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 _____	12/06/2022

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 represent the findings of a resurvey for the above named Home Plus facility conducted on 12/01/22, 12/05/22 and 12/06/22.	S 000		
S 110 SS=D	26-39-103 (c) NOTICE OF RIGHTS AND SERVICES (c) Notice of rights and services. (1) Before admission, the administrator or operator shall ensure that each resident or the resident's legal representative is informed, both orally and in writing, of the following in a language the resident or the resident ' s legal representative understands: (A) The rights of the resident; (B) the rules governing resident conduct and responsibility; (C) the current rate for the level of care and services to be provided; and (D) if applicable, any additional fees that will be charged for optional services. (2) The administrator or operator shall ensure that each resident or the resident ' s legal representative is notified in writing of any changes in charges or services that occur after admission and at least 30 days before the effective date of the change. The changes shall not take place until notice is given, unless the change is due to a change in level of care. This STANDARD is not met as evidenced by: KAR 26-39-103(c) (1)(A)(B)(C) The facility reported a census of 11 residents. Based on interview and record review the operator failed to ensure resident (R)101 was	S 110		

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
	N067008	A. BUILDING: _____ B. WING _____	12/06/2022

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 110	Continued From page 1 informed, both orally and in writing of the rights of the resident, the rules governing resident conduct and responsibility and the current rate for the level of care and services to be provided. Findings included: - R101 was admitted to the facility on 08/01/22 with a diagnosis of COPD. Review of R101's medical records failed to locate documentation that R101 was informed of the rights of the resident, the rules governing resident conduct and responsibility and the current rate for the level of care and services to be provided. On 12/06/22 at 11:50 AM Administrative Staff A stated she was not able to locate the admissions paperwork for R101. The operator failed to ensure R101 was informed of his rights as a resident, the rules governing resident conduct and the current rate for the level of care and services to be provided.	S 110		
S5230 SS=F	26-42-207 (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	S5230		

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 _____	12/06/2022

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
S5230	Continued From page 2 care setting; (c) Each administrator or operator shall ensure the home ' 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 26-42-207(c) The facility reported a census of 11 residents. Based on interview and record review the operator failed to ensure the facility remained in compliance with the department's tuberculosis (TB) guidelines for adult care homes adopted by reference in KAR 26-39-105. Findings included: - Review of Certified Nurse Aide (CNA) D's employee record revealed a hire date of 10/26/22. The facility failed to ensure a TB Screening Questionnaire was completed and the two-step TB skin test (TST) was initiated on 11/14/22 which was 12 days late. On 12/05/22 at 01:50 PM Licensed Nurse (LN) B stated a TB Screening Questionnaire should be completed and a TST should be initiated within seven days of staff being hired. 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 Tuberculosis Symptom Screen Questionnaire	S5230		

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 _____	12/06/2022

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
S5230	Continued From page 3	S5230		

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 operator failed to ensure the facility remained in compliance with the department's tuberculosis guidelines for adult care homes adopted by reference in KAR 26-39-105 regarding newly hired employees.

- Resident (R)102 was admitted to the facility on 03/24/22 with a diagnosis of dementia.

Review of R102's medical records revealed a two-step TST was not completed upon admission to the facility.

The 09/02/22 "Nurses' Notes" documented R102 returned to the facility from the hospital.

There was no documentation a TB Screening Questionnaire was completed for R102 upon returning to the facility after being hospitalized.

On 12/06/22 at 01:02 PM LN B stated she was not able to locate a two-step TST in R102's medical chart. LN B acknowledged that a two-step TST was not completed upon admission to the facility. LN B stated R102 had been admitted to the hospital during her residency at the facility and stated she was not aware a TB Screening Questionnaire needed to be completed for R102 upon returning from a hospitalization.

