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 _____	08/08/2023

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 complaint investigation #177944, 177978 and 181967 at the above named residential care facility conducted on 08/07/23 - 08/08/23.	S 000		
S3026 SS=J	26-41-101 (f) (1) Staff Treatment of Residents ANE (f)The administrator or operator shall ensure that all of the following requirements are met: (1) No resident shall be subjected to any of the following: (A) Verbal, mental, sexual, or physical abuse, including corporal punishment and involuntary seclusion; (B) neglect; or (C) exploitation. This REQUIREMENT is not met as evidenced by: KAR 26-41-101(f)(1)(B) The facility reported a census of 12 residents. The facility identified one resident at risk for elopement. Based on observation, interview and record review the operator failed to ensure resident (R)101 was not subjected to neglect by the failure to ensure the East Hall exit door properly latched when closed and the front entrance door had an adequate alarm in place to notify staff when a resident at risk for elopement exited the building without staff being aware. This resulted in cognitively impaired R101 exiting the facility and being unaccounted for by staff for approximately one hour.	S3026		

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

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S3026	Continued From page 1 Findings included: - R101's medical record revealed the resident moved into the facility on 07/17/23 with a diagnosis of dementia. R101's "Functional Capacity Screen/ Negotiated Service Agreement/Health Care Service Plan " (FCS/ NSA/HCSP) dated 07/17/23 revealed he was independent with transfers and mobility, had a cognitive score of four indicating he was severely cognitively impaired and triggered for impaired decision making. He was identified as an elopement risk due to a history of eloping and he tended to wander. No interventions were included to describe what staff were to do to help prevent R101 from eloping. Review of R101's medical record revealed the following: 08/02/23 at 06:00 AM a "Nursing Note" by Licensed Nurse (LN) B documented: Upon arrival to the facility Certified Nurse Aide (CNA) F notified the nurse that since 05:45 AM she could not find R101. Staff looked in all rooms and outside of the building but was unable to locate R101. 08/02/23 at 06:15 AM a "Nursing Note" by LN B documented, "Call made to police department regarding missing resident. Description given. They said they had a call shortly ago regarding someone walking down road ...deputy on the way to the area." 08/02/23 at 06:40 AM a "Nursing Note" by LN B documented the police located R101 a little way	S3026		

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S3026	Continued From page 2	S3026		

down the road. CNA F went to get R101.

08/02/23 at 07:00 AM a "Nursing Note" by LN B documented R101 arrived at the facility. Thirty-minute checks were initiated, and a sign was placed by R101's door to remind him to let someone know if he goes outside.

An observation on 08/07/23 at 02:50 PM revealed the facility was in a quiet, rural residential neighborhood. The road in front of the facility was paved, did not have any sidewalks, there were no streetlights observed, there was little to no traffic, and the speed limit was 30 miles per hour. Weather conditions at the time of the elopement as verified on https://www.wunderground.com/ revealed it was still dark outside, the temperature was 80 degrees Fahrenheit, and there was no noted precipitation occurring.

An observation on 08/07/23 at 03:45 PM R101 got up from the living room table he was sitting at and headed towards the front entrance. Administrative Staff A came from her office and asked R101 if he wanted to go outside. R101 stated no and said he was just looking for his car. Administrative Staff A redirected R101 back to his room.

An observation on 08/07/23 at 04:11 PM R101 independently walked to the front door and asked staff who were present if he could go "outside to soak up some sunshine". Staff agreed and went outside with R101.

An observation on 08/08/23 at 11:25 AM the East Hall door was fitted with a keypad lock. CMA D

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S3026	Continued From page 3	S3026		

stated the door required a combination to unlock the door, but during the observation she was able to open the door without entering the code. This door led out to a porch where residents frequently went out to smoke or visit with each other.

On 08/08/23 at 11:13 AM CMA D stated before the elopement incident on 08/02/23, R101 would occasionally go outside by the front of the building to pull weeds in the flowerbeds. This area was not fenced in, there were parking spaces for vehicles and there was a very long driveway leading to a paved rural residential road. CMA D stated she only found out about the alarm feature on the front door chime after the elopement incident. CMA D stated R101 tried to go out of the building through the other exits and stated the East door had a keypad needed to unlock the door but it did not always latch when other residents went outside using this door.

On 08/08/23 at 11:32 AM CMA E stated R101 was very disoriented when he first arrived at the facility and would stack his belongings in preparation to go home. CMA E stated R101 would say he needed to go home to eat, or looked for his car and thought his home was down the street. CMA E stated this went on for about a week after he arrived at the facility. CMA E stated the East Hall door was occasionally not completely latched when the other cognitively intact residents frequently went outside. CMA E stated he was aware of the alarm feature on the front door prior to the elopement incident but commented the front door "alarm" was not quite as piercing as the West door alarm. CMA E stated since the elopement incident, staff were

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instructed to activate the alarm feature on the front door but when asked to demonstrate how this was done, CMA E was not able to activate the alarm feature on the front door. CMA E stated after the elopement incident he has had to physically stand in front of the front door to prevent R101 from leaving through the door.

