/21 at 12:00 PM with R21 revealed he needed help. He reported he had his call light on for over an hour and no one would answer, and he had to go to the bathroom. He said he just kept waiting and waiting. Interview on 09/29/21 at 12:40 PM CNA F reported if she saw call lights, she went over to answer them. CNA F stated the hall had only one CNA on this hall and he tried to get to everyone as he could. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175078	A. Building B. Wing	10/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy at College Hill	5005 E 21st Street North Wichita, KS 67208

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	Interview on 09/29/21 at 12:45 PM CNA E reported he always put the catheter bag on the floor beside the toilet because he had nowhere to hang it. He had not used a dignity bag on the resident's urinary catheter drainage bag and said he did not know if R21 ever had one. CNA E said he was the only one working that hall and he was busy passing lunch trays. He said if a resident needed help he always had to go find another staff member on another hall or sometimes the nurse, to help him. Interview on 09/30/21 at 10:00 AM Licensed Nurse (LN) G reported he helps the CNAs. LN G stated all staff knew how to properly care for a urinary catheter. He said the LN on duty flushed and provided catheter care every shift unless the resident had a bowel movement and needed cleaned, then the CNA would make sure the catheter was also cleaned. Interview on 10/05/21 at 8:15 AM LN H reported the nurse did the catheter care to assure it got cleaned each shift. LN H reported the resident received an antibiotic daily to prevent infection due to his disease process. The facility did not provide a policy for ADLs as requested on 10/04/21. The facility failed to provide staff assistance timely to dependent R21 to prevent an episode of bowel incontinence, when he waited for an hour for staff response. - Resident (R)50's signed Physician Orders dated 09/13/21 revealed the following diagnoses: cerebral infarction (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, also called a CVA), dementia (progressive mental disorder characterized by failing memory, confusion), gastrostomy status (the introduction of a nutrient solution through a surgically inserted tube into the stomach through the abdominal wall), dysarthria (slurred speech) following cerebral infarction, and seizures (violent involuntary series of contractions of a group of muscles). The Quarterly Minimum Data Set (MDS) dated [DATE] revealed the resident refused the Brief Interview for Mental Status (BIMS). The resident was independent with activities of daily living (ADLs). The resident rejected care on one to three days of the seven-day observation period. The Discharge MDS dated [DATE] revealed the resident admitted to the hospital. Review of the Admission MDS dated 09//21 and completed on 10/02/21 revealed the resident had severe cognitive impairement and rarely understood. The resident received extensive assistance of one with bed mobility, transfers, toilet use and dependent on staff for hygiene and eating and bathing. The resident had a new diagnosis of a CVA. The resident received 51% or more of his nutrition through G- tube. The resident had no skin issues. Review of the feeding tube CAA dated 10/02/21 revealed the resident returned from the hospital on 09/13/2021 with diagnosis of: Stroke, seizures and placement of gastrostomy tube. Resident receives his fluids and nutrition thru PEG tube. He is allowed two ounces of ice chips two times daily which he needs encouragement to take. The resident is at risk for complications related to tube feedings and receiving proper nutrition. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175078	A. Building B. Wing	10/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy at College Hill	5005 E 21st Street North Wichita, KS 67208

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	The Nurse's Readmission Assessment Initial Care Plan dated 09/13/21 revealed the resident had a gastrostomy tube ((the introduction of a nutrient solution through a surgically inserted tube into the stomach through the abdominal wall) and received nutrition continuous through a tube connected to a pump. The resident was alert and oriented with no behaviors noted. The resident required extensive to total assistance of one to two staff with ADLs and was incontinent of bowel and bladder. The Hospital Records revealed the resident had a CVA and seizures. He went to the hospital on 08/28/21 and returned to the facility on [DATE]. The Nurses Progress Notes dated 09/14/21 at 03:41 AM revealed the resident readmitted from the hospital on 09/13/21 with diagnoses of stroke, and seizure. The resident was alert with eyes open and nonverbal. The gastrostomy tube was in place and patent with Glucerna tube feeding infusing at 50 milliliters (ml)/hour (hr.) and tolerated well. Water flushed easily as ordered. The staff provided the resident with one-person total assistance with ADLs this shift. The resident has been incontinent of bladder. Observation on 09/30/21 at 09:55 AM revealed the resident laid in bed in semi-Fowlers (head elevated part way) position and visiting with a rehabilitation therapist. The resident was weak and talked in a quiet voice. The resident had a gastrostomy tube and received Glucerna 1.5 at 50 cc/hr per enteral tube. Observation of R50 on 09/30/21 at 01:05 PM revealed LN G in the resident's room. He was looking at the resident's peg tube and noticed the end was broken, so a syringe could not be secured on the tube for medication administration. He then disconnected the pump tubing until he could contact the physician. While in the room the surveyor noted the resident was soaked and wet. LN G checked the resident and verified R50 was soaking wet. LN G left the room to find assistance to change the resident. Certified Medication Aide L came back with the nurse and donned gloves to assist in changing the resident. The resident's gown, top sheet, and the residents brief were all soaked with urine. The resident's bottom sheet was stripped off the bed and the mattress was wet from the lower middle portion of the bed mattress up the residents back area. The staff cleaned the resident up and then scrubbed the mattress with peri cleaner and placed a pad over the remaining wet spot on the bed. The staff then placed a brief on the resident and repositioned the resident, in order to replace the bottom sheet. The staff placed a clean gown on the resident and covered him with a top sheet and blanket. The resident did not say much during the care and allowed the staff to perform the task. The nurse then left taking the broken tube with him to contact the physician. Observation of R50 on 10/04/21 at 7:52 AM revealed the resident was restless in bed and yelled out. The resident had a very strong odor of urine. The bed pad had dry areas that were brown, and the rest of the pad was saturated with urine. The sheet under the resident was visibly wet and brown in color. The resident's brief was saturated and bulging and his sleep gown was wet. LN H and CNA F gloved to change the resident. CNA F removed the resident's gown while LN H unplugged the g-tube and flushed the tube with water. LN H then opened the resident's brief and revealed the resident had a bowel movement (BM). LN H proceeded to clean the resident using wet wipes. The resident's coccyx was red and intact. The bed mattress was wet and the wet spot covered with an incontinent pad. LN H placed a brief on the resident, followed by a pair of jeans. LN H wore the same gloves with no hand hygiene performed before or after gloves being worn. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175078	A. Building B. Wing	10/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy at College Hill	5005 E 21st Street North Wichita, KS 67208

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	Interview on 09/30/21 CNA F reported the resident was total care and was incontinent. Before R50 went to the hospital, he pretty much took care of himself with coaxing and supervision from staff. Then he had his stroke and now had a feeding tube. The resident needed to be changed about every two hours because with that tube feeding, he was wet a lot. She reported this was not actually her hall, but she came over and helped if the staff needed help. Interview on 10/04/21 at 08:00 AM CNA F reported she was the only aid scheduled for this hall and was working to get residents up for breakfast. The third shift CNA always left before CNA F arrived, instead of doing walking rounds with her, like she was supposed to. CNA F did not know the resident was wet and was working with another resident. It looked to her like the resident had been wet for a while and maybe all night by the way the pad had dried at the edges. Interview on 09/30 21 at 01:20 PM LN G stated he had never seen a nursing home like this. He stated he was a little overwhelmed by the lack of staff and caring for the residents. He had never worked at a place that only one aide showed up for the whole shift and the other 3 called in. He said he was helping on the floor as much as he could, and the CMA was helping between medication passes. They were getting things done but did not feel the residents were getting the care they needed. The facility did not provide a policy for ADLs as requested on 10/04/21. The facility failed to provide care to a dependent resident to maintain good hygiene, when two observations revealed R50 soaked in urine.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175078	A. Building B. Wing	10/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy at College Hill	5005 E 21st Street North Wichita, KS 67208

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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35556 The facility had a census of 60 residents with 15 residents in the sample and three residents reviewed for pressure ulcers. Based on observation, interview, and record review, the facility failed to prevent the development of a stage 4 (sore that extends below the subcutaneous fat into deep tissues like bone) pressure ulcer (localized injury to the skin and/or underlying tissue usually over a bony prominence as a result of pressure or pressure in combination with shear) for dependent Resident (R)52, who admitted to the facility with intact skin. The facility further failed to monitor and assess the facility acquired pressure ulcer on R52's coccyx (small triangular bone at the base of the spine). Findings included: - R52's Physician Progress Note dated 09/15/21 revealed the following diagnoses: dementia (progressive mental disorder characterized by failing memory, confusion) and metabolic encephalopathy (a brain disease caused by chemical imbalance in the blood due to an illness or organs that are not working as well as they should). The Discharge- return anticipated Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score could not be completed. R52 had short-term memory problems and did not have any pressure ulcer/injury. The Significant Change MDS dated [DATE] revealed a BIMS score of four, which indicated severely impaired cognition. R52 required extensive assistance from staff for bed mobility and toilet use, and limited assistance from staff with eating. R52 was frequently incontinent of bladder and bowel. R52 weighed 108 lbs. (pounds), was 61 inches tall, and experienced weight loss, but was not on a physician prescribed weight-loss program. R52 had one unstageable pressure wound and utilized a pressure reducing device for her chair and bed. The Urinary Incontinence and Indwelling Catheter Care Area Assessment (CAA) dated 07/28/21 revealed R52 triggered for urinary incontinence due to decrease mobility and was at risk for skin breakdown due to being occasionally incontinent of bowel and bladder. The Pressure Ulcer/Injury CAA dated 07/28/21 revealed R52 triggered for pressure ulcer/injury due to periods of incontinence of bowel and bladder, increased weakness, and needed extensive assistance with repositioning. The Care Plan dated 08/03/21 revealed R52 had an alteration in skin related to an open area on her coccyx that was a chronic, unstageable pressure injury. Interventions included for staff to encourage good nutrition and hydration in order to promote healthier skin. Staff would turn and reposition every two hours and as needed (PRN). The licensed nurse would perform a weekly skin assessment. Staff would cleanse the area, pat dry, apply skin prep (a liquid film-forming dressing that, upon application to intact skin, forms a protective film to help reduce friction during removal of tapes) to peri wound (tissue surrounding a wound), apply SilvaKollagen Gel (a silver antimicrobial collagen gel with hydrolyzed collagen which supports autolytic debridement) to wound bed, apply collagen, cover with dry dressing, and change the dressing three times a week. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175078	A. Building B. Wing	10/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy at College Hill	5005 E 21st Street North Wichita, KS 67208

