STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N067009	A. BUILDING: _____ B. WING _____	09/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUEST HOME ESTATES II	1202 S PLUMMER 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 a resurvey of the above residential health care facility on 9/7/16, 9/8/16, and 9/12/16.	S 000		
S3028 SS=D	26-41-101 (f) (3) Staff Treatment of Residents Reporting (f) (3) Each allegation of abuse, neglect, or exploitation shall be reported to the administrator or operator of the facility as soon as staff is aware of the allegation and to the department within 24 hours. The administrator or operator shall ensure that all of the following requirements are met: (A) An investigation shall be started when the administrator or operator, or the designee, receives notification of an alleged violation. (B) Immediate measures shall be taken to prevent further potential abuse, neglect, or exploitation while the investigation is in progress. (C) Each alleged violation shall be thoroughly investigated within five working days of the initial report. Results of the investigation shall be reported to the administrator or operator. (D) Appropriate corrective action shall be taken if the alleged violation is verified. (E) The department ' s complaint investigation report shall be completed and submitted to the department within five working days of the initial report. (F) A written record shall be maintained of each investigation of reported abuse, neglect, or exploitation. This REQUIREMENT is not met as evidenced by: KAR 26-41-101(f)(3)	S3028		

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

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S3028	Continued From page 1 The facility reported a census of 20 residents. The sample included 3 residents. Based on record review and interview for 1 (#252) of 3 residents sampled, the operator failed to report to the department within 24 hours each time staff found the cognitively impaired resident on the floor. Findings included: - Record review for resident #252 revealed an admission date of 5/2/16 and diagnoses of dementia and diabetes mellitus type 2. The admission functional capacity screen dated 5/2/16 indicated the resident required supervision with toileting, transferring, mobility and dressing; physical assistance with bathing; experienced impaired short-term memory, long-term memory, decision making, and memory recall; and not at risk for falls. The record contained a significant change functional capacity screen dated 8/10/16 that indicated the resident required physical assistance with bathing, dressing, toileting, transferring, and mobility; experienced impaired short-term memory, long-term memory, decision making, and memory recall; and was at risk for falls. The negotiated service agreement/health care service plan (NSA/HCSP) dated 5/2/16 contained the following added services of: 5/25/16 Remind resident to call for help before getting up. 6/20/16 Family brought in "buddy bar" to help	S3028		

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S3028	Continued From page 2	S3028		

resident get up and out of bed.

7/20/16 Encourage resident to get close to wall when getting in bed.

8/1/16 Use wheelchair for distance and one-person transfer assistance.

8/4/16 Signs placed in room to remind resident to use call light, top sheet off bed, leave feet uncovered, frequent room check, and order for physical therapy.

The NSA/HCSP dated 8/10/16 documented one-person physical assistance with bathing, dressing, toileting, and transferring. Staff members to provide physical assistance to walk resident with walker and mobilize resident in a wheelchair for longer distances. The NSA/HCSP contained documentation under "Falls, unsteadiness" of one-person transfer assistance, uses walker or wheelchair, can take one to two steps with staff assistance.

Review of the nursing notes revealed the resident experienced 7 falls between 5/25/16 and 9/24/16 as follows:

5/25/16 at 10:00 a.m. licensed nurse B documented that at 4:00 a.m. resident rolled out of bed and was observed on floor beside bed. Resident stated (he/she) got tangled in sheets. Resident received a skin tear to left elbow.

7/27/16 at 4:45 a.m. a certified staff person documented finding resident on floor after resident rolled out of bed.

