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 _____	11/19/2024

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

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S 000	INITIAL COMMENTS The following citations represent the findings of a resurvey at the above named facility conducted on 11/19/24.	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) The facility reported a census of 10 residents. The sample included 3 residents. Based on record review, observation and interview for 2 sampled residents (R)1 and R2, Administrator A failed to ensure the Negotiated Service Agreement (NSA) completed for residents who required health care services identified a description of the services the resident received	S3085		

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

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S3085	Continued From page 1	S3085		

and identified the provider of each service.

Findings included:

- Record review for R1 revealed an admission date of 02/18/23 with diagnoses of diabetes mellitus type II, anxiety disorder, hypertension and insomnia.

The current "Resident Functional Capacity Screen" (FCS) dated 02/16/24 recorded the resident was unable to manage medications and treatments.

Review of R1's current "Negotiated Service Agreement" (NSA) dated 02/16/24 recorded facility managed medications.

The NSA failed to identify the provider of service for R1's glucose monitoring and insulin administration.

Interview on 11/19/24 with Administrator A and Licensed Nurse (LN) B stated Certified Medication Aides (CMA) dial the insulin pen and R1 self-injected.

Interview on 11/19/24 at 02:11 PM with R1 stated facility staff dialed her insulin pen and she self-injected the insulin pen.

Interview on 11/19/24 at approximately 02:37 PM with LN B confirmed R1's NSA failed to identify the provider of services for R1's glucose monitoring and insulin administration.

- Record review for R2 revealed an admission date of 07/10/24 with diagnoses of hypertension, congestive heart failure, chronic kidney disease stage 3, fibromyalgia, and osteoporosis.

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S3085	Continued From page 2 The current "Resident Functional Capacity Screen" (FCS) dated 07/10/24 recorded the resident as independent with eating, required supervision with transfer, walk/mobility and management of medications, physical assistance with bathing, dressing, toileting and was unable to perform management of treatments. The FCS further recorded R2 had impaired short term memory and impaired decision making and was at risk for falls/ unsteadiness. R2 used a walker and wheelchair for ambulation. Review of R2's current "Negotiated Service Agreement" (NSA) dated 07/10/24 recorded facility staff assisted R2 with bathing, dressing, toileting, transfer, walk/mobility, and provided cuing, reminders and nighttime safety checks. The NSA failed to identify a description of services and provider of services related to wound care. "Interdisciplinary Note" dated 10/21/24 by LN B recorded R2 fell out of the transportation vehicle on 10/18/24 and sustained a skin tear to her left shin. Interview and observation on 11/19/24 at 02:11 PM with R2 revealed a dressing to her left lower extremity. R2 stated she has a wound from a recent fall out of the transportation vehicle and facility nurses were changing the dressing every other day. Interview on 11/19/24 at approximately 02:37 PM with LN B stated R2 fell out of the facility's transportation vehicle, resulting in a wound to her left lower leg. LN B further stated facility nursing staff were changing the wound dressing Monday,	S3085		

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S3085	Continued From page 3 Wednesday and Fridays. LN B confirmed the NSA was not updated after R2's fall on 10/18/24 to reflect a description of current nursing services and provider of nursing services for R2's wound. Facility's "Negotiated Service Agreement" dated 03/23 recorded, "Include the following in the NSA: a. A description of services to be provided. b. Identification of the provider of each service." Administrator/ LN A failed to ensure the NSA completed for residents who required health care services identified a description of the services the resident received and identified the provider of each service.	S3085		
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)	S3211		

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S3211	Continued From page 4 The census totaled 10 residents. The sample included 3 residents. Based on observation and interview for 1 sampled Resident (R)1 and 3 non-sampled Residents (R)4, R5 and R6, Administrator A failed to ensure licensed nurses or pharmacists placed the full name of the resident on each package of the resident's over the counter medication. Findings included: - Observation on 11/19/24 at 10:13 AM with Certified Medication Aide (CMA) C revealed a locked medication room in the facility. The following over the counter medications were noted without first and last names: For R1, the cart contained one bottle of Aspirin (non-steroidal anti-inflammatory drug), For R4, the cart contained one bottle of Blink Dry Eye drops, The cart contained one bottle of Acetaminophen (pain reliever/ fever reducer) labeled "stock". Interview on 11/19/24 with CMA C confirmed the above listed medications were without full first and last name for R1 and R4 and further confirmed the Acetaminophen medication was used as stock medication for any resident that needed it. - Observation on 11/19/24 at approximately 10:35 AM with Certified Medication Aide (CMA) D revealed a locked medication room in the facility. The following over the counter medications were noted without first and last names: For R5, the cart contained one bottle of Allergy Relief, For R6, the cart contained one bottle of Systane	S3211		

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S3211	Continued From page 5 Dry Eye Relief eye drops, The cart contained two bottles of Acetaminophen and one bottle of Allergy Tablets, which had no label on them. Interview on 11/19/24 with CMA D confirmed the above listed medications were without full first and last name for R5 and R6 and further confirmed the Acetaminophen and Allergy Tablet bottles were used as stock medication. Facility's "Medication Management" policy dated 03/23 recorded, "If the original manufacturer's package of an OTC medication contained a medication in a container, bottle, or tube that can be removed from the original package, the licensed pharmacist or licensed nurse must place the full name of the resident on both the original manufacturer's medication package and the medication container." Administrator A failed to ensure licensed nurses or pharmacists placed the full name of residents on each package of the resident's over the counter medication.	S3211		
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	S3215		

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S3215	Continued From page 6 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. This REQUIREMENT is not met as evidenced by: KAR 26-41-205 (h) (4) The facility reported a census of 10 residents. Based on observation, interview, and record review, Administrator A failed to ensure staff stored Tuberculin solution properly to ensure it was not accidentally administered beyond the manufacturers recommended date of expiration, which had the potential to affect all residents. - On 11/19/24 at approximately 10:35 AM Certified Medication Aide (CMA) D revealed a medication refrigerator inside the locked medication room in the facility. The medication	S3215		

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S3215	Continued From page 7 refrigerator contained a box with an opened vial of Tuberculin solution. The Tuberculin solution had an open date of 06/30/21. Interview on 11/19/24 with CMA D confirmed the open date on the Tuberculin solution was dated 06/30/21. Interview on 11/19/24 at approximately 02:37 PM with Licensed Nurse (LN) B stated she was unaware the Tuberculin solution was in the medication refrigerator. Tuberculin manufacturer guidelines directions for storage include to date the tuberculin vial when opening and discard it after 30 days. Administrator A failed to ensure staff stored the tuberculin solution, so it was not accidentally administered beyond the manufacturers or pharmacy' recommended date of expiration, which had the potential to affect all residents.	S3215		