STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N008005	A. BUILDING: _____ B. WING _____	01/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEPOINT AUGUSTA, LLC	901 LAKEPOINT DRIVE AUGUSTA, KS 67010

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS The following represent the findings of a resurvey for the above named Assisted Living facility conducted on 01/10/24.	S 000		
S3085 SS=E	26-41-202 (a) Negotiated Service Agreement (a) The administrator or operator of each assisted living facility or residential health care facility shall ensure the development of a written negotiated service agreement for each resident, based on the resident ' s functional capacity screening, service needs, and preferences, in collaboration with the resident or the resident ' s legal representative, the case manager, and, if agreed to by the resident or the resident ' s legal representative, the resident ' s family. The negotiated service agreement shall provide the following information: (1) A description of the services the resident will receive; (2) identification of the provider of each service; and (3) identification of each party responsible for payment if outside resources provide a service. This REQUIREMENT is not met as evidenced by: KAR 26-41-202(a)(1) The facility reported a census of 18 residents with three residents included in the sample. Based on observation, interview, and record review the administrator failed to ensure the "Negotiated Service Agreement" (NSA) was fully developed based on the resident's "Functional	S3085		

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
	N008005	A. BUILDING: _____ B. WING _____	01/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEPOINT AUGUSTA, LLC	901 LAKEPOINT DRIVE AUGUSTA, KS 67010

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S3085	Continued From page 1	S3085		

Capacity Screen" (FCS), service needs, and preferences for resident (R)102 and R103.

Findings included:

- R102's medical record revealed he moved into the facility on 06/28/23.

The 10/25/23 FCS identified R102 was independent with transfers and was at risk for falls.

The 10/25/23 NSA did not identify that R102 used a bed assist device for transfers and did not include fall interventions of non-slip strips provided by the facility and two-hour toileting checks by staff.

On 01/10/24 at 04:40 PM R102 was alert and oriented and sat on his couch barefooted watching television. There were some non-slip strips applied to the floor next to his bed as well as a u-shaped bed assist device was attached to his bed.

On 01/10/24 at 03:17 PM Certified Medication Aide (CMA) C stated R102 was on a toileting schedule and staff checked on him every two hours. CMA C stated R102 has experienced falls and the two-hour toileting checks was one of the interventions. CMA C stated most of R102's falls were due to him sliding off his bed, so staff applied non-slip strips by his bed since he did not like to wear socks.

On 01/10/24 at 05:01 PM Administrative Nurse A stated R102 has had some falls but was not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N008005	A. BUILDING: _____ B. WING _____	01/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEPOINT AUGUSTA, LLC	901 LAKEPOINT DRIVE AUGUSTA, KS 67010

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S3085	Continued From page 2 aware that he used a grab bar. Administrative Nurse A acknowledged the use of non-slip strips and a bed assist device were not included in R102's NSA. The administrator failed to ensure R102's NSA was fully developed to include all items that triggered on the FCS, his service needs, and preferences. - R103's medical record revealed she moved into the facility on 11/16/16. The 08/17/23 FCS identified R103 was at risk for falls and had impaired hearing. The 08/17/23 NSA did not address what services staff provided R103 concerning her impaired hearing or falls and did not identify R103 used a fall mat next to her bed. On 01/10/24 at 04:51 PM R103 slept in her bed with a fall mat placed next to her bed on the floor. On 01/10/24 at 05:27 PM Administrative Nurse A stated R103's NSA did not address falls or impaired hearing, and acknowledged the NSA did not address the use of a fall mat. The administrator failed to ensure R103's NSA was fully developed to include all items that triggered on the FCS, her service needs, and preferences.	S3085		
S3101 SS=D	26-41-202 (h) NSA Signatures (h) Each individual involved in the development	S3101		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N008005	A. BUILDING: _____ B. WING _____	01/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEPOINT AUGUSTA, LLC	901 LAKEPOINT DRIVE AUGUSTA, KS 67010