8/3/16 at 6:00 a.m. a certified staff person

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S3028	Continued From page 3 documented that at 4:05 a.m. heard resident calling out "Please help me" and found resident on floor next to bed. Resident stated (he/she) fell out of bed. 8/3/16 at 2:30 p.m. a certified staff person documented resident found on (his/her) bathroom floor. Resident ambulated to bathroom without assistance and fell hitting head. Nurse notified and resident to hospital by ambulance for evaluation. 8/4/16 at 11:25 a.m. licensed nurse B documented resident found on floor in middle of (his/her) room. Resident stated was going to lunch and knees gave out. 9/4/16 at 4:46 p.m. a certified staff person documented resident on floor in room. Resident stated (he/she) was trying to get to walker and fell. Licensed nurse B provided "Fall Investigation Report" completed for the times staff found resident on floor on 5/25/16, 7/27/16, 8/3/16, 8/4/16, and 9/4/16. The reports did not indicate the incidents were reported to the department. At 12:00 p.m. on 9/8/16, licensed nurse B stated the incidents were not reported to the department. The operator failed to report to the department within 24 hours each time staff found cognitively impaired resident #252 on the floor.	S3028		
S3155 SS=E	26-41-204 (a) Health Care Services . (a) The administrator or operator in each	S3155		

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S3155	Continued From page 4	S3155		

assisted living facility or residential health care facility shall ensure that a licensed 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.

This REQUIREMENT is not met as evidenced by:
KAR 26-41-204(a)

The facility reported a census of 20 residents. The sample included 3 residents. Based on record review, interview, and observation for 2 (#252 and #250) of 3 residents sampled, the operator failed to ensure the licensed nurse provided or coordinated the provision of necessary health care services that met the needs of each resident identified on the functional capacity screen to be at risk for falls. Based on record review and interview for 1 (#251) of 3 residents sampled, the operator failed to ensure the licensed nurse provided or coordinated the provision of necessary health care service of fluid restriction.

Findings included:

- Record review for resident #252 revealed an admission date of 5/2/16 and diagnoses of dementia and diabetes mellitus type 2.

The admission functional capacity screen dated 5/2/16 indicated the resident required supervision with toileting, transferring, mobility and dressing; physical assistance with bathing; experienced impaired short-term memory, long-term memory,

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S3155	Continued From page 5	S3155		

decision making, and memory recall; and not at risk for falls.

The record contained a significant change functional capacity screen dated 8/10/16 that indicated the resident required physical assistance with bathing, dressing, toileting, transferring, and mobility; experienced impaired short-term memory, long-term memory, decision making, and memory recall; and was at risk for falls.

The negotiated service agreement/health care service plan (NSA/HCSP) dated 5/2/16 contained the following added services of:

5/25/16 Remind resident to call for help before getting up.

6/20/16 Family brought in "buddy bar" to help resident get up and out of bed.

7/20/16 Encourage resident to get close to wall when getting in bed.

8/1/16 Use wheelchair for distance and one-person transfer assistance.

8/4/16 Signs placed in room to remind resident to use call light, top sheet off bed, leave feet uncovered, frequent room check, and order for physical therapy.

The NSA/HCSP dated 8/10/16 documented one-person physical assistance with bathing, dressing, toileting, and transferring. Staff members to provide physical assistance to walk resident with walker and mobilize resident in a wheelchair for longer distances. The NSA/HCSP

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S3155	Continued From page 6	S3155		

contained documentation under "Falls, unsteadiness" of one-person transfer assistance, uses walker or wheelchair, can take one to two steps with staff assistance.

Review of the nursing notes revealed the resident experienced 7 falls between 5/25/16 and 9/24/16 as follows:

5/25/16 at 10:00 a.m. licensed nurse B documented that at 4:00 a.m. resident rolled out of bed and was observed on floor beside bed. Resident stated (he/she) got tangled in sheets. Resident received a skin tear to left elbow.

6/6/16 at 11:30 a.m. licensed nurse B documented will contact family to obtained "buddy bar" for bed to assist resident with moving self in bed and getting in and out of bed.

7/27/16 at 4:45 a.m. a certified staff person documented finding resident on floor after resident rolled out of bed.

8/3/16 at 6:00 a.m. a certified staff person documented that at 4:05 a.m. heard resident calling out "Please help me" and found resident on floor next to bed. Resident stated (he/she) fell out of bed.

8/3/16 at 2:30 p.m. a certified staff person documented resident found on (his/her) bathroom floor. Resident ambulated to bathroom without assistance and fell hitting head. Nurse notified and resident to hospital by ambulance for evaluation.

8/4/16 at 11:25 a.m. licensed nurse B documented resident found on floor in middle of (his/her) room. Resident stated was going to

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S3155	Continued From page 7	S3155		

lunch and knees gave out.

