STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N067001S	A. BUILDING: _____ B. WING _____	07/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUEST HOME ESTATES VIII	114 E MARSHALL ERIE, KS 66733

(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 7/22/14, 7/23/14, and 7/24/14. Revised 2567 sent to facility 7/29/14.	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:	S3028		

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
	N067001S	A. BUILDING: _____ B. WING _____	07/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUEST HOME ESTATES VIII	114 E MARSHALL ERIE, KS 66733

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S3028	Continued From page 1 KAR 26-41-101(f)(3)(C) The facility reported a census of 26 residents. The sample included 3 residents. Based on record review and interview for 1 (#253) of 3 residents sampled, the operator failed to conduct a thorough investigation of the resident's elopement from the facility. Findings included: - Record review for resident #253 revealed an admission date of 4/27/11 and diagnoses of dementia, chronic obstructive pulmonary disease, coronary artery disease, hypertension, and muscle weakness. The functional capacity screen (FCS) dated 6/11/14 indicated the resident required supervision with transferring, walking, and eating; physical assistance with dressing and management of medications and treatments; was unable to perform bathing and toileting; and was frequently incontinent of urine. The FCS indicated the resident experienced impaired short-term memory, long-term memory, decision making, and memory recall; was at risk for falls; and exhibited wandering behavior. The negotiated service agreement (NSA) dated 6/11/14 documented a description of services provided by the facility for bathing, dressing, toileting, transferring, walking, eating, and management of medications and treatments. The NSA contained interventions of toileting assistance, pressure alarm on bed, alarm on door to resident room, and audio monitor in resident room as fall risk interventions. The NSA contained documentation of family or staff to assist with decision making and staff to monitor	S3028		

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	N067001S	A. BUILDING: _____ B. WING _____	07/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUEST HOME ESTATES VIII	114 E MARSHALL ERIE, KS 66733

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S3028	Continued From page 2	S3028		

frequently to address resident ' s impaired decision making. Licensed nurse documented by "wandering" section of NSA "Res (resident) has hx (history) of wandering when res has UTI (urinary tract infection). Preventive measures in place. Staff to report any mood disturbances to FN (facility nurse)." The NSA lacked a description of services for staff members to provide to manage the resident's wandering behavior to prevent elopement from the facility. Further review of the nurse's notes revealed the following entries:

7/20/14 at 3:00 p.m. licensed nurse documented that he/she was notified at 8:15 p.m. on 7/19/14 that resident has left the facility unsupervised and ambulated 2 blocks north on Main street. A passerby found resident who had fallen and passerby called emergency medical services. Licensed nurse arrived at the scene and observed that resident had a skin tear on right hand and eyeglasses were bent. Resident was taken by ambulance to the hospital for evaluation and did not have fractures or other injuries. Licensed nurse documented resident returned to the facility at 11:45 p.m. on 7/19/14. At 3:05 p.m. the licensed nurse documented that urinalysis on 7/14/14 did not indicate a urinary tract infection.

At 3:35 p.m. on 7/22/14, asked the operator if he/she had begun the written facility investigation of the resident's elopement. Operator provided a "fall investigation" and "conclusion of investigation" forms completed by the licensed nurse. The investigation lacked written statements or written interviews of the staff members on duty on 7/19/14 at the time of the elopement. The investigation lacked documentation of when staff members last saw the resident and a conclusion of what contributed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N067001S	A. BUILDING: _____ B. WING _____	07/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUEST HOME ESTATES VIII	114 E MARSHALL ERIE, KS 66733

(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
S3028	Continued From page 3	S3028		

to the resident's ability to leave the facility without staff awareness.

During an interview at 3:55 p.m. on 7/22/14, CMA #B stated he/she was working the 2:30 p.m. to 10:30 p.m. shift on 7/19/14 and did not know resident had left the building until he/she received a call from the licensed nurse between 8:10 p.m. and 8:15 p.m. CMA stated he/she had been in resident rooms providing care and last saw resident #253 around 7:50 p.m. to 8:00 p.m. CMA #B stated door alarms were on all exit doors except for the kitchen door which only had the "doorbell" alarm on.

