STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N078005	A. BUILDING: _____ B. WING _____	03/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MENNONITE FRIENDSHIP COMMUNITIES INC	600 W BLANCHARD AVENUE SOUTH HUTCHINSON, KS 67505

(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 re-licensure survey conducted for the above named assisted living facility conducted on 03/14,15/2023	S 000		
S3085 SS=E	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)(3) The facility reported a census of 10 residents (R). The sample included three residents. Based on record review and interview, the administrator failed to ensure designated staff completed the "Negotiated Service Agreement" for two (R3 and	S3085		

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

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S3085	Continued From page 1	S3085		

R4) of three sampled residents based on the resident's "Functional Capacity Screen" and service needs, which included a description of the services the resident received and the provider of each service.

Findings included:

- Review of R3's "Electronic Medical Record" revealed she moved into the facility on 05/02/21 with diagnosis of dementia and muscle weakness.

R3's "Functional Capacity Screen" dated 05/02/22 revealed she needed physical assistance with dressing and toileting, supervision with bathing, and was unable to manage her medications and medical treatments. It also identified she had bladder incontinence, impaired cognition and at risk for falls.

R3's "Negotiated Service Agreement" dated 05/02/22 included a listing of personal care services which included personal hygiene, toileting, and incontinence assistance, and identified the provider of the marked services as the facility. It also included a section for Health Care Services which included management of medications and monitoring vital signs which require special training and identified the provider of marked services as the facility. The "Negotiated Service Agreement" failed to identify what facility staff would provide personal care and health care services, as these services require additional training.

The operator failed to ensure the "Negotiated Service Agreement" identified which facility staff

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S3085	Continued From page 2 would provide health care services for R3. - Review of R4's "Electronic Medical Record" revealed she moved into the facility on 02/18/23 with diagnoses of dementia and diabetes. R4's "Functional Capacity Screen" dated 02/20/23 revealed the resident was unable to manage her medications and medical treatments, had impaired cognition and was at risk for falls. R4's "Negotiated Service Agreement" dated 02/16/23 included a listing of personal care services which included personal hygiene, toileting, and incontinence assistance, and identified the provider of the marked services as the facility. It also included a section for Health Care Services which included management of medications and monitoring vital signs which require special training and identified the provider of marked services as the facility. The "Negotiated Service Agreement" failed to identify what facility staff would provide personal care and health care services, as these services require additional training. The operator failed to ensure the "Negotiated Service Agreement" identified which facility staff would provide health care services for R4.	S3085		
S3101 SS=D	26-41-202 (h) NSA Signatures (h) Each individual involved in the development of the negotiated service agreement shall sign the agreement. The administrator or operator shall ensure that a copy of the initial agreement and any subsequent revisions are provided to the resident or the resident's legal	S3101		

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S3101	Continued From page 3 representative. This REQUIREMENT is not met as evidenced by: KAR 26-41-202 (h) The facility reported a census of 10 residents (R). The sample included three residents. Based on interview and record review for one (R3) of three sampled residents the administrator failed to ensure that everyone involved in the development of the negotiated service agreement signed the agreement. Findings included: - Review of R3's medical record revealed she moved into the facility on 05/02/21 with diagnoses of dementia and muscle weakness. R3's "Functional Capacity Screen" dated 05/02/22 revealed she needed physical assistance with toileting, was unable to manage her medications and medical treatments, was at risk for falls and had impaired cognition. R3's "Negotiated Service Agreement" dated 05/02/22 did not include the signature of the resident and/or her legal representative. The executive director failed to ensure all who participated in the development of R3's negotiated service agreement signed it.	S3101		
S3175 SS=D	26-41-205 (a) (1) Self Administration of Medication	S3175		

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S3175	Continued From page 4 (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 10 residents. The sample included three residents. Based on interview and record review the administrator failed to ensure designated staff completed a medication self-administration assessment for one (R4) of three sampled residents prior to their self-administration of medications. Findings included: - Review of the resident roster on 03/14/23 provided by Licensed Nurse B identified they managed medications for nine of 10 residents	S3175		

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S3175	Continued From page 5 and one of those residents' received insulin. - Review of R4's "Electronic Medical Record" (EMR) revealed she moved into the facility on 02/18/23 with diagnosis of diabetes. R4's "Functional Capacity Screen dated 02/20/23 revealed the resident was unable to manage her medications and medical treatments. R4's "Negotiated Service Agreement" dated 02/16/23 identified "Facility to manage medications". On 03/14/23 at 08:26 AM, Administrative Staff A reported for resident's who receive insulin the CMA dials it and the resident self-injects. Review of R4's EMR lacked evidence a Licensed Nurse assessed R4 to ensure she could safely and accurately self-inject her insulin pen after the CMA had prepared it and dialed it to the correct dosage. The executive director failed to ensure designated staff completed an assessment to for R4's ability to self-inject her insulin pen safely and accurately.	S3175		
S3202 SS=D	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.	S3202		

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S3202	Continued From page 6 This REQUIREMENT is not met as evidenced by: KAR 26-41-205 (d)(4) The facility reported a census to 10 residents. The facility identified they managed medications for nine of 10 residents and one of those residents' received insulin. Based on interview and record review the Administrator failed to ensure a Licensed Nurse (LN) delegated the nursing procedure of checking a resident's blood sugar and preparing and dialing a resident's insulin pen to the correct dosage as ordered for three currently employed Certified Medication Aide's according to the Kansas nurse practice act, K.S.A 65-1124 and amendments thereto. Findings included: - Record review of newly hired employees for the assisted living since the last survey revealed, Record for Certified Medication Aide (CMA) E lacked evidence a licensed nurse had reviewed and educated CMA E on the delegated task for the properly checking a resident's blood sugar and the procedures for preparing and dialing a resident's insulin pen to the ordered dose. Surveyor also requested delegation training for CMA C and CMA D. Both CMAs had training and delegation for glucometer testing (blood sugar testing), but did not have delegation for preparing and dialing a resident's insulin pen to the correct dosage. On 03/14/23 at 02:43 PM Administrative Staff A reported the facility had not developed a process	S3202		

