STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N019012	A. BUILDING: _____ B. WING _____	11/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUEST HOME ESTATES IV	1910 E CENTENNIAL STREET PITTSBURG, KS 66762

(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 represents the findings of a resurvey with attached facility report #185570 at the above named assisted living conducted on 11/12/24 and 11/13/24.	S 000		
S3026 SS=J	26-41-101 (f) (1) Staff Treatment of Residents ANE (f)The administrator or operator shall ensure that all of the following requirements are met: (1) No resident shall be subjected to any of the following: (A) Verbal, mental, sexual, or physical abuse, including corporal punishment and involuntary seclusion; (B) neglect; or (C) exploitation. This REQUIREMENT is not met as evidenced by: KAR 26-41-101(f)(1)(B) The facility reported a census of 24 residents, with three residents included in the sample. Based on observation, interview, and record review the operator failed to protect one resident from neglect by the failure to report to the State Agency within 24 hours and conduct an investigation when cognitively impaired Resident (R) 1 exited the building without staff knowledge on two previous occasions prior to 01/31/24; the failure to implement a method of identifying high-risk for elopement residents; the failure to document actions taken and results of the actions when R1 exited the building without staff knowledge and exhibited increased confusion and exit-seeking behavior; the failure to inform staff of appropriate interventions to implement	S3026		

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

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when a resident wandered to prevent them exiting the facility without staff knowledge; and the failure to secure all exit doors. Cognitively impaired Resident (R) 1 exited the facility through an unlocked door to the outside without staff knowledge for an undetermined amount of time on three separate occasions on 11/01/23, 12/21/23, and 01/31/24. This placed the resident in Immediate Jeopardy.

Findings included:

- Record review for R1 revealed an admission date of 09/01/23 with the following diagnoses: dementia and amnesia.

The 09/01/24 "Functional Capacity Screen" (FCS) identified R1 as unable to perform bathing and management of medications; required physical assistance with dressing; was independent with transfers and walking/mobility; had short-term and long-term memory, memory recall, and impaired decision-making cognitive difficulties; and was marked at risk for impaired decision making and wandering.

The 09/01/24 combined "Negotiated Service Agreement/Healthcare Service Plan" (NSA/HCP) identified facility staff provided assistance twice a week and as needed for bathing, assistance with dressing, management of medications, and redirection on occasion for cognitive difficulties. R1 had a Durable Power of Attorney (DPOA) for impaired decision making. Regarding wandering, the "NSA/HCP" noted the resident "becomes forgetful and wanders." The "NSA/HCP" failed to describe the services the facility provided and/or would provide to R1 for wandering.

Review of the care plan from a previous facility

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where R1 lived that was faxed to the current facility on 08/01/23 at 09:22 AM, and included in R1's medical record, revealed the resident had a diagnosis of dementia. The "Mood/Behavior" section of the care plan documented "elopement risk/wanderer". . . "history of attempts to leave facility unattended, impaired safety awareness, resident wandered aimlessly." The care plan described services provided by the previous facility to meet R1's needs included she wore a wander alert device on her left ankle.

The 09/01/23 at 10:20 AM "Nursing Note" documented R1 arrived to the facility and was pleasantly forgetful.

The 11/01/23 at 01:40 PM "Nursing Note" documented facility staff found R1 outside in the driveway and redirected her back inside.

The 11/27/23 "Telephone Encounter" for increased agitation, yelling, and aggression documented assessment revealed dementia with behavioral disturbance. The Advanced Practice Registered Nurse (APRN) wrote a new order to increase Lexapro medication.

The 12/21/23 at 04:50 PM "Nursing Note" documented an unidentified Certified Nurse Aid (CNA) found R1 outside on the sidewalk unattended and walked her back into the building.

The 01/11/24 at 11:00 AM "Nursing Note" documented R1 walked to the medication room carrying some personal belongings and stated she was going home.