At 4:07 p.m. on 7/22/14, certified nursing assistant (CNA) #C stated he/she last saw resident in the building at a little after 7:00 p.m. on 7/19/14. CNA #C stated (resident #254) was walking resident (#253) down the hall and CNA #C met them by the laundry room door. CNA #C explained that resident had gone into resident's (#254) room and when this happened resident (#254) would put on call light or bring resident (#253) to the CNA. CNA #C stated he/she walked resident (#253) back to his/her room, located in the middle of the north hall that runs east and west, and told resident to stay there while CNA cared for other resident's and that CNA would return. CNA #C stated he/she then went to room of resident #255 and was there for 20 minutes, then to room of resident #256 for 6 minutes, folded towels in laundry room for 6 minutes, and then to room of resident #257 for 6 or 7 minutes. CNA #C stated rooms for residents #255 and #256 located in southwest area of building. CNA #C stated that when he/she went to room of resident #257, located in the northeast hall that he/she walked by room of resident #253 and the door was still closed. CNA #C stated that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N067001S	A. BUILDING: _____ B. WING _____	07/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUEST HOME ESTATES VIII	114 E MARSHALL ERIE, KS 66733

(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
S3028	Continued From page 4	S3028		

when he/she came out of resident #257's room that he/she went into resident #253's room and resident was not there so he/she proceeded to check other resident rooms. Then CNA #C went to medication room to tell CMA #B that resident #253 was missing and CMA #B was on phone with the nurse who had called to say resident was found by a passerby. CNA #C stated that he/she thought all door alarms were on. CNA #C said that resident #253 had the behavior of checking all doors.

At 5:15 p.m. on 7/22/14, the operator stated he/she had completed the investigation of the elopement. Operator confirmed he/she did not obtain written statements from the CMA and CNA working the evening of 7/19/14.

During an interview at 11:20 a.m. on 7/23/14, the licensed nurse stated he/she asked the CMA and CNA after resident eloped if resident had been restless. Licensed nurse stated he/she thought he/she asked if all the door alarms were on. During this interview, the operator stated he/she did not interview the CMA and CNA at the time of the elopement. Operator stated he/she did talk with the CMA and CNA last evening (7/22/14). Operator stated he/she would obtain written statements from the 2 employees this evening. Operator stated he/she had not determined if all door alarms were on at the time of the elopement. Operator confirmed that if only the doorbell alarm was activated on the kitchen exit door then the CMA and CNA would not hear the doorbell if in another resident room.

The operator failed to conduct a thorough investigation of the resident #253's elopement from the facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N067001S	A. BUILDING: _____ B. WING _____	07/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUEST HOME ESTATES VIII	114 E MARSHALL ERIE, KS 66733

(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
S3081	Continued From page 5	S3081		
S3081 SS=D	26-41-201 (c) Functional Capacity Screen Reassessment (c) Designated facility staff shall conduct a screening to determine each resident ' s functional capacity according to the following requirements: (1) At least once every 365 days; (2) following any significant change in condition as defined in K.A.R. 26-39-100; and (3) at least quarterly if the resident receives assistance with eating from a paid nutrition assistant. This REQUIREMENT is not met as evidenced by: KAR 26-41-201(c)(2) The facility reported a census of 26 residents. The sample included 3 residents. Based on record review, interview, and observation for 1 (#251) of 3 residents sampled, the licensed nurse failed to conduct a functional capacity screen (FCS) when the resident experienced a significant change in cognition. Findings included: - Record review for resident #251 revealed an admission date of 5/5/14 and a diagnosis of dementia. The FCS dated 5/5/14 indicated the resident was independent with dressing, toileting, transferring, walking, and eating; required physical assistance with bathing and management of medications and treatments; was at risk for falls; and experienced impaired decision making. The FCS	S3081		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N067001S	A. BUILDING: _____ B. WING _____	07/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUEST HOME ESTATES VIII	114 E MARSHALL ERIE, KS 66733

(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
S3081	Continued From page 6	S3081		

indicated the resident did not have impaired short-term memory, long-term memory, decision making, and memory recall.

The nurse's notes contained the following entries: 6/15/14 at 10:00 p.m. a certified employee documented that resident was disoriented, did not remember moving to the facility, and wanted to find family.

6/16/14 at 11:00 a.m. the licensed nurse documented resident's family notified the nurse on 6/13/14 concerned with the resident's confusion. Licensed nurse documented confusion of resident at this time comparable to status upon admission.

7/15/14 the licensed nurse documented resident was having more confusion between 6:00 p.m. and 9:00 p.m. as reported multiple times by staff. Licensed nurse documented visiting with family that eventually an anti-anxiety medication may need to be discussed with the primary care physician due to resident going into other resident rooms.

During an interview at 1:35 p.m. on 7/22/14, certified nursing assistant (CNA) #A confirmed resident experienced confusion. CNA #A stated the resident wandered and "we have to keep an eye on (resident)." CNA #A said that resident would open exit door but would not go out when the alarm sounded.