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 0686 Level of Harm - Actual harm Residents Affected - Few	The 06/01/21 Admission Summary Progress Note revealed R52's skin was intact. The 06/13/21 Health Status Note revealed R52 had a small open area at the top of her coccyx, which measured 1-centimeter (cm) x 3-millimeter (mm) x 1mm. The 06/17/21 Weekly Skin Evaluation revealed the resident had a dime sized, stage 2 wound to the sacrum. The Weekly Skin Evaluation further had a notice in red letters stating: NOTE: If an open area, proceed to appropriate skin condition report. (A skin condition report was not completed.) An order dated 06/18/21 to apply skin prep to open area on coccyx each shift and as needed (PRN) after incontinence, every shift for skin integrity, and every eight hours as needed. Discontinued on 06/23/21. An order dated 06/23/21 for weekly skin assessments. An order dated 06/24/21 to cleanse right buttock wound with wound cleanser, apply skin prep to wound edge, apply cut to size alginate (a multipurpose type of wound dressing), cover with foam dressing, change Monday through Thursday till healed. Discontinued 06/25/21. An order dated 06/26/21 to cleanse right buttock wound with wound cleanser, apply skin prep to wound edges, apply dime size Santyl (a sterile enzymatic debriding ointment) to wound bed, apply cut to size Xeroform (a fine mesh gauze occlusive dressing impregnated with petrolatum) to wound bed, cover with border dressing, change daily. Discontinued on 08/01/21. The 07/21/21 Social Services Note revealed R52 signed on to hospice care to care for R52's wounds. An order dated 07/22/21 for House Supplement Shake (nutritional supplement drink) 4 ounces (oz). Review of the Hospice Visit Note Report on the following dates revealed: 07/27/21- Sacral wound measured 2.7cm x 2.5cm. 08/02/21- Sacral wound measured 2.7cm x 2.5cm. 08/09/21- Applied sacral wound treatment. 08/12/21- Treatment to coccyx replaced. An order dated 08/04/21 Cleanse sacral wound with wound cleanser, lightly pat dry, apply skin prep to wound edges, apply SilvaKollagen gel to wound bed, cover with cut to size collagen, cover with dry dressing, hospice to change Monday and Friday, our staff to change dressing on Wednesday, one time a day every Wednesday for sacral wound. Discontinued 08/05/21. The 08/05/21 Health Status Note revealed R52's Durable Power of Attorney (DPOA) only wanted hospice to assist with wound care for a two-week period of time between 07/24/21 - 08/06/21, then the facility would provide care similar to before signing on to hospice. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175078	A. Building B. Wing	10/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy at College Hill	5005 E 21st Street North Wichita, KS 67208

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 0686 Level of Harm - Actual harm Residents Affected - Few	An order dated 08/06/21 Cleanse sacral wound with wound cleanser, lightly pat dry, apply Santyl to wound bed, cover with cut to size collagen, over with dry dressing, change dressing Monday-Wednesday-Friday. Discontinued 08/18/21. An order dated 08/19/21 Cleanse buttock open area with wound cleanser, pat dry, apply Santyl to wound bed, cover with cut to size Xeroform, cover with folded 4x4 (sterile dressing), cover with border gauze, change daily. Discontinued 09/12/21. The 08/20/21 Nutrition/ Dietary Note written by Registered Dietician (RD) J revealed R52 had an open area on her coccyx and recommend adding MedPass (nutritional supplement liquid) 120 milliliters (ml), BID for extra calories. The 08/24/21 Activities Note revealed new orders to consult [local wound center] to evaluate and treat the wound on the resident's coccyx. The 09/03/21 Nutrition/Dietary Note revealed RD J again recommended adding MedPass (nutritional supplement liquid) 120 ml, BID for extra calories. The 09/07/21 Health Status Note revealed an order for Metronidazole (antibiotic) 500 mg BID for 14 days for wound infection. The 09/12/21 Weekly Skin Condition Report revealed the resident had a stage three pressure wound to the sacrum, which measured 4.0cm long (l) by 1.4cm wide (w) x 1.7cm depth (d). An order dated 09/12/21 to consult [local wound center] (specialized wound care provider) to evaluate and treat the resident's coccyx wound. An order dated 09/12/21 Coccyx wound, flush open area with normal saline/wound cleanser, pat dry, apply skin prep peri wound. Then apply Santyl to wound bed (thickness of a nickel), pack loosely with alginate. Cover with boarder gauze. Change BID (for excess drainage) and PRN if soiled, damp or dislodged. An order dated 09/12/21 to flush the open area to the resident's coccyx with normal saline and wound cleanser, pat dry, apply skin prep to the peri wound, apply Santyl to wound bed (thickness of a nickel). Staff were to pack the wound loosely with alginate (a multipurpose type of wound dressing) and cover with boarder gauze. Staff would change the dressing twice daily (BID) (for excess drainage) and PRN if soiled, damp, or dislodged. An order dated 09/14/21directed staff to consult hospice to evaluate and treat R52. The 09/15/21 [local wound center] Progress Note revealed an initial coccyx wound encounter, which measured 3.2cm l x 1.5cm w x 1cm d. The resident had bone exposed with undermining noted at 11:00 (on a clock scale) and ending at 6:00 with a maximum distance of 1.6 cm. The wound was noted with copious (abundant) amounts of serosanguineous (semi-thick reddish drainage) drainage. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175078	A. Building B. Wing	10/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy at College Hill	5005 E 21st Street North Wichita, KS 67208

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 0686 Level of Harm - Actual harm Residents Affected - Few	Weekly Skin Evaluations were completed on 06/28, 07/12, 07/19, 07/26, 08/02, 08/09, 08/16, 08/30, and on 09/20/21. (Staff did not complete a Weekly Skin Condition Report which allowed for more in-depth documentation of wound measurements, description of the wound condition, treatment followed, and intervention(s) used.) Review of the September 2021 Electronic Treatment Administration Record (ETAR) revealed the record lacked evidence staff completed weekly skin assessments on 09/06/21 and 09/27/21. Staff did not complete the physician ordered BID wound treatments on the following dates: 09/14, 15, 16, 17, 18, 21, 22, 26, 27, and 09/28/21. Staff further failed to complete wound care at all on 09/23/21. Observation on 09/30/21 at 09:30 AM revealed staff took R52 in her wheelchair from the dining room to her bedroom and placed her in bed on her left side. R52 went to sleep. At approximately 12:00 PM on 09/30/21 staff brought R52 to the dining room for lunch and she had a pressure relieving cushion in her wheelchair. Observation on 10/05/21 at 02:09 PM, Licensed Nurse (LN) H changed R52's dressing to her coccyx. LN H wore gloves and removed the old bordered dressing. The wound was clean, had no sign of infection, no drainage, and no foul odor. LN H used wound cleanser to clean the wound and patted the area dry with gauze. LN H applied skin prep around the peri-wound area, applied Santyl to the wound bed, and packed the wound with calcium alginate. LN H stated there was no bordered gauze available, so he covered the wound with an ABD (highly absorbent sterile dressing) pad and taped the edges. LN H stated there was another wound care company that came in to measure R52's wounds. Interview on 09/30/21 at 09:20 AM, Certified Nurse Aide (CNA) O stated R52 had a sore on her coccyx and the nurses changed the dressing one to two times daily. CNA O stated staff repositioned R52 every two hours and she had a cushion in her wheelchair. CNA O stated R52 had only a standard mattress on her bed and staff packed pillows under her. Interview on 10/04/21 at 04:01 PM, CNA V stated R52 had a sore on her coccyx that was always dressed. CNA V stated R52 would lay down in her bed when she was not in the dining room. CNA V stated R52 had a cushion in her wheelchair and a regular mattress on her bed. Interview on 10/05/21 at 07:30 AM, LN P stated measurements for open sores should be documented in the Skin Condition Report. LN P stated R52 started on hospice care 07/23/21 and was taken off 08/13/21. LN P stated hospice should have documented R52's wound measurements in the hospice communication notebook. LN P stated she could not find any wound measurements beside the Skin Condition Report dated 09/12/21. LN P stated the [local wound center] had not been in to see R52 or anyone since there had been COVID in the building. LN P stated the nursing staff taking care of R52's wound should have documented wound measurements. LN P stated there was no air mattress used for R52 because she moved around a lot in her bed and there was a possibility of this being a fall hazard. LN P stated all mattress used were anti-pressure mattresses. Interview on 10/05/21 at 01:33 PM, Administrative Staff A stated she expected nursing staff to document wound measurements at least on a weekly basis. Interview on 10/06/21 at 11:03 AM, Administrative Assistant M stated Nurse Practioner N stated [local wound center] was on the case to treat R52's wound. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175078	A. Building B. Wing	10/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy at College Hill	5005 E 21st Street North Wichita, KS 67208

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 0686 Level of Harm - Actual harm Residents Affected - Few	In an interview on 10/07/21 at 02:34 PM, Physician Y stated he expected the facility to keep track of the wound measurements in order to follow the progression of the wound. The Pressure Injury/Skin Breakdown- Clinical Guidelines policy revised October 2010 revealed, The nursing staff will complete an evaluation of the skin weekly. The Pressure Injury Treatment Guidelines policy revised November 2017 revealed, Document on the tools provided by the community .information in accordance with the facility policy and professional standards of practice. The facility failed to prevent the development of a stage four pressure ulcer for dependent, Resident (R)52 who admitted to the facility with intact skin. The facility further failed to monitor and assess the facility acquired pressure ulcer on R52's coccyx/sacral area.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175078	A. Building B. Wing	10/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy at College Hill	5005 E 21st Street North Wichita, KS 67208

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31078 The facility census totaled 60 residents with 15 included in the sample. Based on observation, interview, and record review the facility failed to provide necessary services to decrease the risk of a urinary tract infection (Infection of any part of the urinary system, including kidneys, ureters, bladder, and urethra) when the staff failed to ensure Resident (R) 21's urinary catheter drainage bag did not come in direct contact with the floor or to keep the drainage bag below the level of the bladder. Findings included: - Resident (R)21's signed History and Physical dated [DATE] revealed the following diagnoses: benign prostatic hyperplasia/hypertrophy (BPH, non-cancerous enlargement of the prostate which can lead to interference with urine flow, urinary frequency and urinary tract infections), muscle atrophy (wasting or decrease in size of a part of the body), and progressive neurodegenerative disorder with paraparesis (partial paralysis, usually affecting only the lower extremities). The Annual Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15 indicating intact cognition. The resident required extensive assistance of one staff with transfers, locomotion, toilet use, and bathing. The resident had a foley catheter and was continent of bowel. The Quarterly MDS dated [DATE] revealed a BIMS of 15. The resident required total dependence with toileting, had an indwelling urinary catheter, and was frequently incontinent of bowel. The Urinary Catheter Care Area Assessment (CAA) dated [DATE] revealed R21 with indwelling catheter use. R21 had a diagnosis of BPH and was at risk for side effects associated with catheter use. The Care Plan dated [DATE] revealed the resident had an indwelling urinary catheter and noted the resident received preventive antibiotic therapy (Methenamine Hippurate) for urinary tract infection (UTI) prevention related to catheter use. The staff were to encourage the resident to use bell to call for assistance. Review of the Nurse's Progress Note dated [DATE] at 05:00 PM revealed the resident was readmitted to the facility from an area hospital The resident was admitted to the hospital on [DATE] for syncopal episode requiring cardiopulmonary resuscitation (CPR) and had rib fractures (broken bones) from the CPR and a urinary tract infection (UTI). The hospital changed the resident's catheter before discharge for a diagnosis of neurogenic bladder. New medications include sulfamethoxale-trimethoprim (antibiotic) 1 tablet by mouth (PO) two times a day (BID) for seven days. The Nurse's Progress Note dated [DATE] at 07:54 PM revealed an infection follow up note. The resident continued antibiotic therapy for pneumonia and UTI. His urinary catheter drained well to dependent drainage. The urine in the tubing had a yellow color. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175078	A. Building B. Wing	10/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy at College Hill	5005 E 21st Street North Wichita, KS 67208