The 02/01/24 at 08:30 AM "Nursing Note" documented staff found R1 in the parking lot. She stated she was going home. Facility staff assisted

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her back into the building.

The 10/28/24 "Nursing Note" documented R1 had increased confusion and looked for ways to go home.

Review of "Nursing Notes" for R1 revealed a lack of documentation of actions taken and results of the actions when she exited the facility without staff knowledge on 11/01/23, 12/21/23, 02/01/24, exhibited exit-seeking behavior on 01/11/24, and exhibited increased confusion with exit-seeking behavior on 10/28/24.

Review of the 02/28/24 (most recent) "In-Service Sign in Sheet" revealed staff completed dementia and safety training on 02/28/24.

The 02/01/24 facility's "Intake Report" to the department documented facility staff saw R1 outside of the building from the medication room window on 01/31/24 at approximately 02:40 PM. A staff member brought R1 back inside. The facility did not have locked doors. Staff placed a sign in R1's room to remind her to tell staff when she wanted to go outside, and staff checked on her every hour.

The 02/06/24 facility's investigation report to the department documented R1 walked outside toward the driveway. Certified Medication Aide (CMA) M saw her and redirected her back into the facility. Staff hung a sign on her door to remind others that R1 was exit-seeking. Staff installed door alarms and ensured they worked properly.

R1's record lacked evidence of documentation of an elopement risk assessment.

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R1's record lacked evidence of documentation facility staff checked on her every hour.

On 11/12/24 at 12:12 PM Administrative Staff A stated staff left the front door unlocked during the day and it was locked at night. An alarm on the door sounded each time it opened and stopped sounding when the door closed.

On 11/12/24 at approximately 02:55 PM Administrative Staff A and Administrative Nurse B confirmed R1's record lacked evidence of documentation of an elopement risk assessment.

On 11/12/24 at approximately 02:55 PM Administrative Nurse B stated R1's family reported before admission R1 talked about going home. It was a concern when she admitted to the facility that R1 was an elopement risk.

On 11/12/24 at 03:36 PM CMA J stated staff kept a close eye on R1, but she went out of the facility about once a week and usually sat on the front porch. Staff knew she went outside because another resident told them R1 was outside. Staff could not hear the front door alarm activate if she was in another resident's room.

On 11/12/24 at 04:26 PM per phone interview, CNA K stated R1 went outside the facility during her shift but only to the front porch. She knew R1 was outside because she saw her out a window. She did not always hear the front door alarm.

On 11/12/24 at 04:54 PM the most recent "Elopement Drill" provided to facility staff was requested, which the facility failed to provide.

Observation on 11/12/24 at approximately 03:29 PM revealed R1 walked in the hallway of the

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facility. Upon state surveyor's request, R1 led state surveyor to her apartment. A sign on the inside of R1's door read "please let staff know if you are going outside." R1 was unable to read the sign for state surveyor. She stated she did not know what the sign meant. She was able to go outside by herself, the facility was not her home because she was just visiting, and no one told her not to go outside.

Observation on 11/12/24 at approximately 06:10 PM revealed the front door opened and alarm did not activate. Facility staff were aware.

Observation on 11/13/24 at 09:05 AM revealed the unlocked front door had a newly installed alarm, which activated when the door opened and shut off when the door closed. No staff responded to the door alarm to check if a resident went outside.

Observation on 11/13/24 at 09:25 AM revealed a resident went out the front door, which activated the alarm. No staff responded to the alarm to check if a resident went outside.

Observation on 11/13/24 at 09:48 AM revealed facility staff went out the front door. The door alarm activated. No other staff responded to the door alarm to check if a resident went outside.

Observed CMA H through a window in the wall to the medication room did not turn her head to look through the window toward the door to check it.

On 11/13/24 at 09:59 AM CMA H stated she completed elopement training during the last in-service. When the door alarm activated, she would go to the door, open it, and look outside in all directions to ensure a resident did not get out.