At 2:25 p.m. on 7/22/14, interviewed resident #251 in the resident's room. Resident disoriented to time and place. Resident recognized picture on dresser as spouse but stated he/she did not know if they were now divorced or if (spouse) had died. Noted thermostat in room at 85 degrees F

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N067001S	A. BUILDING: _____ B. WING _____	07/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUEST HOME ESTATES VIII	114 E MARSHALL ERIE, KS 66733

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S3081	Continued From page 7 and resident stated room needed to be warm for the dog on the bed. Observed a stuffed animal wrapped up in a blanket between the pillows on the bed. Resident stated he/she wanted to go on a short trip but could not explain when or where. At 12:05 p.m. on 7/23/14, the licensed nurse stated resident had a significant change in cognition and now experienced impaired short-term memory, long-term memory, decision making, and memory recall. The licensed nurse failed to conduct an FCS when the resident #251 experienced a significant change in cognition.	S3081		
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.	S3085		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N067001S	A. BUILDING: _____ B. WING _____	07/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUEST HOME ESTATES VIII	114 E MARSHALL ERIE, KS 66733

(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 8 This REQUIREMENT is not met as evidenced by: KAR 26-41-202(a)(1)(2)(3) The facility reported a census of 26 residents. The sample included 3 residents. Based on record review and interview for 1 (#250) of 3 residents sampled, the operator failed to ensure the development of a negotiated service agreement (NSA) based on the resident's service needs that included a description of services provided by an outside resource, the name of the outside resource, and the party responsible for payment of the services. Findings included: - Record review for resident #250 revealed an admission date of 11/5/13 and diagnoses of vascular dementia, diabetes, anemia, and congestive heart failure. The functional capacity screen dated 11/5/13 indicated the resident was independent with toileting, transferring, and eating; supervision with dressing and walking; physical assistance with bathing and management of medications and treatments; experienced impaired short-term memory, decision making, and memory recall; and was at risk for falls. The nurse's notes contained an entry on 5/30/14 by the licensed nurse that resident returned from a hospital stay and now had oxygen continuously at 3 liters per minute via nasal cannula. On 7/9/14 the licensed nurse documented the resident returned from the hospital with orders for hospice services. The record contained hospice admission documentation dated 7/9/14.	S3085		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N067001S	A. BUILDING: _____ B. WING _____	07/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUEST HOME ESTATES VIII	114 E MARSHALL ERIE, KS 66733

(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 9 The NSA dated 11/5/13 lacked the name of the oxygen provider on 5/30/14 and party responsible for payment of the oxygen supplies. The NSA lacked a description of services provided by hospice, the name of the hospice, and the party responsible for payment. During an interview at 12:10 p.m. on 7/23/14, the licensed nurse stated hospice provided bathing assistance and nursing assessments of the resident. Licensed nurse stated hospice now provided oxygen supplies. Licensed nurse confirmed the NSA was not revised on 5/30/14 to reflect oxygen services or on 7/9/14 with the addition of hospice services. The operator failed to ensure the development of an NSA for resident #250 based on the resident's service needs that included a description of services provided by an outside resource, the name of the outside resource, and the party responsible for payment of the services.	S3085		
S3155 SS=F	26-41-204 (a) Health Care Services . (a) The administrator or operator in each 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)	S3155		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N067001S	A. BUILDING: _____ B. WING _____	07/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUEST HOME ESTATES VIII	114 E MARSHALL ERIE, KS 66733

(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
S3155	Continued From page 10 The facility reported a census of 26 residents. The sample included 3 residents. Based on record review and interview for 1 (#253) of 3 residents sampled, the operator failed to ensure the licensed nurse accurately assessed and provided or coordinated necessary health care services to the cognitively impaired resident with wandering and exit-seeking behaviors to prevent the resident from eloping from the facility. Resident #253 eloped from the facility on 4/28/13 and 7/19/14. Based on record review, observations, and interviews for 1 of 3 (#251) of 3 residents sampled, the operator failed to ensure the licensed nurse accurately assessed and provided or coordinated necessary health care services to the cognitively impaired resident with wandering behavior. Findings included: - Record review for resident #253 revealed an admission date of 4/27/11 and diagnoses of dementia, chronic obstructive pulmonary disease, coronary artery disease, hypertension, and muscle weakness. The nurse's notes contained an entry by a certified medication aide (CMA) at 3:00 p.m. on 4/28/13 that CMA found resident had fallen in the road outside, emergency medical services was called and resident was sent to the hospital. CMA documented in the nurse's notes at 8:00 p.m. on 4/28/13 that resident returned from the hospital and started 72 hour vital sign monitoring. On 4/29/13 at 9:00 a.m. the licensed nurse documented in the nurse's notes that he/she was contacted at 2:39 p.m. that resident had fallen outside by the road and that resident was last	S3155		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N067001S	A. BUILDING: _____ B. WING _____	07/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUEST HOME ESTATES VIII	114 E MARSHALL ERIE, KS 66733

(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
S3155	Continued From page 11	S3155		

seen at 2:30 p.m. by the CMA. The nurse documented that out of town family came to visit resident and it was discovered then that resident was missing. A passerby found resident and called emergency medical services. Nurse documented that resident resting this morning and alert to self as usual.

