STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N006001	A. BUILDING: _____ B. WING _____	C 10/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUEST HOME ESTATES VI	737 HEYLMAN STREET FORT SCOTT, KS 66701

(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 are the result of a survey for re-licensure with attached complaints 156671, 156531 and 15683 conducted on 10/12/20, 10/13/20, 10/14/20, 10/15/20 and 10/19/20 at the above named assisted living facility in Fort Scott, KS.	S 000		
S3085 SS=D	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)(2) The facility reported a census of 27 residents. The sample included 3 residents. Based on record review and interview for 1 (#113) sampled resident requiring health care services, the administrator failed to ensure that a licensed	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
	N006001	A. BUILDING: _____ B. WING _____	C 10/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUEST HOME ESTATES VI	737 HEYLMAN STREET FORT SCOTT, KS 66701

(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		

nurse provides or coordinates the provision of necessary health care services that meet the needs of each resident and are in accordance with the functional capacity screening and the negotiated service agreement.

Findings included:

- Record review for resident #113 recorded admission date of 3-13-20 with diagnoses including diabetes, gastroesophageal reflux disease, seasonal allergies, anxiety and depression.

Functional Capacity screen dated 3-13-20 recorded resident required supervision with bathing, physical assistance with management of medications and supervision of medical treatments.

Negotiated service agreement/ health care service plan (NSA/HCSP) dated 3-13-20 recorded resident independent with medication management and independent with medical treatments.

October 2020 medication administration record recorded 18 medications and 0 treatments documented as administered by staff from October 1, 2020 to October 13,2020.

Interview with licensed nurse #B on 10-15-20 at 11:20 AM confirmed resident's NSA/HCSP lacked a description of the service for administration of medications and treatments by facility staff.

For resident #113 the administrator failed to ensure the written negotiated service agreement was based on the resident's functional capacity

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N006001	A. BUILDING: _____ B. WING _____	C 10/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUEST HOME ESTATES VI	737 HEYLMAN STREET FORT SCOTT, KS 66701

(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 screening with a description of the services the resident was receiving and identification of the provider of the services.	S3085		
S3165 SS=F	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 27 residents. The sample included 3 residents. Based on record review and interview, for all residents, the administrator failed to ensure the negotiated service agreement contained the name of the licensed nurse responsible for the implementation and supervision of the health care service plan for residents who required health care services. Findings included: - Record review for resident #112 recorded admission date of 1-30-17 with diagnoses including chronic obstructive pulmonary disease and multiple sclerosis. Functional Capacity screen dated 12-26-19 recorded resident requires assistance with	S3165		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N006001	A. BUILDING: _____ B. WING _____	C 10/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUEST HOME ESTATES VI	737 HEYLMAN STREET FORT SCOTT, KS 66701

(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 3 bathing, dressing, toileting, transfers, mobility, management of medications and management of medical treatments. Negotiate service agreement/health care service plan dated 12-26-19 recorded staff to assist with bathing, dressing, toileting, transfers, mobility and medication management. Negotiated service agreement/health care service plan lacked the name of the currently employed licensed nurse responsible for the implementation and supervision of the plan. Record review for resident #113 recorded admission date of 3-13-20 with diagnoses including diabetes, gastroesophageal reflux disease, seasonal allergies, anxiety and depression. Functional Capacity screen dated 3-13-20 recorded resident requires supervision with bathing and staff assistance with management of medications and supervision of medical treatments. Negotiated service agreement/ health care service plan dated 3-13-20 recorded resident as independent with medication management and independent with medical treatments. Review of resident medication administration record for October 2020 confirm staff providing assistance with medication management and medical treatments. Negotiated service agreement/health care service plan lacked the name of the currently employed licensed nurse responsible for the implementation	S3165		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N006001	A. BUILDING: _____ B. WING _____	C 10/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUEST HOME ESTATES VI	737 HEYLMAN STREET FORT SCOTT, KS 66701

(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 4 and supervision of the plan. Record review for resident #114 recorded admission date of 9-17-20 with diagnoses including diabetes, chronic kidney disease, obesity and osteoarthritis. Functional Capacity screen dated 9-17-20 recorded resident unable to perform management of medications and supervision of medical treatments. Negotiated service agreement/ health care service plan dated 9-17-20 recorded staff to assist with medication management and independent with medical treatments. Negotiated service agreement/health care service plan lacked the name of the currently employed licensed nurse responsible for the implementation and supervision of the plan. Interview on 10-15-20 at 11:16 AM Licensed Nurse #B confirmed name of licensed nurse on the care plan is not a current employee of facility and the care plan and the NSA lacked the name of licensed nurse #B as responsible for the implementation and supervision of the health care services plan. For all residents, the administrator failed to ensure the negotiated service agreement contained the name of the licensed nurse responsible for the implementation and supervision of the health care service plan.	S3165		
S3175 SS=D	26-41-205 (a) (1) Self Administration of Medication	S3175		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N006001	A. BUILDING: _____ B. WING _____	C 10/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUEST HOME ESTATES VI	737 HEYLMAN STREET FORT SCOTT, KS 66701