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S3101	Continued From page 3 of the negotiated service agreement shall sign the agreement. The administrator or operator shall ensure that a copy of the initial agreement and any subsequent revisions are provided to the resident or the resident's legal representative. This REQUIREMENT is not met as evidenced by: KAR 26-41-202(h) The facility reported a census of 18 residents. The sample included three residents. Based on interview, and record review the administrator failed to ensure the "Negotiated Service Agreement" (NSA) for resident (R)103 was signed by all individuals involved in the development of the NSA. Findings included: - R103's medical record revealed the resident moved into the facility on 11/16/16. The 08/17/23 NSA documented signatures for the nurse who developed the NSA but lacked signatures of either the resident or her legal representative. On 01/10/24 at 05:27 PM Administrative Nurse A acknowledged there were no resident or durable power of attorney (DPOA) signatures included on R103's NSA. The administrator failed to ensure R103's NSA	S3101		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N008005	A. BUILDING: _____ B. WING _____	01/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEPOINT AUGUSTA, LLC	901 LAKEPOINT DRIVE AUGUSTA, KS 67010

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S3101	Continued From page 4 was signed by all individuals involved in the development of the NSA.	S3101		
S3165 SS=E	26-41-204 (d) Health Care Services (d) The negotiated service agreement shall contain a description of the health care services to be provided and the name of the licensed nurse responsible for the implementation and supervision of the plan. This REQUIREMENT is not met as evidenced by: KAR 26-41-204(d) The facility reported a census of 18 residents with three residents included in the sample. Based on interview and record review the administrator failed to ensure the "Negotiated Service Agreement" (NSA) identified the licensed nurse responsible for the implementation and supervision of the health care services plan for resident (R)101, R102 and R103. Findings included: - R101's medical record revealed the resident moved into the facility on 07/17/23. R101's most recent NSA was completed on 11/06/23 and did not identify the nurse responsible for the implementation and supervision of the health care services plan. On 01/10/24 at 05:00 PM Administrative Nurse A	S3165		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N008005	A. BUILDING: _____ B. WING _____	01/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEPOINT AUGUSTA, LLC	901 LAKEPOINT DRIVE AUGUSTA, KS 67010

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S3165	Continued From page 5	S3165		

acknowledged R101's NSA did not identify the name of the nurse responsible for the implementation and supervision of the care plan.

The administrator failed to ensure R101's NSA identified the licensed nurse responsible for the implementation and supervision of the health care services plan.

- R102's medical record revealed the resident moved into the facility on 06/28/23.

R102's most recent NSA was completed on 10/25/23 and did not identify the nurse responsible for the implementation and supervision of the health care services plan.

On 01/10/24 at 05:01 PM Administrative Nurse A acknowledged R102's NSA did not identify the name of the nurse responsible for the implementation and supervision of the care plan.

The administrator failed to ensure R102's NSA identified the licensed nurse responsible for the implementation and supervision of the health care services plan.

- R103's medical record revealed the resident moved into the facility on 11/16/16.

R103's most recent NSA was completed on 08/17/23 and did not identify the nurse responsible for the implementation and supervision of the health care services plan.

On 01/10/24 at 05:27 PM Administrative Nurse A acknowledged R103's NSA did not identify the name of the nurse responsible for the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N008005	A. BUILDING: _____ B. WING _____	01/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEPOINT AUGUSTA, LLC	901 LAKEPOINT DRIVE AUGUSTA, KS 67010

