STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175221	A. BUILDING _____ B. WING _____	C 03/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADVENA LIVING AT FOUNTAINVIEW	**601 N ROSE HILL ROAD ROSE HILL, KS 67133**

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F 000	INITIAL COMMENTS The following citations represent the findings of complaint investigations #164211, #164339, #164386, #165225, #165277, #165806, #168856, and #170373. This 2567 was electronically sent to the facility on 04/05/2022.	F 000		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: The facility reported a census of 41 residents with three reviewed for accidents. Based on record review and interview, the facility failed to thoroughly investigate a resident's report to the facility staff of a fall sustained by R1 in the facility to ensure no abuse or neglect to the resident.	F 610		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 610	Continued From page 1	F 610		

Findings included:

- The "Physician Orders" (PO), dated 01/24/22, documented R1 with a diagnosis of unspecified dementia without behavioral disturbance (progressive mental disorder characterized by failing memory and confusion).

The "Admission Minimum Data Set" (MDS), dated 01/25/22, documented the resident with short-term and long-term memory problems and moderately impaired cognition for daily decision making. He required extensive assistance of one to two staff members for "Activities of Daily Living" (ADLs). The resident had no history of falls prior to admission.

The "Care Area Assessment" (CAA), dated 02/01/22, for "Activities of Daily Living" (ADLs) and "Falls", documented the resident was alert and able to communicate some needs. He required extensive assistance of one to two staff with ADLs and transfers. The resident had no falls during the lookback period.

The "Baseline Care Plan," dated 01/20/22, documented the resident required extensive assistance for all ADLs and used a wheelchair for mobility.

A "Progress Note", dated 02/08/22, documented Consultant Staff GG assessed the resident for a fall. Severity of the fall graded as mild. Onset of the fall was in the morning walking from his bed to the sink. R1 reported no injuries. The resident was ambulating to the sink with the use of his wheelchair. He was pushing the wheelchair and walking behind it instead of using his walker and asking for assistance from the staff. R1 had an

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175221	A. BUILDING _____ B. WING _____	C 03/29/2022

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F 610	Continued From page 2	F 610		

abrasion to the left scalp parietal area and normal range of motion in his extremities.

Interview on 03/21/22 at 4:10 PM, Licensed Nurse (LN) G reported on 02/08/22, she assessed R1 in his room and noticed he could not sit up on the side of the bed without her assistance. His roommate reported he fell during the night a few days before and that R1's roommate told the aides working that night about the fall. She also reported R1 hit his head. LN G did some investigating and found two aides, Certified Medication Aide (CMA) M and CMA N who stated R1's roommate told them he fell by the closet and hit his head. The CMAs did not report the fall to the charge nurse. That same day, Consultant Staff GG was in the building to assess the residents. LN G reported her assessment of R1 and told Consultant Staff GG about the fall. LN G did not report it to administration. LN G stated the fall should have been reported to the Director of Nursing (DON) and the administrator so they could investigate.

Interview, on 03/23/22 at 08:30 AM, with Administrative Nursing Staff D stated staff did not report the fall sustained by R1 to her. The staff should have reported the suspected fall immediately so the facility could do an appropriate investigation and provide interventions to reduce any more falls.

The facility policy "Accidents and Incidents - Investigating and Reporting," revised October 2021, documented ...Policy Statement ...All accidents or incidents involving resident ...occurring on our premises shall be investigated and reported to the Administrator ...Policy Interpretation and Implementation ...1. The Nurse

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175221	A. BUILDING _____ B. WING _____	C 03/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADVENA LIVING AT FOUNTAINVIEW	601 N ROSE HILL ROAD ROSE HILL, KS 67133

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F 610	Continued From page 3 Supervisor/Charge Nurse and/or the department director or supervisor shall promptly initiate and document investigation of the accident or incident ... The facility failed to thoroughly investigate a resident reported fall sustained by R1 in the facility to ensure no abuse or neglect to the resident.	F 610		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: The facility reported a census of 41 residents with four reviewed for unnecessary medications.	F 757		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADVENA LIVING AT FOUNTAINVIEW	601 N ROSE HILL ROAD ROSE HILL, KS 67133

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F 757	Continued From page 4	F 757		

Based on record review and interview, the facility failed to ensure three of the four residents reviewed, remained free of unnecessary medications, including Resident (R)1, R3 and R6 when facility staff failed to monitor blood sugars and administer diabetic medications as ordered by the physician, to ensure no unnecessary medication usage.