The June 2013 "Tuberculosis (TB) Guidelines for Adult Care Homes" documented, " ...Each new

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 _____	12/06/2022

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
S5230	Continued From page 4 resident ...shall receive a two-step TST or an IGRA for Mycobacterium tuberculosis within 7 days of residency ...Each resident shall have a TB Symptom Screen Questionnaire completed upon return from a hospitalization ..." The operator failed to ensure the facility remained in compliance with the department's tuberculosis guidelines for adult care homes adopted by reference in KAR 26-39-105.	S5230		
S5250 SS=D	26-42-105 (f) (1 - 10) Resident Records Content (f) Each resident record shall contain at least the following: (1) The resident's name; (2) the dates of admission and discharge; (3) the admission agreement and any amendments; (4) the functional capacity screenings; (5) the health care service plan, if applicable; (6) the negotiated service agreement and any revisions; (7) the name, address, and telephone number of the physician and the dentist to be notified in an emergency; (8) the name, address, and telephone number of the legal representative or the individual of the resident's choice to be notified in the event of a significant change in condition; (9) the name, address, and telephone number of the case manager, if applicable; (10) records of medications, biologicals, and treatments administered and each medical care provider ' s order if the facility is managing the resident's medications and medical treatments; and	S5250		

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 _____	12/06/2022

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
S5250	Continued From page 5 This REQUIREMENT is not met as evidenced by: KAR 26-42-105(f)(3) The facility reported a census of 11 residents. Based on interview and record review the operator failed to ensure resident (R)101's records contained the admission agreement and any amendments. Findings included: - R101 was admitted to the facility on 08/01/22 with a diagnosis of COPD. Review of R101's records failed to locate an admission agreement completed upon admission to the facility. On 12/06/22 at 11:50 AM Administrative Staff A stated she was not able to locate the admission agreement for R101. The operator failed to ensure R101's records contained an admission agreement.	S5250		
S5313 SS=F	26-42-205 (g) (3) Over the counter medication (g) (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	S5313		

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 _____	12/06/2022

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
S5313	Continued From page 6	S5313		

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:
KAR 26-42-205 (g)(3)

The facility reported a census of 11 residents. Based on observation 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 medications for four residents. A total of seven containers of medications were not labeled.

Findings included:

- Observation on 12/01/22 at 01:34 PM revealed the medication room and medication cart contained the following over-the counter medications which were not labeled with a resident's full name:

Resident (R)109:
A bottle of Spring Valley Iron 65 milligrams (mg) with no name.
A bottle of Spring Valley Magnesium 400 mg with no name.

R110:

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 _____	12/06/2022

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
S5313	Continued From page 7 A bottle of Tylenol 325 mg with no name. R111: A bottle of Leader 8hr Muscle Aches and Pain with no name. A bottle of Rugby Vitamin D3 with no name. A bottle of Spring Valley Melatonin 1 mg with no name. R112: A container of Natrol Melatonin 10 mg with no name. On 12/01/22 at 01:36 PM License Nurse B acknowledged all over-the-counter medications belonging to residents were to be labeled with the resident's full name. The operator failed to ensure all over-the-counter medications were labeled with the resident's full name.	S5313		
S5325 SS=E	26-42-205 (l) Medication Regimen Review Frequency (l) Medication regimen review. A licensed pharmacist or licensed nurse shall conduct a medication regimen review at least quarterly for each resident whose medication is managed by the home and each time the resident experiences any significant change in condition. This REQUIREMENT is not met as evidenced by:	S5325		

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 _____	12/06/2022

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
S5325	Continued From page 8 KAR 26-42-205(l) The facility reported a census of 11 residents. Based on interview and record review the operator failed to ensure a licensed pharmacist or license nurse conducted a medication regimen review (MRR) at least quarterly for each resident (R) whose medication was managed by the facility. Findings included: - Resident (R)102 was admitted to the facility on 03/24/22 with a diagnosis of dementia. Review of R102's medical records failed to locate documentation of quarterly MMRs completed. On 12/06/22 at 10:37 AM Licensed Nurse (LN) B stated, the pharmacist hasn't completed quarterly pharmacy reviews for any of the residents. The operator failed to ensure quarterly medication regimen reviews were completed for R102. - R101 was admitted to the facility on 08/01/22 with a diagnosis of COPD. Review of R101's medical records failed to locate documentation of quarterly MMRs completed. On 12/06/22 at 10:37 AM Licensed Nurse (LN) B stated, the pharmacist hasn't completed quarterly pharmacy reviews for any of the residents. The operator failed to ensure quarterly	S5325		

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 _____	12/06/2022

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
S5325	Continued From page 9 medication regimen reviews were completed for R101.	S5325		