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S3165	Continued From page 6 implementation and supervision of the care plan. The administrator failed to ensure R103's NSA identified the licensed nurse responsible for the implementation and supervision of the health care services plan.	S3165		
S3211 SS=F	26-41-205 (g) (3) OVER THE COUNTER DRUGS (3) A licensed nurse or medication aide may accept over-the-counter medication only in its original, unbroken manufacturer ' s package. A licensed pharmacist or licensed nurse shall place the full name of the resident on the package. If the original manufacturer ' s package of an over-the-counter medication contains a medication in a container, bottle, or tube that can be removed from the original package, the licensed pharmacist or a licensed nurse shall place the full name of the resident on both the original manufacturer ' s medication package and the medication container. This REQUIREMENT is not met as evidenced by: 3211 KAR 26-41-205 (g)(3) The facility reported a census of 18 residents. Based on observation, record review, and interview the administrator failed to ensure a licensed pharmacist or licensed nurse placed the full name of the resident on the original package of over the counter (OTC) medications for six residents.	S3211		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N008005	A. BUILDING: _____ B. WING _____	01/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEPOINT AUGUSTA, LLC	901 LAKEPOINT DRIVE AUGUSTA, KS 67010

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S3211	Continued From page 7 Findings included: - Observation on 01/10/24 at 09:45 AM revealed the facility's medication room contained the following OTC medications which were not labeled with a resident's full name: Resident (R)104: One bottle of MiraLAX did not have the full name of the resident. R105: One bottle of Williams Nutrient Joint Advantage Gold 5X R106: One bottle of Tylenol Extra Strength One bottle of Rexall Allergy Relief Three bottles of Equate Vegetable Laxative. One bottle of AZO Cranberry R107: One bottle of Kroger Acetaminophen 500 milligrams (mg.) R108: One bottle of Tums antacid One box of Dulcolax R109: One bottle of GeriCare Milk of Magnesia One bottle of MiraLAX One bottle of Equate Mucus Relief DM One bottle of Equate Famotidine One bottle of Equate Stool Softener One bottle of Nature's Bounty Acidophilous	S3211		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N008005	A. BUILDING: _____ B. WING _____	01/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEPOINT AUGUSTA, LLC	901 LAKEPOINT DRIVE AUGUSTA, KS 67010

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S3211	Continued From page 8 Probiotic One spray bottle of Walgreens Allergy Nasal Spray The medication cart contained the following OTC medications which were not labeled with a resident's full name: R109: One bottle of Nature's Bounty Acidophilous Probiotic R106: One bottle of MiraLax One bottle of Kroger Senna-S One bottle of Tylenol 8hr. Arthritis Pain The 06/2016 "Medications and Treatments-Labelling Policy" documented, "All medications and treatments (including over-the-counter and sample medications) should be labeled with the necessary information to provide safe medication management administration." The administrator failed to ensure all OTC medications were labeled by a pharmacist or licensed nurse with the resident's full name.	S3211		
S3280 SS=F	26-41-104 (d) Disaster and Emergency Preparedness (d) Each administrator or operator shall ensure disaster and emergency preparedness by ensuring the performance of the following: (1) Orientation of new employees at the time of employment to the facility ' s emergency management plan; (2) education of each resident upon	S3280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N008005	A. BUILDING: _____ B. WING _____	01/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEPOINT AUGUSTA, LLC	901 LAKEPOINT DRIVE AUGUSTA, KS 67010

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S3280	Continued From page 9 admission to the facility regarding emergency procedures; (3) quarterly review of the facility ' s emergency management plan with employees and residents; and (4) an emergency drill, which shall be conducted at least annually with staff and residents. This drill shall include evacuation of the residents to a secure location. This REQUIREMENT is not met as evidenced by: KAR 26-41-104(d)(3) The facility reported a census of 18 residents. Based on record review and interview for all residents and all facility employees, the administrator failed to ensure disaster and emergency preparedness by ensuring performance of quarterly review of the facility's emergency management plan with employees. Findings included: - On 01/10/24 Administrative Staff B provided documentation of reviews of the emergency management plan completed with facility staff. On 01/11/24 at 11:55 AM Administrative Staff B stated reviews of the emergency management plan as provided, were completed with staff upon hire and on an annual basis only and not completed on a quarterly basis.	S3280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N008005	A. BUILDING: _____ B. WING _____	01/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEPOINT AUGUSTA, LLC	901 LAKEPOINT DRIVE AUGUSTA, KS 67010

