STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N067008	A. BUILDING: _____ B. WING _____	06/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUEST HOME ESTATES III	7440 220TH ROAD CHANUTE, KS 66720

(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 the licensure resurvey for the above named facility conducted on 6/13/19 and 6/17/19.	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) The facility reported a census of 11 residents. The sample included 3 residents. Based on observation, interview and record review licensed nurse/operator B failed to ensure the development of a written negotiated service agreement (NSA) for 2 of 3 sampled residents (#186 and #207) based on the functional capacity screening, service needs and resident	S3085		

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

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preferences in regard to medication management. The NSA lacked specific description of the services the resident would receive regarding which medications the facility administered and which medications the resident self-administered.

Findings included:

- Record review for resident #186 revealed an admission date of 1/03/19 with diagnoses of congestive heart failure, stage 3 renal failure, coronary artery disease, seizure disorder, hypertension, Crohn's disease, hypothyroidism, hypomagnesemia, depression and cervical spine degeneration.

The admission functional capacity screening dated 1/03/19 identified the resident with intact cognition. He/she needed physical assistance with transfers, mobility/walking, toileting, dressing and medication/treatment management.

The resident's qualification for self-medication administration dated 1/03/19 indicated the resident could name medications, give the reason for the medication, name main side effects and remember to take the medications timely. He/she could identify medication and read the labels with physical ability to open containers without spilling and apply medications safely and accurately. The approved medications included OTC (over the counter) ointments (cortizone and other OTC itch creams), rubbing alcohol and hydrogen peroxide, blood sugar testing and Novolog insulin PRN (as needed).

The negotiated service agreement/care plan dated 1/03/19 directed staff to store, reorder, set-up and administer medications per

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medication administration record (MAR). Resident may keep ointments in room. Under medical treatments was blood sugar testing 4 times a day without identification of who would perform the testing.

On 6/13/19 at approximately 9:30 AM licensed nurse/operator B provided a resident roster which indicated the resident self-administered insulin, inhalers and performed his/her own blood sugar testing.

Review of the June 2019 MAR revealed facility staff initialed administration times to indicated he/she administered 29 routine by mouth pills/tablets/capsules and 1 medication by aerosolized nebulizer (DuoNeb). The MAR indicated the resident self-administered and kept the following medications in his/her room: Breo inhaler, Ventolin inhaler, DuoNeb treatments, accuchecks (blood sugar testing) and Novolog insulin.

Observation on 6/13/19 at 11:30 AM revealed the resident kept the following medications in his/her room for self-administration: Novolog insulin, blood sugar testing equipment and supplies, inhalers and OTC anti-itch cream.

Interview on 6/13/19 at 9:23 AM certified medication aide A reported the resident managed and self-administered his/her own insulin.

Interview on 6/13/19 at 11:45 AM with licensed nurse/operator B confirmed the resident self-administered some of his/her medications and the facility administered the rest of the resident's medications. He/she confirmed the NSA did not provide a description of the services the facility provided or for which the resident was

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responsible in regard to self-administered medications.

Licensed nurse/operator B failed to ensure the development of a written negotiated service agreement for this resident which was based on the functional capacity screening, service needs and resident preferences regarding medication management to included which medications the facility administered and which medications the resident self-administered.

- Record review for resident #207 revealed an admission date of 12/16/15 with diagnoses of dementia, cerebral vascular accident, hypertension, diabetes mellitus type 2, depression, anxiety and spinal cord stenosis.

The annual functional capacity screening dated 12/11/18 identified the resident with short-term memory deficit, impaired memory/recall and decision making. The resident needed physical assistance with medication and treatment management.

The negotiated service agreement/care plan dated 12/11/18 directed staff the resident had difficulty with memory and decision making, staff will pick out matching clothes for residents and family will make major decisions for the resident. Under communication - resident has history of stroke and occasionally gets mixed up on his/her words. Staff to be patient and give the resident time to get words out. Under medications - staff to store, reorder, set-up and administer all medications per medication administration record (MAR). Resident does self-med for insulin pen. Staff to take blood sugar testing 4 times a day. The NSA failed to provide description of the staff's need to prepare the insulin pen, dial the

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prescribed dose and the resident would only injection the insulin by the pen.

