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LAKEPOINT EL DORADO, LLC	1313 S HIGH STREET EL DORADO, KS 67042

(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 an abbreviated survey for complaint #186415 of the above named facility conducted on 03/12/24 and 03/13/24.	S 000		
S3080 SS=E	26-41-201 (a) (b) Functional Capacity Screen on Admission a) On or before each individual ' s admission to an assisted living facility or residential health care facility, a licensed nurse, a licensed social worker, or the administrator or operator shall conduct a screening to determine the individual ' s functional capacity and shall record all findings on a screening form specified by the department. The administrator or operator may integrate the department ' s screening form into a form developed by the facility, which shall include each element and definition specified by the department. (b) A licensed nurse shall assess any resident whose functional capacity screening indicates the need for health care services. This REQUIREMENT is not met as evidenced by: K.A.R 26-41-201 (a) The facility reported a census of 31 residents. The sample included 2 "Residents'" (R)1 and R2. Based on record review and interview the Administrator failed to ensure the facility's screening form used to record the findings from the screening conducted to determine functional capacity included the definitions specified from the department.	S3080		

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

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Findings included:

- Record review for R1 revealed an admission date of 03/02/24 with diagnoses of chronic pain, degenerative lumbar disc, Spondylosis of lumbar region, bilateral hearing loss, obesity, dementia unspecified dementia type, major depressive disorder, anxiety, frequent falls, and dementia with behavioral disturbance.

Review of R1's FCS dated 03/06/24 located in R1's electronic medical record under the "Forms Tab" revealed a document titled "Kansas Resident Functional Capacity Screen" and identified R1 was independent with bathing, dressing, toileting, transferring, walking/mobility, and eating. He lacked the ability to manage his own medications and was continent of his bladder. Under the section titled "Cognition-Memory, Recall" instructed the assessor to "Record results from exam in manual." "Short Term Memory" was scored with a number "2", "Long Term Memory" was scored with a number "2", "Memory/Recall" was scored with a number "2", and "Decision-Making" was scored with a number"2". In the "Total Score" section was the number "6".

- Record review for R2 revealed an admission date of 03/02/24 with a diagnosis of Alzheimer's disease.

Review of R2's FCS dated 03/06/24 located in R2's electronic medical record under the "Forms Tab" revealed a document titled "Kansas

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S3080	Continued From page 2	S3080		

Resident Functional Capacity Screen" and identified R2 was independent with bathing, dressing, toileting, transferring, walking/mobility, and eating. She required supervision with the management of her medications and was continent of her bladder. Under the section titled "Cognition - Memory, Recall" instructed the assessor to "Record results from exam in manual." "Short Term Memory" was scored with a number "2", "Long Term Memory" was scored with a number "0", "Memory/Recall" was scored with a number "1", and "Decision-Making" was scored with a number"2". In the "Total Score" section was the number "5".

Interview on 03/12/23 at approximately 04:55 PM with R2 revealed she could not recall the morning meal or the names of her medications. She stated she took several medications, and she manages her medications herself. She stated she had 3 sons and was able to recall their names.

Interview on 03/13/24 at 01:13PM by phone with "Licensed Nurse" C, and Administrator A and Resource Nurse B present in the room, LN C confirmed the cognition scoring for R1and R2 did not match the departments provided definitions. LN C continued to state that R2 would have scored a "0" for short-term memory, long-term memory, memory recall and decision making. She stated R1 could recall past events and could not recall current events.

Review of the Departments "Resident Functional Screen Manual" Dated February 1997 (Updated 07/11/08) revealed the following instructions in

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section D for "Cognition, Memory, Recall":

Section A instructs the assessor to:
"Enter a "0" at A if the resident was able to recall recent events (short term memory). Enter a "1" at A if the resident had difficulty recalling recent events (short term memory)."

Section B instructs the assessor to:
"Enter a "0" at B if the resident was able to demonstrate long term memory. Enter a "1" at B if the resident had difficulty with long term memory."

Section C instructs the assessor to:
"Enter a "0" at C if the resident does not appear to have difficulty with memory/recall. Enter a "1" at C if the resident had difficulty with memory/recall."

