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 _____	12/05/2023

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

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S 000	INITIAL COMMENTS The following citations represent the findings of an abbreviated survey for complaints # 184186, 184107, 184109, and 183151, of the above named facility conducted on 12/04/23 and 12/05/23.	S 000		
S3092 SS=D	26-41-202 (d) Negotiated Service Agreement Revisions (d) Each administrator or operator shall ensure the review and, if necessary, revision of each negotiated service agreement according to the following requirements:(1) At least once every 365 days; (2) following any significant change in condition, as defined in K.A.R. 26-39-100; (3) at least quarterly, if the resident receives assistance with eating from a paid nutrition assistant; and (4) if requested by the resident or the resident ' s legal representative, facility staff, the case manager, or, if agreed to by the resident or the resident ' s legal representative, the resident ' s family. This REQUIREMENT is not met as evidenced by: K.A.R. 26-41-202 (d) (2) The facility reported a census of 51 residents. The sample included 5 "Residents'" (R). Based on record review and interview the operator failed to ensure the revision of the "Negotiated Service Agreement" (NSA) for R4 when he exhibited a change of condition for an incident that was self-reported to the department for	S3092		

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

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S3092	Continued From page 1	S3092		

hypersexual behavior that included R3.

Findings included:

- Record review for R4 revealed an admission date of 10/03/23 with diagnoses of heart disease, essential primary hypertension, presence of a cardiac pacemaker, mechanical complication of heart valve prothesis, atrial fibrillation, unspecified other amnesia, dementia in other diseases classified elsewhere, unspecified severity with behavioral disturbance.

Review of R4's "Functional Capacity Screen" (FCS) dated 10/10/23 revealed R4 required supervision with bathing and dressing. He was independent with toileting, transferring, walking/mobility, and eating. He lacked the ability to manage his own medications and was usually continent of his bladder. He had impaired short-term memory, impaired long-term memory, impaired memory recall, and impaired decision making. He was able to make himself understood and he understood others. He was marked with falls/unsteadiness, impaired vision, and wandering, and he used a walker mobility device.

R4's FCS was not marked with socially inappropriate disruptive behavior.

Review of R4's combined NSA/" Health Service Plan" (HSP) dated 10/03/23 identified facility staff would provide the following health services: Under the section titled "Behaviors" it stated R4 exhibited normal, functional behavior patterns. Care staff would report any changes from baseline behaviors. Under the section titled

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"Reluctance to Accept Care" facility staff were instructed to stop and assure R4 of his safety and resume/re-approach at a later time if they met resistance when providing "Activities of Daily Living" (ADL)'s. Under the section titled "Falls" it stated R4 was a fall risk related to his medical diagnosis. The section lacked instructions to facility staff for fall interventions. Facility staff were instructed to provide stand by assistance for transferring in/out of the shower, manage his medications and treatments.

Review of R4 electronic medical record under the "Progress Notes" tab revealed the following entries:

On 10/10/23 at 12:35PM R4 admitted to the facility with his daughter. He had a steady gait with his four wheeled walker.

On 10/11/23 at 08:30PM R4 is noted to have "twist tie around his genitals". When staff asked R4 about the twist tie his response was "I am not taking it off my dick". R4 indicated that he liked having the twist tie in place as it was "holding up" his "balls". R4 was asked if he would remove the twist tie until his doctor gave his ok to wear it. R4 became angry and said "NO!"

On 10/14/23 at 03:24PM R4's "Durable Power of Attorney" (DPOA) was contacted about the twist tie. She was unaware R4 had this in place, and staff informed the DPOA that R4 became very agitated when it comes to the twist tie and he will yell. The staff informed the DPOA that the facility staff would monitor the area when assisting R4 with bathing.

