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S 000	INITIAL COMMENTS The following citations represent the findings of the licensure resurvey, complaint investigations #136704 and #136962 for the above named facility conducted on 4/03/19, 4/04/19, 4/08/19 and 4/09/19.	S 000		
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. This REQUIREMENT is not met as evidenced by: KAR 26-41-202 (a) The facility reported a census of 19 residents. The sample included 3 residents. Based on record review and interview the operator failed to ensure the negotiated service agreement included services provided by an outside source and the party responsible for payment of the	S3085		

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

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S3085	Continued From page 1 outside services in regards for 1 of 3 sampled residents #416 regarding Hospice services. Findings included: - On 4/03/19 operator A provided a resident roster which indicated no residents received outside services. Record review for resident #416 revealed an admission date of 7/05/18 with diagnoses of hypertension, anxiety, both hips replaced, heart mitral valve regurgitation and PSVT (Paroxysmal supraventricular tachycardia). The admission functional capacity screen (FCS) dated 7/05/18 identified the resident with short-term and long-term memory deficit, impaired memory recall and decision making. He/she needed physical assistance with dressing and could ambulate independently with a 4-wheeled walker. He/she required supervision for toileting. The FCS also indicated the resident can perform task or activity but was very slow, had a major difference in activities of daily living (ADL) functioning in the morning and evening. He/she tires noticeably most days. The negotiated service agreement/health service plan (NSA/HSP) dated 7/05/18 included identification of cognitive impairment and directed staff the family would make any major decision making. The resident was able to hear when spoken to loudly. Staff would encourage the resident to toilet and change incontinent product. The NSA/HSP directed staff to assist the resident PRN (as needed) with him/her ambulating independently using a 4-wheeled walker. Staff to assist the resident with dressing in the morning and evening. The NSA/HSP was updated with a	S3085		

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S3085	Continued From page 2 fall on 7/30/18 related to resident's report of losing balance and was not wearing proper footwear. The intervention was for the resident to wear proper footwear at all time. On 9/5/18 the resident fell and again attributed it to lost balance. Staff noted the resident did not use his/her walker at the time. Intervention for resident to use the walker while ambulating. On 9/25/18 the resident fell attempting to pick items off the floor with an intervention to ask staff for assistance when items on the floor. The NSA/HSP had no other revisions. Under the miscellaneous tab of the chart was a document from a Hospice provided dated 3/18/19 which read I will see the resident once a week ... Review of the nursing notes revealed the last entry was dated 3/12/19. Interview with licensed nurse F on 4/03/19 at 2:30 PM confirmed the resident received Hospice services and the NSA/HSP was not revised to reflect these services. The operator failed to ensure the negotiated service agreement included services provided by an outside source and the party responsible for payment of the outside services regarding Hospice services for this resident.	S3085		
S3155 SS=E	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	S3155		

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S3155	Continued From page 3 capacity screening and the negotiated service agreement. This REQUIREMENT is not met as evidenced by: KAR 26-41-204 (a) The facility reported a census of 19 residents. The sample included 3 residents. Based on observation, interview and record review the operator failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services to meet the needs for 1 of 3 sampled residents (#416) in accordance with the functional capacity screening and negotiated service agreement regarding investigations into causal factors of repeated falls and implementation of interventions to reduce the risk of further falls. Findings included: - Record review for resident #416 revealed an admission date of 7/05/18 with diagnoses of hypertension, anxiety, both hips replaced, heart mitral valve regurgitation and PSVT (Paroxysmal supraventricular tachycardia). The admission functional capacity screen (FCS) dated 7/05/18 identified the resident with short-term and long-term memory deficit, impaired memory recall and decision making. He/she needed physical assistance with dressing and could ambulate independently with a 4-wheeled walker. He/she required supervision for toileting. The FCS also indicated the resident	S3155		

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S3155	Continued From page 4	S3155		

can perform task or activity but was very slow, had a major difference in activities of daily living (ADL) functioning in the morning and evening. He/she tires noticeably most days.