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S3026	Continued From page 6 She did not respond to the door alarm that morning because maintenance was present working on the door. On 11/13/24 at 10:13 AM Administrative Staff A stated the facility did not provide dementia training upon hire. Staff completed dementia training during staff in-service meetings throughout the year. Administrative Staff A confirmed R1's record lacked evidence of documentation staff provided checks every hour following when she exited the facility without staff knowledge on 01/31/24 and starting the evening of 11/12/24 as documented in the abatement plan approved by the department. The weather per Weather Underground at Wunderground.com on 01/31/24 at 02:53 PM was a temperature of 64 degrees Fahrenheit and wind speed of 12 mph (miles per hour) with gusts up to 20 mph. Observation on 11/13/24 revealed a four-lane street in front of the facility with a speed limit of 35 mph. The street was approximately 34 steps from the facility's front door. Distance measurements by GoogleMaps.com revealed the following distances from the facility's front door: A small, wooded area east of the facility by approximately 265 feet. A single set of railroad tracks west of the facility by approximately 840 feet. A lake southwest of the facility by approximately 887 feet. Wooded area with creek north of the facility by approximately 1,316 feet.	S3026		

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S3026	Continued From page 7 The facility's undated "Guidelines to staff on what to do in case of an elopement" policy documented the nurse would (sic) "assist the resident for medical evaluation." Designated facility staff would report to the department within 24 hours; begin an investigation by gathering witness statements from other residents, staff, or visitors and add them to the investigation; and immediately take steps to ensure the resident was safe to stay in the building. The operator failed to protect one resident from neglect by the failure to report to the department within 24 hours and conduct an investigation when cognitively impaired R1 exited the building without staff knowledge on two previous occasions prior to 01/31/24; the failure to implement a method of identifying high-risk for elopement residents; the failure to inform staff of appropriate interventions to implement when a resident wandered to prevent them exiting the facility without staff knowledge; and the failure to secure all exit doors. Cognitively impaired Resident (R) 1 exited the facility through an unlocked door to the outside without staff knowledge for an undetermined amount of time on three separate occasions on 11/01/23, 12/21/23, and 01/31/24. Jeopardy was removed on 11/12/24 when the following actions were documented by the facility in the "Elopement Abatement" and accepted by the department at 06:25 PM. 1) Maintenance staff placed a new Defiant (louder) alarm on the front door and was tested to be working in the evening on 11/12/24. 2) Designated staff updated R1's "NSA" in the evening on 11/12/24. 3) Staff in-service scheduled for 11/13/24 to	S3026		

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S3026	Continued From page 8 re-educate staff on how to care for residents diagnosed with dementia and facility's elopement policy. 4) Designated staff would provide re-education to Administrative Nurse B regarding nursing documentation and follow-up, with completion by the end of the month. 5) Notify R1's primary care provider (PCP) regarding increased confusion and elopement risk by 10:00 AM on 11/13/24. 6) Notify family and schedule a care plan meeting to discuss R1's care. 7) Designated staff would provide checks for R1 every starting the evening of 11/12/24.	S3026		
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	S3028		

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S3028	Continued From page 9 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)(C) The facility reported a census of 24 residents with three residents included in the sample. Based on interview and record review the operator failed to report to the department within 24 hours when Resident (R) 1 exited the building unattended and without staff knowledge on 11/01/23 and 12/21/23. The operator further failed to ensure facility staff completed an investigation after each incident to see what steps should be taken to ensure R1 was kept safe from exiting the building without staff knowledge. Findings included: - Record review for R1 revealed an admission date of 09/01/23 with diagnoses of dementia and amnesia. The 09/01/24 "Functional Capacity Screen" (FCS) identified R1was independent with transfers and walking/mobility; had short-term and long-term memory, memory recall, and impaired decision-making cognitive difficulties; and was marked at risk for impaired decision making and wandering. The 09/01/24 combined "Negotiated Service	S3028		

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Agreement/Healthcare Service Plan" (NSA/HCP) identified facility staff provided redirection on occasion for cognitive difficulties; and she had a Durable Power of Attorney (DPOA) for impaired decision making. For wandering, the "NSA/HCP" read "becomes forgetful and wanders." The "NSA/HCP" failed to describe the services provided to R1 for wandering.