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Physician Orders dated [DATE] revealed an order for Methenamine Hippurate Tablet (antibiotic) 1-gram (GM) BID for UTI prevention. And an [DATE] order for catheter care every shift, cleanse with soap and water, flush the urinary catheter with 60 milliliters (ml) warm sterile normal saline twice a day (BID), and re-insert the urinary catheter if it dislodged or clogged. Observation on [DATE] at 12:27 PM Certified Nurse Aide (CNA) E and CNA F arrived to provide care to the resident. The staff brought in a sit to stand mechanical lift to transfer the resident and placed the resident's urinary catheter drainage bag on the footpads of the lift. When the staff lifted the resident with the mechanical lift, there appeared to be a substance which looked like feces on his chair pad and pants. The resident reported to the staff he had called for assistant to go to the bathroom an hour ago. The staff lowered the resident onto the toilet and removed his pants and brief. CNA E tossed the urinary catheter bag from lift to the floor near the side of the toilet. CNA F then wiped and cleaned the feces off of the floor in front of toilet, then cleaned the resident up with wipes, and proceeded to put a clean brief on the resident without changing gloves or performing hand hygiene. CNA F started to remove the resident's pants with feces on them without first taking his shoes off and the resident insisted CNA F remove his shoes before removing the pants and he then asked CNA F to put a pair of shorts on him. CNA F put the shorts on the resident and wore the same gloves throughout cleaning of the feces and subsequently dressing the resident. The resident was then allowed to sit awhile on the toilet and CNA E returned to the room a short time later. CNA E then proceeded to do peri care with wet wipes and then pulled up the brief and pants while the resident stood in the lift. CNA E took the catheter bag from the floor near the toilet, with no dignity bag on it, and placed it back on the foot pad of the lift to transfer the resident to his wheelchair. The staff laid R21's urinary catheter bag that was just on the floor by the toilet and on the foot pad of the lift, and then hung it onto the arm rest of the wheelchair with no dignity bag. CNA E and CNA F did not change their gloves or wash their hands, during the entire observation. Observation on [DATE] at 01:40 PM revealed the resident in the hallway in his wheelchair holding his catheter bag in his hand trying to hang it on his chair. The resident struggled with the urinary catheter bag. There were no staff noted in the area to assist the resident. Observation on [DATE] at 02:05 PM revealed the resident wheeled himself slowly in the hall. His urinary catheter bags hung on the arm rest of his wheelchair and not in the dignity bag. There were no staff in hall to assist the resident. Interview on [DATE] at 12:00 PM R21 reported he needed help. He reported he had his call light on for over an hour and no one would answer, and he had to go to the bathroom. R21 said he just kept waiting and waiting. During an interview on [DATE] at 12:40 PM CNA F reported the resident had a dignity bag a while back, but she did not know what happened to it, and did not use it. During an interview on [DATE] at 12:45 PM CNA E reported he always put the catheter bag on the floor beside the toilet because he had nowhere to hang it. He had not used a dignity bag on the resident and did not know if he ever had one. He always just hung the bag on the arm of his wheelchair and did not know it had to be lower than that. He was the only one working the hall and had been busy passing lunch trays when the resident called for help. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175078	A. Building B. Wing	10/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy at College Hill	5005 E 21st Street North Wichita, KS 67208

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 10:00 AM Licensed Nurse (LN) G reported all staff knew how to properly care for a urinary catheter. LN G said the LN completed the catheter care and flush every shift unless the resident had a bowel movement and needed cleaned, then the CNA would make sure the catheter was also cleaned. An interview on [DATE] at 03:10 PM Administrative Staff A reported she had no knowledge of indwelling catheters and had no medical training. Review of the [DATE] facility policy Indwelling Urinary Catheter revealed for infection control staff were to ensure the urinary catheter tubing and drainage bag were kept off floor. The policy further noted the staff should ensure the urinary catheter bag always be held or positioned lower than the bladder to prevent urine in the tubing and drainage bag from flowing back into the bladder. The facility failed to provide necessary services to decrease the risk of a UTI when staff failed to ensure the urinary catheter drainage bag remained off the floor and below the level of the bladder.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175078	A. Building B. Wing	10/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy at College Hill	5005 E 21st Street North Wichita, KS 67208

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 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35556 The facility had a census of 60 residents with 15 residents in the sample and three residents reviewed for nutrition. Based on observation, interview, and record review the facility failed to monitor weights regularly, place effective interventions, and follow-up on registered dietician recommendations for nutritional supplementation, which resulted in Resident (R)52 experiencing severe weight loss of 17.73 percent in 108 days between 05/13/21 through 09/03/21. Findings included: - R52's Physician Progress Note dated 09/15/21 revealed the following diagnoses: dementia (progressive mental disorder characterized by failing memory, confusion) and metabolic encephalopathy (a brain disease caused by chemical imbalance in the blood due to an illness or organs that are not working as well as they should). The Significant Change Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of four, which indicated severely impaired cognition. R52 required limited assistance with eating. R52 weighed 108 pounds was 61 inches tall, and experienced weight loss, but was not on a physician prescribed weight-loss program. The Quarterly MDS dated [DATE] revealed a BIMS score of four, which indicated severely impaired cognition. R52 required limited assistance with eating. R52 weighed 108 pounds, was 61 inches tall, and experienced weight loss, but was not on a physician prescribed weight-loss program. The Nutritional Status Care Area assessment dated [DATE] revealed R52 recently upgraded to a regular diet with regular texture and thin liquids. R52 had no difficulty noted with eating. The Care Plan dated 06/30/21 revealed R52 had a potential for alteration in nutrition and fluid intake related to dementia. R52 required a mechanical soft diet with thin liquids. Interventions included house shakes (nutritional supplement drink) two times daily initiated on 07/28/21, staff would maintain R52's focus by redirecting her to eat at mealtimes, monitor intake of food and fluids, offer diet as ordered, and take R52 to the dining room for meals. The Care Plan dated 07/06/21 revealed R52 had a potential for nutritional problem related to needing increased assistance with meals due to dementia. Interventions included for staff to invite R52 to activities that promoted additional nutritional intake. Staff were to monitor and document refusals to eat, assist with eating as needed, and the registered dietician would evaluate and make diet change recommendations as needed (PRN). A review of the Physician Orders included the following: Order dated 07/27/21 for regular diet, regular texture, thin consistency. Order dated 07/22/21 for house supplement shake, 4 oz. (ounces). Further review of Physician Orders lacked an order to obtain the resident's weights. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175078	A. Building B. Wing	10/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy at College Hill	5005 E 21st Street North Wichita, KS 67208

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 0692 Level of Harm - Actual harm Residents Affected - Few	The July 2021- September 2021 Electronic Medication Administration Record (EMAR) lacked any documentation of house supplements given to R52 as ordered. Review of the Nutrition- Amount Eaten Task in the EHR from 09/07/21 - 10/05/21 lacked any documentation noting the percentage of meals the resident consumed. (Access to this information was limited to the last 30 days.) A Nutrition/ Dietary Note dated 08/20/21 by Registered Dietician (RD) J revealed R52 weighed 108 pounds and triggered for a weight loss of 13.8 lbs. (pounds) or an 11.3 percent weight loss in 90 days. R52 received a regular diet, regular texture, and had meal intakes of less than 50 percent. R52 had an order for house shakes provided with meals and RD J recommended to add Med Pass (nutritional supplement to add calories, protein, and other nutrients) 120 milliliters (ml) twice a day. Review of the EHR revealed a lack of evidence staff implemented Med Pass 120 ml, BID and was recommended by RD J on 08/20/21. A Nutrition/ Dietary Note dated 09/03/21 by RD J revealed R52 weighed 100.2 pounds and had a weight loss of 16 lbs. or a 14.4 percent weight loss in 90 days. R52 received a regular diet, regular texture, and had meal intakes usually of less than 50 percent. R52 had an order for house shakes provided with meals and RD J recommended to add Med Pass 120 ml, twice a day. Review of the EHR revealed a lack of evidence staff implemented Med Pass 120 ml, BID as recommended by RD J on 09/03/21. Review of the EHR revealed the following weights: 05/13/21 119.0 lbs. 05/19/21 121.8 lbs. No weights available in the Electronic Health Record (EHR) from 05/20/21 through 08/05/21. 08/06/21 108.0 lbs. which indicated a 11.33 percent weight loss in 80 days (a severe weight loss.) No weights available in the EHR from 08/07/21 through 09/02/21. 09/03/21 100.2 lbs. which indicated a 17.73 percent weight loss in 108 days (a severe weight loss.) Observation on 09/30/21 at 8:38 AM revealed R52 had a breakfast of scrambled eggs, a bowl of oatmeal, French toast, sausage, an 8 oz. cup of orange juice, and an 8 oz. cup of milk. Staff assisted R52 with her meal and she consumed approximately 20 percent of her meal, 75 percent of her orange juice, and no milk. No observation that staff offered R52 a supplement during this meal. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175078	A. Building B. Wing	10/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy at College Hill	5005 E 21st Street North Wichita, KS 67208