The negotiated service agreement/health service plan (NSA/HSP) dated 7/05/18 included identification of cognitive impairment and directed staff the family would make any major decision making. The resident was able to hear when spoken to loudly. Staff would encourage the resident to toilet and change incontinent product. The NSA/HSP directed staff to assist the resident PRN (as needed) with him/her ambulating independently using a 4-wheeled walker. Staff to assist the resident with dressing in the morning and evening. The NSA/HSP was updated with a fall on 7/30/18 related to resident's report of losing balance and was not wearing proper footwear. The intervention was for the resident to wear proper footwear at all time. On 9/5/18 the resident fell and again attributed it to lost balance. Staff noted the resident did not use his/her walker at the time. Intervention for resident to use the walker while ambulating. On 9/25/18 the resident fell attempting to pick items off the floor with an intervention to ask staff for assistance when items on the floor. The NSA/HSP had no other revisions related to falls.

Record review revealed of nursing notes between 9/07/18 and 3/12/19 revealed the following entries:
on 2/9/19 at 5:15 AM certified medication aide (CMA) C wrote the resident had a rough night, confused, cried most of the time he/she was awake seeing/talking to a family member who was not there. Another entry on that date and without a time - the resident fell onto his/her knees at about 2:40 AM. CMA C called the nurse.

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S3155	Continued From page 5	S3155		

The resident had no pain or marks from the fall. The resident said he/she was "here" and then "gone". He/she said a family member was coming to get him/her. The resident refused to have vital signs taken at this time but was able to at 4:00 AM. The note lacked any interventions implemented to reduce the resident's anxiety, tearfulness or risk for further falls. Another entry on that date without a time - resident fell again at approximately 5:30 AM - left by ambulance at 5:50 AM, called nurse and family. The next entry 2/09/19 at 7:00 AM returned from hospital via family at 6:45 AM with no new orders. The notes lacked any information into causal factors or interventions to reduce the risk of further falls.

On 3/06/19 at 11:22 PM the resident fell going to the bathroom with no injuries. The note lacked any information about the fall or investigation into causal factors and no interventions to reduce the risk of further falls.

Observation on 4/04/19 at 9:35 AM revealed certified staff D provided stand by assistance for the resident to ambulate with a four wheeled walker, the cognitively impaired resident needed instructions/directions of what the staff wanted him/her to do and certified staff D occasionally took hold of the resident's arm to guide/maneuver him/her to walk and not sit on the seat of the walker. Certified staff D assisted the resident to a rocking recliner in the common area. At 9:37 AM the cognitively impaired resident stood up independently and began walking with a 4-wheeled walker in the hallway looking at names and room numbers as if looking for his/her room.

Interview on 4/04/19 at 9:35 AM with certified staff D revealed the resident was confused and would look for his/her family. He/she was at risk for falls

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S3155	Continued From page 6 and had fallen before. Staff D reported he/she would check on the resident frequently and try to assist the resident to walk when needed. Staff D said the resident needed reminders to use the restroom. Interview with licensed nurse F on 4/04/19 at 10:54 AM revealed he/she was not aware of the 2 falls which occurred on 2/09/19 or the fall on 3/06/19. He/she reported an expectation for staff to complete an incident report at the time of a fall and then he/she would do a further investigation to determine a cause and develop an intervention. He/she confirmed the facility lacked any incident reports or investigations for the 2 falls on 2/09/19 or the fall on 3/06/19. The operator failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services to meet the needs for this resident in accordance with the functional capacity screening and negotiated service agreement regarding investigations into causal factors of repeated falls and implementation of interventions to reduce the risk of further falls.	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:	S3200		

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S3200	Continued From page 7 (1) Only licensed nurses and medication aides shall administer and manage medications for which the facility has responsibility. (2) Medication aides shall not administer medication through the parenteral route. This REQUIREMENT is not met as evidenced by: KAR 26-41-205 (d) The facility reported a census of 19 residents. The sample included 3 residents. Based on record review and interview the operator failed to ensure licenses nurses and certified medication aides administered medications in accordance with a medical care provider's written order and professional standards for 1 of 3 residents (#519) regarding missing doses of a controlled substance pain medication. Findings included: - Record review for resident #519 revealed an admission date of 10/25/13 with diagnoses of Alzheimer's, dementia, stroke, seizures, restless leg syndrome and gait disturbance. The annual functional capacity screen dated 10/18/18 indicated the resident had intact cognition and needed physical assistance with medication management. The negotiated service agreement/health service plan (NSA/HSP) dated 10/18/18 indicated facility staff would set-up, store, reorder and administer the resident's medications.	S3200		