Section D instructs the assessor to:

"Enter a "0" at D for decision -making if the resident is able to make consistent, reasonable and organized decisions. Enter a "1" at D if the client has difficulty with decision -making or does not make decisions."

The manual then instructs the assessor to enter the total score at D (Memory/Recall) on the screening form. The total from the scores would range from "0" to "4".

The Administrator failed to ensure the facility's screening form used to record the findings from the screening conducted to determine functional capacity included the definitions specified from the department when scoring R1 and R2's

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S3080	Continued From page 4 cognition, memory, and memory recall, and decision making.	S3080		
S3082 SS=E	26-41-201 (d) Functional Capacity Screen Accurate d) Designated facility staff shall ensure that each resident ' s functional capacity at the time of screening is accurately reflected on that resident ' s screening form. This REQUIREMENT is not met as evidenced by: K.A.R. 26-41-201 (d) The facility reported a census of 31 residents. The sample included 2 "Residents'" (R)1 and R2. Based on observation, interview, and record review, the Administrator failed to ensure the screening for the "Functional Capacity" (FCS) of R1 and R2 was accurately reflected on R1 and R2's FCS screening forms. Findings included: - Record review for R1 revealed an admission date of 03/02/24 with diagnoses of chronic pain, degenerative lumbar disc, Spondylosis of lumbar region, bilateral hearing loss, obesity, dementia unspecified dementia type, major depressive disorder, anxiety, frequent falls, and dementia with behavioral disturbance. Review of R1's FCS dated 03/06/24 revealed the date of assessment was entered in as 03/02/24, and R1 was independent with bathing, dressing,	S3082		

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S3082	Continued From page 5	S3082		

toileting, transferring, walking/mobility, and eating. He lacked the ability to manage his own medications and was 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. Under the section titled "Current or Recent Problems and Risks" R1 was marked with impaired decision making. He used no mobility device, and in the section titled "Comments" it was typed "DNR" (Do Not Resuscitate).

The FCS did not acknowledge in the "Current or Recent Problems and Risks" that R1 had bilateral hearing loss, and frequent falls.

R1's electronic medical record and the paper medical record lacked a "Negotiated Service Agreement" (NSA) and further lacked a "Health Service Plan" (HSP).

Record review of R1's paper medical record revealed a fax cover sheet sent to the facility on 03/04/24 from R1's medical provider. The record was dated 11/09/23 and was a follow up visit note from the primary care provider. Within the document were the diagnoses for R1 and on the second page in the "Medications" section LN C initialed on 03/04/24 with "Noted" written under the date. In the "History of Present Illness" section of the document the following was recorded:

Patient's living situation was: "at home with wife requiring assistance with some ADL's" (Activities of Daily Living). He remained living at home with his wife. He continued to "exhibit a slow but

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significant decline in memory and functionality in the last year" He ambulates without assistance "for the most part but holds onto wife for long distances." R1 was noted with a "considerable decline" in his memory. He was very easily upset when he forgot things and names. He had difficulty remembering names and dates. He was very paranoid at times and was frequently incontinent of urine and wore briefs.

Observation on 03/12/24 at approximately 04:00 PM posted on the outside of R1's chart it was typed in large print on a piece of red paper was the following "FULL CODE".

Interview on 03/13/24 at 01:13PM by phone with "Licensed Nurse" C, and Administrator A and Resource Nurse B present in the room, LN C confirmed she did not complete an NSA or a HSP for R1, she stated that he was not a DNR, and he was a "Full Code". She further confirmed she was unaware of the diagnosis of dementia with behavioral disturbances. She stated R1's cognition impairment was that he could recall past events, and was unable to recall current events. She stated she did do the FCS on 03/02/24 in the electronic medical record and went back in and changed the FCS in the electronic record on 03/04/24.

The electronic signature date on the FCS was 03/06/24.

- Record review for R2 revealed an admission date of 03/02/24 with a diagnosis of Alzheimer's disease.