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 0692 Level of Harm - Actual harm Residents Affected - Few	Observation on 09/30/21 at 12:12 PM revealed staff assisted R52 with her meal and offered her a lunch that consisted of spinach, beans, cornbread, a cookie, an 8 oz. cup of lemonade, and an 8 oz. cup of water. R52 was not very cooperative and consistently wanted to lean forward in her wheelchair. R52 consumed less than 25 percent of her meal, and approximately 50 percent of her lemonade and water. No observation that staff offered R52 a supplement during this meal. In an interview on 09/30/21 at 09:20 AM Certified Nurse Aide (CNA) O stated R52 was totally dependent with feeding. CNA O stated R52 used to feed herself, but in the past month she needed staff help. CNA O stated R52 no longer ate snacks when offered. CNA O stated he thought R52's weight was pretty consistent and did not think she had lost weight recently. CNA O stated R52 was offered Mighty Shakes (nutritional supplement), but trying to get R52 to drink it was a real challenge. CNA O stated R52 could be very stubborn. In an interview on 10/05/21 at 07:30 AM, Licensed Nurse (LN)P stated R52 had not been eating very well. LN P stated if the Registered Dietician recommended Med Pass and weekly weights due to weight loss, staff should have followed up on this recommendation. In an interview on 10/05/21 at 01:33 PM Administrative Staff A stated if the Registered Dietician recommended Med Pass for R52, the facility should follow-up on this recommendation. In an interview on 10/06/21 at 02:50 PM, Registered Dietician J stated she gave her recommendations to the dietary manager to pass on to the Director of Nursing (DON) to follow-up on, but the facility did not have a DON for some time. Registered Dietician J stated she was not sure if the facility could implement an order for weekly weights or if the physician had to write an order for this. Registered Dietician J was not sure if the facility followed up on her recommendations, but stated she expected the facility would follow-up on her recommendations. In an interview on 10/06/21 at 11:03 AM, Administrative Assistant M stated Nurse Practitioner N was unavailable for interview, but would pass on what she said. Administrative Assistant M stated Nurse Practitioner N stated she was going to write an order for Med Pass, resident weights should be on the Medication Administration Record (MAR), and the dietician would have been the one who ordered weights more frequently. According to Administrative Assistant M, Nurse Practitioner N stated R52 had dementia, many co-morbidities, and was failing in health. The Nutrition (Impaired)/Unplanned Weight Loss- Clinical Protocol policy revised February 2018 stated, Monitor and document the weight and dietary intake of residents in a format which permits readily available comparison over time .weight loss .greater than 10% is severe .The Interdisciplinary Team, should attempt to identify conditions and medications that may be causing anorexia, weight loss .Identify pertinent interventions based on identified causes and overall resident condition, prognosis, and treatment wishes . Strategies to increase a resident's intake of nutrients and calories may include .nutritional supplementation . The Physician, with input from the staff, will determine the most appropriate intervals for weight assessments. The facility failed to ensure staff regularly monitored weights and implemented recommendations from the Registered Dietician to help reduce weight loss, which resulted in R52's severe weight loss.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175078	A. Building B. Wing	10/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy at College Hill	5005 E 21st Street North Wichita, KS 67208

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35556 The facility census totaled 60 residents, with 15 included in the sample, and one resident reviewed for oxygen use. Based on observation, interview, and record review the facility failed to ensure staff provided a storage bag to properly/sanitarily store oxygen tubing when not in use for Resident (R)24. Findings included: - Review of R24's signed Physician Order Set dated 08/02/21 revealed the following diagnosis: pneumonia (inflammation of the lungs). The Quarterly Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of three, which indicated severe cognitive impairment. R24 did not receive oxygen therapy. The Significant Change MDS dated [DATE] revealed a BIMS of three which indicated severe cognitive impairment, and R24 received oxygen therapy. The 02/09/21Care Plan lacked interventions related to R24's oxygen use and care. A Physician Order dated 09/20/21 revealed staff were to administer oxygen to R24 at two liter per nasal cannula (a device used to deliver supplemental oxygen or increased airflow to a patient or person in need of respiratory help) continuously as patient allows every shift for pneumonia. An observation on 09/30/21 at 11:26 AM revealed R24's oxygen tubing was draped over the bedside table. An observation on 10/05/21 at 08:59 AM revealed R24's oxygen tubing was draped over the oxygen concentrator, and there was no storage bag available for storing the tubing when not in use. On 10/04/21 at 01:32 PM, Certified Nurse Aide (CNA) AA, stated there was no bag in the room to store the oxygen tubing when not in use. On 10/04/21 at 01:11 PM, Licensed Nurse (LN) C stated R24 was on oxygen as he allowed. LN C stated there should be a large plastic bag where the tubing should be stored when not in use. On 10/05/21 at 01:39 PM, Administrative Staff A stated oxygen tubing should be stored in a plastic bag on the side of the oxygen concentrator when not in use. The facility did not provide a policy concerning oxygen storage as requested on 10/05/21. The facility failed to ensure R24's oxygen tubing was stored in accordance with sanitary practices, when not in use.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175078	A. Building B. Wing	10/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy at College Hill	5005 E 21st Street North Wichita, KS 67208

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 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 41302 The facility reported a census of 60 residents, with 15 residents sampled. Based on observation, interview, and record review the facility failed to employ a (DON) Director of Nursing for the 60 residents who resided in the facility. Findings included: - Review of the licensed and registered nurse staffing schedules revealed the facility lacked Director of Nursing coverage from June 2021 until the completion of the survey October 5, 2021 (over 100 days). The facility provided Census Report dated 09/28/21 noted 60 residents resided in the facility. On 09/29/21 at 09:30 AM, observation revealed 60 residents resided in the facility. On 09/29/21 at 10:36 AM, Administrative Staff A verified the facility lacked a DON from June 2021 and did not have a DON hired as of exit conference on 10/05/21 at 06:00 PM. The facility did not provide a policy regarding DON coverage as requested on 10/04/21 at 04:00 PM. The facility failed to employ a DON for the 60 residents who resided in the facility, placing the residents at risk for unsupervised nursing care and services.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175078	A. Building B. Wing	10/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy at College Hill	5005 E 21st Street North Wichita, KS 67208

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** 35556 The facility census totaled 60 residents with five residents reviewed for unnecessary medications. Based on observation, interview, and record review the facility failed to ensure three of five residents did not receive unnecessary medications by the failure to follow the consultant pharmacist recommendations for behavior monitoring for Resident (R)32. The facility failed to adequately monitor blood glucose levels and for unnecessary medication side effects from use of high dose of Seroquel (antipsychotic medication.) The facility failed to add Not to Exceed (NTE) cautions to R17's medications to reduce the potential for liver damage. The facility further failed to ensure R45 did not receive unnecessary medications at an excessive dose and without adequate monitoring, to prevent possible drops in blood glucose levels and unnecessary side effects from high dose Seroquel. Findings included: - R32's History and Physical dated 07/19/21 revealed diagnoses of depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness), and dementia (progressive mental disorder characterized by failing memory, confusion.) The Admission Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of three which indicated severe cognitive impairment, and received an antipsychotic and antidepressant daily. The Cognitive Loss / Dementia Care Area Assessment (CAA) dated 07/25/21 revealed R32 triggered due to a diagnosis of unspecified dementia with behavioral disturbance. R32 did not show any behaviors at the time of this assessment. The Psychotropic Drug Use CAA revealed R32 had a diagnosis of unspecified dementia with behavioral disturbances. R32 was at risk for side effects of psychotropic drugs related to the use of Seroquel and Zoloft (antidepressant medication.) The Care Plan dated 07/29/21 revealed R32 had chronic confusion related to unspecified dementia with behavioral disturbances. Interventions included to administer medications as ordered, monitor/document/report side effects and effectiveness. The Care Plan did not include any information on which psychotropic drugs R32 received or what specific targeted behaviors staff monitored R45 for. A review of the Physician Orders included the following: Order dated 07/12/21 for Seroquel 200 milligrams (mg), give one tablet by mouth three times a day for dementia. Order dated 07/12/21 for Depakote 250 mg, give one tablet by mouth three times a day for dementia. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175078	A. Building B. Wing	10/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy at College Hill	5005 E 21st Street North Wichita, KS 67208

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	Review of the July, August, and September 2021 Electronic Medication Administration Record (EMAR) or Electronic Treatment Administration Record (ETAR) failed to reveal any monitoring for specific targeted behaviors. Review of the Progress Notes from 07/12/21 through 09/10/21 failed to reveal any documentation for monitoring for specific targeted behaviors. Observation on 10/04/21 at 04:15 PM, revealed R32 sat in a chair in the dining room and seemed somewhat sedated or sleepy. R32 got up from his chair and staff assisted R32 to a different chair where he sat down and looked down towards the ground. In an interview on 10/05/21 at 09:48 AM, Licensed Nurse (LN) H stated there were no behaviors listed to monitor for Seroquel or Depakote for R32. In an interview on 10/05/21 at 09:38 AM, Administrative Nurse B stated there should be specific targeted behaviors to monitor for the use of psychotropic medications used. In an interview on 10/05/21 at 01:33 PM, Administrative Staff A stated she expected nursing staff to monitor for specific targeted behaviors for the use of psychotropic medications. In an interview on 10/07/21 at 02:00 PM, Pharmacy Consultant X stated she expected the facility to monitor for specific targeted behaviors as she requested the facility to do back in September 2021. The facility's Medication Regimen Review policy dated November 2016 documented the Director of Nursing and the Consultant Pharmacist will agree on the process and steps to be taken once an irregularity has been identified. The facility failed to follow the consultant pharmacist recommendation to monitor for behaviors concerning R32. 45491 - The signed Physician Orders in the Electronic Health Record (EHR) dated 08/02/21 documented R45 had a diagnosis of insomnia (inability to sleep) and type 2 diabetes mellitus (when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin). The 08/15/21 Admission Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of 14, which indicated intact cognition. R45 received an antipsychotic medication daily, insulin daily, and hypnotic medication one time during the seven-day look back period. The 08/16/21 Psychotropic Drug Use Care Area Assessment (CAA) documented R45 received Seroquel (an antipsychotic medication that works by changing the actions of chemicals in the brain) daily for insomnia at bedtime. The 08/16/21Nutritional Status CAA documented the resident's nutritional status and alteration in nutrition were related to type 2 diabetes mellitus. The 08/05/21 Care Plan for R45 lacked documentation regarding insomnia. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175078	A. Building B. Wing	10/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy at College Hill	5005 E 21st Street North Wichita, KS 67208

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 08/05/21 Care Plan documented R45 had diabetes mellitus, staff were to administer diabetes medication as ordered by the doctor, monitor for side effects and document for effectiveness, obtain a dietary consult for a nutritional regimen with ongoing monitoring, and obtain fasting serum blood sugar as ordered by the doctor. Review of the Physician's Orders revealed the following: 08/02/21, Lantus (a long-acting insulin used to treat adults with type 2 diabetes) 25 units by injection two times a day for diabetes. 08/02/21, Ambien 10 milligrams (mg) every 24 hours as needed (PRN), for insomnia, with no stop date noted. (Further review revealed the order discontinued on 09/10/21). 08/03/21, Obtain blood glucose checks, fasting and two hours after meals. 08/12/21, Seroquel 400 milligrams (mg) at bedtime for insomnia. (Further review revealed the order discontinued on 08/13/21). 08/13/21, Seroquel 200 milligrams (mg) at bedtime for insomnia. 09/10/21, Ambien five mg every 24 hours PRN for insomnia, with no stop date noted. The Electronic Medication Administration (EMAR) from 08/01/21 - 09/30/21 revealed R45 received Seroquel daily and Lantus twice daily, and PRN Ambien five times. The Weights and Vitals tab in the EHR for R45 documented blood glucose checks obtained on 08/07/21 at 08:16 AM and 09/09/21 at 09:21 AM and no blood glucose checks were obtained from 08/02/21 through 08/06/21 (5 days), from 08/08/21 through 09/08/21 (a month), and from 09/10/21 until 10/04/21 (almost a month). The EHR reviewed for August and September 2021 lacked documentation of any labs. The undated Note to Attending Physician/Prescriber documented the diagnosis associated with the rather large dose of Seroquel 200 mg daily order was insomnia, which seemed likely inaccurate. The undated Note to Attending Physician/Prescriber documented R30 was diabetic and was taking an antipsychotic medication which may increase her risk of dyslipidemia (abnormal level of cholesterol and other lipids in the blood). No current labs were noted in R30's record. The note further recommended to consider ordering the following labs: CBC (complete blood count), CMP (comprehensive metabolic profile), Lipid profile and A1c (glycated hemoglobin, a percentage that measures how much sugar is attached to the blood's hemoglobin protein). The 08/22/21 Note to Attending Physician/Prescriber documented all PRN psychotropics can only have a 14-day order duration unless the prescribing physician provides a specified stop date and a rationale for the resident to continue the medication. The note further recommended to please correct PRN Ambien order to ensure compliance. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175078	A. Building B. Wing	10/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy at College Hill	5005 E 21st Street North Wichita, KS 67208