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S3200	Continued From page 8 Review of the physician orders revealed on 11/27/18 the physician reduced the dosage of Oxy IR to 5 milligrams (mg) by mouth 3 times a day and 10 mg at HS (hours of sleep) for chronic pain. Review of the January 2019 medication administration record (MAR) revealed the Oxy IR 5 mg was scheduled for administration at 9:00 AM, noon, and 4:00 PM. The record reflected administration of the 9:00 AM dose on 1/05/19 then CMA A circled his/her initials for the noon and 4:00 PM dose. Certified medication aide (CMA) J circled his/her initials for the 9:00 AM dose on 1/06/19, CMA A circled his/her initials for the noon dose and CMA G circled his/her initials for the 4:00 PM dose. On 1/07/19 CMA A circled his/her initials for the 9:00 AM dose and noon dose with the 4:00 PM dose being administered. A total of 7 doses were circled. The January 2019 MAR documentation sheet had 2 entries about the medications - 1/05/19 12:00 PM Oxy 5 mg not given - out of medicine with no documentation of the reason why or whether the pharmacy was contacted. On 1/06/19 AM and lunch Oxy 5 mg not given - out of med with no documentation of the reason why or whether the pharmacy was contacted. The January 2019 MAR for the Oxy IR 10 mg at HS revealed initials circled on 1/05/19 and 1/06/19. The MAR documentation sheet lacked any information for the circled initials regarding the Oxy IR 10 mg. Review of the resident's narcotic/scheduled drug administration record revealed for both the Oxy IR 5 mg and Oxy IR 10 mg (on separate sheets)	S3200		

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and compared to pharmacy delivery receipts revealed all doses accounted for. However, the staff failed to follow standards of practice regarding administration and record keeping as follows:
On 12/28/18 staff used a tablet from the Oxy IR 10 mg card to administer 2 scheduled 5 mg doses. According to the PDR (physician drug reference) Oxycodone cannot be split into 2 pills. The administration directions for Oxycodone IR (immediate release) said to swallow whole, do not break, crush, cut, chew or dissolve.

The January 2019 resident narcotic/scheduled drug administration record for the Oxy IR 5 mg tablets delivered on 12/28/18 reflected on 1/01/19, 1/02/19, 1/03/19, and 1/04/19 staff removed 2 tablets of 5 mg to administer for the 10 mg ordered for HS. None of the documentation reflected contacting the pharmacy to obtain the needed 10 mg tablets.

Note - Staff preparing medications inappropriately as documented above instead of calling the pharmacy when out of the Oxy (first 5 mg on 12/28/18 and then 10 mg on 1/01/19) created the medication shortage of both the 5 mg and 10 mg Oxy IR. This shortage resulted in the resident going without adequate pain management for 2.5 days.

Review of the nursing notes revealed entry on 1/05/19 at 2:00 AM resident resting all night with eyes closed no vital signs obtained. The next entry was dated 1/14/19 at 9:05 AM resident out of facility with family. The notes lacked any information regarding the resident not having his/her scheduled narcotic medication for chronic pain, no consulting with the pharmacy regarding the lack of prescribed medication or notification of

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the physician.

Interview on 4/03/19 with the resident revealed he/she had some trouble with the facility management of his/her medications in January 2019. He/she could not remember the details but was about his/her pain medications.

Interview on 4/04/19 at 12:20 PM with licensed nurse F revealed the circling of initials on the MAR meant the medication was not given or some alteration of the scheduled administration. He/she expected staff to document the reason on the MAR documentation sheet.

Interview on 4/04/19 at 12:30 PM with certified medication aide/operator A confirmed the resident's record lacked any documentation about the lack of medications, contacting the pharmacy to obtain the medication, notification of the physician or how the resident tolerated not having the controlled substance pain medication.