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S3082	Continued From page 7 Review of R2's FCS dated 03/06/24 revealed the date of assessment was entered in as 03/02/24, and R2 was independent with bathing, dressing, toileting, transferring, walking/mobility, and eating. She required supervision with the management of her medications and was continent of her bladder. She had impaired short-term memory, impaired memory recall and impaired decision making. She was able to make herself understood and she understood others. Under the section titled "Current or Recent Problems and Risks" R2 was marked with impaired decision making. The section titled Mobility Appliances and Devices" lacked any documentation, and in the section titled "Comments" it was typed "DNR" (Do Not Resuscitate). R2's electronic medical record and the paper medical record lacked a "Negotiated Service Agreement" (NSA) and further lacked a "Health Service Plan" (HSP). Review of the facility provided document titled "Assisted Living Admission Orders" dated 03/04/24, it was acknowledged that R2 was a "Full Code", and she was taking two medications. Observation on 03/12/24 at approximately 04:00 PM posted on the outside of R2's chart it was typed in large print on a piece of red paper was the following "FULL CODE". Interview on 03/12/23 at approximately 04:55 PM with R2 revealed she could not recall the morning meal or the names of her medications. She stated she took several medications, and she manages her medications herself. She stated she had 3 sons and was able to recall	S3082		

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S3082	Continued From page 8 their names. Interview on 03/12/24 at approximately 02:00PM with Administrator A, she stated the R2's "Durable Power of Attorney" (DPOA) indicated to her that R2 did not remember the incident on 03/07/24 involving R1. The incident included the local police department and local emergency medical technicians' response to assist R1, and R1 leaving the facility by ambulance. Interview on 03/13/24 at 01:13PM by phone with "Licensed Nurse" C, and Administrator A and Resource Nurse B present in the room, LN C confirmed she did not complete an NSA or a HSP for R2, she stated that she was not a DNR, and she was a "Full Code". She stated R2's cognition was not impaired. She stated she did do the FCS on 03/02/24 in the electronic medical record and went back in and changed the FCS in the electronic record on 03/04/24. The electronic signature date on the FCS was 03/06/24. The Administrator failed to ensure the screening for the functional capacity of R1 and R2 was accurately reflected on R1 and R2's FCS screening forms identifying appropriate resuscitative orders and cognition.	S3082		
S3090 SS=E	26-41-202 (c) Admission Negotiated Service Agreement (c) Each administrator or operator shall ensure the development of an initial negotiated service agreement at admission.	S3090		

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This REQUIREMENT is not met as evidenced by:
K.A.R 26-41-202 (c)

The facility reported a census of 31 residents. The sample included 2 "Residents'" (R)1 and R2. Based on record review and interview the Administrator failed to ensure the development of a "Negotiated Service Agreement" at the time of admission for R1 and R2, that was based on the screenings conducted to determine R1 and R2's functional capacity (FCS), at the time of admission that identified the need for healthcare services to be provided by qualified facility staff. R1 and R2 were a married couple who lived in the same apartment.

Findings included:

- Record review for R1 revealed an admission date of 03/02/24 with diagnoses of chronic pain, degenerative lumbar disc, Spondylosis of lumbar region, bilateral hearing loss, obesity, dementia unspecified dementia type, major depressive disorder, anxiety, frequent falls, and dementia with behavioral disturbance.

Review of R1's FCS dated 03/06/24 revealed the date of assessment was entered in as 03/02/24, and R1 was independent with bathing, dressing, toileting, transferring, walking/mobility, and eating. He lacked the ability to manage his own medications and was continent of his bladder. He had impaired short-term memory, impaired

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long-term memory, impaired memory recall and impaired decision making. He was able to make himself understood and he understood others. Under the section titled "Current or Recent Problems and Risks" R1 was marked with impaired decision making and he used no mobility device.

The FCS did not acknowledge in the "Current or Recent Problems and Risks" that R1 had the diagnoses of bilateral hearing loss, frequent falls, and dementia with behaviors.

R1's electronic medical record and the paper medical record lacked a "Negotiated Service Agreement" (NSA) and further lacked a "Health Service Plan" (HSP).

Record review of R1's paper medical record revealed a fax cover sheet sent to the facility on 03/04/24 from R1's medical provider. The record was dated 11/09/23 and was a follow up visit note from the primary care provider. Within the document were the diagnoses for R1 which included dementia with behavioral disturbance and anxiety, on the second page in the "Medications" section were the following medications:

Donepezil Hydrochloride 23 milligram tablet. Take 1 tablet orally once a day at bedtime. Donepezil is used to treat dementia (memory loss and mental changes) associated with mild, moderate, or severe Alzheimer's disease. https://www.mayoclinic.org/drugs-supplements

Lorazepam 0.5 milligram tablet. 1 tablet orally twice a day as needed for anxiety.