Review of the FCS/NSA dated 4/26/13 that was in effect at the time of the resident's elopement on 4/28/13, revealed the resident experienced impaired short-term memory, long-term memory, decision making, and memory recall and was at risk for falls. The FCS/NSA did not indicate the resident was at risk for wandering. The FCS/NSA contained documentation by the licensed nurse in the fall section that resident fell in street outside of facility 4/28/13 and 15 minute checks implemented. Licensed nurse documented resident was being treated for UTI. The FCS/NSA lacked a description of services to address the resident ' s wandering and exit-seeking behaviors.

The FCS/NSA dated 6/11/13 contained documentation by the licensed nurse in the wandering section that resident wandered from building 4/28/13, had UTI, and 15 minute checks to continue until urinalysis (lab test of urine to determine presence or absence of UTI) returns clear. Nurse documented on 6/13/13 that urinalysis was clear and 15 minute checks discontinued, staff monitoring frequently.

Further review of the nurse's notes revealed the following entries:

7/20/14 at 2:00 p.m. a CMA documented resident complained of pain "Oh my ribs hurt" said by resident as resident grabbed his/her side.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N067001S	A. BUILDING: _____ B. WING _____	07/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUEST HOME ESTATES VIII	114 E MARSHALL ERIE, KS 66733

(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
S3155	Continued From page 12 7/20/14 at 3:00 p.m. licensed nurse documented that he/she was notified at 8:15 p.m. on 7/19/14 that resident had left the facility unsupervised and ambulated 2 blocks north on Main street. A passerby found resident who had fallen and passerby called emergency medical services. Licensed nurse arrived at the scene and observed that resident had a skin tear on right hand and eyeglasses were bent. Resident was taken by ambulance to the hospital for evaluation and did not have fractures or other injuries. Licensed nurse documented resident returned to the facility at 11:45 p.m. on 7/19/14. At 3:05 p.m. the licensed nurse documented that urinalysis on 7/14/14 did not indicate a urinary tract infection. 7/20/14 at 5:00 p.m. a CMA documented resident complained of rib pain. 7/21/14 at 6:00 a.m. a CMA documented had complained of hurting. 7/21/14 at 12:00 p.m. a CMA documented resident complained of ribs hurting. 7/22/14 at 11:00 a.m. licensed nurse documented a meeting with family at 12:30 p.m. on 7/21/14 to give notification of 30 days for resident to find alternative facility to meet resident's increasing safety needs. Frequent checks have continued and family advised that private sitters would need to be implemented. Licensed nurse documented that at 2:30 p.m. on 7/21/14 was notified resident would be moving to another facility and that resident was dismissed from the facility. The functional capacity screen (FCS) dated 6/11/14 indicated the resident required supervision with transferring, walking, and eating;	S3155		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N067001S	A. BUILDING: _____ B. WING _____	07/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUEST HOME ESTATES VIII	114 E MARSHALL ERIE, KS 66733

(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
S3155	Continued From page 13	S3155		

physical assistance with dressing and management of medications and treatments; was unable to perform bathing and toileting; and was frequently incontinent of urine. The FCS indicated the resident experienced impaired short-term memory, long-term memory, decision making, and memory recall; was at risk for falls; and exhibited wandering behavior.

The negotiated service agreement (NSA) dated 6/11/14 documented a description of services provided by the facility for bathing, dressing, toileting, transferring, walking, eating, and management of medications and treatments. The NSA contained interventions of toileting assistance, pressure alarm on bed, alarm on door to resident room, and audio monitor in resident room as fall risk interventions. The NSA contained documentation of family or staff to assist with decision making and staff to monitor frequently to address resident ' s impaired decision making. Licensed nurse documented by "wandering" section of NSA "Res (resident) has hx (history) of wandering when res has UTI (urinary tract infection). Preventive measures in place. Staff to report any mood disturbances to FN (facility nurse)." The NSA lacked a description of services for staff members to provide to manage the resident ' s wandering behavior to prevent elopement from the facility.

