Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N002001	A. BUILDING: _____ B. WING _____	04/28/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS The following citations represent the findings of a resurvey with complaint investigations 74747, 74761, 72356 and 72373 at the above named residential health care facility conducted on 4-24-14 and 4-28-14.	S 000		
S3028 SS=D	26-41-101 (f) (3) Staff Treatment of Residents Reporting (f) (3) Each allegation of abuse, neglect, or exploitation shall be reported to the administrator or operator of the facility as soon as staff is aware of the allegation and to the department within 24 hours. The administrator or operator shall ensure that all of the following requirements are met: (A) An investigation shall be started when the administrator or operator, or the designee, receives notification of an alleged violation. (B) Immediate measures shall be taken to prevent further potential abuse, neglect, or exploitation while the investigation is in progress. (C) Each alleged violation shall be thoroughly investigated within five working days of the initial report. Results of the investigation shall be reported to the administrator or operator. (D) Appropriate corrective action shall be taken if the alleged violation is verified. (E) The department ' s complaint investigation report shall be completed and submitted to the department within five working days of the initial report. (F) A written record shall be maintained of each investigation of reported abuse, neglect, or exploitation. This REQUIREMENT is not met as evidenced	S3028		

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

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S3028	Continued From page 1 by: KAR 26-41-101(f)(3) The facility reported a census of 23 residents. The sample included 3 residents and 1 focus review resident. Based on observation, record review and interview for 1 (#234) of 3 sampled residents, the operator failed to ensure each allegation of abuse shall be reported to the department within 24 hours. Finding included: - Record review for resident #234 revealed admission on 8-17-02 with diagnoses Hypothyroidism, Anxiety, Hypertension, Depression, Hemorrhoids, Rectal Bleeding, Hyperlipidemia, Psychotic Mood Disorders and Early Parkinson's. The functional capacity screen dated 12-26-13 recorded resident required physical assistance with bathing, dressing, eating management of medications and management of treatments; supervision with toileting, transfers and walking/mobility. Occasionally incontinent of bladder. Cognition: problems with decision-making. No problems with communication. Current problems/risks identified: Falls/unsteadiness, impaired hearing and impaired decision-making. The negotiated service agreement dated 12-26-13 recorded the following services: staff assistance with bathing and dressing; staff to cut up/mash foods; staff to store, reorder and administer all medications; and to monitor and assist with changing of incontinent products. On 2-17-14 NSA amended to include admission to hospice.	S3028		

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S3028	Continued From page 2 Confidential Interview on 4-24-14 expressed concerns regarding resident's right to privacy during personal care and performing a procedure without consent. Interview on 4-24-14 at 10:35 pm with administrative staff A stated there had been a concern from a staff member regarding "not treating a resident right." Interview on 4-24-14 at 3:50 pm with adminsitrative staff B confirmed he/she received a call on the company hotline number about an allegation of resident abuse. Further confirmed he/she performed an investigation and failed to report the allegation to the department. For resident #234, the operator failed to ensure all allegations of abuse are reported to the department within 24 hours.	S3028		
S3261 SS=D	26-41-105 (f) (11) Resident Record Documentation of Incidents (f) (11) documentation of all incidents, symptoms, and other indications of illness or injury including the date, time of occurrence, action taken, and results of the action This REQUIREMENT is not met as evidenced by: KAR 26-41-105(f)(11) The facility reported a census of 23 residents. The sample included 3 residents and one focus review. Based on record review and interview for	S3261		

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S3261	Continued From page 3 1(#234) of 3 sampled residents, the operator failed to ensure documentation of all incidents including date, time of occurrence, action taken and results of the action. Findings included: - Record review for resident #234 revealed admission on 8-17-02 with diagnoses Hypothyroidism, Anxiety, Hypertension, Depression, Hemorrhoids, Rectal Bleeding, Hyperlipidemia, Psychotic Mood Disorders and Early Parkinson's. The functional capacity screen dated 12-26-13 recorded resident required physical assistance with bathing, dressing, eating management of medications and management of treatments; supervision with toileting, transfers and walking/mobility. Occasionally incontinent of bladder. Cognition: problems with decision-making. No problems with communication. Current problems/risks identified: Falls/unsteadiness, impaired hearing and impaired decision-making. The negotiated service agreement dated 12-26-13 recorded the following services: staff assistance with bathing and dressing; staff to cut up/mash foods; staff to store, reorder and administer all medications; and to monitor and assist with changing of incontinent products. On 2-17-14 NSA amended to include admission to hospice. Fax to physician dated 4-3-14 from hospice nurse: "Resident has a very red periarea. Resident's urine has an odor and is dark with sediment. Can we please get a urinalysis?" Request approved by the physician.	S3261		

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S3261	Continued From page 4 Hospice Nursing Visit Record dated 4-3-14 stated: "...staff report residents periarea is fire engine red. Staff describe urine as dark with sediment and with a foul odor. This nurse sent email to bring out moisture barrier. Fax sent to physician requesting an order for a urinalysis." Signed by hospice nurse. 4-7-14: "...resident continues to have a red periarea." Signed by hospice nurse. 4-10-14: "...resident having increased difficulty with pericare and requires assistance from staff. Resident's periarea continues to be red. Staff is applying barrier cream." Signed by hospice nurse. 4-14-14: "...resident's periarea remains red. Moisture barrier applied." Signed by hospice nurse. 4-17-14: "Resident has experienced an increase in incontinent episodes. Resident requiring more assistance from staff with pericare and changing pull up. Resident using towels in pullup and then trying to flush them down the toilet." Signed by hospice nurse. The facility record lacked documentation of conversations with the resident in which he/she was informed of the reasoning for procedures and consent was obtained. The record further lacked documentation of the date/time of a pericare procedure, who completed the procedure and follow up of effectiveness of the procedure. The record also lacked documentation of a nursing assessment regarding resident's skin. Interview on 4-24-14 at 2:15 pm with hospice nurse stated resident had started becoming incontinent of bowel and bladder which was new for him/her. As a result, was having skin irritation	S3261		

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S3261	Continued From page 5 and required extensive staff assistance with toileting, pericare and skin care by both hospice staff and facility staff. Confirmed there had been discussions between hospice and facility staff regarding a means to keep resident's skin free of irritation. Interview on 4-24-14 at 3:30 pm with administrative staff A confirmed the staff had been inserviced regarding proper pericare for the resident after explaining what they were doing and obtaining resident's permission to train staff by demonstration. Also confirmed he/she did not document the conversation with resident #234 or that resident gave permission. In a separate incident, administrative staff A stated the resident had been fully informed about a procedure to improve pericare and confirmed he/she had not documented resident's consent, performance of the procedure or the outcome. For resident #234, the operator failed to ensure documentation of conversations with the resident regarding procedures, obtaining of the resident's consent for the procedures and followup of effectiveness.	S3261		