STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087073	A. BUILDING: _____ B. WING _____	R-C 06/06/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLEN CARR HOUSE	1433 N HAMILTON DRIVE DERBY, KS 67037

(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 are the result of a Revisit and Correction Order 17-57 at the above named Residential Health Care facility in Derby, Kansas on 6/01/17, 6/05/17, and 6/06/17.	{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) The census equalled 51 the sample included four Residents. Based on interviews and reviews of records, for four of four sampled (#1070, #1072, #1074, and #1085), the Operator failed to ensure the Negotiated Service Agreement (NSA) contained a description of the services the Resident to receive, and identification of the	{S3085}		

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
	N087073	A. BUILDING: _____ B. WING _____	R-C 06/06/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLEN CARR HOUSE	1433 N HAMILTON DRIVE DERBY, KS 67037

(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
{S3085}	Continued From page 1 provider of each service. Findings included: - Review of record revealed #1085 admitted to facility 11/19/11 with diagnoses of Dementia, Reynauds, Osteoarthritis, Hyperlipidemia, Alzheimer's, and Gastroesophageal reflux disease. The current Functional Capacity Screen (FCS) of 12/02/16 assessed #1085 in need of physical assistance with bathing, dressing, toileting; in need of supervision with transfers, mobility, and eating; unable to perform medication and treatment management; incontinent of bladder; usually understood, usually understands for communication; with short term, memory recall and decision making impairments; with falls/unsteadiness, vision impairment, and used walker. The current 12/02/16 Negotiated Service Agreement (NSA) and Health Service Plan (HSP) documented: Resident requests occasional stand-by assist with ambulating, with walker Resident requests stand-by assist and cuing with transfers, with walker Resident requests staff to wake in AM and partial assist with dressing/morning care, shoes, socks, belt Resident requests verbal cuing and minimal assistance to complete daily hygiene or grooming, teeth brushing Extensive incontinence assist of one with pull ups Requests staff make bed daily Requests staff remind for bed time care and provide partial assist with undressing/night time care	{S3085}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087073	A. BUILDING: _____ B. WING _____	R-C 06/06/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLEN CARR HOUSE	1433 N HAMILTON DRIVE DERBY, KS 67037

(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
{S3085}	Continued From page 2 Requests staff check on resident every two hours during night, teeth Requests cueing from staff and assistance with bathing twice weekly Requests staff to remind of meal times Resident is on a Regular diet Resident requests apartment cleaned weekly Requests staff to administer medications Resident requires no wound care Resident generally oriented but may need occasional cuing to find direction Resident understands with some difficulty, easily understood Judgement is frequently poor, needs supervision Needs complete physical assistance to evacuate. The HSP contained the note "fall management program" but lacked interventions associated with this program, and lacked Resident/representative collaboration/acknowledgement. The HSP contained the note "keep alarm on music/high" but lacked a date of implementation, lacked who was to apply and monitor the alarm, and lacked Resident/representative collaboration/acknowledgement. The HSP contained the name of Hospice company, but lacked services and tasks this company to provide (such as bathing), and lacked Resident/representative collaboration/acknowledgement. By interview on 6/05/17 at 2:40pm Care Manager #B confirmed the NSA/HSP lacked a full description of the services to be provided, failed to specify who to perform the service, and lacked the signature or acknowledgement of the Resident or the Resident's representative. The Operator failed to ensure the NSA for #1085 contained a description of the services to be	{S3085}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087073	A. BUILDING: _____ B. WING _____	R-C 06/06/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLEN CARR HOUSE	1433 N HAMILTON DRIVE DERBY, KS 67037

(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
{S3085}	Continued From page 3 provided, identified the provider of the services, and demonstrated collaboration with the Resident/representative. - Review of record revealed #1074 admitted to facility 12/01/15 with diagnoses of Dementia, Scalp hematoma, Atrial fibrillation, Hypothyroid, and Depression. The current Functional Capacity Screen (FCS) of 11/17/16 assessed #1074 in need of physical assistance with bathing, dressing, toileting; in need of supervision with transfers, mobility, and eating; unable to perform medication and treatment management; rarely incontinent of bladder; usually understood, usually understands for communication; with short term, lon term, memory recall and decision making impairments; with falls/unsteadiness, vision impairment, and used walker. The current 11/17/16 Negotiated Service Agreement (NSA) and Health Service Plan (HSP) documented: Resident requests staff to escort Resident to most meals, activities and outings. Resident requests stand-by assist and cuing with transfers Resident requests staff to wake in AM and partial assist with dressing/morning care Resident requests minimal assistance to complete daily hygiene or grooming Provide incontinent/peri care... verbal cuing... removal of trash each shift Requests staff make bed daily Requests staff remind for bed time care and provide partial assist with undressing/night time care Requests staff check on resident every two hours	{S3085}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087073	A. BUILDING: _____ B. WING _____	R-C 06/06/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLEN CARR HOUSE	1433 N HAMILTON DRIVE DERBY, KS 67037