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S3092	Continued From page 3 10/22/23 at 10:00PM Staff reported that R4 was having inappropriate sexual behaviors. He was flirting with staff and making inappropriate comments to them. R4 told one staff member that he needed "some boobs to nibble on", referring to the staff member's breast. R4 had also been coming out of his room "often" with no clothing on from the waist down. R4 told another staff member he "Liked the way they swing back and forth and hang freely", while he moved his hips from side to side. R4 had been told "those comments were inappropriate and that he needed to refrain from such behavior". R4 continued with the behavior. 10/23/23 at 03:49PM R4 saw his primary care provider, staff sent a written communication with concerns over his inappropriate behaviors. No new orders were received related to the concerns over R4's behaviors. 11/13/23 at 02:38PM late entry DPOA was notified of incident of finding R4's hands "under another residents blanket". Review of the facility investigation provided to the department dated 11/12/23 revealed "Certified Nurse Aide" E observed R4 whisper into R3's ear. She approached R3 and R4 and found R4's hands under R3's blanket. CNA E assisted R3 to the dining room and R4 got up and walked down to his room. CNA E called LN B and Operator A. Review of the immediate interventions provided with the investigation revealed the facility performed 30-minute checks on R3 and R4 the remainder of the shift. The intervention page had the statement R4 "does not have a history of these types of behaviors	S3092		

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S3092	Continued From page 4 since coming to this building on 10/03/23. Interventions for R4 were to include the care plan would need to be updated with the family approval for two-hour monitoring of behaviors, and log for R4 behaviors to establish a pattern for a period of 30 days. If inappropriate sexual behaviors are found during the monitoring, care plan with family for R4 to seek care with house psychiatrist for possible medication interventions. Interview on 12/05/23 at approximately 04:30PM with Operator A and LN B confirmed the behavior monitoring for R4 had not been started at this time. They further confirmed that according to the plan of correction sent to the department they were going to do the monitoring for 30 days. LN B confirmed the NSA/HSP for R4 had not been updated to show interventions for inappropriate/disruptive behavior. The operator failed to ensure the revision of R4's NSA/HSP for an incident of inappropriate/disruptive behavior involving R3 that happened on 11/12/23. The operator further failed to ensure the completion of the submitted plan of correction to the department that included documentation for 30 days for R4 to establish a pattern for inappropriate disruptive behavior.	S3092		
S3200 SS=G	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	S3200		

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S3200	Continued From page 5 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. This REQUIREMENT is not met as evidenced by: K.A.R. 26-41-205 (d) The facility reported a census of 51 residents. The sample included 5 Residents (R). Based on observation, interview and record review for R1, R2 and R5, the operator failed to ensure that all medications were administered in accordance with a medical care provider's written order, when R1's "electronic Medication Administration Record" (e-MAR) lacked documentation for administration of Levothyroxine (a medication for hypothyroidism) on eleven occasions from 08/23/23 to 12/05/23, and R2's e-MAR which lacked documentation for Toujeo Solostar insulin 9 times from 08/01/23 to 12/05/23, and Insulin Lispro 16 times from 08/01/23 to 12/05/23. The operator further failed to ensure the outside agency "Licensed Nurse" (LN) C properly administered insulin in accordance with professional standards of practice. This failure resulted in R1 receiving 30 units of Lantus (long-acting) insulin, that was ordered for R5,	S3200		

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S3200	Continued From page 6 which resulted in a hospital stay for R1. Findings included: - Record review for R1 revealed an admission date of 06/07/21 with diagnoses of adjustment disorders, encephalopathy, cognitive communication deficit, obesity, chronic hepatitis, hypothyroidism, and sleep apnea. Review of R1's "Functional Capacity Screening" (FCS) dated 06/28/23 revealed R1 required physical assistance with bathing, and supervision with dressing and eating. He was independent with toileting, transferring, and walking. He lacked the ability to manage his own medications. He had impaired short-term memory, impaired long-term memory, impaired memory recall and impaired decision making. He was able to make himself understood and he usually understood others. Review of R1's combined "Negotiated Service Agreement" (NSA)/" Health Service Plan" (HSP), identified the facility staff would provide the following health services: staff to provide redirection and one-on-one interaction with resident when he is worried or wandering. Staff to ensure R1 had his glasses and proper foot attire on to reduce risk of falls and provide physical assistance with transferring in/out of shower, and the bathing process. Staff to provide frequent reminders and cues for memory loss and speak slowly and allow resident time to process the information. Facility would manage medications and treatments; delegated to "Certified Medication Aides'" (CMA's) when applicable.	S3200		