Review of the June 2019 MAR revealed certified medication aide staff initialed to indicate he/she administered the resident's Levemir insulin.

Observation on 6/13/19 at 9:23 AM revealed a Levemir insulin pen in the facility medication cart labeled for the resident.

Interview on 6/13/19 at 9:23 AM with certified medication aide A revealed he/she would clean the insulin pen injection cap with alcohol, attach the needle, dial the pen to the prescribed dose and hand the pen to the resident who would place the pen on his/her skin and push the plunger (self-injection).

Interview on 6/13/19 at 1:00 PM with licensed nurse/operator B confirmed facility staff stored, prepared, dialed the dose of the insulin and the resident only pushed the plunger for the injection of the medication.

Regulatory definitions (qqq) defined "Self-administration of medications" as the determination by a resident of when to take a medication or biological and how to apply, inject, inhale, ingest or take a medication or biological by any other means, without assistance from nursing staff.

Licensed nurse/operator B failed to ensure the development of a written negotiated service agreement for this resident based on the functional capacity screening, service needs and resident preferences regarding description of the staff's need to prepare the insulin pen, dial the prescribed dose and the resident would only

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S3085	Continued From page 5 injection the insulin by the pen.	S3085		
S3200 SS=D	26-41-205 (d) (1-2) Facility Administration of Medications (d) Facility administration of resident ' s medications. If a facility is responsible for the administration of a resident ' s medications, the administrator or operator shall ensure that all medications and biologicals are administered to that resident in accordance with a medical care provider ' s written order, professional standards of practice, and each manufacturer ' s recommendations. The administrator or operator shall ensure that all of the following are met: (1) Only licensed nurses and medication aides shall administer and manage medications for which the facility has responsibility. (2) Medication aides shall not administer medication through the parenteral route. This REQUIREMENT is not met as evidenced by: KAR 26-41-205 (d) The facility reported a census of 11 residents. The sample included 3 residents. Based on interview and record review licensed nurse/operator B failed to transcribe and/or clarify a medical care provider's orders for 1 of 3 sampled residents (#178) for whom the facility managed medications. Findings included:	S3200		

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- Record review for resident #178 revealed an admission date of 2/01/14 with diagnoses of hypertension, hypothyroidism, depression, chronic pain, overactive bladder and recurrent urinary tract infections, Parkinson's and seizure disorder.

The record included a document for a durable power of attorney for health care.

The annual functional capacity screen dated 1/22/19 identified the resident with intact cognition who needed physical assistance with transfers, mobility/walking, toileting and medication/treatment management.

The negotiated service agreement and care plan dated 1/22/19 directed staff to assist the resident with transfers, walking, toileting and to store, re-order, set-up and administer all medications per medication administration record (MAR).

Review of the medical care provider's orders dated 6/04/19 and compared to the June 2019 MAR revealed the MAR lacked the following orders: hydrocodone-acetaminophen 5-325 milligrams (mg) 1 or 2 tablets by mouth every 4 hours PRN (as needed) for pain, Urogesic-blue 81.6 mg 1 tablet by mouth 3 times a day PRN for bladder spasms.

Review of the nursing notes between 6/01/19 and 6/05/19 at 2:30 PM (last entry) revealed no information regarding why licensed nurse/operator B did not transcribe the orders or consult with the medical care provider about the orders for clarification or discontinuation if needed.

Interview on 6/13/19 at 11:10 AM with licensed

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S3200	Continued From page 7 nurse/operator B revealed he/she did not transcribe the hydrocodone-acetaminophen order to the MAR because the resident's family requested the resident not be given the hydrocodone-acetaminophen. He/she did not contact the medical care provider for an alternative or to convey the family wishes and have the medication discontinued. He/she reported the Urogesic-blue was not covered by the resident's insurance, so he/she did not transcribe the order to the MAR. He/she did not consult with the medical care provider to see if there was an alternative medication or other payment means for the resident. Licensed nurse/operator B failed to transcribe and/or clarify a medical care provider's orders for this resident for whom the facility managed his/her medications.	S3200		