The 11/01/23 at 01:40 PM "Nursing Note" documented facility staff found R1 outside in the driveway and redirected her back inside.

Review of records provided by the facility revealed a lack of evidence of documentation the facility reported the incident to the department within 24 hours or conducted an investigation to rule out abuse, neglect, or exploitation.

The 12/21/23 at 04:50 PM "Nursing Note" documented an unidentified Certified Nurse Aid (CNA) found R1 outside on the sidewalk unattended and walked her back into the building.

Review of records provided by the facility revealed a lack of evidence of documentation the facility reported the incident to the department within 24 hours or conducted an investigation to rule out abuse, neglect, or exploitation.

On 11/12/24 at approximately 02:55 PM Administrative Nurse B confirmed facility records lacked evidence of documentation the incident was reported to the department within 24 hours or an investigation to rule out abuse, neglect, or exploitation was completed.

The facility's undated "Guidelines to Staff on what to do in case of an elopement" policy documented designated facility staff would report to the

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S3028	Continued From page 11 department within 24 hours; begin an investigation by gathering witness statements from other residents, staff, or visitors and add them to the investigation; and immediately take steps to ensure the resident was safe to stay in the building. The operator failed to report to the department within 24 hours when R1 exited the building unattended and without staff knowledge on 11/01/23 and 12/21/23. The operator further failed to ensure facility staff completed an investigation after each incident to see what steps should be taken to ensure R1 was kept safe from exiting the building without staff knowledge.	S3028		
S3080 SS=D	26-41-201 (a) (b) Functional Capacity Screen on Admission a) On or before each individual ' s admission to an assisted living facility or residential health care facility, a licensed nurse, a licensed social worker, or the administrator or operator shall conduct a screening to determine the individual ' s functional capacity and shall record all findings on a screening form specified by the department. The administrator or operator may integrate the department ' s screening form into a form developed by the facility, which shall include each element and definition specified by the department. (b) A licensed nurse shall assess any resident whose functional capacity screening indicates the need for health care services. This REQUIREMENT is not met as evidenced by: KAR 26-41-201(a)	S3080		

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S3080	Continued From page 12 The facility reported a census of 24 residents with three residents included in the sample. Based on interview and record review the operator failed to ensure designated staff recorded all findings of Resident (R) 3's functional capacity on a screening form. Findings included: - Record review for R3 revealed an admission date of 01/01/24 with diagnoses of type two diabetes mellitus and bipolar disorder. The 01/01/24 "Functional Capacity Screen" (FCS) identified R3 required physical assistance with bathing and management of medications; she had memory/recall and decision-making cognitive difficulties; and was marked at risk for impaired decision-making. The 01/01/24 "FCS" page to score her functional capacity for management of treatments was missing. The 01/01/24 "NSA" identified facility staff provided R3 assistance with bathing and management of medications; and her daughter assisted with cognitive difficulties and impaired decision-making. The "NSA" failed to describe services provided for management of treatments. On 11/13/24 at approximately 10:34 AM Administrative Staff A confirmed R3's "NSA" failed to document the findings of her functional capacity for management of treatments. The 07/2005 facility's "FCS, NSA, and Care Plan Manual" documented management of treatments were to be scored 0 for independent, 1 if	S3080		

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S3080	Continued From page 13 supervision was needed, 2 if physical assistance was needed, and 3 if resident was unable to perform all tasks related to treatments. The operator failed to ensure designated staff recorded all findings of R3's functional capacity on a screening form.	S3080		
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) The facility reported a census of 24 residents with three residents included in the sample. Based on interview and record review the operator failed to ensure the "Negotiated Service Agreement"	S3085		