Interview on 4/08/19 and 4/09/19 with pharmacy staff H revealed the pharmacy filled and delivered 30 tablets of Oxy IR 5 mg a 10-day supply on 12/28/18. He/she said the facility should have had enough Oxy IR 5 mg to last through the morning dose of 1/08/19. The pharmacy filled the Oxy IR 10 mg prescription on 11/27/18 with 30 tablets and was not requested again until 1/07/19. He/she provided documentation of the deliveries which were reviewed and compared to the facility records as identified above.

The operator failed to ensure licenses nurses and certified medication aides administered medications in accordance with a medical care provider's written order and professional standards for this resident regarding controlled

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S3200	Continued From page 11 substance pain medication.	S3200		
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 19 residents. The facility reported managing the medications for 12 of the 19 residents. Based on observation and interview the operator failed to ensure a licensed nurse or licensed pharmacist placed the full name of the resident on the original manufacturer's package of over-the-counter medications. Findings included: - On 4/03/19 at 12:22 PM certified medication aide (CMA) C opened only medication room and medication cart. Observation revealed the	S3211		

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S3211	Continued From page 12 following over-the-counter (OTC) medications in bottles/tubes/containers. The following OTC medications lacked proper labeling with the resident's full name: Resident #187 had 3 OTC medications labeled with only a room number Resident #296 had 1 OTC medication labeled with a first initial and last name Resident #318 had 2 OTC medications 1 labeled with a room number and 1 labeled with a last name only Resident #417 had 1 OTC medication labeled with a room number Resident #423 had 1 OTC medication labeled with a room number The cart also had a container of OTC petroleum jelly labeled a stock medication for the facility. Interview on 4/03/19 at 12:22 PM with CMA C revealed when the resident or the family brings in an OTC medication he/she would write the resident's room number on the box/container. either the family or resident would write the resident's name on the bottle or the CMA would write it on there and then date it when opened. Interview on 4/03/19 at 12:25 PM with licensed nurse F confirmed he/she was not aware of the regulation for a licensed nurse or licensed pharmacist to label the OTC medications or that the OTCs must be labeled with the resident's full name. The operator failed to ensure a licensed nurse or licensed pharmacist placed the full name of the resident on the original manufacturer's package of over-the-counter medications.	S3211		

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S3215	Continued From page 13	S3215		
S3215 SS=E	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. This REQUIREMENT is not met as evidenced by: KAR 26-41-205 (h) (4)	S3215		

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	N002001	A. BUILDING: _____ B. WING _____	04/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUEST HOME ESTATES VII	806 W 4TH STREET GARNETT, KS 66032

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S3215	Continued From page 14 The facility reported a census of 19 residents. The facility identified 12 residents received medication management by the facility. Based on observation, interview and record review the operator failed to ensure licensed nurses and medication aides could not administer medication beyond the manufacture's or pharmacy provider's recommended date of expiration for resident #166. Findings included: - On 4/03/19 operator A provided the facility resident roster which identified 12 residents received facility managed medications. On 4/03/19 at 12:22 PM certified medication aide (CMA) C opened the only medication room and medication cart. Observation of the medication cart revealed an open and in-use Victoza (a medication to treat diabetes) injection pen without a date of when open to ensure the medication was used in the time frame recommended by the manufacture. CMA C said the medication was for resident #166. The cart also had an open and in-use injector pen of Lantus (a medication to treat diabetes) for resident #166 which had a date but was illegible and rubbed off. Observation of the medication storage refrigerator revealed a vial of tuberculosis testing solution dated when opened as 2/04/19 (59 days). The manufacture recommended to discard any unused portion after 30 days once opened Licensed nurse F entered the medication room during the above observation and confirmed his/her expectation for staff to write the open date on the injector pens and the medications were to	S3215		