9/4/16 at 4:46 p.m. a certified staff person documented resident on floor in room. Resident stated (he/she) was trying to get to walker and fell.

At 10:35 a.m. on 9/8/16, certified staff C stated he/she used a gait belt when transferring and walking short distances with resident and wheelchair for longer distances. Certified staff C stated he/she made certain resident had call light when resident in room and reminded resident to use call light. Certified staff C stated resident did at times remember to use call light to call for assistance.

During an interview at 12:00 p.m. on 9/8/16, licensed nurse B confirmed the resident's current NSA/HCSP lacked health care services to address the resident's risk for falls due to rolling out of bed and getting up without staff assistance.

At 12:35 p.m. on 9/8/16 accompanied licensed nurse B to the room of resident #252. Resident #252 was sitting in a recliner and stated "carelessness" as the cause of rolling out of bed. Observed a twin bed in the resident's room with one side of the bed against the wall. When asked if this was the same size bed resident slept in at home, resident stated he/she slept in a bigger bed at home. Observed a curved metal bar at the head of the bed that easily slid out from the bed when pushing against the bar. When asked resident how he/she summoned help when needed he/she pointed to a call cord coming from a wall. The cord had been extended to the recliner to enable resident to use to call for assistance when sitting in recliner. Did not observe a call cord by the resident's bed.

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S3155	Continued From page 8 The operator failed to ensure the licensed nurse provided or coordinated the provision of necessary health care services that met the needs of resident #252 identified on the functional capacity screen to be at risk for falls. - Record review for resident #250 revealed an admission date of 12/30/06 and diagnoses of congestive heart failure, hypertension, and anxiety. The functional capacity screen dated 12/16/15 indicated the resident required physical assistance with bathing, dressing, toileting, and transferring; supervision with mobility; utilized a walker; and experienced impaired short-term memory. The functional capacity screen did not indicate the resident was at risk for falls. The negotiated service agreement/health care service plan (NSA/HCSP) dated 12/16/15 documented the health care services of physical assistance with bathing, dressing, toileting, and staff to monitor resident when walking in halls. The NSA/HCSP contained documentation by licensed nurse D on 6/16/16 of resident on floor in room. No new changes to plan of care. On 8/15/16 licensed nurse B documented resident sitting on floor of room beside bed. New interventions of bright signs to remind resident to use call light, personal alarm on, frequent monitoring, and leave door open to resident's room. Review of the nursing notes revealed the following: 8/31/15 at 10:20 a.m. licensed nurse D documented certified staff reported resident fell in	S3155		

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room.

10/11/15 at 9:40 p.m. certified staff person documented resident found sitting on floor by bed. Resident stated (he/she) slid out of bed.

1/25/16 at 11:50 a.m. licensed nurse B documented resident fell when walking with walker to dining room.

2/2/16 at 12:30 p.m. certified staff documented resident fell in bathroom, hit head, and to hospital by ambulance for evaluation.

6/16/16 at 11:50 a.m. licensed nurse B documented resident found on floor of room.

7/5/16 at 9:30 a.m. certified staff documented resident on floor of room.

8/13/16 at 12:00 p.m. certified staff documented resident removed personal alarm and fell to floor in room.

9/8/16 at 9:00 a.m. licensed nurse B documented resident was transferring self from wheelchair to bed and slid to floor. Resident did not use call light. Resident stated (his/her) legs gave out.

During an interview at 10:45 a.m. on 9/8/16, certified staff C stated he/she encouraged resident to use call light for assistance, monitored when resident finished with meal and going back to room in order to help resident transfer from wheelchair to bed, personal alarm on resident at all times, one-person assistance with transfers using gait belt, and toileting assistance as interventions provided due to resident's risk for falls.