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S3085	Continued From page 14 (NSA) for Residents (R)1, R2, and R3 described the services they received based on their Functional Capacity Screen (FCS), service needs, and preferences. Findings included: - Record review for R1 revealed an admission date of 09/01/23 with diagnoses of dementia, dysphagia, and amnesia. The 09/01/24 "FCS" identified R1 sometimes understood others during communication and was marked at risk for wandering. The 09/01/24 "NSA" failed to describe services provided to R1 for communication and wandering. The 11/01/23 at 01:40 PM "Nursing Note" documented facility staff found R1 outside in the driveway and redirected her back inside. The 12/21/23 at 04:50 PM "Nursing Note" documented an unidentified Certified Nurse Aid (CNA) found R1 outside on the sidewalk unattended and walked her back into the building. The 01/11/24 at 11:00 AM "Nursing Note" documented R1 walked to the medication room carrying some personal belongings and stated she was going home. The 02/01/24 at 08:30 AM "Nursing Note" documented staff found R1 in the parking lot. She stated she was going home. Facility staff assisted her back into the building. The 10/28/24 "Nursing Note" documented R1 had increased confusion and looked for ways to go home.	S3085		

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S3085	Continued From page 15 On 11/12/24 at approximately 02:55 PM Administrative Nurse B confirmed R1's "NSA" failed to describe the services provided for communication and wandering. - Record review for R2 revealed an admission date of 04/11/22 with a diagnoses of dementia and diabetes mellitus. The 04/11/24 "FCS" identified R2 had short-term memory, memory/recall, and decision-making cognitive difficulties. The 04/11/24 "NSA" failed to describe services provided for to R2 for cognitive difficulties. On 11/13/24 at approximately 11:21 AM Licensed Nurse L confirmed R2's "NSA" failed to describe the services provided for cognition. - Record review for R3 revealed an admission date of 01/01/24 with diagnoses of type two diabetes mellitus and bipolar disorder. The 01/01/24 "FCS" revealed the treatments section was missing. The 01/01/24 "NSA" revealed the treatments section was missing. On 11/13/24 at approximately 10:34 AM Administrative Staff A confirmed the page with the treatments section on it was missing from R3's "NSA." The 07/2005 facility's "FCS, NSA, and Care Plan Manual" documented how to score residents for treatments, communication, cognition, and wandering for the "FCS" portion. The manual	S3085		

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S3085	Continued From page 16 failed to address description of services required to be on the "NSA" for each resident. The operator failed to ensure the "NSA" for R1, R2, and R3 described the services they received based on their "FCS," service needs, and preferences.	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 representative. This REQUIREMENT is not met as evidenced by: KAR 26-41-202(h) The facility reported a census of 24 residents with three residents included in the sample. Based on interview and record review the operator failed to ensure that each individual involved in the development of the "Negotiated Service Agreement" (NSA) signed the agreement for Resident (R) 1. Findings included: - Record review for R1 revealed an admission date of 09/02/23 with a diagnoses of dementia, dysphagia, and amnesia. The 09/01/24 "Functional Capacity Screen" (FCS) identified R1 was unable to perform bathing and	S3101		

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S3101	Continued From page 17	S3101		

management of medications, she required physical assistance with dressing, eating, and management of treatments; she had short-term and long-term memory, memory recall, and impaired decision-making cognitive difficulties; she sometimes understood others during communication; and was marked at risk for impaired decision-making and wandering.

The 09/01/24 "NSA" identified facility staff provided R1 assistance two times a week and as needed for bathing; physical assistance with dressing and eating; management of medications; assistance with treatments by providing monthly vital signs and weight; redirection on occasion for cognitive difficulties; she had a durable power of attorney (DPOA) for impaired decision-making. The "NSA" failed to describe services provided for communication and wandering.

The 09/01/24 "NSA" contained signatures by Administrative Staff A and Administrative Nurse B. The "NSA" lacked signatures of each individual who participated in the development of the "NSA."