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S3200	Continued From page 7 Review of the electronic medical record under the "Progress Notes" tab dated 08/01/23 to 12/05/23 revealed the following entries: 11/10/23 at 07:39 PM as a late entry and signed by outside agency LN C, the note revealed agency provided LN C, had been administering long-acting insulin to the "designated resident's" at 06:00 PM. LN C spoke to R1 at 06:50PM using the name of R5, and asked how R1 was doing, R1 responded to LN C. LN C then told R1 she had "long-acting insulin for you" and said R5's name. She asked R1 if she could "put it in" his arm? R1 responded with "yes" and lifted his sleeve. LN C continued to write "this resident" did not take insulin and had a "different name". R5 was sitting on the couch next to R1. LN C then notified the Operator of the facility, R1's "Durable Power of Attorney for Healthcare" (DPOAH) and R1's healthcare provider. R1's healthcare provider requested R1 be sent to the emergency room for evaluation. R1 was transferred to the hospital at 07:40 PM by his DPOAH. Review of the facility provided investigation dated 11/17/23 revealed the following: On 11/10/23 LN C arrived at the facility at approximately 06:50 PM to administer 30 units of Lantus insulin to R5. R1 and R5 were confirmed to be sitting next to each other on the couch. LN C asked R1 if he was R5 and R1 responded "yes". LN C then administered the Lantus to R1. CMA D asked LN C who she administered the insulin to, and LN C identified R1. CMA D identified R1 as the wrong resident to receive the	S3200		

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S3200	Continued From page 8 insulin. On 11/13/23 LN B called and spoke to R1's DPOAH who stated R1 was in observation at the hospital and was stable with no adverse effects. Review of the facility provided document titled "Witness Statement" dated 11/10/23 and signed by CMA D revealed she was in the kitchen with her co-workers when LN C arrived. She observed LN C go up to R1 and ask if he was R5. CMA D wrote LN C did not ask facility staff to confirm the resident's identity. Interview on 12/05/23 with Operator revealed LN C had been to the facility to administer insulin on prior occasions. She stated when a new agency staff member came to the facility the CMA in charge would provide agency staff their "Point Click Care" (PCC) log ins, and the diabetic resident information. Review of R1 e-Mar dated 08/01/23 to 11/16/23 revealed the following order: Levothyroxine 200 micrograms, take one tablet by mouth every morning before meal. (Give first thing in the morning, wait 30 to 40 minutes before eating food/taking other medications. The administration time was set for 06:00AM. The following eleven dates lacked documentation for the administration of the daily Levothyroxine: 08/03/23 08/18/23 08/21/23 08/28/23	S3200		

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S3200	Continued From page 9 09/04/23 09/11/23 09/18/23 10/02/23 10/09/23 10/11/23 10/16/23 The following Levothyroxine dates were marked as administered to R1 when he was out of the building and in the hospital due to receiving R5's insulin. 11/14/24 11/16/23 Record review of the facility provided document titled "Patient Inquiry" from R1's hospital stay revealed his date of admission was 11/10/23 and his date of discharge was 11/21/23. The "Principal Diagnoses" was "accidental wrong medication". Under the "Brief hospital course" section it recorded; Upon R1'a arrival to the emergency room an immediate (STAT) dose of Lorazepam 1 milligram was given due to R1's agitation. Under the "Hospital Course" section it stated R1 was treated, and his blood sugar stabilized. "He was appropriate to discharge previous" but because of some difficulties his discharge was not until 11/21/23. Interview on 12/05/23 at approximately 04:00 PM with Operator A, she confirmed R1 left for the hospital on 11/10/23 and did not return to the facility until 11/21/23. She further confirmed R1's e-MAR lacked 11 days of documentation for the daily administration of his Levothyroxine. Review of the facility policy titled "Medication	S3200		

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Administration" and dated 05/11/23 stated the following:

1. Drugs shall be administered to each resident in accordance with a physician's written order.

4. Practice the 'five rights' of medication administration:
- a. Right Resident
- b. Right drug
- c. Right time
- d. Right dose
- e. Route

Interview on 12/05/23 at approximately 04:30PM with Operator A and LN B, confirmed the e-MAR for R1 lacked documentation for 11 days of his Levothyroxine from 08/01/23 to 12/05/23. The e-MAR for R1 contained documentation for Levothyroxine administered on days he was confirmed to be out of the facility, and further confirmed agency provided LN C administered 30 Units of Lantus to him, and not to R5 who it was ordered for.