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S3090	Continued From page 11 Desvenlafaxine 50 milligram tablet extended release. 1 tablet orally once a day. Desvenlafaxine is used to treat is used to treat depression. https://www.mayoclinic.org/drugs-supplements Meloxicam 7.5 milligram tablets. Take 1 tablet orally one time a day. Meloxicam is a non-steroidal anti-inflammatory medication used to treat the symptoms of arthritis. https://www.mayoclinic.org/drugs-supplements Aspirin 81 milligrams delayed release tablet. Take 1 tablet by mouth one time a day. Levothyroxine 25 micrograms (0.025 milligrams) tablet. Take orally once a day. Acetaminophen-Hydrocodone Bitartrate 325 milligrams - 7.5 milligrams tablet orally every 6 hours. LN C initialed on 03/04/24 with "Noted" written under the date. In the "History of Present Illness" section of the document the following was recorded: Patient's living situation was: "at home with wife requiring assistance with some ADL's" (Activities of Daily Living). He remained living at home with his wife. He continued to "exhibit a slow but significant decline in memory and functionality in the last year" He ambulates without assistance "for the most part but holds onto wife for long distances." R1 was noted with a "considerable decline" in his memory. He was very easily upset	S3090		

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when he forgot things and names. He had difficulty remembering names and dates. He was very paranoid at times and was frequently incontinent of urine and wore briefs. In the "Treatment" Section of the document the following was recorded: R1's memory and functionality had "Significantly declined in the last year." The provider recorded that earlier in the year there were concerns of self - care deficit and worsening memory. The options of home health and hospice were discussed on this visit with R1's DPOA.

Review of R1 electronic medical record under the "Progress" note tab revealed the following entries:

On 03/02/24 at 06:01PM R1 was admitted to the facility and his family was present. R1 was alert times "3" with some confusion. R1 ambulated by himself and was continent of his bowel and his bladder. R1's "wife to assist with administration" of his medications. The entry was initialed by LN C.

On 03/06/24 at 07:03 AM an administration note read "Ativan Oral Tablet 0.5 milligrams. Give 1 tablet by mouth every 12 hours as needed for agitation." and signed by "Certified Medication Aide" D.

On 03/06/24 at 07:54 AM a follow up administration note read the as needed administration of the Ativan 0.5 milligrams administered at 07:03 AM was effective.

Review of the facility provided self-reported incident to the department dated 03/08/24

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revealed the following information:

On 03/07/24 at approximately 08:30 AM R1 was being physically combative with facility staff and after numerus failed attempts at redirection, R1's physical aggression escalated, and for safety reasons, Administrator A made the decision to call the emergency number "911" for assistance and for the facility staff to lower R1 to the ground and facility staff provided "physical restraint" until the arrival of the local police department and "Emergency Medical Services" (EMS) for the safety of the other residents and staff. When EMS arrived and started treating R1, they administered Haldol 5 milligrams intramuscularly, Versed 2.5 milligrams intramuscularly, and 2,5 milligrams of Versed intravenously. When the resident was calm the local police officers and the EMS team assisted R1 to the ambulance cot and transported him to the ambulance then to the local hospital where he remained during the survey process.

Review of the facility provided video footage from Cameras 1, 3, 9 and 11 date stamped 03/07/24 revealed the following:

At 06:37 AM R1 and R2 are walking into the dining room and sit down at the dining room table. R1 appeared restless and laid his down on the table and rubbed his head several times.

At 07:10 AM R2 assist R1 with breakfast by feeding him.

At 07:28 AM R2 reaches for her purse and was going thru her purse, she has something small in her hand and a with a twisting motion removes

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the top off of something and lays the lid down with her left hand on the table. The small container is in her right hand, and she shook the container over her left and whatever she shook out of the container she handed to R1 and at 07:28:57AM R1 raised his hand to his mouth and placed what was in his hand in his mouth and took a drink at 07:29 AM.