(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
S3175	Continued From page 5 (a) Self-administration of medication. Any resident may self-administer and manage medications independently or by using a medication container or syringe prefilled by a licensed nurse or pharmacist or by a family member or friend providing this service gratuitously, if a licensed nurse has performed an assessment and determined that the resident can perform this function safely and accurately without staff assistance. (1) An assessment shall be completed before the resident initially begins self-administration of medication, if the resident experiences a significant change of condition, and annually. This REQUIREMENT is not met as evidenced by: KAR 26-41-205(a)(1) The facility reported a census of 27 residents. The sample included 3 residents. Based on record review and interview for 1 (#114), of two sampled residents who self-administer insulin, the Administrator failed to ensure a licensed nurse performed an assessment of the resident's ability to safely and accurately self-administer medications. Findings included: - Record review for resident #114 recorded admission date of 9-17-20 with diagnoses including diabetes, chronic kidney disease, obesity and osteoarthritis.	S3175		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N006001	A. BUILDING: _____ B. WING _____	C 10/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUEST HOME ESTATES VI	737 HEYLMAN STREET FORT SCOTT, KS 66701

(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
S3175	Continued From page 6 Functional Capacity screen dated 9-17-20 recorded resident unable to perform management of medications and required supervision of medical treatments. Negotiated service agreement/ health care service plan dated 9-17-20 recorded resident required assistance with medication management and was independent with medical treatments. Review of MAR (Medication Administration Record) recorded physician's order for Insulin, Tresiba Flexpen, 10 units subcutaneously, daily at 8:00AM and Humalog U-100 Insulin subcutaneously 3 times a day, inject 25 units prior to meals 8:00AM, 12:00PM and 5:00PM. Interview with licensed nurse #B on 10/15/20 at 11:15AM confirmed Certified Medication Aides or Nurse dials insulin pen to ordered dose and resident #114 self-injects the insulin. Record lacked an assessment of competency completed by a licensed nurse prior to resident self-injecting insulin. For resident #114, the Administrator failed to ensure a licensed nurse performed an assessment of the resident's ability to safely and accurately self-administer medications.	S3175		
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	S3200		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N006001	A. BUILDING: _____ B. WING _____	C 10/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUEST HOME ESTATES VI	737 HEYLMAN STREET FORT SCOTT, KS 66701

(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
S3200	Continued From page 7	S3200		

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 census equaled 27 the sample included 3 residents. Based on interviews and review of facility records for 1 resident (#112) the administrator failed to ensure the resident record contained documentation of medication administration and medical treatments.

Findings included:

- Record review for resident #112 recorded an admission date of 1/30/17 with diagnosis of Chronic Obstructive Pulmonary Disease, and Multiple Sclerosis.

October 2020 medication administration record (MAR) recorded: Right buttock, cleanse with NS (normal saline), pat dry, apply Medihoney (wound gel), gauze dressing, tape in place. Change daily, HH (home health) does on Friday.

Right heel: Cleanse with NS, pat dry, coat with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N006001	A. BUILDING: _____ B. WING _____	C 10/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUEST HOME ESTATES VI	737 HEYLMAN STREET FORT SCOTT, KS 66701

(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
S3200	Continued From page 8 Betadine (antiseptic), dry, cover with clean sock. Change QD (every day) HH on Friday. Record lacked documentation by certified medication aides and licensed nurses of the treatments being completed according to doctor's orders, from 10-1-20 to 10-15-20. Interview with licensed nurse #C on 10-15-20 at 11:40AM confirmed record lacked documentation from certified medication aides and licensed nurses of documentation of the medical treatments as ordered. For resident (#112), the administrator failed to ensure all medications and treatments were administered in accordance with a medical care provider's written order, professional standards of practice and each manufacturer's recommendations.	S3200		
S3202 SS=E	26-41-205 (d) (4) Delegation of Medication Administration (4) Any licensed nurse may delegate nursing procedures not included in the medication aide curriculum to medication aides under the Kansas nurse practice act, K.S.A. 65-1124 and amendments thereto. This REQUIREMENT is not met as evidenced by: KAR 26-41-205(d)(4) The facility reported a census of 27 residents. The sample included 3 residents. Based on record review and interview for 2 sampled	S3202		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N006001	A. BUILDING: _____ B. WING _____	C 10/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUEST HOME ESTATES VI	737 HEYLMAN STREET FORT SCOTT, KS 66701

(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
S3202	Continued From page 9	S3202		

residents (#113 and #114) and 4 non-sampled residents (#115, #116, #117 #118) who received insulin injections and 2 sampled residents (#113 and #114) and 4 non-sampled residents (#115,#116, #117 and #118) who received Accuchecks (blood glucose) the administrator failed to ensure the licensed nurse delegated nursing procedures not included in the medication aide curriculum to medication aides under the Kansas nurse practice act, K.S.A. 65-1124 and amendments thereto when medication aides dialed insulin pens and performed accuchecks for the residents without an assessment for competency by a licensed nurse.