Findings included:

- The "Physician Orders" (PO), dated 01/24/22, documented R1 with a diagnosis of type 1 diabetes mellitus (a chronic disease characterized by high levels of sugar in the blood).

The "Admission Minimum Data Set" (MDS), dated 01/25/22, documented the resident with short-term and long-term memory problems and moderately impaired cognition for daily decision making. He required extensive assistance of one to two staff members for "Activities of Daily Living" (ADLs). The resident received insulin injections during the seven-day lookback period.

The "Care Area Assessment" (CAA), dated 02/01/22, for "Activities of Daily Living" (ADLs), documented the resident was alert and able to communicate some needs. He required extensive assistance of one to two staff with ADLs and transfers.

The "Baseline Care Plan," dated 01/20/22, documented the resident was diabetic and required insulin (antidiabetic medication).

The PO, dated 01/24/22, documented orders as follows:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175221	A. BUILDING _____ B. WING _____	C 03/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 757	Continued From page 5	F 757		

1. Insulin Aspart Solution (antidiabetic medication) 100 units (u)/milliliter (ml), inject five units subcutaneously in the evening for diabetes before dinner (04:00 PM). Hold if the resident refuses meal. Ordered on 01/20/22.

2. Insulin Glargine Solution (antidiabetic medication) 100u/ml. Inject 16 units subcutaneously at bedtime for diabetes. Ordered on 01/19/22.

3. Accu-checks (diabetic testing) fasting (before meals) and 2-hour PC (after meal). Notify the physician if less than 60 or greater than 500. Four times daily. Ordered on 01/19/22.

4. Insulin Aspart Solution (antidiabetic medication) 100 units (u)/milliliter (ml), inject five units subcutaneously in the afternoon for diabetes before lunch (12:00 PM). Hold if the resident refuses meal. Ordered on 01/20/22.

5. Insulin Aspart Solution (antidiabetic medication) 100 units (u)/milliliter (ml), inject five units subcutaneously in the morning for diabetes before breakfast (06:00 AM). Hold if the resident refuses meal. Ordered on 01/20/22.

Review of the January 2022 Treatment Administration Record (TAR), revealed lack of documentation for evening insulin administration on 01/30/22, lack of documentation for bedtime insulin administration on 01/31/22, and lack of Accu-check documentation on 01/31/22 at bedtime.

Review of the February, 2022 TAR, revealed lack of documentation for morning insulin

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175221	A. BUILDING _____ B. WING _____	C 03/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 757	Continued From page 6	F 757		

administration on 02/06/22, afternoon administration of insulin on 02/01/22, 02/06/22, and 02/15/22, evening administration of insulin on 02/01/22 and 02/15/22, bedtime administration of insulin on 02/15/22, and Accu-check documentation on 02/01/22 for afternoon and evening, 02/06/22 for morning and afternoon, and 02/15/22 for afternoon, evening and bedtime.

Interview, on 03/22/22 at 08:30 AM, with Administrative Nurse D reported her expectations of nursing staff were to monitor and document the resident's blood sugars and administer insulin as ordered. Nurse D stated she could not say for sure they were not done, but the instances where documentation was lacking showed that the nursing staff were not monitoring the resident's blood sugars appropriately.