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S3155	Continued From page 10 At 11:35 a.m. on 9/8/16, licensed nurse B stated make certain call light within resident's reach, signs in room to remind resident to call for assistance, personal alarm on resident, door to resident's room open, and staff to check on resident frequently. Licensed nurse B stated staff were not instructed on how frequently to monitor resident and toilet resident. The operator failed to ensure the licensed nurse provided or coordinated the provision of necessary health care services that met the needs of resident #250 who experienced falls. - Record review for resident #251 revealed an admission date of 9/28/12 and diagnoses of congestive heart failure, coronary artery disease, atrial fibrillation, and diabetes mellitus type 2. The functional capacity screen dated 9/24/15 indicated the resident was independent with activities of daily living except required physical assistance with dressing; did not exhibit impaired cognition; and required physical assistance with management of medications. The functional capacity screen lacked a score for resident ' s ability to manage medical treatments. The negotiated service agreement/health care service plan (NSA/HCSP) dated 9/24/15 documented staff administered all medications except those managed by the resident as listed on medication administration record and staff monitored resident's vital signs, weight, and blood sugar level with glucometer. The resident's September 1 through September 30, 2016 medication administration record contained an entry of 2 liter fluid restriction daily due to congestive heart failure with a start date of	S3155		

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S3155	Continued From page 11 12/5/14 for monitoring fluid intake. The medication administration record lacked documentation to indicate staff monitored and measured the resident's fluid intake for each 24 hour period. During an interview at 11:50 a.m. on 9/8/16, licensed nurse B stated he/she did not know how staff monitored the resident's fluid intake. Licensed nurse B stated he/she did not monitor the resident's 24 hour fluid intake. Licensed nurse B confirmed the NSA/HCSP did not address the resident ' s fluid restriction. For resident #251, the operator failed to ensure the licensed nurse provided or coordinated the provision of necessary health care service of fluid restriction.	S3155		
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.	S3200		

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S3200	Continued From page 12 This REQUIREMENT is not met as evidenced by: KAR 26-41-205(d) The facility reported a census of 20 residents. The sample included 3 residents. Based on record review and interview for 1 (#252) of 3 residents sampled, the operator failed to ensure certified medication aides administered pain medication to the resident in accordance with professional standards of practice. Findings included: - Record review for resident #252 revealed an admission date of 5/2/16 and diagnoses of dementia and diabetes mellitus type 2. The admission functional capacity screen dated 5/2/16 and the significant change functional capacity screen dated 8/10/16 each indicated the resident required physical assistance with management of medications and experienced impaired short-term memory, long-term memory, decision making, and memory recall. The negotiated service agreement/health care service plans dated 5/2/16 and 8/10/16 documented the health care service of medication administration. Review of the September medication administration record (MAR) revealed the resident received Tramadol (opioid pain medication to treat moderate to severe pain) 50 milligrams 1/2 tablet by mouth every 8 hours as needed for pain. The MAR contained	S3200		

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S3200	Continued From page 13 documentation that resident received one dose of Tramadol on 9/1/16, 9/2/16, 9/3/16, and 9/6/16 and received 2 doses of Tramadol on 9/4/16 and 9/5/16. Review of the "PRN Medication Record" (documentation of medications administered on an as needed basis) dated 7/27/16 through 8/31/16 revealed resident received Tramadol 50 milligrams 1/2 tablet, Tylenol Arthritis 650 milligrams 2 tablets, and Mylanta 30 milliliters. Certified medication aides administered 1 to 2 doses of Tramadol every day from 7/28/16 through 8/31/16 except on 8/6/16 for "knee pain." Resident received Tylenol Arthritis 650 milligrams 2 tablets by mouth on July 27 and 31, 2016 and August 4, 8, 11, 13, 14, 17, 18, 19, 22, and 26, 2016 for leg pain or knee pain. Resident received Mylanta 30 milliliters by mouth on 8/28/16 and 8/31/16 for nausea. The PRN medication record and/or nursing notes lacked documentation of a licensed nurse assessment prior to the administration of these medications. During an interview at 10:35 a.m. on 9/8/16, certified staff C stated he/she did not notify the licensed nurse prior to administering pain medications to resident. Certified staff C stated he/she knew resident had pain in the morning and would go ahead and administer pain medication with routine morning medications. At 12:00 p.m. on 9/8/16, licensed nurse B stated certified medication aides administered the as needed medications without licensed nurse B assessing the resident. The operator failed to ensure certified medication aides administered pain medication to resident #252 in accordance with professional standards of practice.	S3200		