On 11/12/24 at approximately 02:55 PM Administrative Nurse B confirmed R1's "NSA" lacked the signatures of each individual involved in the development of the "NSA."

The facility's 07/2005 "FCS, NSA, Care Plan Manual" documented the "NSA" must be signed by the resident, nurse, and manager. Signatures of legal representative or family may also be added. The only time a resident was not required to sign is if they had a legal guardian."

The operator failed to ensure that each individual involved in the development of the "NSA" for R1

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S3101	Continued From page 18 signed the agreement.	S3101		
S3165 SS=D	26-41-204 (d) Health Care Services (d) The negotiated service agreement shall contain a description of the health care services to be provided and the name of the licensed nurse responsible for the implementation and supervision of the plan. This REQUIREMENT is not met as evidenced by: KAR 26-41-204(d) The facility reported a census of 24 residents with three residents included in the sample. Based on interview and record review the operator failed to ensure designated staff ensured the "Negotiated Service Agreement" (NSA) for Resident (R) 3 named the licensed nurse responsible for implementing and supervising her "Healthcare Service Plan" (HSP). Findings included: - Record review for R3 revealed an admission date of 01/01/24 with diagnoses of type two diabetes mellitus and bipolar disorder. The 01/01/24 "Functional Capacity Screen" (FCS) identified R3 required physical assistance with bathing and management of medications; she had memory/recall and decision-making cognitive difficulties; and was marked at risk for impaired decision-making. The 01/01/24 "NSA" identified facility staff	S3165		

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S3165	Continued From page 19 provided R3 assistance with bathing and management of medications; and her daughter assisted with cognitive difficulties and impaired decision-making. The 01/01/24 "NSA" for R4 failed to document the name of the licensed nurse responsible for implementing and supervising her "HSP." On 11/13/24 at approximately 10:34 AM Administrative Staff A confirmed R3's "NSA" failed to name the nurse responsible for implementing and supervising her "HSP." The facility's 07/2005 "FCS, NSA, and Care Plan Manual" documented the nurse responsible should be listed in the area of the form designated "nurse responsible for care." The operator failed to ensure designated staff ensured R3's "NSA" named the licensed nurse responsible for implementing and supervising her "HSP."	S3165		
S3171 SS=D	26-41-204 (i) Health Care Services Standards of Practice (i) All health care services shall be provided to residents by qualified staff in accordance with acceptable standards of practice. This REQUIREMENT is not met as evidenced by: KAR 26-41-204(i) The facility reported a census of 24 residents with three residents included in the sample. Based on	S3171		

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S3171	Continued From page 20	S3171		

observation, interview, and record review the operator failed to ensure designated staff ensured a gap greater than 4.75 inches between the rails of a bed assist device for Resident (R) 3 was covered to prevent entrapment.

Findings included:

- Record review for R3 revealed an admission date of 01/01/24 with diagnoses of type two diabetes mellitus and bipolar disorder.

The 01/01/24 "Functional Capacity Screen" (FCS) identified R3 required physical assistance with bathing and management of medications; she had memory/recall and decision-making cognitive difficulties; and was marked at risk for impaired decision-making. She was independent with transfers and walking/mobility.

The 01/01/24 "NSA" identified facility staff provided R3 assistance with bathing and management of medications; and her daughter assisted with cognitive difficulties and impaired decision-making.

Observation on 11/13/24 at 10:01 AM revealed a bed assist device was attached to the left side of R3's bed. There was a 10-inch gap between the rails of the bed assist device that lacked a cover to prevent entrapment between the rails.

On 11/13/24 at approximately 10:01 AM Administrative Staff A confirmed R3's bed assist device lacked a cover to prevent entrapment between the rails.