Findings included:

- Resident roster identified 6 residents as receiving insulin injections.

Record review for resident #113 recorded admission date of 3-13-20 with diagnoses including diabetes, gastroesophageal reflux disease, seasonal allergies, anxiety and depression.

Functional Capacity screen dated 3-13-20 recorded resident unable to perform management of medications and required supervision of medical treatments.

Negotiated service agreement/ health care service plan dated 3-13-20 recorded resident as independent with medication management and independent with medical treatments.

October 2020 medication administration record (MAR) recorded:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N006001	A. BUILDING: _____ B. WING _____	C 10/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUEST HOME ESTATES VI	737 HEYLMAN STREET FORT SCOTT, KS 66701

(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
S3202	Continued From page 10	S3202		

Novolin N insulin (diabetes) 100 units/milliliter, inject 50 units subcutaneously at 7:30AM; May self-administer insulin after staff draws up dose. Medication documented as administrated by CMA's (certified medication aides) 3 of 13 days.

Novolin N insulin (diabetes) 100 units/milliliter, inject 50 units subcutaneously at 8:00PM; May self-administer insulin after staff draws up dose. Medication documented as administrated by CMA's 4 of 13 days.

Record review for resident #114 recorded admission date of 9-17-20 with diagnoses including diabetes, chronic kidney disease, obesity and osteoarthritis.

Functional Capacity screen dated 9-17-20 recorded resident unable to perform management of medications and required supervision of medical treatments.

Negotiated service agreement/ health care service plan dated 9-17-20 recorded resident required assistance with medication management and was independent with medical treatments.

October 2020 medication administration record (MAR) recorded:
Insulin Tresiba Flexpen Humulin (diabetes) 10 units subcutaneously every AM at 8:00AM

Medication documented as administrated by CMA's (certified medication aides) 3 of 13 days.

Humalog U100 insulin (diabetes) U-100 inject 25 units subcutaneously 3 times a day before meals.

Medication documented as administered by

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N006001	A. BUILDING: _____ B. WING _____	C 10/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUEST HOME ESTATES VI	737 HEYLMAN STREET FORT SCOTT, KS 66701

(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
S3202	Continued From page 11 CMA's at 8:00AM 4 of 13 days. Medication documented as administered by CMA's at 12:00PM 1 of 13 days. Medication documented as administered by CMA's at 5:00PM 4 of 13 days. On 10-14-20 at 10:05AM, Personnel review revealed 2 CMAs (#F #G) who dialed insulin pens for resident injections. Interview on 10/15/20 at 9:45AM with licensed nurse #C confirmed CMAs dial insulin pens for residents to self-administer. Interview on 10/15/20 at 10:05AMpm with licensed nurse #B confirmed CMAs dial insulin pens, and all CMA records lacked completed competency exams for the delegated task. The administrator failed to ensure the licensed nurse delegated nursing procedures not included in the medication aide curriculum to medication aides under the Kansas nurse practice act, K.S.A. 65-1124 and amendments thereto when medication aides dialed insulin pens for the residents without an assessment for competency by a licensed nurse.	S3202		
S3248 SS=F	26-41-102 (d) Staff Qualifications Employee Records (d) The employee records and agency staff records shall contain the following documentation: (1) Evidence of licensure, registration, certification, or a certificate of successful completion of a training course for each	S3248		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N006001	A. BUILDING: _____ B. WING _____	C 10/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUEST HOME ESTATES VI	737 HEYLMAN STREET FORT SCOTT, KS 66701

(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
S3248	Continued From page 12 employee performing a function that requires specialized education or training; (2) supporting documentation for criminal background checks of facility staff and contract staff, excluding any staff licensed or registered by a state agency, pursuant to K.S.A. 39-970 and amendments thereto; (3) supporting documentation from the Kansas nurse aide registry that the individual does not have a finding of having abused, neglected, or exploited a resident in an adult care home; and (4) supporting documentation that the individual does not have a finding of having abused, neglected, or exploited any resident in an adult care home, from the nurse aide registry in each state in which the individual has been known to have worked as a certified nurse aide. This REQUIREMENT is not met as evidenced by: KAR 26-41-102(d)(1)(2) The census equaled 27 the sample included 3 residents and 3 non sampled residents. Based on interviews and review of facility records, for 2 of 3 certified staff (#D and #E) and 1 of 2 non-certified staff (#H) the Administrator failed to ensure the employee record contained supporting documentation for criminal background checks and nurse aide registry checks. Findings included: - Review of personnel records on 10/14/20 for 2 certified staff and 1 non-certified staff revealed the following:	S3248		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N006001	A. BUILDING: _____ B. WING _____	C 10/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUEST HOME ESTATES VI	737 HEYLMAN STREET FORT SCOTT, KS 66701