During an interview at 3:55 p.m. on 7/22/14, CMA #B stated he/she was working the 2:30 p.m. to 10:30 p.m. shift on 7/19/14 and did not know resident had left the building until he/she received a call from the licensed nurse between 8:10 p.m. and 8:15 p.m. CMA stated he/she had been in resident rooms providing care and last saw resident #253 around 7:50 p.m. to 8:00 p.m. CMA #B stated door alarms were on all exit doors

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N067001S	A. BUILDING: _____ B. WING _____	07/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUEST HOME ESTATES VIII	114 E MARSHALL ERIE, KS 66733

(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
S3155	Continued From page 14 except for the kitchen door which only had the "doorbell" alarm on. At 4:07 p.m. on 7/22/14, certified nursing assistant (CNA) #C stated he/she last saw resident in the building at a little after 7:00 p.m. on 7/19/14. CNA #C stated (resident #254) was walking resident (#253) down the hall and CNA #C met them by the laundry room door. CNA #C explained that resident had gone into resident's (#254) room and when this happened resident (#254) would put on call light or bring resident (#253) to the CNA. CNA #C stated he/she walked resident (#253) back to his/her room, located in the middle of the north hall that runs east and west, and told resident to stay there while CNA cared for other resident's and that CNA would return. CNA #C stated he/she then went to room of resident #255 and was there for 20 minutes, then to room of resident #256 for 6 minutes, folded towels in laundry room for 6 minutes, and then to room of resident #257 for 6 or 7 minutes. CNA #C stated rooms for residents #255 and #256 located in southwest area of building. CNA #C stated that when he/she went to room of resident #257, located in the northeast hall that he/she walked by room of resident #253 and the door was still closed. CNA #C stated that when he/she came out of resident #257's room that he/she went into resident #253's room and resident was not there so he/she proceeded to check other resident rooms. Then CNA #C went to medication room to tell CMA #B that resident #253 was missing and CMA #B was on phone with the nurse who had called to say resident was found by a passerby. CNA #C stated that he/she thought all door alarms were on. CNA #C said that resident #253 had the behavior of checking all doors.	S3155		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N067001S	A. BUILDING: _____ B. WING _____	07/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUEST HOME ESTATES VIII	114 E MARSHALL ERIE, KS 66733

(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
S3155	Continued From page 15 During an interview at 11:20 a.m. on 7/23/14, the licensed nurse stated staff members were to call the nurse if resident was restless and he/she would call family to come sit with the resident. If family could not come to facility then staff members were instructed to visually check on resident every 30 minutes. Licensed nurse stated that resident was more restless when he/she had a UTI so resident had a monthly urinalysis to monitor for a UTI. Licensed nurse stated resident was not restless and was not being treated for a UTI the evening the resident left the facility. Licensed nurse confirmed staff members did not implement these measures since staff members did not think resident was restless. The operator failed to ensure the licensed nurse accurately assessed and provided or coordinated necessary health care services to cognitively impaired resident #253 with wandering and exit-seeking behaviors to prevent the resident from eloping from the facility. - Record review for resident #251 revealed an admission date of 5/5/14 and a diagnosis of dementia. The functional capacity screen (FCS) dated 5/5/14 indicated the resident was independent with dressing, toileting, transferring, walking, and eating; required physical assistance with bathing and management of medications and treatments; was at risk for falls; and experienced impaired decision making. The FCS indicated the resident did not have impaired short-term memory, long-term memory, decision making, and memory recall. The nurse's notes contained the following entries:	S3155		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N067001S	A. BUILDING: _____ B. WING _____	07/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUEST HOME ESTATES VIII	114 E MARSHALL ERIE, KS 66733

(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
S3155	Continued From page 16	S3155		

6/15/14 at 10:00 p.m. a certified employee documented that resident was disoriented, did not remember moving to the facility, and wanted to find family.

6/16/14 at 11:00 a.m. the licensed nurse documented resident's family notified the nurse on 6/13/14 concerned with the resident's confusion. Licensed nurse documented confusion of resident at this time comparable to status upon admission.

7/15/14 the licensed nurse documented resident was having more confusion between 6:00 p.m. and 9:00 p.m. as reported multiple times by staff. Licensed nurse documented visiting with family that eventually an anti-anxiety medication may need to be discussed with the primary care physician due to resident going into other resident rooms.

During an interview at 1:35 p.m. on 7/22/14, certified nursing assistant (CNA) #A confirmed resident experienced confusion. CNA #A stated the resident wandered and "we have to keep an eye on (resident)." CNA #A said that resident would open exit door but would not go out when the alarm sounded.