At 09:20 AM R1 opening the door to the kitchen located on the north wall of the dining room where he was redirected by facility staff.

At 09:22 AM R1 came back into the dining room accompanied by two facility staff. He was speaking. Staff were speaking to him, and he was acknowledging them. He then walked out the camera view at 09:23 AM and then the residents in the dining room all look to the area out of view of the camera.

At 09:24 R1 was back on camera screen, and he was holding hands with CMA E who showed him the dining room table and a chair to sit in. R1 appeared to be trying to explain something to staff and was using his hands to assist in in speaking in a non-threatening manner.

At 09:25 AM he appeared to be getting agitated and started pointing and shaking his finger in the direction of the facility female staff member. The staff member then held her arm out and R1 and the female staff member then walked out of the dining room together.

At 09:28 AM R1 was at the elevator with facility staff where he started pushing the button and then kicked the elevator.

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S3090	Continued From page 15 At 09:35 AM the R1 and R2 were standing at the dining room table and R1 appeared to be grabbing at the upper part of R2's right arm. She then took his hand is held it. R2 then appeared to try and withdrawal her hand from R1's and he then started speaking to her and shaking his left forefinger at her. R1 then shrugged/pushed R2's hand away and he turned to walk away from the dining room table. At 09:36 AM R1 was walking down hallway with staff, and he appeared agitated. At 09:41 AM you saw R1 walking back towards the dining room with staff, and you saw R2 standing in the hallway in front of R1. At 09:45AM you saw a staff member on the floor, and two police officers walked in. At 09:46 there were at least 2 police officers and 2 other officials who were to far away from the camera to tell if they were police officials or EMS officials. In the video and they were attempting to assist R1 from the floor. At 09:47 one police officer was speaking to R1 and wanting him to sit on a chair, R1 was combative and there was one police officer addressing R1 from the front and two or three other police/EMS from the back and sides. There were three other police/EMS officials standing and guiding the police/EMS officials who were assisting R1 to a sitting position in the dining room chair. R1 remained combative/aggressive with police/EMS officials until they lowered him to the floor at 10:12 AM.	S3090		

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S3090	Continued From page 16 At 10:20 AM The police/EMS officials assisted R1 into a standing position and assisted him to the cot where they applied white wrist restraints to each of R1's wrist, and he was wheeled out of the facility at 10:24AM to be transported to the local hospital where he remained during the survey process on 03/13/24. Observation on 03/13/24 at approximately 04:00 PM of the video footage provided from camera 11 there is a time lapse from 09:42:06AM to 09:45:14AM and on camera 1 there is a time lapse from 09:41:25AM to 09:49:33AM. Interview on 03/13/24 at approximately 04:00 PM with Administrator A and Resource Nurse B confirmed the time lapse on cameras 1 and 11, and the video time stamp was 70 minutes fast. The time stamp of 09:10 AM is actually 08:00 AM. Review of the facility provided witness statements related to the incident with R1 on 03/07/24 revealed the following: CMA F wrote she arrived at work at 05:30 AM and was asked by CMA I to assist with R2 because R1 had "already made her cry and has been aggressive." She redirected him and approximately 30 minutes to an hour later "one of the aides came and told me that they needed help because he was being aggressive again." She continued to write that she and CMA E were redirecting R1, and he started exit seeking, kicked the elevator, and started getting "physical again" with CMA E. She continued to write that when R1 saw R2 he started running and at that	S3090		

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point the decision was made to restrain R1 to keep him from "attacking anyone else."

"Director of Nursing" (DON) J wrote upon arrival to the Assisted Living after receiving the call from staff for help she witnessed R1 walking with CMA E and CMA I, DON J wrote she assisted in trying to redirect R1, "he walked out of the dining room towards the courtyard door. While at the door he knocked a picture frame off the window ledge, hit the window and kicked the window frame." DON J continued to write that R1 attempted to "strike/push" CMA E. DON J continued that when R1 saw R2, R1 began yelling and moving towards her. DON J then placed herself between R1 and R2, and when R1 reached DON J he began "striking and pushing" her.
The staff removed R2 from the area and CMA E had his back turned and was walking away and R1 started hitting and pushing CMA E repeatedly. DON J wrote that "Multiple attempts to redirect" R1 "were unsuccessful" and they decided to lower him to the floor and provide physical restraint until law enforcement could arrive.