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S3280	Continued From page 10 The administrator failed to ensure the completion of quarterly reviews of the emergency management plan with employees.	S3280		
S3310 SS=F	26-41-207 (b) (5-6) (c) Infection Control Policies (b) (5) prohibiting any employee with a communicable disease or any infected skin lesions from coming in direct contact with any resident, any resident ' s food, or resident care equipment until the condition is no longer infectious; (6) providing orientation to new employees and employee in-service education at least annually on the control of infections in a health care setting; and (c) Each administrator or operator shall ensure the facility ' s compliance with the department ' s tuberculosis guidelines for adult care homes adopted by reference in K.A.R. 26-39-105 This REQUIREMENT is not met as evidenced by: KAR 26-41-207(c) The facility reported a census of 18 residents. Based on record review and interview the administrator failed to ensure the facility was in compliance with the department's tuberculosis (TB) guidelines for adult care homes adopted by reference in K.A.R. 26-39-105. Findings include:	S3310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N008005	A. BUILDING: _____ B. WING _____	01/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEPOINT AUGUSTA, LLC	901 LAKEPOINT DRIVE AUGUSTA, KS 67010

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S3310	Continued From page 11 - Review of five newly hired staff records revealed the following: Certified Medication Aide (CMA) D hired on 05/12/23 did not have a TB symptom screening questionnaire or a two-step TB skin test (TST) completed upon hire. CMA E hired on 02/10/23 did not have a TB symptom screening questionnaire TST completed upon hire. CMA F hired on 08/18/23 did not have a TB symptom screening questionnaire or a TST completed upon hire. Certified Nurse Aide (CNA) G hired on 08/28/23 did not have a TB symptom screening questionnaire or a TST completed upon hire. The June 2013 "Tuberculosis (TB) Guidelines for Adult Care Homes" documented, "Each new ...employee shall have an initial TB symptom screen that includes the components of the TB symptom questionnaire within 7 days of ...employment ...Each new ...employee shall receive a two-step TST or an IGRA for Mycobacterium tuberculosis within 7 days of ...employment ..." The administrator failed to ensure the compliance with the department's tuberculosis guidelines for adult care homes adopted by reference in K.A.R. 26-39-105. - Resident (R)101 admitted to the facility on 07/17/23 did not have a TB symptom screening questionnaire or a two-step TST completed upon admission.	S3310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N008005	A. BUILDING: _____ B. WING _____	01/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEPOINT AUGUSTA, LLC	901 LAKEPOINT DRIVE AUGUSTA, KS 67010

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S3310	Continued From page 12 On 01/10/24 at 01:30 PM Administrative Nurse A acknowledged a TB symptom screening questionnaire and a two-step TST were not completed upon admission for R101. The June 2013 "Tuberculosis (TB) Guidelines for Adult Care Homes" documented, "Each new resident ...shall have an initial TB symptom screen that includes the components of the TB Symptom Screen Questionnaire within 7 days of residency ...Each new resident ...shall receive a two-step TST or an IGRA for Mycobacterium tuberculosis within 7 days of residency ..." The administrator failed to ensure the compliance with the department's tuberculosis guidelines for adult care homes adopted by reference in K.A.R. 26-39-105. - R102 admitted to the facility on 06/28/23 did not have a TB symptom screening questionnaire completed upon admission. On 01/10/24 at 05:01 PM Administrative Nurse A stated she was not able to find documentation of a completed TB symptom screening questionnaire for R102 when he admitted to the facility. The June 2013 "Tuberculosis (TB) Guidelines for Adult Care Homes" documented, "Each new resident ...shall have an initial TB symptom screen that includes the components of the TB Symptom Screen Questionnaire within 7 days of residency." The administrator failed to ensure the	S3310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N008005	A. BUILDING: _____ B. WING _____	01/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEPOINT AUGUSTA, LLC	901 LAKEPOINT DRIVE AUGUSTA, KS 67010

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S3310	Continued From page 13 compliance with the department's tuberculosis guidelines for adult care homes adopted by reference in K.A.R. 26-39-105.	S3310		