The facility's "Side Rail/Bed Cane Assessment" policy documented any openings in the rail should be small enough to prevent the resident's head

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S3171	Continued From page 21 from going through. A loosened bar or rail can change the size of the space. The space should be less than 4.75 inches or 120 millimeters representing head breadth. The operator failed to ensure designated staff ensured a gap greater than 4.75 inches between the rails of a bed assist device for R3 was covered to prevent entrapment.	S3171		
S3215 SS=F	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	S3215		

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S3215	Continued From page 22 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. This REQUIREMENT is not met as evidenced by: KAR 26-41-205(h) The facility reported a census of 24 residents. Based on observation, interview, and record review the operator failed to ensure tuberculin (medication used to test for tuberculosis (TB) was stored in accordance with the manufacturer's recommendations. Findings included: - Record review for Resident (R) 4 revealed an admission date of 08/03/24. The "Resident TB Skin Testing" record revealed Administrative Nurse B administered the first of a two-step TB skin test to R4 on 08/03/24. Administrative Nurse B administered the second step on 08/14/24. The "TB Skin Testing" record lacked the lot number and the expiration date of the tuberculin vial. Record review for R 5 revealed an admission date of 10/22/24. The "Resident TB Skin Testing" record revealed Administrative Nurse B administered the first of a two-step TB skin test to R5 on 10/22/24. Administrative Nurse B administered the second step on 11/05/24. The "TB Skin Testing" record lacked the lot number and the expiration date of the tuberculin vial. Review of staff records for Certified Nurse Aide	S3215		

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S3215	Continued From page 23 (CNA) F revealed a hire date of 08/20/24. The "Employee Health Form" revealed Administrative Nurse B administered the first of a two-step TB skin test to CNA F on 08/20/24. Administrative Nurse B administered the second step on 09/02/24. The "Employee Health Form" lacked the lot number and the expiration date of the tuberculin vial. Review of staff records for CNA G revealed a hire date of 10/21/24. The "Employee Health Form" revealed Administrative Nurse B administered the first of a two-step TB skin test to CNA G on 10/21/24. Administrative Nurse B administered the second step on 10/31/24. The "Employee Health Form" lacked the lot number and the expiration date of the tuberculin vial. Observation on 11/12/24 at 12:37 PM of the facility's medication room revealed a refrigerator that contained an unsealed vial of tuberculin inside an opened box. The box and/or vial lacked a label with an open date. The box, product insert, and the vial of tuberculin itself contained instructions that a vial which had been opened and in use for 30 days should be discarded. On 11/12/24 at approximately 01:17 PM Administrative Nurse B confirmed she failed to label the tuberculin with an open date and she had administered it to two residents and two staff. The operator failed to ensure medications were stored in accordance with each manufacturer's recommendations.	S3215		

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S3240	Continued From page 24	S3240		
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 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 24 residents. Based on interview and record review the operator failed to provide dementia training to direct care staff upon hire for five out of five sampled staff. Findings included: - Record review for Certified Medication Aide (CMA) C revealed a hire date of 12/06/23. The record lacked evidence of documentation dementia training was completed upon hire. Record review for CMA D revealed a hire date of 08/29/24. The record lacked evidence of documentation dementia training was completed upon hire. Record review for Certified Nurse Aide (CNA) E revealed a hire date of 08/29/24. The record lacked evidence of documentation dementia training was completed upon hire. Record review for CNA F revealed a hire date of 08/20/24. The record lacked evidence of documentation dementia training was completed	S3240		

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S3240	Continued From page 25 upon hire. Record review for CNA G revealed a hire date of 10/22/24. The record lacked evidence of documentation dementia training was completed upon hire. Review of the resident roster provided by the facility during the survey revealed the "impaired cognition" column was missing, thus preventing accurate count of residents with cognitive difficulties, however 3 of 3 residents sampled had cognitive issues based on review of their medical records. On 11/13/24 at 10:13 AM Administrative Staff A confirmed dementia training for staff had not been completed upon hire. On 11/13/24 at 10:34 AM a staff development policy was requested which the facility failed to provide. The operator failed to provide dementia training to direct care staff upon hire for five out of five sampled staff.	S3240		
S3299 SS=F	26-41-206 (e) (1) Facility Food Storage (e) Food storage. Facility staff shall store all food under safe and sanitary conditions. (1) Containers of poisonous compounds and cleaning supplies shall not be stored in the areas used for food storage, preparation, or serving. This REQUIREMENT is not met as evidenced	S3299		