The facility policy "Nursing Care of the Resident with Diabetes Mellitus," revised December 2015, documented ...Purpose ...2. Help the resident control his/her diabetes with diet, exercise and insulin (as ordered) ...Medication Management ...1. Insulin (injectable or inhaled) is required for individuals with type I diabetes ...7. The nurse will closely monitor the diabetes management of cognitively impaired residents ...Documentation ...Documentation should reflect the carefully assessed diabetic resident...14. Blood sugar results and other pertinent laboratory studies ...

The facility failed to ensure R1 received adequate monitoring of blood sugars and appropriate administration of antidiabetic medication to ensure no unnecessary medication usage.

- The "Physician Orders", (PO) dated 03/01/22,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175221	A. BUILDING _____ B. WING _____	C 03/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADVENA LIVING AT FOUNTAINVIEW	601 N ROSE HILL ROAD ROSE HILL, KS 67133

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F 757	Continued From page 7	F 757		

documented R3 with type 2 diabetes mellitus (a chronic disease characterized by high levels of sugar in the blood) and Schizophrenia (a serious mental disorder which may result in some combination of hallucinations, delusions, and extremely disordered thinking and behavior that impairs daily functioning).

The "Admission Minimum Data Set" (MDS), dated 07/25/21, documented the resident with short-term and long-term memory problems and physical behavioral symptoms directed towards others from one to three days and rejection of care from four to six days. The resident required one to two staff members for "Activities of Daily Living" (ADLs).

The "Care Area Assessment" (CAA), dated 07/30/21, documented the resident's refusal to participate in the MDS assessment and would not answer questions.

The "Quarterly MDS", dated 01/12/22, documented the resident with a Brief Interview for Mental Status score of six or severely impaired cognition. The resident required extensive assistance from one to two staff members for ADLs.

The "Care Plan," dated 01/01/22, documented the resident had a self-care performance deficit related to a cerebral vascular accident (stroke) and required assistance from one to two staff for ADLs.
The PO, dated 03/01/22, documented orders as follows:

1. Accu-checks (diabetic testing), fasting (before meals) and HS (bedtime). Notify the physician if

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175221	A. BUILDING _____ B. WING _____	C 03/29/2022

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ADVENA LIVING AT FOUNTAINVIEW	601 N ROSE HILL ROAD ROSE HILL, KS 67133

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F 757	Continued From page 8	F 757		

less than 60 or greater than 500 two times daily. Ordered on 07/21/21.

Review of the September 2021 Treatment Administration Record (TAR), revealed lack of documentation of the resident's blood sugar results on 09/17 and 09/24/21 during morning shift.

Review of the December 2021 TAR, revealed lack of documentation of the resident's blood sugar results on 12/26 and 12/27/21 during morning shift.

Review of the January 2022 TAR, revealed the resident's blood sugar result was 34 on 01/08/22. The resident's electronic medical record (EMAR) lacked documentation that the staff notified the physician of the result.

Review of the, February 2022 TAR, revealed lack of documentation of the resident's blood sugar results on 02/06 and 02/24/22 during morning shift and 02/22/22 during evening shift.

Review of the, March 2022 TAR, revealed lack of documentation of the resident's blood sugar results on 03/03/22 during morning shift and 03/14/22 during evening shift.

Interview, on 03/22/22 at 08:30 AM, Administrative Nurse D reported her expectations of nursing staff were to monitor and document the resident's blood sugars and administer insulin as ordered. Nurse D stated she could not say for sure they were not done, but the instances where documentation was lacking showed that the nursing staff were not monitoring the resident's blood sugars appropriately.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175221	A. BUILDING _____ B. WING _____	C 03/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADVENA LIVING AT FOUNTAINVIEW	601 N ROSE HILL ROAD ROSE HILL, KS 67133

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F 757	Continued From page 9	F 757		

The facility policy "Nursing Care of the Resident with Diabetes Mellitus," revised December 2015, documented ... Medication Management ...7. The nurse will closely monitor the diabetes management of cognitively impaired residents ...Documentation ...Documentation should reflect the carefully assessed diabetic resident...14. Blood sugar results and other pertinent laboratory studies ...