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S3215	Continued From page 15 be discarded after 30 days of being opened. He/she reported the tuberculosis testing solution is good for 60 days. The manufacture written instruction pamphlet in the box recommended to discard any unused portion after 30 days. The operator failed to ensure licensed nurses and medication aides could not administer medication beyond the manufacture's or pharmacy provider's recommended date of expiration.	S3215		
S3248 SS=D	26-41-102 (d) Staff Qualifications Employee Records (d) The employee records and agency staff records shall contain the following documentation: (1) Evidence of licensure, registration, certification, or a certificate of successful completion of a training course for each employee performing a function that requires specialized education or training; (2) supporting documentation for criminal background checks of facility staff and contract staff, excluding any staff licensed or registered by a state agency, pursuant to K.S.A. 39-970 and amendments thereto; (3) supporting documentation from the Kansas nurse aide registry that the individual does not have a finding of having abused, neglected, or exploited a resident in an adult care home; and (4) supporting documentation that the individual does not have a finding of having abused, neglected, or exploited any resident in an adult care home, from the nurse aide registry in each state in which the individual has been known to have worked as a certified nurse aide.	S3248		

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S3248	Continued From page 16 This REQUIREMENT is not met as evidenced by: KAR 26-41-102 (d)(1)(3) The facility reported a census of 19 residents. Based on interview and record review the operator failed to have evidence he/she checked with the nurse aide registry as required to ensure the individual did not have a finding of abuse/neglect/exploitation for 1 of 3 certified nurse aides/certified medication aides hired since the last resurvey (nurse aide E). Certified nurse aide E had the potential to provide care to all the residents. Findings included: - Personnel record review on 4/03/19 at 4:30 PM revealed the personnel record for certified nursing assistant E revealed he/she began employment on 3/04/19. The personnel file lacked registry verification. Operator A confirmed the record lacked evidence of a nurse aide registry verification for CNA E. The Operator failed to have evidence he/she verified the nurse aide registry for CNA E who had the potential to provide care to all the residents.	S3248		
S3265 SS=F	26-41-104 (a) Disaster and Emergency Preparedness (a) The administrator or operator of each assisted living facility or residential health care facility shall	S3265		

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S3265	Continued From page 17	S3265		

ensure the provision of a sufficient number of staff members to take residents who would require assistance in an emergency or disaster to a secure location.

This REQUIREMENT is not met as evidenced by:
KAR 26-41-104 (a)

The facility reported a census of 19 residents. The facility reported 16 of the 19 residents had cognitive impairment. Based on observation, record review and interview the operator failed to conduct an emergency evacuation drill with the least amount of staff on duty to ensure the provision of a sufficient number of staff members to take residents who would require assistance in an emergency or disaster to a secure location.

Findings included:

- On 4/03/19 Operator A provided the resident roster which identified 16 residents with cognitive impairment. He/she reported staffing between 10:00 PM and 6:00 AM with 1 certified nursing assistant.

On 4/03/19 at 4:40 PM operator A provided documentation for the annual evacuation of the facility conducted on 9/20/17 and 9/16/18.

The 6/29/18 monthly fire drill report marked as evacuation indicated the time of the drill was 11:00 AM. The report indicated an audible alarm was activated and staff responded to the alarm. Operator B conducted the evacuation drill and noted 3 staff names and marked all residents were evacuated but failed to list the residents who

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S3265	Continued From page 18 participated. Observation on 4/03/19 at 12:47 PM revealed resident #728 required assistance from certified staff C to ambulate with a wheeled walker from the dining room table to his/her room and frequently had to provide the cognitively impaired residents with instructions/directions. Observation on 4/04/19 at 9:35 AM revealed certified staff D provided stand by assistance for resident #416 to ambulate with a four wheeled walker, the cognitively impaired resident needed instructions/directions of what the staff wanted him/her to do and certified staff D occasionally took hold of the resident's arm to guide/maneuver him/her to walk and not sit on the seat of the walker. Interview on 4/03/19 at 4: 40 PM with operator A confirmed the only evacuation drill since the last resurvey (1/30/18) was the drill conducted on 6/29/18. He/she confirmed the document lacked evidence of an evacuation with the least amount of staff to ensure that amount of staff was adequate to evacuate the residents in a timely manner during an emergency or disaster. The operator failed to conduct an emergency evacuation drill with the least amount of staff on duty to ensure the provision of a sufficient number of staff members to take residents who would require assistance in an emergency or disaster to a secure location.	S3265		