(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
S3248	Continued From page 13 Certified staff #D (hire date 10/9/19). No record of date when KBI (Kansas Bureau of Investigations) request was made. Record shows KBI produced date of 1-24-19 (104 days after hire date). Certified staff #E (hire date 8/13/20). Record shows KBI requested date of 9/15/20 (33 days after hire date). Documentation lacked record of registry check. Non-Certified staff #H (hire date 8-18-20). Record shows KBI requested date of 9/15/20 (28 days after hire date). Interview on 10/14/20 at 9:15am with facility Administrator #A confirmed staff records lacked documentation of KBI checks and registry checks upon hire. For all residents of the facility. the Administrator failed to ensure the employee record contained supporting documentation for criminal background checks and nurse aide registry checks.	S3248		
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 admission to the facility regarding emergency procedures;	S3280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N006001	A. BUILDING: _____ B. WING _____	C 10/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUEST HOME ESTATES VI	737 HEYLMAN STREET FORT SCOTT, KS 66701

(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 14 (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 census equaled 27 the sample included 3 residents. Based on record review and interview for all residents, the administrator failed to ensure disaster and emergency preparedness when the administrator failed to ensure quarterly reviews of the facility's emergency management plan with employees and residents. Findings included: - On 10-14-20 review of facility's quarterly disaster and emergency plan recorded 10-9-18 the most recent review of the facility's disaster and emergency plan was completed with residents. Record lacked documentation of quarterly reviews of the emergency management plan completed with employees for 2019 and 2020. Interview with administer #A on 10-14-20 at 9:45AM confirmed records lacked documentation quarterly disaster and emergency plan reviews were completed with staff and residents.	S3280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N006001	A. BUILDING: _____ B. WING _____	C 10/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUEST HOME ESTATES VI	737 HEYLMAN STREET FORT SCOTT, KS 66701

(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 15 For all residents, the administrator failed to ensure disaster and emergency preparedness when the administrator failed to ensure quarterly reviews of the facility's emergency management plan with employees and residents.	S3280		
S3395 SS=F	28-39-255 LAUNDRY (c) Laundry facility. (1) The facility shall store soiled laundry in a manner which prevents odors and spread of disease. (2) If laundry is processed in the facility, the facility shall provide washing and drying machines. The facility shall arrange the work area to provide a "one-way flow" of laundry from a soiled area to a clean area. (3) The facility shall provide a work counter and a locked cabinet for storage of chemicals and supplies. (4) The facility shall provide a handwashing lavatory with a non-reusable method of hand-drying within or accessible to the laundry facility. This REQUIREMENT is not met as evidenced by: KAR 28-39-255(c)(3) The facility reported a census of 27 residents. The sample included 3 residents. Based on observation and interview for all residents, the administrator failed to ensure the facility was maintained to protect the health and safety of the	S3395		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N006001	A. BUILDING: _____ B. WING _____	C 10/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUEST HOME ESTATES VI	737 HEYLMAN STREET FORT SCOTT, KS 66701

(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
S3395	Continued From page 16 residents when chemicals were unsecured in a resident use area. Findings included: - Observation on 10-12-20 at 1:20pm revealed facility laundry room door was unlocked. Observation in laundry room revealed unlocked storage cabinet that contained 121 ounce bottle Clorox Bleach 1 pound container of Boric Acid 22 ounce bottle Bissell stain pretreat 24 ounce bottle Round up weed/grass killer 32 ounce bottle Windex 32 ounce bottle All-purpose rust, lime, calcium remover Two 81 ounce bottles low splash bleach 5 gallon bucket Acro-KLO bleach 5 gallon bucket Acro-Wash dishwashing liquid 5 gallon bucket Dri-Quick high rinse solution 265 ounce bottle Arm and Hammer Color Burst laundry detergent Resident roster recorded 10 residents had impaired cognitive status. Interview on 10/12/20 at 1:30pm with facility Administrator #A confirmed the laundry room door and chemical storage cabinet containing	S3395		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N006001	A. BUILDING: _____ B. WING _____	C 10/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUEST HOME ESTATES VI	737 HEYLMAN STREET FORT SCOTT, KS 66701

(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
S3395	Continued From page 17 chemicals were unlocked. Facility policy stated that chemicals will be locked. For all residents of the facility, the administrator failed to ensure the facility was maintained to protect the health and safety of the residents when chemicals were unsecured in a resident use area.	S3395		