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	Observation on 10/04/21 at 11:46 AM revealed R45 in her room seated on her bed and transferred herself to her wheelchair. She was alert, oriented, calm, did not appear agitated, anxious, depressed, or in pain. R45 did not exhibit any negative behaviors. On 10/04/21 at 03:24 PM Certified Nurse Aid (CNA) K stated he had heard no complaints from R45 of being unable to sleep. On 10/04/21 at 09:10 AM Licensed Nurse (LN) C stated she had not obtained any blood glucose checks on R45 during her day shifts. LN C located the order in the EMAR and stated she would call the ordering physician for verification. Interview on 10/07/21 at 01:48 PM Consultant Pharmacist X stated she checked if the facility was following physician orders but missed the glucose monitoring orders for R45. Consultant Pharmacist X would like clarification on the diagnosis of insomnia. She interpreted the order as associated with the wrong diagnosis because a resident with a diagnosis of insomnia would not typically use antipsychotic medication. The Medication Regimen Reviews policy dated November 2016 documented the Director of Nursing and the Consultant Pharmacist would agree on the process and steps to take once an irregularity had been identified. The facility failed to ensure R45 did not receive unnecessary medications at an excessive dose and without adequate monitoring, to prevent possible drops in blood glucose levels and unnecessary side effects from high dose Seroquel. 41302 - R17's pertinent diagnoses from the Physician's Orders in the Electronic Health Record (EHR) dated 09/08/21 documented back pain, and alcohol dependence with withdrawal. The 10/12/21 Annual Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. R17 received an antidepressant and diuretic daily in the seven-day look back period. The 07/29/21 Care Plan for R17 instructed staff to administer medications and monitor for side effects as ordered by the physician The Physicians Orders documented an order dated 02/03/21 for Tylenol Arthritis 650 milligrams (mg) four times daily, an order on 06/08/21 for Tylenol 500 mg daily as needed (PRN), and an order on 08/06/21 for hydrocodone-acetaminophen 5/325mg every four to six hours as needed. All acetaminophen above orders lacked the Not to Exceed (NTE) pharmacist recommendation. Review of the monthly Pharmacy Medication Record Review (MRR) for December 2020 through August 2021 revealed multiple recommendations for the prescriber of R17, to review the administration of acetaminophen, and to consider adding an order NTE three grams (GM), as high dosages of acetaminophen can be harmful to the liver and if a person takes too much in a short period of time, they can damage the liver or even die. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175078	A. Building B. Wing	10/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy at College Hill	5005 E 21st Street North Wichita, KS 67208

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 10/04/21 at 01:15 PM R17 sat in a chair in her well-lit room, watched TV, and had a word game book in her lap with a pen in her hand. On 09/27/21 at 07:59 AM Administrative Staff A stated she expected the nursing staff to give medications as ordered by the physician and be mindful of the dosages given. She confirmed the MRR's had been lacking and the information the facility provided was all that they had. She expected nursing staff to complete the MRR's as signed by the provider. On 10/07/21 at 02:00 PM Consultant Staff X revealed she had just started with this facility in June 2021. Consultant Pharmacist X stated the decision on three grams to four grams of acetaminophen was still a discussion. Deciding on the true upper threshold to be within reasonable limits, she would ask the prescriber what upper threshold they would like their resident to be on. She stated there was no reason to put NTE on every Tylenol order. The facility's Medication Regimen Review policy dated November 2016 documented the Director of Nursing and the Consultant Pharmacist will agree on the process and steps to be taken once an irregularity has been identified. The facility failed to follow the consultant pharmacist recommendations to add NTE cautions to R17's medications to reduce the potential for liver damage. 31078

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175078	A. Building B. Wing	10/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy at College Hill	5005 E 21st Street North Wichita, KS 67208

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. 41302 The facility had a census of 60 residents with five residents reviewed for unnecessary medications. Based on observation, interview, and record review the facility failed to ensure two of five residents did not receive unnecessary medications when facility staff admnistered more than the recommended daily amount of Acetaminophen (a pain reliever and fever reducing drug) to R17 and failed to monitor blood glucose levels as ordered by the physician for R45. Findings included: - R17's pertinent diagnoses from the Physician's Orders in the Electronic Health Record (EHR) dated 09/08/21 documented back pain, and alcohol dependence with withdrawal. The 10/12/21 Annual Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. R17 received an antidepressant and diuretic daily in the seven-day look back period. The 07/29/21 Care Plan for R17 instructed staff to administer medications and monitor for side effects as ordered by the physician The Physicians Orders documented an order dated 02/03/21 for Tylenol Arthritis 650 milligrams (mg) four times daily, an order on 06/08/21 for Tylenol 500 mg daily as needed (PRN), and an order on 08/06/21 for hydrocodone-acetaminophen 5/325mg every four to six hours as needed. Review of the monthly Pharmacy Medication Record Review (MRR) for December 2020 through August 2021 revealed multiple recommendations for the prescriber of R17, to review the administration of acetaminophen, and to consider adding an order Not to Exceed (NTE) three grams (GM), as high dosages of acetaminophen can be harmful to the liver and if a person takes too much in a short period of time, they can damage the liver or even die. Review of the June through September 2021 Electronic Medication Administration Record (EMAR) documented R17 received the following doses that exceeded the three GMs: 06/11/21 received Tylenol Arthritis 650mg four times daily (QID) plus Tylenol 500mg PRN once totaling 3100 mg. 06/18/21 received Tylenol Arthritis 650mg QID plus Tylenol 500mg PRN twice totaling 3600 mg. 07/19/21 received Tylenol Arthritis 650mg QID plus Tylenol 500mg PRN once totaling 3100 mg. 08/08/21 received Tylenol Arthritis 650mg QID plus hydrocodone/acetaminophen 5/325 mg twice for a total of 3250mg. 09/02/21 received Tylenol Arthritis 650mg QID plus hydrocodone/acetaminophen 5/325mg twice for a total of 3250 mg. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175078	A. Building B. Wing	10/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy at College Hill	5005 E 21st Street North Wichita, KS 67208

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	09/07/21 received Tylenol Arthritis 650mg QID plus Tylenol 500mg PRN once totaling 3100 mg. 09/17/21 received Tylenol Arthritis 650mg QID plus Tylenol 500mg PRN once totaling 3100 mg. 09/18/21 received Tylenol Arthritis 650mg QID plus Tylenol 500mg PRN once totaling 3100 mg. 09/30/21 received Tylenol Arthritis 650mg QID plus Tylenol 500mg PRN once totaling 3100 mg. On 10/04/21 at 01:15 PM R17 sat in a chair in her well-lit room, watched TV, and had a word game book in her lap with a pen in her hand. On 10/04/21 at 01:22 PM Certified Medication Aid (CMA) T stated R17 took her medications whole and would generally let you know if she needed anything PRN. On 09/27/21 at 07:59 AM Administrative Staff A stated she would expect the nursing staff to give medications as ordered by the physician and be mindful of the dosages given. The facility's Medication Regimen Review policy dated November 2016 documented unnecessary medications were medications given in excessive dose and without adequate monitoring. The facility failed to ensure facility staff did not administer more than the recommended dosage of acetaminophen to R17. 45491 - The signed Physician Orders in the Electronic Health Record (EHR) dated 08/02/21 documented R45 had a diagnosis of insomnia (inability to sleep) and type 2 diabetes mellitus (when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin). The 08/15/21 Admission Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of 14, which indicated intact cognition. R45 received an antipsychotic medication daily and insulin daily during the seven-day look back period. The 08/16/21 Psychotropic Drug Use Care Area Assessment (CAA) documented R45 received Seroquel (an antipsychotic medication that works by changing the actions of chemicals in the brain) daily for insomnia at bedtime. The 08/16/21Nutritional Status CAA documented the resident's nutritional status and alteration in nutrition were related to type 2 diabetes mellitus. The 08/05/21 Care Plan for R45 lacked documentation regarding insomnia. The 08/05/21 Care Plan documented R45 had diabetes mellitus, staff were to administer diabetes medication as ordered by the doctor, monitor for side effects and document for effectiveness, obtain a dietary consult for a nutritional regimen with ongoing monitoring, and obtain fasting serum blood sugar as ordered by the doctor. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175078	A. Building B. Wing	10/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy at College Hill	5005 E 21st Street North Wichita, KS 67208

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 08/02/21 Physicians Orders for R45 documented an order for Lantus 25 units by injection two times a day for diabetes. The 08/03/21 Physicians Orders for R45 documented an order to obtain blood glucose checks fasting and two hours after meals. The 08/12/21 Physicians Orders for R45 documented an order for Seroquel 400 milligrams (mg) at bedtime for insomnia. Further review revealed the order discontinued on 08/13/21. The 08/13/21 Physicians Orders for R45 documented an order for Seroquel 200 milligrams (mg) at bedtime for insomnia. The Electronic Medication Administration (EMAR) from 08/01/21 - 09/30/21 revealed R45 received Seroquel daily and Lantus (a long-acting insulin used to treat adults with type 2 diabetes) twice daily. The Weights and Vitals tab in the EHR for R45 documented blood glucose checks obtained on 08/07/21 at 08:16 AM and 09/09/21 at 09:21 AM. No blood glucose checks were obtained from 08/02/21 through 08/06/21 (5 days), from 08/08/21 through 09/08/21 (a month), and from 09/10/21 until 10/04/21 (almost a month). The EHR reviewed for August and September 2021 lacked documentation of any labs. The undated Note to Attending Physician/Prescriber documented the diagnosis associated with the rather large dose of Seroquel 200 mg daily order was insomnia, which seemed likely inaccurate. The undated Note to Attending Physician/Prescriber documented R30 was diabetic and was taking an antipsychotic medication which may increase her risk of dyslipidemia (abnormal level of cholesterol and other lipids in the blood). No current labs were noted in R30's record. The note further recommended to consider ordering the following labs: CBC (complete blood count), CMP (comprehensive metabolic profile), Lipid profile and A1c (glycated hemoglobin, a percentage that measures how much sugar is attached to the blood's hemoglobin protein). Observation on 10/04/21 at 11:46 AM revealed R45 in her room seated on her bed and transferred herself to her wheelchair. She was alert, oriented, calm, did not appear agitated, anxious, depressed, or in pain. R45 did not exhibit any negative behaviors. On 10/04/21 at 03:24 PM Certified Nurse Aid (CNA) K stated he had heard no complaints from R45 of being unable to sleep. On 10/04/21 at 09:10 AM Licensed Nurse (LN) C stated she had not obtained any blood glucose checks on R45 during her day shifts. LN C located the order in the EMAR and stated she would call the ordering physician for verification. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175078	A. Building B. Wing	10/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy at College Hill	5005 E 21st Street North Wichita, KS 67208