The facility failed to ensure R3 received adequate monitoring of blood sugar results to ensure no unnecessary medication usage.

- The "Physician Orders" (PO), dated 02/15/22, documented R6 with diagnoses of type 2 diabetes mellitus (a chronic disease characterized by high levels of sugar in the blood) and morbid (severe) obesity.

The "Admission Minimum Data Set" (MDS), dated 02/20/22, documented the resident with a Brief Interview for Mental Status score of nine or moderately impaired cognition. The resident required total assistance of two staff members for "Activities of Daily Living" (ADLs). The resident received insulin injections during the seven-day lookback period.

The "Care Area Assessment" (CAA), dated 02/27/22, for "Activities of Daily Living" (ADLs), documented the resident was able to voice her needs and required extensive to total assistance with all of her ADL functioning.

The "Care Plan," dated 03/09/22, advised the staff that the resident was extensive to total

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175221	A. BUILDING _____ B. WING _____	C 03/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADVENA LIVING AT FOUNTAINVIEW	601 N ROSE HILL ROAD ROSE HILL, KS 67133

(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) COMPLETION DATE
F 757	Continued From page 10	F 757		

assistance with all ADLs. The resident had diabetes mellitus and was insulin dependent. R6 was to receive diabetes medications and fasting serum blood sugar testing as ordered by the physician.

The PO, dated 02/25/22, documented orders as follows:

1. Humalog (antidiabetic medication) KwikPen Solution Pen-injector 100 units (u)/milliliter (ml), inject 25 units subcutaneously before meals for diabetes mellitus. Give with meals. Ordered on 02/22/22.

2. Accu-checks (diabetic testing) fasting (before meals) and 2-hour PC (after meals). Notify physician if less than 60 or greater than 500. Four times daily. Ordered on 02/14/22.

3. Lantus Solution (antidiabetic medication) 100u/ml, inject 33 units subcutaneously at bedtime for diabetes mellitus. Ordered on 02/22/22.

Review of the, February 2022 Diabetic Medication Administration Record (MAR), revealed lack of documentation of Humalog administration on 02/24/22 for morning, noon and night, and 02/26/22 for noon and night. There was no documentation for Accu-checks the entire day of 02/15/22 and documentation was missing on 02/24/22 for morning and afternoon testing.

Review of the, March 2022 Diabetic MAR, revealed lack of documentation for administration of Lantus on 03/14/22. Accu-check documentation was missing for 03/03/22 for morning, noon and evening, 03/14/22 for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175221	A. BUILDING _____ B. WING _____	C 03/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADVENA LIVING AT FOUNTAINVIEW	601 N ROSE HILL ROAD ROSE HILL, KS 67133

(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) COMPLETION DATE
F 757	Continued From page 11	F 757		

bedtime.

Interview, on 03/22/22 at 08:30 AM, Administrative Nurse D reported her expectations of nursing staff were to monitor and document the resident's blood sugars and administer insulin as ordered. Nurse D stated she could not say for sure they were not done, but the instances where documentation was lacking showed that the nursing staff were not monitoring the resident's blood sugars appropriately.

The facility policy "Nursing Care of the Resident with Diabetes Mellitus," revised December 2015, documented ...Purpose ...2. Help the resident control his/her diabetes with diet, exercise and insulin (as ordered) ...Medication Management ...1. Insulin (injectable or inhaled) is required for individuals with type I diabetes ...7. The nurse will closely monitor the diabetes management of cognitively impaired residents ...Documentation ...Documentation should reflect the carefully assessed diabetic resident...14. Blood sugar results and other pertinent laboratory studies ...

The facility failed to ensure R6 received adequate monitoring of blood sugars and appropriate administration of antidiabetic medication to ensure no unnecessary medication usage.