Facility Staff G wrote she arrived at work around 06:00 AM and R1 appeared to be "OK". She continued to write that at 08:00 AM R1 came out with R2 and R1 seemed very agitated. Stated he wanted to get out of the facility. "His dementia caused him to be confused and very agitated".

Facility Staff H wrote that around 08:30AM R1 was yelling and hitting CMA E with his coffee cup.

R2 witness statement written by facility staff and

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signed by R2, revealed that R2 and R1 were up at 05:00 AM. R2 could not "remember how it started or what may have triggered it." She remembered eating breakfast and them R1 getting very upset.

Interview on 03/12/24 at 04:55 PM with CMA I by phone with administrator A and Resource Nurse B in the room confirmed that CMA I hear R1 giving R2 "a hard time" at approximately 04:30 AM on 03/07/24. She stated she tried to talk to R1 and that R1 did "settle some". She stated that she called CMA E to see if he would "come up" to redirect R1, she continued that R1 knew who CMA E was. CMA I confirmed this was not typical behavior for R1 and R1 stated he wanted to go home. CMA I stated that this was the first time she had witnessed this behavior from R1. She stated she gave R1 his Levothyroxine and she further confirmed she did not call the nurse available to report R1's new behavior.

03/13/24 at 05:30 PM R1 remained admitted to the local hospital during the survey process, and the records did not include an NSA.

- Record review for R2 revealed an admission date of 03/02/24 with a diagnosis of Alzheimer's disease.

Review of R2's FCS dated 03/06/24 revealed the date of assessment was entered in as 03/02/24, and R2 was independent with bathing, dressing, toileting, transferring, walking/mobility, and eating. She required supervision with the management of her medications and was continent of her bladder. She had impaired

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short-term memory, impaired memory recall and impaired decision making. She was able to make herself understood and she understood others. Under the section titled "Current or Recent Problems and Risks" R2 was marked with impaired decision making.

R2's electronic medical record and the paper medical record lacked an NSA.

Record review of R2's electronic medical records under the "Progress Notes" tab revealed the following entries:

On 03/02/24 at 06:07PM R2 admitted to the facility with her "spouse". R2 was independent with all ADL's, she ambulated by herself without an assistive device, and her family was present.

The progress note lacked documentation that R2 would self-administer her own medications and further lacked documentation that she would administer R1's medications.

Interview on 03/13/24 at approximately 12:00 PM with Administrator A she confirmed after watching the facility video on the incident on 03/07/24, and after obtaining permission from R2's DPOA she went to R2's room and asked if she had any medications in her room. Administrator A stated that R2 got in her purse and pulled out a prescription medication bottle and handed it to her. Administrator A then asked R2 if she could look in the bathroom for any more medication bottles and R2 gave permission. Administrator A found another bottle of prescription medication in the bathroom in a holder. Administrator A stated she asked R2 if she had given any medications

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to R1, she stated R2 confirmed she gave R1 a pill from the bottle in her purse "the day we got here, and then he went home." Administrator A brought both bottles to the interview for observation.

Observation on 03/13/24 at approximately 12:00PM during the Interview with Administrator A confirmed 1 bottle of Hydrocodone-Acetaminophen 5 milligrams/325 milligrams filled on 03/27/20 and expired on 03/27/21. The bottle was empty and labeled with R1's name.

The second bottle was a full bottle of Donepezil HCL 23 milligrams filled on 10/11/22 and expired on in 2023.

Interview on 03/13/24 at 01:13PM by phone with "Licensed Nurse" (LN) C, and Administrator A and Resource Nurse B present in the room, LN C confirmed she did not complete an NSA or a HSP for R1, she stated she had planned on completing the NSA and HSP on 03/12/24. She further confirmed she was unaware of the diagnosis of dementia with behavioral disturbances. She stated R1's cognition impairment was that he could not recall past or current events. She stated she left a note on the medication cart for facility staff on what health services R1 and R2 would need, she continued to state she had a verbal conversation with the facility CMA's about R1 and R2 and what they would require. LN C stated that R2 was going to self-administer her own medications and R1's medications under the family supervision per the DPOA request. She stated that on 03/04/24 the DPOA requested that the facility provide

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medication management for R1 and R2. LN C then stated she went to R2 and obtained the medications from their room. She stated that R2 kept the medication bottles in her purse. LN C confirmed at the time of admission for R1 and R2 she was aware that R1 and R2 were not successful in self-administration of their own medications when they lived at home per the DPOA. LN C stated she did perform an assessment on R2 for the self-administration of medications in the electronic medical record system on 03/02/24.