On 08/08/23 at 07:00 PM "Certified Nurse Aide" CNA F stated she was on duty by herself the night of the elopement on 08/02/23. CNA F stated she was not told R101 was an elopement risk. CNA F stated on the night of the elopement R101 was very adamant about going home and looked for his car. CNA F stated R101 first started leaving his room at approximately 01:00 AM after he was already in bed asleep. CNA F stated from then on R101 on was up and down approximately every 15-20 minutes and would head towards the front door. CNA F stated the last time she redirected R101 back to his room was at approximately 05:00 AM and after 30 minutes she went to the laundry room to attend to resident laundry and checked on another resident whose bed alarm sounded. CNA F stated the door chime worked at the time of the incident but stated she never heard the door chime go off when R101 exited the building. CNA F stated she went to R101's room to put away some laundry of his that she had folded and found R101 was not in his room. She checked the other resident's rooms, the public bathroom and the kitchen looking for the resident. CNA F stated she called Licensed Nurse (LN) B about 05:45 AM who arrived at the facility about 06:00 AM. LN B drove around looking for R101 but was unable to locate him so she called the police. CNA F stated the police called the facility about

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S3026	Continued From page 5 06:30 AM to say they found R101 about one half of a mile east of the facility. CNA F stated R101 was unaccounted for about 45 minutes or less. On 08/07/23 at 4:40 PM LN B stated when R101 first arrived at the facility he was confused and roamed throughout the facility, would go outside, pull weeds in the front yard as that is what he did at home. LN B stated during the first week of being at the facility, R101 stated he wanted to go home, and packed and unpacked his belongings. LN B stated the resident had a low blood sugar upon returning to the facility on the morning of 08/02/23 and was confused. On 08/08/23 at approximately 11:40 AM Administrative Staff A stated the front door had an alarm setting, but when asked to demonstrate, she was unable to change the door chime to the alarm setting. On 08/09/23 a policy on elopement prevention was requested from Administrative Staff A but was told the facility did not have one. The operator failed to ensure R101 was not subjected to neglect when the operator failed to ensure exit doors were properly latched and door "alarms" were functioning and set. This resulted in cognitively impaired R101 exiting the facility and being unaccounted for by staff for approximately one hour. On 08/08/23 at 12:03 PM Administrative Staff A was informed of the findings which resulted in immediate jeopardy regarding a cognitively impaired resident exiting the facility, failure of staff to ensure the East Hall exit door properly latched when closed and failed to ensure the	S3026		

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S3026	Continued From page 6 front entrance door had an adequate alarm in place to notify staff when a resident at risk for elopement exited the building without staff being aware. Administrative Staff A submitted an abatement plan which included the following: Elopement Monitoring: Thirty-minute checks on R101 started upon his return to the facility starting on 08/02/23 at 07:00 AM. Placement of sign: A sign reminding R101 to notify staff when he wanted to leave the building was posted in his room by the door on 08/02/23. Door Repair: East exit door latch fixed to allow the door to properly lock when closed completed on 08/08/23. Staff In-service / Education: Staff were educated on elopement policy and procedures starting 08/08/23. The immediate jeopardy was abated on 08/08/23 at 05:08 PM based on the facility's plan of correction and approved by the department.	S3026		
S3101 SS=D	26-41-202 (h) NSA Signatures (h) Each individual involved in the development 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.	S3101		

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S3101	Continued From page 7 This REQUIREMENT is not met as evidenced by: KAR 26-41-202(h) The facility had a census of 12 residents. Resident (R)101 was included in an abbreviated record review. The facility failed to ensure each individual involved in the development of R101's combined "Functional Capacity Screen/Negotiated Service Agreement/Healthcare Service Plan" (FCS/NSA/HCSP) signed the agreement. Findings included: - R101 admitted to the facility on 07/17/23. The 07/17/23 FCS/NSA/HCSP revealed R101 was cognitively impaired and did not include the signature of his legal representative or the facility operator. On 08/08/23 at 04:08 PM Administrative Staff C acknowledged R101's FCS/NSA/HCSP was not signed by R101's legal representative or the operator. Administrative Staff C stated the nurse who developed the FCS/NSA/HCSP did not pass it on for other signatures and said she expected all required signatures to be obtained at the time the FCS/NSA/HCSP was completed. The operator failed to ensure the FCS/NSA/HCSP was signed by the resident's legal representative.	S3101		
S3102 SS=D	26-41-202 (i) Negotiated Service Agreement Service Received	S3102		