(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
{S3085}	Continued From page 4 during night Requests cueing from staff and assistance with bathing twice weekly Resident independent at meal times Resident is on a Regular diet offer potatoes if not eating Resident requests laundry completed twice or more a week Resident requests apartment cleaned weekly Requests staff to administer medications, crush with pudding at times Resident requires no wound care Resident requires weight weekly due to weight loss Resident needs verbal reminders daily to orient to time and place in facility Resident understands with some difficulty, difficult to understand Judgement is always poor, constantly puts self at risk Can evacuate self in 1 or fewer minutes The HSP contained the notes "elopement risk", but lacked a description of the services to address this risk, and Resident/representative collaboration/acknowledgement. . The HSP contained a 5/30/17 note to change Hospice companies, but lacked Resident/representative collaboration/acknowledgement. The HSP failed to address treatment management, who to provide, in reference to the FCS assessment of "3" Resident "unable to perform" The HSP indicated physical assistance with bathing... but failed to identify who to perform the service... the NSA indicated facility staff to assist with bathing and bed making, the Hospice plan of care indicated Hospice to complete bathing and bed making.	{S3085}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087073	A. BUILDING: _____ B. WING _____	R-C 06/06/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLEN CARR HOUSE	1433 N HAMILTON DRIVE DERBY, KS 67037

(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
{S3085}	Continued From page 5	{S3085}		

The HSP contained notes of various fall interventions, but lacked the date added to the plan, and lacked Resident/representative acknowledgment/collaboration.

By interview on 6/05/17 at 2:50pm Care Manager #B confirmed the NSA/HSP lacked a full description of the services to be provided, failed to specify who to perform the service, and lacked the signature or acknowledgement of the Resident or the Resident's representative.

The Operator failed to ensure the NSA for #1074 contained a description of the services to be provided, identified the provider of the services, and demonstrated collaboration with the Resident/representative.

- Review of record revealed #1072 admitted to facility 12/29/16 with diagnoses of Dementia, Dysphagia, Aortic stenosis, Hypertension, Chronic obstructive pulmonary disease, Benign prostatic hypertrophy, and Hyperlipidemia.

The current Functional Capacity Screen (FCS) of 12/29/16 assessed #1072 in need of supervision with bathing and eating; independent with dressing, toileting, transfers, mobility; unable to perform medication and treatment management; incontinent of bladder; understood and understands for communication; with short term, memory recall and decision making impairments; with falls/unsteadiness, vision impairment, wanders, and used walker.

The current 12/29/16 Negotiated Service Agreement (NSA) and Health Service Plan (HSP) documented:
Resident independent with ambulating, transfers,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087073	A. BUILDING: _____ B. WING _____	R-C 06/06/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLEN CARR HOUSE	1433 N HAMILTON DRIVE DERBY, KS 67037

(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
{S3085}	Continued From page 6 dressing, hygiene Provide incontinent/peri care... verbal cuing... removal of trash each shift Requests staff make bed daily Requests staff remind for bed time care and provide partial assist with undressing/night time care Requests staff check on resident once during night Requests to receive "supervision during times of acute illness" with bathing twice weekly Resident independent at meal times, staff to remind of meal times Resident requires special diet, the word dysphasia crossed out, the word diet remained, no other description of service Resident requests laundry completed twice or more a week Resident requests apartment cleaned weekly Requests staff to administer medications Resident requires no wound care Resident requires staff to monitor blood pressure Resident generally oriented but may need occasional cuing to find direction, remember information Resident understands without difficulty, is understood Judgement is occasionally poor Can evacuate self with supervision The HSP contained the notes "waver signed", "5/4/17 d/c (discontinue) current diet orders change to mechanical soft", but lacked Resident/representative collaboration/acknowledgement. The HSP contained the name of a Home Health company, and "3/07/17 pt/ot (physical therapy/occupational therapy) to eval and treat", but lacked Resident/representative collaboration/acknowledgement.	{S3085}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087073	A. BUILDING: _____ B. WING _____	R-C 06/06/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLEN CARR HOUSE	1433 N HAMILTON DRIVE DERBY, KS 67037

(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
{S3085}	Continued From page 7 The HSP contained the identification of falls, unsteadiness, impaired vision, wandering, initiate Fall protocol... but lacked a description of the services to meet these identified needs, and lacked Resident/representative collaboration/acknowledgement. By interview on 6/05/17 at 3:20pm Care Manager #B stated the Resident's family requested a change of Hospice providers... confirmed no documentation in the record of this request... confirmed the NSA/HSP lacked a full description of the services to be provided, failed to specify who to perform the service (such as facility staff or Hospice for bathing and bed making), and lacked the signature or acknowledgement of the Resident or the Resident's representative. The Operator failed to ensure the NSA for #1072 contained a description of the services to be provided, identified the provider of the services, and demonstrated collaboration with the Resident/representative. - Review of record revealed #1070 admitted to facility 5/09/15 with diagnoses of Dementia, Diabetes, and Depressive disorder. The current Functional Capacity Screen (FCS) of 12/02/16 assessed #1070 unable to perform bathing, dressing, toileting, transfers, mobility; in need of supervision with eating; unable to perform medication and treatment management; incontinent of bladder; rarely understood, rarely understands for communication; with short term, long term, memory recall and decision making impairments; with falls/unsteadiness, vision impairment, hearing impairment, and used wheelchair.	{S3085}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087073	A. BUILDING: _____ B. WING _____	R-C 06/06/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLEN CARR HOUSE	1433 N HAMILTON DRIVE DERBY, KS 67037