Interview on 03/13/24 at approximately 02:20 PM with Administrator A and Resource Nurse B confirmed the electronic medical record lacked the documentation of an assessment for R2 for the self -administration of medications.

Interview with Administrator A on 03/13/24 at approximately 11:20 AM, she confirmed per her phone conversation with the DPOA that R1 was to receive his medications from R2, and that R2 could self-administer her own medications.

Review of the facility policy titled "Abuse, Neglect and Misappropriation Policy" dated 10/2016 revealed the following statements:

Section 1 Abuse was defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish.

Neglect was defined as a failure to provide goods and services necessary to avoid physical harm, mental anfuish, or mental illness.

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Section 2 Parties Potentially involved
a. two or more residents.
b. one or more resident(s), family member(s) and/or visitors.
c. one or more resident(s) and associates.

Section 3 Internal Reporting
a. "Associate obligations. Any associate who witnessess or becomes aware of alleged abuse, neglect or misappropriation of resident property, should report such incident to the Administraitor and or Executive Director or supervisor on duty immediately."

"Immediate action will be taken in all cases of abuse or aggressive behaviors..."

"The Administrator / Director of Nursing will be immediately notified when a resident to residnt abuse incident has occured"

Review of the undated facility policy titled "Resident to Resident Altercations" it revealed the following:
"If a resident to resident interaction occurs, the community will do whatever possible to prevent and control resident to resident altercations in order to prevent mental, physical, sexual and verbal abuse or exploitation of personal property from occurring."

The administrator failed to ensure the development at the time of admission of an NSA for R1 based on an accurate FCS that would have identified R1 would require the following health care services: the administration of his medication by R2, services to assist with impaired cognition, bilateral hearing loss, the

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S3090	Continued From page 23 diagnoses of dementia with behaviors, socially disruptive behaviors of paranoia and bladder incontinence. The administrator further failed to ensure the development at the time of admission of an NSA for R2 based on an accurate FCS that would have identified R2 would require services for impaired cognition and services for the safe self-administration of her own medications and safe administration of R1's medications.	S3090		
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 capacity screening and the negotiated service agreement. This REQUIREMENT is not met as evidenced by: K.A.R. 26-41-204 (a) The facility reported a census of 31 residents. The sample included 2 "Residents'" (R)1 and R2. Based on interview, and record review, the Administrator failed to ensure the licensed nurse coordinated the provision of necessary health care services that met the needs of each resident and were in accordance with the accurately reflected "Functional Capacity Screening" (FCS) and the "Negotiated Service Agreement" (NSA)	S3155		

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S3155	Continued From page 24 for R1 and R2. Findings included: - Record review for R1 revealed an admission date of 03/02/24 with diagnoses of chronic pain, degenerative lumbar disc, Spondylosis of lumbar region, bilateral hearing loss, obesity, dementia unspecified dementia type, major depressive disorder, anxiety, frequent falls, and dementia with behavioral disturbance. Review of R1's FCS dated 03/06/24 revealed the date of assessment was entered in as 03/02/24, and R1 was independent with bathing, dressing, toileting, transferring, walking/mobility, and eating. He lacked the ability to manage his own medications and was 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. Under the section titled "Current or Recent Problems and Risks" R1 was marked with impaired decision making and he used no mobility device. The FCS did not acknowledge in the "Current or Recent Problems and Risks" that R1 had bilateral hearing loss, and frequent falls. R1's electronic medical record and the paper medical record lacked a "Health Service Plan" (HSP). Record review of R1's paper medical record revealed a fax cover sheet sent to the facility on	S3155		