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	Interview on 10/07/21 at 01:48 PM Consultant Pharmacist X stated she checked if the facility was following physician orders but missed the glucose monitoring orders for R45. Consultant Pharmacist X would like clarification on the diagnosis of insomnia. She interpreted the order as associated with the wrong diagnosis because a resident with a diagnosis of insomnia would not typically use antipsychotic medication. The Medication Regimen Reviews policy revised November 2016 documented Unnecessary drugs, as defined by CMS, are medications given: In excessive dose . or . Without adequate monitoring. The facility failed to ensure R45 did not receive unnecessary medications at an excessive dose and without adequate monitoring, to prevent possible drops in blood glucose levels and unnecessary side effects from high dose Seroquel.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175078	A. Building B. Wing	10/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy at College Hill	5005 E 21st Street North Wichita, KS 67208

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** 35556 The facility census totaled 60 residents with five residents reviewed for unnecessary medications. Based on observation, interview, and record review the facility failed to ensure appropriate diagnoses were provided for the use of Seroquel (antipsychotic medication) and Depakote (anticonvulsant medication) and failed to ensure behavior monitoring for the specific targeted behaviors for Resident (R)32, and continued to administer to R45 an as needed (PRN) psychotropic medication, longer than 14 days without a renewed physician order or reason provided by the physician for the continued administration of Ambien (hypnotic drug) on a PRN basis. Findings included: - R32's History and Physical dated 07/19/21 revealed diagnoses of depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness), and dementia (progressive mental disorder characterized by failing memory, confusion.) The Admission Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of three which indicated severe cognitive impairment, and received an antipsychotic and antidepressant daily. The Cognitive Loss / Dementia Care Area Assessment (CAA) dated 07/25/21 revealed R32 triggered due to a diagnosis of unspecified dementia with behavioral disturbance. R32 did not show any behaviors at the time of this assessment. The Psychotropic Drug Use CAA revealed R32 had a diagnosis of unspecified dementia with behavioral disturbances. R32 was at risk for side effects of psychotropic drugs related to the use of Seroquel and Zoloft (antidepressant medication.) The Care Plan dated 07/29/21 revealed R32 had chronic confusion related to unspecified dementia with behavioral disturbances. Interventions included to administer medications as ordered, monitor/document/report side effects and effectiveness. The Care Plan did not include any information on which psychotropic drugs R32 received or what specific targeted behaviors staff monitored R45 for. A review of the Physician Orders included the following: Order dated 07/12/21 for Seroquel 200 milligrams (mg), give one tablet by mouth three times a day for dementia. Order dated 07/12/21 for Depakote 250 mg, give one tablet by mouth three times a day for dementia. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175078	A. Building B. Wing	10/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy at College Hill	5005 E 21st Street North Wichita, KS 67208

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	Review of the July, August, and September 2021 Electronic Medication Administration Record (EMAR) or Electronic Treatment Administration Record (ETAR) failed to reveal any monitoring for specific targeted behaviors. Review of the Progress Notes from 07/12/21 through 09/10/21 failed to reveal any documentation for monitoring for specific targeted behaviors. Observation on 10/04/21 at 04:15 PM, revealed R32 sat in a chair in the dining room and seemed somewhat sedated or sleepy. R32 got up from his chair and staff assisted R32 to a different chair where he sat down and looked down towards the ground. In an interview on 10/04/21 at 04:08 PM, Certified Nurse Aide (CNA) Z stated R32 slept a lot in his chair or in his bed and always seemed to be sedated. CNA Z stated R32 was not usually verbally or physically aggressive and was easily redirected. In an interview on 10/05/21 at 09:48 AM, Licensed Nurse (LN) H stated there were no behaviors listed to monitor for Seroquel or Depakote for R32. In an interview on 10/05/21 at 09:38 AM, Administrative Nurse B stated there should be specific targeted behaviors to monitor for the use of psychotropic medications used. In an interview on 10/05/21 at 01:33 PM, Administrative Staff A stated she expected nursing staff to monitor for specific targeted behaviors for the use of psychotropic medications. The Medication Regimen Review policy revised November 2016 revealed, Unnecessary drugs, as defined by CMS (Centers for Medicare and Medicaid Services), are medications given .without adequate monitoring. The facility failed to ensure R32 did not receive unnecessary medications by not completing documentation for specific targeted behaviors related to the use of Seroquel and Depakote. 45491 - The signed Physician Orders in the Electronic Health Record dated 08/02/21 revealed Resident (R)45 with a diagnosis of insomnia (inability to sleep). The 08/15/21 Admission Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of 14, which indicated intact cognition. R45 received hypnotic medication one time during the seven day look back period. The 08/16/21 Psychotropic Drug Use Care Area Assessment (CAA) documented R45 received Ambien (a hypnotic medication that helps with sleep) as needed (PRN) for insomnia (inability to sleep) at bedtime. The 08/05/21 Care Plan for R45 lacked documentation regarding insomnia. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175078	A. Building B. Wing	10/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy at College Hill	5005 E 21st Street North Wichita, KS 67208

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	The 08/02/21 Physicians Orders for R45 documented an order for Ambien 10 milligrams (mg) every 24 hours as needed (PRN), for insomnia, with no stop date noted. Further review revealed the order discontinued on 09/10/21. The 09/10/21 Physicians Orders for R45 documented an order for Ambien five mg every 24 hours PRN for insomnia, with no stop date noted. The Electronic Medication Administration (EMAR) from August and September of 2021 revealed R45 received PRN Ambien five times. Observation on 10/04/21 at 11:46 AM revealed R45 in her room seated on her bed and transferred herself to her wheelchair. She was alert, oriented, calm, did not appear agitated, anxious, depressed, or in pain. R45 did not exhibit any negative behaviors. On 10/04/21 at 03:24 PM Certified Nurse Aid (CNA) K stated he had heard no complaints from R45 of being unable to sleep. On 10/06/21 at 02:42 PM Licensed Nurse (LN) S stated R45's order for Ambien was for an indefinite amount of time. She did not know that PRN psychoactive medications only have a 14-day duration unless there was rationale provided by the ordering physician. On 10/06/21 at 03:19 PM Administrative Staff A stated she would expect a PRN psychoactive medication order to be discontinued after 14 days or a rationale be provided by the physician The Medication Regimen Reviews policy revised November 2016 documented a review of the residents' with PRN psychotropic medications, for a documented diagnoses or specific condition, are limited to 14 days and if greater than 14 days, the rationale for such must be listed in the resident's medical record. The facility failed to ensure R45 did not receive unnecessary medications by the failure to ensure the prescribing physician provided a rationale to extend the use of PRN Ambien beyond the 14-day time limit for use of PRN psychotropic medications.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175078	A. Building B. Wing	10/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy at College Hill	5005 E 21st Street North Wichita, KS 67208

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. 31078 The facility reported a census of 60 residents. The facility had two medications rooms where medications were stored. Based on observation, interview, and record review the facility failed to destroy an outdated vial of Apisol (tuberculin test serum) after its expiration date with approximately one to two doses remaining in the vial and accessible for use, as stored in the medication refrigerator. Findings included: - Observation on 10/04/21 at 01:15 PM revealed a medication room on the 200 hall. The room contained a refrigerator for storage of medication and a vial of Apisol with a label identifying the vial was opened on 08/20/21 and to be discarded in 30 days (15 days prior). Interview on 10/04/21 at 01:20 PM, Licensed Nurse H reported he would contact the facility infection control nurse LN P so she could reorder the Apisol. According to the fda.gov Prescribing Information website dated November 2013, Apisol vials in use for more than 30 days should be discarded. The facility did not provide a policy for TB skin tests as requested on 10/04/21 at 04:00 PM from Administrative staff A. The facility failed to remove an outdated vial of Apisol, 15 days after its expiration date, with approximately one to two doses remaining in the vial and accessible for use in the medication refrigerator.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175078	A. Building B. Wing	10/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy at College Hill	5005 E 21st Street North Wichita, KS 67208

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. 35556 The facility had a census of 60 residents. Based on interview, observation, and record review the facility failed to assign overall supervisory responsibility for dietetic services to a full-time employee, who was a Certified Dietary Manager (CDM). Findings included: - In an interview on 10/05/21 at 11:43 AM, Dietary Manager (DM) W stated she worked as the dietary manager for approximately two years but did not currently have a certification as a CDM. DM W stated she was currently enrolled in a CDM class through the University of North Dakota and was about halfway through the course. An observation on 10/05/21 at 11:43 AM revealed DM W helped prepare the lunch meal and supervised dietary staff. The facility did not provide a policy concerning CDM as requested on 10/07/21. The facility failed to assign overall supervisory responsibility for dietetic services to a full-time employee who was a certified dietary manager.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175078	A. Building B. Wing	10/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy at College Hill	5005 E 21st Street North Wichita, KS 67208

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35556 The facility reported a census of 60 residents. The facility had one main kitchen where food was stored and prepared for one dining room. Based on observation, interview, and record review the facility failed to store and prepare food under sanitary conditions for all the residents of the facility. Findings included: - During the initial environmental tour of the dietary department on [DATE] at approximately 09:50 AM, the following concerns were identified: Observation of the preparation area: 1. A closed bin of powdered milk had a scoop stored in the bin, instead of outside of the bin. 2. A measuring cup with an unknown white powder still in it, sat on top of a bin. 3. A bag of bread in its original packaging was placed across the top of a toaster on the counter in the main preparation area, with a staff members smart phone laying on top of the bread packaging. 4. A large manually operated can opener had brown/black greasy build up on the can opener base which held the can opener mechanism. Observation of the walk-in refrigerator: 1. Three bowls of strawberries and one bowl of grapes, undated and covered with plastic wrap, were on a tray in the walk-in refrigerator 2. One opened package of hotdog buns located in the walk-in cooler, contained three hotdog buns and had an illegible date. 3. One freezer bag contained an opened and undated package of margarine. 4. One opened 32 oz. (ounce) carton of DEBEL liquid egg whites was left open at the top and had no open date on the carton. 5. A plastic container containing approximately 12- 4 oz. cartons of Strawberry/Banana Mighty Shakes and a cardboard box of 19 mighty shakes all with no thaw date. There were instructions printed on each carton to use the product within 14 days thawing. 6. An unlabeled, shrink-wrapped portion of meat laid on top of a cardboard box, on a shelf located above an open box of lettuce. Observations of the walk-in freezer: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175078	A. Building B. Wing	10/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy at College Hill	5005 E 21st Street North Wichita, KS 67208

