

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N063013	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/03/2017
NAME OF PROVIDER OR SUPPLIER GUEST HOME ESTATES		STREET ADDRESS, CITY, STATE, ZIP CODE 400 S MCGEE STREET CANEE, KS 67333		
(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 citations represent the findings of resurvey with complaints #107453 and #106074 at the above named facility on 3-27-17, 3-29-17, 3-30-17, and 4-3-17.	S 000		
S 140 SS=F	26-39-103 (i) Resident Right Privacy and Confidentiality (i) Privacy and confidentiality. The administrator or operator shall ensure that each resident is afforded the right to personal privacy and confidentiality of personal and clinical records. (1) The administrator or operator shall ensure that each resident is provided privacy during medical and nursing treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups. (2) The administrator or operator shall ensure that the personal and clinical records of the resident are maintained in a confidential manner. (3) The administrator or operator shall ensure that a release signed by the resident or the resident's legal representative is obtained before records are released to anyone outside the adult care home, except in the case of transfer to another health care institution or as required by law. This STANDARD is not met as evidenced by: KAR 26-41-103(i)(1)(2) The facility identified a census of 21 residents. The sample included 3 residents. Based on observations and interviews for all residents, the operator failed to ensure that each resident is afforded the right to personal privacy, confidentiality of personal and clinical records,	S 140		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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S 140	Continued From page 1 privacy during medical and nursing treatment, written and telephone communications, and failed to ensure clinical records of the resident are maintained in a confidential manner. Findings included: - Upon arrival to facility on 3-27-17 at 11:50 a.m., observed licensed nurse at desk in dining room where residents are eating lunch. On 3-27-17 at 2:25 p.m. heard licensed nurse A yell out to certified staff D that resident #400 just came back and gave orders to administer 2:00 p.m. medication while he/she was at desk in dining room charting and also observed orders on desk in dining room for resident #400. On 3-29-17 at 1:15 p.m., observed licensed nurse A on phone at desk in dining room talking loudly about resident #600 and the reason he/she needed to see a nephrologist. The operator went out to licensed nurse A's desk and asked him/her to go to medication room to talk on phone. Licensed nurse A stepped away from desk with resident #700's medical record on desk and opened. Observed visitors walking by desk looking at it when going into operator's office. On 3-27-17 at 1:20 p.m. observed certified staff C and D provide incontinent care to resident #100 with licensed nurse A in room. Resident #100 shared a room with resident #200. No privacy curtain or screen available in room. Licensed nurse A stated they asked resident #200 to step out of room when providing incontinent care. Licensed nurse A stated during the night shift staff provided incontinent care while alert resident in room. Licensed nurse A also stated no privacy screens or curtains are available in rooms or in	S 140		

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S 140	Continued From page 2 facility at this time and had one other room that had two residents with one being incontinent. For all residents, the operator failed to ensure that each resident is afforded the right to personal privacy, confidentiality of personal and clinical records, privacy during medical and nursing treatment, written and telephone communications, and failed to ensure clinical records of the resident are maintained in a confidential manner.	S 140		
S3171 SS=D	26-41-204 (i) Health Care Services Standards of Practice (i) All health care services shall be provided to residents by qualified staff in accordance with acceptable standards of practice. This REQUIREMENT is not met as evidenced by: KAR 26-41-204(i) The facility identified a census of 21 residents. The sample included 3 residents. Based on record review, interview, and observation for 1 (#100) of 3 residents sample, the operator failed to ensure all health care services provided to residents by qualified staff in accordance with acceptable standards of practice. For resident #100, the operator failed to ensure all health care services provided to resident by qualified staff in accordance with acceptable standards of practice when resident was moved by certified staff following a fall before receiving	S3171		

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S3171	Continued From page 3 instructions from a licensed nurse. Findings included: - Record review for resident #100 revealed an admit date of 3-17-14 with diagnoses type two diabetes mellitus, atrial fibrillation, alzheimer's disease, dementia, neuropathy and hypothyroidism. The annual functional capacity screen dated 3-17-15 and amended on 4-2-15 recorded resident required physical assistance with bathing, toileting, mobility, walking, transfer assist, experienced short term memory loss, long term memory loss, memory/recall, decision making and impaired decision making. The negotiated service agreement/health care service plan date 3-17-15 and amended on 4-2-17 recorded resident required physical assistance with bathing, to and from toilet, staff to provide one person assist with ambulation and mobility due to fall risk. Staff to use gait belt with ambulation and mobility. Staff to assist to and from dining room and make sure chair alarm is on. Staff to remind resident of meal times and activities. Resident unable to make appropriate decisions. The nurses notes recorded the following: 7-26-15 at 5:25 p.m. "Resident was down hallway with another resident talking. Then all of a sudden we heard someone yelling for help. Went down hallway and observed resident on bottom. Resident stated, 'I am ok, just slipped out.'	S3171		