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S3102	Continued From page 8 (i) Each administrator or operator shall ensure that each resident receives services according to the provisions of that resident ' s negotiated service agreement This REQUIREMENT is not met as evidenced by: KAR 26-41-202(i) The facility reported a census of 12 residents. Based on interview and record review the operator failed to ensure that each resident received services according to the provisions of that resident's combined "Functional Capacity Screen/Negotiated Service Agreement/Healthcare Service Plan" (FCS/NSA/HCSP) by not honoring resident (R)102's legal representative's choice of pharmacy where prescribed medications were purchased. Findings included: - Review of R102's medical record revealed she was admitted to the facility on 02/01/23 with diagnoses of dementia and multiple sclerosis. The 02/01/23 FCS/NSA/HCSP documented "Medicine Shoppe" as the pharmacy of R102's choice. Review of R101's medical records revealed a face sheet which identified the "Medicine Shoppe" as the pharmacy of choice. On 08/07/23 at 06:45 PM R102's legal	S3102		

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S3102	Continued From page 9 representative stated R102 previously used "The Medicine Shoppe Pharmacy" to fill her medication prescriptions. The facility wanted to use "Cardinal Drug Store" and asked R102's legal representative if they could switch pharmacies but R102's legal representative denied the facility's request. R102's legal representative stated the facility did not honor her request and filled R102's medications through "Cardinal Drug Store" without her permission. On 08/08/23 at 02:35 PM Pharmacist G verified that "Cardinal Drug Store" filled R102's medications on 02/03/23 per facility staff's request. On 08/09/23 at 04:16 PM Administrative Staff A stated that upon admission the facility lets the resident choose what pharmacy they would like and give them a copy of their "Resident Rights." The operator failed to ensure that R102 received services according to the provisions of the combined FCS/NSA/HCSP by not honoring R102's legal representative's choice of pharmacy where prescribed medications were purchased.	S3102		
S3201 SS=D	26-41-205 (d) (3) Facility Administration of Medication (3) A licensed nurse or medication aide shall perform the following: (A) Administer only the medication that the licensed nurse or medication aide has personally prepared; (B) identify the resident before medication is administered;	S3201		

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S3201	Continued From page 10 (C) remain with the resident until the medication is ingested or applied; and (D) document the administration of each resident ' s medication in the resident ' s medication administration record immediately before or following completion of the task. If the medication administration record identifies only time intervals or events for the administration of medication, the licensed nurse or medication aide shall document the actual clock time the medication is administered. This REQUIREMENT is not met as evidenced by: KAR 26-41-205 (d) (3)(B) The facility reported a census of 12 residents. Based on interview, and record review the operator failed to ensure staff verified the medication being administered belonged to the resident prior to administration of the medication, which resulted in R102 receiving double the amount of a prescribed medication each day for three days total. Findings included: - Review of R102's medical record revealed she was admitted to the facility on 02/01/23 with diagnoses of dementia and multiple sclerosis. The 02/01/23 combined "Functional Capacity Screen/Negotiated Service Agreement/Healthcare Service Plan" (FCS/NSA/HCSP) identified R102 required	S3201		

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S3201	Continued From page 11 physical assistance with management of her medications and facility staff administered all her medications. Review of R102's medical records revealed the following: A physician's order dated 12/16/22 for Donepezil (cognition enhancing medication) 5 milligrams (mg.), take one tablet every day by oral route. The February 2023 "Medication Administration Record" (MAR) documented administration of Donepezil 5 mg. twice daily at 08:00 AM and at 08:00 PM resulting in R102 receiving double the prescribed amount of this medication on 02/02/23, 02/03/23 and 02/04/23. Review of the "Rx Incident Report Form" from "Cardinal Drugstore" dated 02/03/23 revealed a bubble pack of Donepezil 5 mg. filled for a resident who lived at a different facility was delivered to R102's facility in error. On 08/07/23 at 06:45 PM R102's legal representative stated the facility messed up R102's medications. R102's legal representative stated according to the physician's order R102 was to only receive one dose of Donepezil 5 mg. daily. R102's legal representative stated that R102's MAR documented she received Donepezil 5 mg. once at 08:00 AM and again at 08:00 PM. R102's legal representative stated that she found a medication bubble pack containing the same prescription order for Donepezil but belonged to a resident who lived in a different facility with some pills missing from the bubble pack.	S3201		

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S3201	Continued From page 12 On 08/08/23 at 03:00 PM Pharmacist G stated there was an incident where an order for Donepezil 5mg. once daily for a resident at a different facility was mistakenly sent to [this facility]. Pharmacist G stated there were some pills missing from the bubble pack but didn't know why the facility would sign-off on this medication and administer the medication to the wrong resident." On 08/08/23 at 04:16 PM Administrative Staff C stated the Donepezil 5 mg. meant for another resident was incorrectly sent to this facility. Administrative Staff C stated, according to the report she received from nursing staff at the time of this incident, no pills from this bubble pack were ever administered to R102 and was returned to the pharmacy. The "Kansas Certified Medication Aide Curriculum" p. 171 documented, "Always follow the "7 Rights" of Medication Administration...1. Right resident--always make a positive identification of the resident. 2. Right medication...Read the label three times..." The operator failed to ensure staff followed professional standards of practice when administering medications to R102 by not verifying the medication being given belonged to R102 before it was administered to her.	S3201		