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	1. One box of turkey,stored in the corner of the walk-in freezer, on the floor. 2. One unopened cardboard box of beef patties, stored on the floor. 3. One box of diced green peppers, stored on the floor. 4. One box of lamb, stored on the floor, and one box of lamb stored on top of a box on the floor. 5. One undated zip lock bag of pancakes on the shelf. 6. One bag of opened peanut butter cookie dough opened and not dated. Observation of the dry goods storage room: 1. One undated large plastic container of Nilla wafers. 2. Two undated bags of opened plain Lays potato chips. 3. One undated bag of [NAME] BBQ potato chips. 4. One undated bag of [NAME] cheese flavored puffed corn. 5. The above-mentioned potato chip bags were stored in a plastic container which contained a package of facemasks opened and at the bottom of the plastic container. 6. There was evidence of mouse droppings on the floor along the walls and behind the rolling shelving units. 7. One large white storage bin with a bag of opened flour contained a scoop stored in the bag with the flour. Observation of the dry goods room outside of walk in refrigerator/freezer unit: 1. Evidence of mouse droppings along the floor next to the wall. 2. A can of food, a broom head, and an aluminum can of soda were located on the floor behind the canned goods. During the follow-up kitchen tour on [DATE] at 10:45 AM revealed a box of approximately 42- 4oz. cartons of Vanilla Mighty Shakes in the walk-in refrigerator with no date when thawed. Observation on [DATE] at 03:40 PM revealed a water temperature log filled out daily with highest water temperature documented at 120 degrees Fahrenheit (unit of measurement for heat.) Observation revealed no chemical sanitization log located in the kitchen. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175078	A. Building B. Wing	10/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy at College Hill	5005 E 21st Street North Wichita, KS 67208

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	In an interview on [DATE] at 03:40 PM, Dietary Staff (DS) W stated the dishwasher was a low-temperature dishwasher and used chlorine to sanitize dishes. DS W stated she didnot realize that dietary staff were to log the chlorine levels for dishwasher sanitation. When asked to demonstrate the use of available chemical test strips, DS W stated the test strips were expired. In an interview on [DATE] at 02:50 PM, Registered Dietician (RD) J stated she visited the kitchen at least once a month but had not been able to complete any kitchen inspections of the dietary kitchen in the past month or so. RD J stated she expected the dietary staff to monitor the sanitizing chemical strength. Review of the undated, Equipment Operation, Infection Control and Sanitization Manual, Section 8: Recording of Dishmachine Temperatures revealed, The concentration of the sanitary solution during the rinse cycle is 50 ppm (parts per million) with Chlorine sanitizer .This is used on low temperature dishmachines .Record ppm on low temperature machines three times a day. The undated Food Storage Policy revealed, Food items should be stored, thawed, and prepared in accordance with good sanitary practice .Thaw meat by placing in deep pans and setting on lowest shelf in refrigerator .date meat when taken out of freezer .The walls, ceiling, and floor should be maintained in good repair and regularly cleaned .All foods should be stored away from the walls and off the floor .Label and date all storage containers or bins. Keep free of scoops .Check for pest infestation regularly. The facility failed to properly store food items, clean kitchen equipment and floors, and monitor the chemical sanitization function of the dishwasher.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175078	A. Building B. Wing	10/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy at College Hill	5005 E 21st Street North Wichita, KS 67208

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 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. 41302 The facility reported a census of 60 residents. Based on interview and record review the facility failed to address staffing in the Facility Assessment to document resources required to provide necessary care to the residents regarding staffing across all shifts. This failure had the ability to affect all resident care in the facility. Findings included: - Review of the 09/30/20 Facility Assessment documented no determination of facility staffing. On 10/05/21 at 04:10 PM Administrative Staff A confirmed the facility assessment did not have a breakdown of how staffing was determined. Administrative Staff A stated she had not completed the facility assessment. The facility's 11/17 Staffing policy documented the facility would complete the facility assessment annually, review quarterly to address staffing. The facility failed to address staffing in the Facility Assessment to document resources required to provide necessary care to the residents regarding staffing across all shifts. This failure had the ability to affect all resident care in the facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175078	A. Building B. Wing	10/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy at College Hill	5005 E 21st Street North Wichita, KS 67208

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 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 31078 The facility reported a census of 60 residents. Based on observation, interview, and record review the facility failed to maintain an effective Quality Assessment and Assurance (QAA, facility meeting of key personnel to identify issues with care and services in the facility and develop action plans to correct the concerned) program ensure that problems related to resident care were identified and action plans were developed through the QAA program to address those concerns. Findings included: - On 10/05/21 at 03:00 PM Administrative Staff A reported the Quality Assessment and Assurance Committee (QAA) met at a minimum of quarterly, with no Director of Nurses in attendance, since June 2021. Administrative Staff A confirmed the QAA committee failed to identify the areas of deficient practice identified during the survey. Refer to F550, the facility failed to ensure the resident's dignity by the failure to place the catheter drainage bag in a dignity bag and away from public view for Resident (R)21. Refer to F574, the facility failed to ensure staff and residents knew how to contact outside sources for assistance with concerns by the failure to post the State of Kansas Department of Aging and Disability Services (KDADS) Complaint hotline information in the facility. Refer to F623, the facility failed to send a copy of the facility-initiated hospitalization transfer/discharge notice to the representative of the Office of the State Long-Term Care Ombudsman for R10, R21, and R50. Refer to F625, the facility failed to provide R10, R21, R50 or the resident representative with a bed hold policy upon transfer to the hospital. Refer to F656, the facility failed to develop a person-centered comprehensive care plan to include the use of psychoactive drugs and the specific targeted behaviors staff were to monitor the resident for regarding the psychoactive medications for R32. The facility also failed to develop a person-centered comprehensive care plan to address the needs and cares of R55. Refer to F657, the facility failed to revise the care plan for R52 related to nutritional supplementation and treatment of a pressure injury, and R24 related to the use of oxygen. Refer to F677, the facility failed to provide ADL assistance to include bathing services to maintain good grooming for R29 who required limited assistance with bathing, R21 with assistance to the bathroom in a timely manner to avoid an accident in his clothing, and R50 with timely checks to avoid lying in urine-soaked bed linens. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175078	A. Building B. Wing	10/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy at College Hill	5005 E 21st Street North Wichita, KS 67208

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 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Refer to F686, the facility failed to prevent the development of a stage 4 (sore that extends below the subcutaneous fat into deep tissues like bone) pressure ulcer (localized injury to the skin and/or underlying tissue usually over a bony prominence as a result of pressure or pressure in combination with shear) for dependent R52, who admitted to the facility with intact skin. The facility further failed to monitor and assess the facility acquired pressure ulcer on R52's coccyx (small triangular bone at the base of the spine). Refer to F690, the facility failed to provide necessary services to decrease the risk of a urinary tract infection (Infection of any part of the urinary system, including kidneys, ureters, bladder, and urethra) when the staff failed to ensure R21's urinary catheter drainage bag did not come in direct contact with the floor or to keep the drainage bag below the level of the bladder. Refer to F692, the facility failed to monitor weights regularly, place effective interventions, and follow-up on registered dietician recommendations for nutritional supplementation, which resulted in R52 experiencing severe weight loss of 17.73 percent in 108 days between 05/13/21 through 09/03/21. Refer to F695, the facility failed to ensure staff provided a storage bag to properly/sanitarily store oxygen tubing when not in use for R24. Refer to F725, the facility failed to have sufficient nursing staff to provide nursing and related services to maintain each resident's highest practicable physical well-being, safety, and quality of care. Refer to F727, the facility failed to employ a Director of Nursing (DON) for the 60 residents who resided in the facility. Refer to F756, the facility failed to ensure three of five residents did not receive unnecessary medications by the failure to follow the consultant pharmacist recommendations for behavior monitoring for R32. The facility failed to adequately monitor blood glucose levels and for unnecessary medication side effects from use of high dose of Seroquel (antipsychotic medication.) The facility failed to add Not to Exceed (NTE) cautions to R17's medications to reduce the potential for liver damage. The facility further failed to ensure R45 did not receive unnecessary medications at an excessive dose and without adequate monitoring, to prevent possible drops in blood glucose levels and unnecessary side effects from high dose Seroquel. Refer to F757, the facility failed to ensure two of five residents did not receive unnecessary medications by not ensuring R17 did not receive more than the recommended daily amount of Acetaminophen (a pain reliever and fever reducing drug) and failed to monitor blood glucose levels as ordered by physician for R45. Refer to F758, the facility failed to ensure appropriate diagnoses were provided for the use of Seroquel (antipsychotic medication) and Depakote (anticonvulsant medication), failed to ensure behavior monitoring for the specific targeted behaviors for R32, and continued to administer to R45 an as needed (PRN) psychotropic medication, longer than 14 days without a renewed physician order or reason provided by the physician for the continued administration of Ambien (hypnotic drug) on a PRN bases. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175078	A. Building B. Wing	10/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy at College Hill	5005 E 21st Street North Wichita, KS 67208

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 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Refer to F761, the facility failed to destroy an outdated vial of Apisol (tuberculin test serum) after its expiration date with approximately one to two doses remaining in the vial and accessible for use, as stored in the medication refrigerator. Refer to F801, the facility failed to assign overall supervisory responsibility for dietetic services to a full-time employee, who was a Certified Dietary Manager (CDM). Refer to F812, the facility failed to store and prepare food under sanitary conditions for all the residents of the facility. Refer to F838, the facility failed to address staffing in the Facility Assessment to document resources required to provide necessary care to the residents regarding staffing across all shifts. This failure had the ability to affect all resident care in the facility. Refer to F867, the facility failed to ensure the required members attended the QAA meetings quarterly. Refer to F868, the facility failed to conduct quarterly Quality Assessment and Assurance (QAA) committee meetings with the required members present when the facility not having a Director of Nursing (DON) present for the last two quarterly meetings. Refer to F880, the facility failed to ensure a sanitary environment by the failure of staff to change gloves and perform hand hygiene when going from dirty to clean areas, while changing the briefs of two residents. R21 and R50. The Quality Assessment and Performance Improvement Program policy revised November 2017 documented, This facility shall develop, implement, and maintain an ongoing, facility-wide Quality Assessment and Performance Improvement program (QAPI), designed to monitor and evaluate the quality of resident care, pursue methods to improve care quality, and resolve identified problems. The facility failed to develop and implement an effective system to ensure that problems related to resident care were identified and action plans were developed through the QAA program to address those concerns.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175078	A. Building B. Wing	10/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy at College Hill	5005 E 21st Street North Wichita, KS 67208