At 2:20 p.m. on 7/22/14, observed resident walking around dining room and going to front door of facility and looking out. Licensed nurse walked resident back to the resident's room.

At 2:25 p.m. on 7/22/14, interviewed resident #251 in the resident's room. Resident disoriented to time and place. Resident recognized picture on dresser as spouse but stated he/she did not know if they were now divorced or if (spouse) had died. Noted thermostat in room at 85 degrees F

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N067001S	A. BUILDING: _____ B. WING _____	07/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUEST HOME ESTATES VIII	114 E MARSHALL ERIE, KS 66733

(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
S3155	Continued From page 17 and resident stated room needed to be warm for the dog on the bed. Observed a stuffed animal wrapped up in a blanket between the pillows on the bed. Resident stated he/she wanted to go on a short trip but could not state when or where. The negotiated service agreement dated 5/5/14 lacked services for the safety of the cognitively impaired resident with wandering behavior. At 12:05 p.m. on 7/23/14, the licensed nurse stated resident had a significant change in cognition and now experienced impaired short-term memory, long-term memory, decision making, and memory recall. Licensed nurse confirmed the negotiated service agreement lacked a description of services related to the resident's impaired cognition. The operator failed to ensure the licensed nurse accurately assessed and provided or coordinated necessary health care services to cognitively impaired resident #251 with wandering behavior.	S3155		
S3200 SS=E	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	S3200		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N067001S	A. BUILDING: _____ B. WING _____	07/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUEST HOME ESTATES VIII	114 E MARSHALL ERIE, KS 66733

(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 18 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 26 residents. The sample included 3 residents. Based on record review and interview for 2 (#250 and #253) of 3 residents sampled, the operator failed to ensure PRN (as needed) medications were administered to the residents in accordance with professional standards of practice. Certified medication aides (CMA) administered pain medications and anti-anxiety medications without contacting the licensed nurse to assess the resident and instruct the CMA. Findings included: - Record review for resident #250 revealed an admission date of 11/5/13 and diagnoses of vascular dementia, diabetes, anemia, and congestive heart failure. The functional capacity screen dated 11/5/13 indicated the resident required physical assistance with medication. The negotiated service agreement 11/5/13 documented the service of staff to administer medications. The record contained a medical care provider's	S3200		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N067001S	A. BUILDING: _____ B. WING _____	07/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUEST HOME ESTATES VIII	114 E MARSHALL ERIE, KS 66733

(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 19	S3200		

order dated 11/11/13 for Tylenol 325 milligrams (mg) 2 tablets by mouth every 4 to 6 hours PRN pain/fever. Review of the monthly medication administration records since resident's admission on 11/5/13 revealed the CMAs administered Tylenol to the resident as follows:

11/11/13 at 12:00 p.m. for complaint of back pain.
11/11/13 at 6:00 p.m. for complaint of headache.
3/9/14 at 8:00 p.m. for shoulder and back pain.
3/20/14 at 8:50 p.m. for back pain.
3/21/14 at 9:00 p.m. for complaint of pain.
3/28/14 at 1:00 p.m. for shoulder pain.
4/3/14 at 9:00 p.m. for shoulder pain.
4/6/14 at 7:00 p.m. sore throat.
4/7/14 at 2:50 p.m. for sore throat.
4/9/14 at 8:30 p.m. sore throat.
4/13/14 at 8:00 p.m. complaint of pain.
4/16/14 at 8:45 p.m. shoulder pain.
4/19/14 at 9:15 p.m. complaint of pain.
4/26/14 10:00 p.m. complaint of pain.
4/27/14 at 1:00 p.m. back pain.
Resident also received Tylenol 325 mg 2 tablets on May 7, 12, 24, July 12, and 19, 2014.

The record lacked documentation of licensed nurse notification and a licensed nurse assessment of the resident's pain prior to the administration of these doses of Tylenol.