(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
{S3085}	Continued From page 8 The current 12/02/16 Negotiated Service Agreement (NSA) and Health Service Plan (HSP) documented: Extended services of wheelchair for mobility Extended service and assist of two for transfers Extended service and assistance with dressing, hygiene, toileting Requests staff make bed daily Requests staff remind for bed time care and provide partial assist with undressing/night time care Requests staff check on resident every two hours during night Extended service with bathing twice weekly Resident physically assisted with meal times Resident is on special diet Resident requests laundry completed twice or more a week Resident requests apartment cleaned weekly Requests staff to administer medications, provide diabetic care Resident does not need staff to provide wound care Resident requires to monitor weight or blood pressure monthly Resident not oriented to time or place and cannot remember or use information Resident understands with some difficulty, does not communicate or convey needs Judgement is always frequently poor, needs supervision Needs complete physical assistance with evacuation The HSP contained the name of a Hospice provider, but lacked the Resident/representative acknowledgment/collaboration. The HSP contained the notes 01/21/17 treatment to wound under breast, but failed to identify who	{S3085}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087073	A. BUILDING: _____ B. WING _____	R-C 06/06/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLEN CARR HOUSE	1433 N HAMILTON DRIVE DERBY, KS 67037

(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
{S3085}	Continued From page 9 completed this treatment. The HSP contained notes of various fall interventions, but lacked all dates added to the plan, and lacked Resident/representative acknowledgment/collaboration. By interview on 6/05/17 at 2:45pm Care Manager #B confirmed the NSA/HSP lacked a full description of the services to be provided, failed to specify who to perform the service, and lacked the signature or acknowledgement of the Resident or the Resident's representative. The Operator failed to ensure the NSA for #1070 contained a description of the services to be provided, identified the provider of the services, and demonstrated collaboration with the Resident/representative.	{S3085}		
{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: (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.	{S3200}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087073	A. BUILDING: _____ B. WING _____	R-C 06/06/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLEN CARR HOUSE	1433 N HAMILTON DRIVE DERBY, KS 67037

(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
{S3200}	Continued From page 10 This REQUIREMENT is not met as evidenced by: KAR 26-41-205(d)(1-2) The census equalled 51 the sample included four Residents. The facility identified all Residents as receiving medication management. Based on interview and review of record, for one of four sampled (#1074), the Operator failed to ensure all medications and biologicals administered in accordance with a medical provider's written orders and in accordance with professional standards. Findings included: - Review of record revealed #1074 admitted to facility 12/01/15 with diagnoses of Dementia, Scalp hematoma, Atrial fibrillation, Hypothyroid, and Depression. The current 11/17/16 FCS (functional capacity screen) assessed #1074 unable to perform medication and treatment management. The current 11/17/16 NSA (negotiated service agreement) and Health Care Service Plan documented facility staff to manage all medications and treatments for #189. Review of the medical record and the June 2017 MAR's (medication administration records) revealed: MAR contained a 5/01/17 order for Systane Ultra eye drop instill one drop to each eye two times daily.	{S3200}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087073	A. BUILDING: _____ B. WING _____	R-C 06/06/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLEN CARR HOUSE	1433 N HAMILTON DRIVE DERBY, KS 67037

(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
{S3200}	Continued From page 11 The medical record lacked a written order for this medication. On 6/01/17 at 1:45pm, Care Manager #B confirmed the Stystane order not on the POS (physician order sheet) signed on 5/10/17 and the original written order not found in the chart. On 6/01/17 at 1:55pm, Care Manager #B stated the pharmacy is faxing me the order... don't know how they got an order and got it on the MAR but I don't have one and it's not on the 5/10/17 POS... On 6/01/17 Care Manager #B then provided pharmacy fax which revealed Systane Order hand written on pharmacy communication to the APRN (advance practice registered nurse). This communication listed the original order of 4/28/17 for Restasis eye drop two times daily, and requested a substitute order due to not covered by insurance. Care Manager #B confirmed the written order for Restasis also not in facility record... confirmed the medication administered by staff from 5/01/17 to 6/01/17, without licensed nurse verification of medical provider order in record. By interview on 6/05/17 at 4:20pm, Operator #A and Care Manager #B provided facility medication policy. Policy title: Ordering and Labeling of Medications - page 71 - #4. Physicians, advanced registered nurse practitioners, and physican assistants shall give verbal orders for drugs only to a licensed nurse... the licensed nurse shall immediately record the verbal order in the Resident's clinical record... " The Operator failed to ensure all medications and	{S3200}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087073	A. BUILDING: _____ B. WING _____	R-C 06/06/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLEN CARR HOUSE	1433 N HAMILTON DRIVE DERBY, KS 67037

(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
{S3200}	Continued From page 12 biologicals administered to #1074 in accordance with written medical care provider orders and in accordance with professional standards.	{S3200}		