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S3171	Continued From page 4 8-31-15 at 3:40 p.m. "This nurse received a call at 9:42 a.m. from facility operator/Certified Medication Aide (CMA) stating resident's roommate came out of room yelling that (resident #100) needed help because he/she fell on the floor. Resident was lying on left side. Resident was hollering and wanting to get up. The cook (granddaughter) and facility operator/CMA assisted resident into wheelchair. Resident began to complain of pain in left thigh and hip area. This nurse instructed staff to call hospice to see if they wanted to come to facility to do an assessment or have resident sent to the hospital for assessment for possible fracture. Hospice came out and assessed resident and decided to have resident assessed at hospital. Resident's granddaughter later called and stated resident had a fracture to left hip. After investigating fall, Resident's roommate said resident was getting out of chair and fell trying to head to the bathroom. Resident was not using walker." Investigation report dated 8-31-15 recorded resident's roommate came out of room yelling (resident #100) needed help because he/she fell. Resident observed lying on left side with head under bed and legs bent to left side. Resident was hollering and wanting to get up. Resident's granddaughter (who works at facility) and operator/CMA assisted resident up to wheelchair. Resident complained of hip pain and pain in left thigh. Nurse instructed staff to call Hospice to assess. Injuries: left hip pain resulting in left hip fracture resident admitted to hospital for left hip fracture and surgery repair. Witness: resident attempted to get out of recliner and walk. The investigation report lacked information if chair alarm was in place and sounding.	S3171		

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S3171	Continued From page 5 Interview on 3-29-17 at 2:15 p.m. with operator/CMA stated he/she and cook (granddaughter) got resident up off floor and into wheelchair and then called nurse for instructions. For resident #100, the operator failed to ensure all health care services provided to resident by qualified staff in accordance with acceptable standards of practice when resident was moved by certified staff following a fall before receiving instructions from a licensed nurse.	S3171		
S3265 SS=J	26-41-104 (a) Disaster and Emergency Preparedness (a) The administrator or operator of each assisted living facility or residential health care facility shall ensure the provision of a sufficient number of staff members to take residents who would require assistance in an emergency or disaster to a secure location. This REQUIREMENT is not met as evidenced by: KAR 26-41-104(a) The facility identified a census of 21 residents. The sampled included 3 residents. Based on record review, interview and observations for one of 3 (#100) residents, the operator failed to ensure the provision of a sufficient number of staff members on night shift to take residents who would require assistance in an emergency or disaster to a secure location. The failure to have a sufficient number of staff members on duty from 8:00 p.m. to 6:00 a.m. placed residents in	S3265		

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S3265	Continued From page 6 immediate jeopardy. Findings included: - Record review for resident #100 revealed an admit date of 3-17-14 with diagnoses of diabetes mellitus, atrial fibrillation, alzheimer's disease, dementia, neuropathy, and hypothyroidism. The annual functional capacity screen dated 9-12-16 recorded resident required two staff assistance with bathing, toileting, transfer, and staff to propel resident in wheelchair. The negotiated service agreement/health care service plan dated 9-12-16 recorded two staff assist with bathing, toileting, transfer, and staff to propel resident in wheelchair. On 3-27-17 at 1:20 p.m. observed certified staff C attempt to transfer resident #100 from wheelchair to bed using gait belt. Certified staff C was unable to get resident out of wheelchair. Certified staff D was in room and assisted certified staff C using a gait belt to transfer resident from wheelchair to bed. Resident did not assist with transfer. Licensed nurse A in room during transfer and confirmed resident was a two person transfer. Interview on 3-27-17 at 11:55 a.m. with licensed nurse A stated had two staff on 6:00 a.m. to 2:00 p.m. shift and 2:00 p.m. to 8:00 p.m. shift and one staff on duty from 8:00 p.m. to 6:00 a.m. shift. On 3-27-17 at approximately 12:00 p.m. licensed nurse A provided a resident roster that identified one resident as a two person assist for transfer and eight residents with impaired cognition.	S3265		

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S3265	Continued From page 7 Interview on 3-27-17 at 12:00 p.m. with operator/Certified Medication Aide (CMA) stated and confirmed two certified staff on 6:00 a.m. to 2:00 p.m., 2:00 p.m. to 8:00 p.m., and one certified staff on duty from 8:00 p.m. to 6:00 a.m. Interview on 3-27-17 at 12:20 p.m. with operator/CMA stated had not performed an evacuation on the night shift with one staff on duty. The only documented evacuation drill completed with one staff on duty was dated 8-13-15 at 5:15 p.m. when all residents were up for dinner. The operator/CMA documented that he/she evacuated the residents to a safe place. On 3-27-17 at 12:55 p.m. operator/CMA provided staffing schedules from 8-1-16 through 4-1-17 that identified one certified staff on duty from 8:00 p.m. to 6:00 a.m. For all residents, the operator failed to ensure the provision of a sufficient number of staff members on night shift to take residents who would require assistance in an emergency or disaster to a secure location. The failure to have a sufficient number of staff members on duty from 8:00 p.m. to 6:00 a.m. placed residents in immediate jeopardy. The jeopardy was corrected on 3-27-17 at 4:30 p.m. when the operator/CMA provided a written statement that recorded, " he/she would have a second certified staff member on night shift until arrangements are made otherwise."	S3265		