The record contained documentation on the monthly medication administration records of resident to receive Depakote sprinkles (mood stabilizer) 125 mg by mouth daily as needed. The entry lacked a reason for the medication to be administered. Documentation revealed the resident received the Depakote 12/23/13 for increased anxiety and 2/21/14 without reason given documented. The record lacked documentation of licensed nurse notification and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N067001S	A. BUILDING: _____ B. WING _____	07/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUEST HOME ESTATES VIII	114 E MARSHALL ERIE, KS 66733

(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 20 assessment prior to administering Depakote. During an interview at 11:20 a.m. on 7/23/14, the licensed nurse stated CMAs did not notify him/her that the resident was in pain prior to administering Tylenol. Licensed nurse stated CMAs were to contact nurse prior to administering Depakote and nurse determined if CMA would administer the medication. Licensed nurse confirmed the record lacked documentation of a licensed nurse assessment prior to resident receiving Depakote. Medication aides my not administer PRN anti-anxietymedications which require a nursing assessment. When the medical care provider's order for a pain medication lacks a specific reason for administration, the CMA must contact the licensed nurse to assess the resident and determine if the PRN medication is appropriate. The operator failed to ensure PRN medications were administered to resident #250 in accordance with professional standards of practice. CMA administered Tylenol and Depakote without contacting the licensed nurse to assess the resident and instruct the CMA. - Record review for resident #253 revealed an admission date of 4/27/11 and diagnoses of dementia, chronic obstructive pulmonary disease, coronary artery disease, hypertension, and muscle weakness. The functional capacity screen dated 6/11/14 indicated the resident required physical assistance with management of medications. The negotiated service agreement dated 6/11/14 documented the service of staff will administer medications.	S3200		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N067001S	A. BUILDING: _____ B. WING _____	07/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUEST HOME ESTATES VIII	114 E MARSHALL ERIE, KS 66733

(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 21 The record contained a medical care provider's written order signed on 4/26/11 for Tylenol 500 milligrams (mg) 1 or 2 tablets by mouth every 4 hours PRN for pain/fever. The record contained a medical care provider's order dated 4/30/14 for Tylenol 500 milligrams (mg) 1 or 2 tablets every 6 hours as needed. This order lacked the reason for Tylenol to be given to the resident. Review of the March and April 2014 medication administration records revealed the resident received Tylenol 500 mg 2 tablets on March 7, 8, 9, 10 and April 1, 2, 7, 8, and 9, 2014. The record lacked documentation of nurse licensed nurse notification or licensed nurse assessment of the resident's pain. The June and July 2014 medication administration records revealed CMAs administered Tylenol 500 mg 2 tablets on 6/4/14, 7/20/14 at 10:30 p.m. for resident's complaint of ribs hurting and 7/21/14 at 4:00 p.m. for resident's complaint of pain. The record lacked documentation of nurse notification, nurse assessment of the resident's pain, and instruction to the CMA. Review of the February, March, April, May, June, and July 2014 revealed an entry for lorazepam (anti-anxiety medication) 0.25 mg PRN every 4 to 6 hours restlessness. "Must contact nurse first." CMAs documented the resident received the lorazepam as follows: 2/13/14 lorazepam 0.25 mg without documentation of nurse notification, reason administered, and time of administration.	S3200		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N067001S	A. BUILDING: _____ B. WING _____	07/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUEST HOME ESTATES VIII	114 E MARSHALL ERIE, KS 66733

(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 22 6/4/14 lorazepam 0.25 mg at 4:00 p.m. for restlessness. The CMA did not document licensed nurse notification. The CMA documented in the nurse's notes at 9:00 p.m. that the resident had no complaints. The nurse's notes lacked documentation of the resident's restlessness. During an interview at 11:20 a.m. on 7/23/14, the licensed nurse stated CMAs did not notify him/her that the resident was in pain prior to administering Tylenol. Licensed nurse stated CMAs were to contact nurse prior to administering lorazepam and nurse determined if CMA would administer the medication. Licensed nurse confirmed the record lacked documentation of a licensed nurse assessment prior to resident receiving lorazepam. Medication aides my not administer PRN anti-anxiety medications which require a nursing assessment. When the medical care provider's order lacks a specific reason for administration of Tylenol, the CMA must contact the licensed nurse to assess the resident and determine if the PRN medication is appropriate. The operator failed to ensure PRN medications were administered to resident #253 in accordance with professional standards of practice. CMA administered Tylenol and lorazepam without contacting the licensed nurse to assess the resident and instruct the CMA.	S3200		
S3240 SS=F	26-41-103 (c) Staff Development on Dementia (c) If the facility admits residents with dementia, the administrator or operator shall ensure the provision of staff orientation and in-service education on the treatment and appropriate	S3240		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N067001S	A. BUILDING: _____ B. WING _____	07/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUEST HOME ESTATES VIII	114 E MARSHALL ERIE, KS 66733