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S3202	Continued From page 7 for the delegation of preparing and dialing of an insulin pen to the ordered dosage. The executive director failed to ensure the Licensed Nurse delegated the procedures of blood sugar checking and preparing and dialing of insulin pens to CMA's according to the Kansas Nurse Practice Act.	S3202		
S3211 SS=E	26-41-205 (g) (3) OVER THE COUNTER DRUGS (3) A licensed nurse or medication aide may accept over-the-counter medication only in its original, unbroken manufacturer ' s package. A licensed pharmacist or licensed nurse shall place the full name of the resident on the package. If the original manufacturer ' s package of an over-the-counter medication contains a medication in a container, bottle, or tube that can be removed from the original package, the licensed pharmacist or a licensed nurse shall place the full name of the resident on both the original manufacturer ' s medication package and the medication container. This REQUIREMENT is not met as evidenced by: KAR 26-41-205 (g)(3) The facility reported a census of 10 residents. Based on observation and interview, the executive director failed to ensure all over-the-counter medications were labeled with the resident's full name. This includes the resident's full name needs to be on the original	S3211		

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S3211	Continued From page 8	S3211		

manufacturer's medication package and the medication container/insert.

Findings included:

- During initial tour on 03/14/23 at 09:40 AM Certified Medication Aide (CMA) C opened the medication closet and unlocked the medication cabinets for inspection. Observation revealed a plastic basket without a resident's name on it which contained a variety of over-the-counter medications. They included Melatonin, Vitamin D3, 2 bottles of Vitamin C, Bayer low dose aspirin, Womens multivitamins, and a box of cranberry supplement. Another basket included a package insert of Biotene lozenges that did not include a resident's name on it. Other over the counter medications included a box of Allergy Relief Nasal spray, bottle of Complete Multivitamin, Ibuprofen, Vitamin B12, 2 bottles of Vitamin D3, Aspirin, Preser Vision, Caltrate, box of Cranberry supplement and a box of antidiarrheal medication.

On 03/14/23 at 09:52 AM Licensed Nurse B stated all of the Over-The-Counter medications were supposed to have the residents' full names on them.

On 03/14/23 at 10:03 AM Certified Medication Aide D opened the medication closet and unlocked the cabinets which revealed the following over-the-counter medications without a resident's full name on them: Aspirin, low dose, Biotin, and three bottles of Acetaminophen.

The director failed to ensure all over-the-counter medications included the full name of the

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S3211	Continued From page 9 resident they belonged to and included the name on the original manufacturer's medication package and the medication container.	S3211		
S3215 SS=D	26-41-205 (h) Medication Storage (h) Storage. Licensed nurses and medication aides shall ensure that all medications and biologicals are securely and properly stored in accordance with each manufacturer ' s recommendations or those of the pharmacy provider and with federal and state laws and regulations. (1) Licensed nurses or medication aides shall store non-controlled medications and biologicals managed by the facility in a locked medication room, cabinet, or medication cart. Licensed nurses and medication aides shall store controlled medications managed by the facility in separately locked compartments within a locked medication room, cabinet, or medication cart. Only licensed nurses and medication aides shall have access to the stored medications and biologicals. (2) Each resident managing and self-administering medication shall store medications in a place that is accessible only to the resident, licensed nurses, and medication aides. (3) Any resident who self-administers medication and is unable to provide proper storage as recommended by the manufacturer or pharmacy provider may request that the medication be stored by the facility. (4) A licensed nurse or medication aide shall not administer medication beyond the manufacturer ' s or pharmacy provider ' s recommended date of expiration.	S3215		

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S3215	Continued From page 10	S3215		

This REQUIREMENT is not met as evidenced by:
KAR 26-41-205 (h) (4)

The facility reported a census of 10 residents (R). Based on observation and interview the operator failed to ensure licensed nurses and certified medication aides did not administer medications beyond the medication manufacturer's or pharmacy provider's recommended date of expiration by a failure to ensure staff dated insulin pens once opened.

Findings included:

- Review of the resident roster provided by Licensed Nurse B, revealed the facility had one resident whom the facility was responsible for administering their insulin.

On 03/14/23 at 09:50 AM while inspecting the medication room with License Nurse B present, observation revealed a Novolog 70/30 insulin pen on a shelf. The pen had the resident's name on it but did not include a date that it had been initiated into use. The pen had 150 units remaining.

On 03/14/23 at 09:52 AM Licensed Nurse B acknowledged the insulin pen needed to have a date of when staff first used the pen written on it.

Review of the manufacturer's instructions revealed, when NovoLog Mix 70/30 FlexPen is punctured, it may be used for up to 14 days if it is

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S3215	Continued From page 11 kept at room temperature. The executive director failed to ensure licensed nurses and certified medication aides stored the NovoLog 70/30 Flex Pen correctly and did not administer medications beyond the medication manufacturer's or pharmacy provider's recommended date of expiration by a failure to ensure staff dated insulin pens once opened.	S3215		