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S3299	Continued From page 26 by: KAR 26-41-206(e) The facility reported a census of 24 residents. The facility had a main kitchen where dietary staff stored, prepared, and served food. Based on observation and interview the operator failed to ensure designated staff stored food items under safe conditions. Findings included: - Observation on 11/12/24 at approximately 12:24 PM of the kitchen revealed a countertop on which sat a plastic bag of hamburger, a plastic bag of roast beef chunks, and a paper wrapped item which was labeled "turkey." On 11/12/13 at approximately 12:24 PM Dietary Staff I confirmed the items were thawing and should not be there. She removed them and placed them in the refrigerator. The August 2017 Kansas Department of Agriculture's "Focus on Food Safety" booklet documented to never thaw foods at room temperature. The thawed portions on the outside would support bacterial growth and can result in an unsafe product. On 11/13/24 at 10:34 AM a food storage policy was requested which the facility failed to provide. On 11/13/24 at approximately 11:15 AM Administrative Staff A confirmed the facility did not have a food storage for thawing foods policy. The operator failed to ensure designated staff stored food items under safe conditions.	S3299		

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S3310	Continued From page 27	S3310		
S3310 SS=F	26-41-207 (b) (5-6) (c) Infection Control Policies (b) (5) prohibiting any employee with a communicable disease or any infected skin lesions from coming in direct contact with any resident, any resident ' s food, or resident care equipment until the condition is no longer infectious; (6) providing orientation to new employees and employee in-service education at least annually on the control of infections in a health care setting; and (c) Each administrator or operator shall ensure the facility ' s compliance with the department ' s tuberculosis guidelines for adult care homes adopted by reference in K.A.R. 26-39-105 This REQUIREMENT is not met as evidenced by: KAR 26-41-207(c) The facility reported a census of 24 residents. Based on interview and record review the operator failed to ensure the facility remained in compliance with the department's tuberculosis (TB) guidelines for adult care homes adopted by reference in KAR 26-39-105. Findings included: - Review of Certified Medication Aide (CMA) D's employee record revealed a hire date of 08/29/24. She was administered a first step TB skin test on 08/29/24 which read negative on 09/01/24. The second TB skin test was administered on 09/08/24 and read on 09/12/24.	S3310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N019012	A. BUILDING: _____ B. WING _____	11/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUEST HOME ESTATES IV	1910 E CENTENNIAL STREET PITTSBURG, KS 66762

(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
S3310	Continued From page 28 CMA D's record lacked evidence of documentation her second step test results were read within 72 hours of administration. Review of Certified Nurse Aide (CNA) E's employee record revealed a hire date of 08/29/24. She was administered a first step TB skin test on 08/29/24 which read negative on 09/01/24. The second TB skin test was administered on 09/08/24 and read on 09/12/24. CMA D's record lacked evidence of documentation her second step test results were read within 72 hours of administration. On 11/12/24 at approximately 02:18 PM Administrative Nurse B confirmed staff records lacked evidence of documentation the second step of the TB skin test administered to CMA D and CNA E results were read within 72 hours. The facility's undated "TB Guidelines" policy documented the second step of the TB skin test was read by a nurse after three days. The June 2013 department's "Tuberculosis (TB) Guidelines for Adult Care Homes" documented the first and second step of the TB skin test should be read within 48 - 72 hours. The operatore failed to ensure the facility remained in compliance with the department's tuberculosis guidelines for adult care homes adopted by reference in KAR 26-39-105.	S3310		