(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
S3240	Continued From page 23 response to persons who exhibit behaviors associated with dementia. This REQUIREMENT is not met as evidenced by: KAR 26-41-103(c) The facility reported a census of 26 residents. The sample included 3 residents. Based on record review, observation, and interview for 3 (#253, #251, and #250) of 3 resident's sampled, the operator failed to ensure the provision of staff orientation on the treatment and appropriate response to persons who exhibit behaviors associated with dementia. Findings included: - Record review for resident #253 revealed an admission date of 4/27/11 and diagnoses of dementia, chronic obstructive pulmonary disease, coronary artery disease, hypertension, and muscle weakness. The functional capacity screen (FCS) dated 6/11/14 indicated the resident experienced impaired short-term memory, long-term memory, decision making, and memory recall; was at risk for falls; and exhibited wandering behavior. The nurse's notes contained documentation that the resident eloped from the facility on 4/28/13 and 7/19/14. - Record review for resident #251 revealed an admission date of 5/5/14 and a diagnosis of dementia.	S3240		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N067001S	A. BUILDING: _____ B. WING _____	07/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUEST HOME ESTATES VIII	114 E MARSHALL ERIE, KS 66733

(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
S3240	Continued From page 24 The FCS dated 5/5/14 indicated the resident did not have impaired short-term memory, long-term memory, decision making, and memory recall. The nurse's notes contained the following entries: 6/15/14 at 2:00 p.m. certified medication aide (CMA) documented that resident thought he/she was in Wichita. CMA documented that he/she tried to re-orient the resident. 6/15/14 at 10:00 p.m. a CMA documented that resident was disoriented, did not remember moving to the facility, and wanted to find family. Employee documented that he/she tried reasoning with resident which made the resident irritable. 6/16/14 at 11:00 a.m. the licensed nurse documented resident's family notified the nurse on 6/13/14 concerned with the resident's confusion. Licensed nurse documented confusion of resident at this time comparable to status upon admission. 7/15/14 the licensed nurse documented resident was having more confusion between 6:00 p.m. and 9:00 p.m. as reported multiple times by staff. Licensed nurse documented visiting with family that eventually an anti-anxiety medication may need to be discussed with the primary care physician due to resident going into other resident rooms. During an interview at 1:35 p.m. on 7/22/14, certified nursing assistant (CNA) #A confirmed resident experienced confusion. CNA #A stated the resident wandered and "we have to keep an eye on (resident)." CNA #A said that resident would open exit door but would not go out when	S3240		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N067001S	A. BUILDING: _____ B. WING _____	07/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUEST HOME ESTATES VIII	114 E MARSHALL ERIE, KS 66733

(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
S3240	Continued From page 25	S3240		

the alarm sounded.

At 2:20 p.m. on 7/22/14, observed resident walking around dining room and going to front door of facility and looking out. Licensed nurse walked resident back to the resident's room.

At 2:25 p.m. on 7/22/14, interviewed resident #251 in the resident's room. Resident disoriented to time and place. Resident recognized picture on dresser as spouse but stated he/she did not know if they were now divorced or if (spouse) had died. Noted thermostat in room at 85 degrees F and resident stated room needed to be warm for the dog on the bed. Observed a stuffed animal wrapped up in a blanket between the pillows on the bed. Resident stated he/she wanted to go on a short trip but could not state when or where.

At 12:05 p.m. on 7/23/14, the licensed nurse stated resident had a significant change in cognition and now experienced impaired short-term memory, long-term memory, decision making, and memory recall.

- Record review for resident #250 revealed an admission date of 11/5/13 and a diagnosis of vascular dementia.

The FCS dated 11/5/13 indicated the resident experienced impaired short-term memory, decision making, and memory recall.

The nurse's notes contained the following entries:

6/24/14 at 10:00 p.m. CMA documented that resident was confused and had been wandering.

6/26/14 at 6:00 a.m. CMA documented that resident had been very confused.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N067001S	A. BUILDING: _____ B. WING _____	07/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUEST HOME ESTATES VIII	114 E MARSHALL ERIE, KS 66733

(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
S3240	Continued From page 26 6/27/14 at 1:30 a.m. CMA documented that resident very restless. CMA called licensed nurse who advised CMA to call a family member to sit with resident. At 12:10 p.m. on 7/23/14, the operator provided documentation of one in-service on 2/24/14 provided by an outside resource titled "Challenging Behaviors." Operator stated when a certified employee is hired, the licensed nurse talked with the employee regarding redirection of resident's with dementia and when to call the nurse. Operator confirmed the lack of staff orientation on the treatment and appropriate response to persons who exhibit behaviors associated with dementia. For residents #253, #251, and #250, the operator failed to ensure the provision of staff orientation on the treatment and appropriate response to persons who exhibit behaviors associated with dementia.	S3240		