The operator failed to ensure that all medications were administered to R1 in accordance with a medical care provider's written order, when the e-MAR lacked documentation for administration of levothyroxine on eleven occasions from 08/23/23 to 12/05/23, the operator further failed to ensure that outside agency provided LN C administered insulin in accordance with professional standards of practice ensuring she had the right resident. This failure resulted in possible harm when R1 received 30 units of Lantus (long-acting) insulin that was ordered for R5, which resulted in a hospital stay for R1.

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- Record review for R2 revealed an admission date of 05/04/22 with diagnoses of diabetes mellitus due to underlying condition, unspecified dementia, unspecified severity without behavioral disturbance, mood disturbance, anxiety, and diverticular disease of intestine.

Review of R2's FCS dated 06/26/23 revealed R2 required physical assistance with bathing, dressing, toileting, transferring, walking/mobility, and eating. She lacked the ability to manage her own medications/treatments, was incontinent of her bladder and had impaired short-term memory, impaired long-term memory, impaired memory recall and impaired decision making. She was able to make herself understood, and she understood others. She was marked with falls/unsteadiness, impaired vision, socially inappropriate disruptive behavior, and impaired decision making. She used a walker and wheelchair mobility devices.

Review of R2's combined NSA/HSP identified the facility staff would provide the following health services; provide frequent visual checks as needed, observe location in the community frequently, reminders to call for assistance and to use mobility devices when going to the bathroom and activities. Transferring in/out of the shower and assistance with washing and drying her body. Staff to verbally remind R2 of the day, time, mealtimes, seasons, sleep and waking times. LN to administer all insulin injections as ordered by provider. Staff to follow standing orders for hyper/hypoglycemia and R2 had a

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S3200	Continued From page 12 "Dextron" blood sugar monitoring device that R2's spouse would maintain all supplies/costs and tasks for. Review of R2's e-MAR dated 08/01/23 to 12/04/23 recorded the following orders: Toujeo Solostar 300 units/milliliter, inject 24 units subcutaneous at 06:00PM The following nine dates lacked documentation for the daily administration of Toujeo Solostar: 08/10/23 08/13/23 08/17/23 08/25/23 08/27/23 09/20/23 09/22/23 09/23/23 10/22/23 Insulin Lispro 100 units/milliliter, inject subcutaneous with meals per the sliding scale: blood sugar results of 150 milligrams/ per deciliter (mg/dl) or less inject 6 units blood sugar results of 151 to 200 (mg/dl) inject 10 units blood sugar results of 201 to 250 (mg/dl) inject 14 units blood sugar results of greater than 250 (mg/dl) inject 18 units The following 16 date/times lacked documentation for the administration of the Lispro Insulin per the sliding scale as ordered with meals: 08/02/23 at 05:30PM	S3200		

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S3200	Continued From page 13 08/09/23 at 05:30PM 08/13/23 at 08:00AM, 12:00PM, and 05:30PM 08/17/23 at 05:30PM 08/25/23 at 05:30PM 08/27/23 at 05:30PM 08/30/23 at 12:00PM and 05:30PM 09/22/23 at 12:00PM and 05:30PM 09/23/23 at 08:00AM, 12:00PM, and 05:30PM 10/22/23 at 05:00PM Review of the facility provided investigation dated 09/25/23 revealed a concern was brought to Operator A about a onetime order for increased insulin to be administered to R2 on approximately 09/22/23, and the resident record lacked documentation of the administration of the insulin. The reported results of the investigation revealed the following: There had been no adverse reactions witnessed. On 09/22/23 R2 was diagnosed with a urinary tract infection and her blood sugar was over 500 (mg/dl). The Resident Care Director and one LN were terminated related to R2 not receiving her insulin. Interview on 12/05/23 at approximately 04:00PM with Operator A and LN B confirmed the continued monitoring of insulin administration for R2, after the completion of the investigation of R2 not receiving her insulin. The operator failed to ensure that all medications were administered to R2, when her e-MAR	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 _____	12/05/2023

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 14 lacked documentation for Toujeo Solostar insulin 9 times from 08/01/23 to 12/05/23, and Insulin Lispro 16 times from 08/01/23 to 12/05/23. This placed R2 at potential for harm.	S3200		