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 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 31078 The facility census totaled 60 residents with 15 residents included in the sample. Based on record review and interview the facility failed to conduct quarterly Quality Assessment and Assurance (QAA) committee meetings with the required members present when the facility not having a Director of Nursing (DON) present for the last two quarterly meetings. Findings included: - On 10/05/21 PM Administrative Staff A produced sign in sheets for quarterly QA meetings from November 2020 through September 2021. The sign in sheet revealed no DON signed as present for last two meetings. On 10/05/21 at 03:00 PM Administrative Staff A reported the facility had not had a DON since June of 2021. The DON left when she came to work there in June. There was an Interim DON for approximately two weeks in August then she left and there has not been a DON since. Corporate had tried to recruit but has not had any good candidates. The facility policy named Quality Assessment and Improvement Program dated August 2021 did not include who should attend the Quarterly meetings. The facility failed to conduct quarterly Quality Assessment and Assurance (QAA) committee meetings with the required members, when the facility not having a Director of Nursing (DON) present.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175078	A. Building B. Wing	10/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy at College Hill	5005 E 21st Street North Wichita, KS 67208

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31078 The facility census totaled 60 residents with 15 included in the sample. Based on observation, interview and record review the facility failed to ensure a sanitary environment by the failure of staff to change gloves and perform hand hygiene when going from dirty to clean areas, while changing the briefs of two residents. Resident (R)21 and R50. Findings included: - Resident (R)21's signed History and Physical dated 09/14/21 revealed the following diagnoses: benign prostatic hyperplasia/hypertrophy (BPH, non-cancerous enlargement of the prostate which can lead to interference with urine flow, urinary frequency and urinary tract infections), muscle atrophy (wasting or decrease in size of a part of the body), and progressive neurodegenerative disorder with paraparesis (partial paralysis, usually affecting only the lower extremities). The Annual Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The resident required extensive assistance of one staff with transfers, locomotion, toilet use, and bathing. The resident had a foley catheter and was continent of bowel. The Quarterly MDS dated [DATE] revealed a BIMS of 15. The resident required extensive assistance of two staff for transfer, locomotion, bathing, and total dependence with toileting. The resident had an indwelling urinary catheter and was frequently incontinent of bowel. The Activities of daily living (ADL) Care Area Assessment (CAA) dated 01/09/21 revealed R21 required assistance with his ADLs due to a diagnosis of multi-system degeneration of the autonomic nervous system and ambulatory dysfunction (a rare neurodegenerative disease that affects the autonomic system functions like respiration, blood pressure and bladder control). The Care Plan dated 01/24/20 revealed the resident had a self-care deficit related to his limited mobility and impairment. He could assist in part of his bathing with extensive assistance of one staff. The resident needed staff supervision with toileting and had an indwelling urinary catheter. The staff encouraged the resident to use the bell to call for assistance. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175078	A. Building B. Wing	10/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy at College Hill	5005 E 21st Street North Wichita, KS 67208

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 09/29/21 at 12:27 PM Certified Nursing Assistant (CNA) E and CNA F arrived to provide care to the resident. The staff brought in a sit to stand mechanical lift to transfer the resident and placed the resident's catheter bag on the footpads of the lift. When the staff lifted the resident with the mechanical lift, there appeared to be a substance which looked like feces on his chair pad and pants. The resident reported to the staff he had called for assistant to go to the bathroom an hour ago. The staff lowered the resident onto the toilet and removed his pants and brief. CNA E tossed the urinary catheter bag from lift to the floor near the side of the toilet. CNA F then wiped and cleaned the feces off the floor in front of toilet, then cleaned the resident up with wipes, and proceeded to put a clean brief on the resident without changing gloves or performing hand hygiene. CNA F started to remove the resident's pants with feces on them without first taking his shoes off and the resident insisted CNA F remove his shoes before removing the pants and he then asked CNA F to put a pair of shorts on him. CNA F put the shorts on the resident and wore the same gloves throughout cleaning of the feces and subsequently dressing the resident. The resident was then allowed to sit awhile on the toilet and CNA E returned to the room a short time later. CNA E then proceeded to do peri care with wet wipes and then pulled up the brief and pants while the resident stood in the lift. CNA E took the catheter bag from the floor near the toilet with no dignity bag on it and placed it back on the foot pad of the lift to transfer the resident to his wheelchair. The staff laid R21's urinary catheter bag that was just on the floor by the toilet and on the foot pad of the lift, then hung it onto the arm rest of the wheelchair with no dignity bag. CNA E and CNA F did not change their gloves or wash their hands, during the entire observation. Observation on 10/04/21 at 02:05 PM revealed the resident wheeled himself slowly in the hall. His urinary catheter bag hung on the arm rest of his wheelchair above the level of the bladder and not in a dignity bag. There were no staff in hall to assist the resident. The facility policy named Personal Protective Equipment- Gloves dated 08/09 revealed gloves must be worn when handling blood, body fluids, secretions, excretions, mucous membranes and/or non-intact skin. Gloves shall be used only once and discarded into appropriate receptacle located in the room the procedure was performed. Wash your hands after removing gloves. The facility failed to ensure a sanitary environment by the failure of staff to change gloves and perform hand hygiene when going from dirty to clean areas, while changing the brief of R21. - Resident (R) 50's signed Physician Orders dated 09/13/21 revealed the following diagnoses: cerebral infarction (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, also called a CVA), dementia (progressive mental disorder characterized by failing memory, confusion), gastrostomy status (the introduction of a nutrient solution through a surgically inserted tube into the stomach through the abdominal wall), dysarthria (slurred speech) following cerebral infarction, and seizures (violent involuntary series of contractions of a group of muscles). The Quarterly Minimum Data Set (MDS) dated [DATE] revealed the resident refused the Brief Interview for Mental Status (BIMS). The resident was independent with activities of daily living (ADLs). The resident rejected care on one to three days of the seven-day observation period. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175078	A. Building B. Wing	10/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy at College Hill	5005 E 21st Street North Wichita, KS 67208

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Admission MDS dated 09//21 and completed on 10/02/21 revealed the resident had severe cognitive impairment and rarely understood. The resident received extensive assistance of one with bed mobility, transfers, toilet use and dependent on staff for hygiene and eating and bathing. The resident had a new diagnosis of a CVA. The resident received 51% or more of his nutrition through G- tube. The resident had no skin issues. The Nurse's Readmission Assessment Initial Care Plan dated 09/13/21 revealed the resident had a gastrostomy tube and received nutrition continuous through a tube connected to a pump. The resident was alert and oriented with no behaviors noted. The resident required extensive to total assistance of one to two staff with ADLs and was incontinent of bowel and bladder. The Nurses Progress Notes dated 09/14/21 at 03:41 AM revealed the resident readmitted from the hospital on 09/13/21 with diagnoses of stroke, and seizure. The staff provided the resident with one-person total assistance with ADLs this shift. The resident was incontinent of bladder. Observation of R50 on 09/30/21 at 01:05 PM revealed Licensed Nurse (LN) G in the resident's room. While in the room the surveyor noted the resident was soaked and wet. LN G checked the resident and verified R50 was soaking wet. LN G left the room to find assistance to change the resident. Certified Medication Aide L came back with the nurse and donned gloves to assist in changing the resident. The resident's gown, top sheet, and the residents brief were all soaked with urine. The resident's bottom sheet was stripped off the bed and the mattress was wet from the lower middle portion of the bed mattress up the residents back area. The staff cleaned the resident up and then scrubbed the mattress with peri cleaner and placed a pad over the remaining wet spot on the bed. The staff then placed a brief on the resident and repositioned the resident, in order to replace the bottom sheet. The staff placed a clean gown on the resident and covered him with a top sheet and blanket. The resident did not say much during the care and allowed the staff to perform the task. Both staff wore the same gloves throughout the care of the resident. No handwashing noted after removal of the gloves. Observation of R50 on 10/04/21 at 07:52 AM revealed the resident was restless in bed and yelled out. The resident had a very strong odor of urine. The bed pad had dry areas that were brown, and the rest of the pad was saturated with fluid. The sheet under the resident was visibly wet and brown in color. The resident's brief was saturated and bulging and his sleep gown was wet. LN H and CNA F gloved to change the resident. CNA F removed the resident's gown while LN H unplugged the g-tube and flushed the tube with water. LN H then opened the resident's brief and revealed the resident had a bowel movement (BM). LN H proceeded to clean the resident using wet wipes. The resident's coccyx was red and intact. The bed mattress was wet, and the wet spot covered with an incontinent pad. LN H placed a brief on the resident, followed by a pair of jeans. LN H wore the same gloves with no hand hygiene performed before or after gloves being worn. Interview on 09/30/21 CMA L reported the resident was total care and was incontinent. Before R50 went to the hospital, he pretty much took care of himself with coaxing and supervision from staff. Then he had his stroke and now had a feeding tube. The resident needed to be changed about every two hours because with that tube feeding, he was wet a lot. CMA L acknowledged she should have changed her gloves and washed her hands when they got all the wet linens and clothes off and before redressing the resident. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175078	A. Building B. Wing	10/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy at College Hill	5005 E 21st Street North Wichita, KS 67208

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 10/04/21 at 08:00 AM CNA F reported she was the only aid scheduled for this hall and was working to get residents up for breakfast. The third shift CNA always left before CNA F arrived, instead of doing walking rounds with her, like she was supposed to. CNA F reported she should have had new gloves to put on before getting the resident dressed and up in his chair. She was in a hurry and did not think about it. Interview on 09/30 21 at 01:20 PM LN G stated he had never seen a nursing home like this. He stated he was a little overwhelmed by the lack of staff and caring for the residents. He said he was helping on the floor as much as he could but did not normally do incontinent care on the resident's and really did not realize he had not changed his gloves the entire time. Interview on 10/04/21 at 08:05 AM LN H reported he had double gloves on during part of the incontinent care and removed the second pair. He acknowledged he did not change his gloves when he should have and had not washed hands when he was done. The facility policy named Personal Protective Equipment- Gloves dated 08/09 revealed gloves must be worn when handling blood, body fluids, secretions, excretions, mucous membranes and/or non-intact skin. Gloves shall be used only once and discarded into appropriate receptacle located in the room the procedure was performed. Wash your hands after removing gloves. The facility failed to ensure a sanitary environment by the failure of staff to change gloves and perform hand hygiene when going from dirty to clean areas, while changing the brief of R50.