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03/04/24 from R1's medical provider. The record was dated 11/09/23 and was a follow up visit note from the primary care provider. Within the document were the diagnoses for R1 and on the second page in the "Medications" section LN C initialed on 03/04/24 with "Noted" written under the date. In the "History of Present Illness" section of the document the following was recorded: Patient's living situation was: "at home with wife requiring assistance with some ADL's" (Activities of Daily Living). He remained living at home with his wife. He continued to "exhibit a slow but significant decline in memory and functionality in the last year" He ambulates without assistance "for the most part but holds onto wife for long distances." R1 was noted with a "considerable decline" in his memory. He was very easily upset when he forgot things and names. He had difficulty remembering names and dates. He was very paranoid at times and was frequently incontinent of urine and wore briefs. In the "Treatment" Section of the document the following was recorded: R1's memory and functionality had "Significantly declined in the last year." The provider recorded that earlier in the year there were concerns of self - care deficit and worsening memory. The options of home health and hospice were discussed on this visit with R1's DPOA.

Review of R1 electronic medical record under the "Progress" note tab revealed the following entry:

On 03/02/24 at 06:01PM R1 was admitted to the facility and his family was present. R1 was alert times "3" with some confusion. R1 ambulated by himself and was continent of his bowel and his

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bladder. R1's "wife to assist with administration" of his medications. The entry was initialed by LN C.

- Record review for R2 revealed an admission date of 03/02/24 with a diagnosis of Alzheimer's disease.

Review of R2's FCS dated 03/06/24 revealed the date of assessment was entered in as 03/02/24, and R2 was independent with bathing, dressing, toileting, transferring, walking/mobility, and eating. She required supervision with the management of her medications and was continent of her bladder. She had impaired short-term memory, impaired memory recall and impaired decision making. She was able to make herself understood and she understood others. Under the section titled "Current or Recent Problems and Risks" R2 was marked with impaired decision making. The section titled Mobility Appliances and Devices" lacked any documentation.

R2's electronic medical record and the paper medical record lacked a lacked a "Health Service Plan" (HSP).

Interview on 03/12/23 at approximately 04:55 PM with R2 revealed she could not recall the morning meal or the names of her medications. She stated she took several medications, and she manages her medications herself. She stated she had 3 sons and was able to recall their names.

Interview on 03/13/24 at 01:13PM by phone with

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S3155	Continued From page 27 "Licensed Nurse" C, and Administrator A and Resource Nurse B present in the room, LN C confirmed she did not complete an a HSP for R1 or R2. She further confirmed she was unaware of the diagnosis of dementia with behavioral disturbances for R1. She stated R1's cognition impairment was that he could not recall past or current events and LN C continued to state R2's cognition was not impaired. LN C stated that R2 was going to self-administer her own medications and R1's medications under the family supervision per the DPOA request. She stated that on 03/04/24 the DPOA requested that the facility provide medication management for R1 and R2. The Administrator failed to ensure the licensed nurse coordinated the provision of necessary health care services that met the needs of each resident and were in accordance with the accurately reflected FCS and the NSA for R1 and R2.	S3155		
S3171 SS=E	26-41-204 (i) Health Care Services Standards of Practice (i) All health care services shall be provided to residents by qualified staff in accordance with acceptable standards of practice. This REQUIREMENT is not met as evidenced by: K.A.R 26-41-204(i) The facility reported a census of 31 residents. The sample included 2 "Residents'" (R)1 and R2.	S3171		

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Based on record review and interview the Administrator failed to provided health care services to R1 and R2, a married couple who live in the same apartment, in accordance with acceptable standards of practice when the night shift "Certified Medication Aide" (CMA) failed to notify the nurse on duty when she noticed a change in behavior in R1 that had a direct effect on R2 at approximately 04:30AM. The day shift staff further failed to notify the day shift nurses of R1's change of condition until R1 exhibited no control over his angry and aggressive behaviors and called the nurse at approximately 08:31 AM, this resulted in R1being lowered to the floor and physically restrained until local law enforcement and "Emergency Medical Services" (EMS) arrived to provide assistance and then transport R1 to the local hospital.

Findings included:

- Record review for R1 revealed an admission date of 03/02/24 with diagnoses of chronic pain, degenerative lumbar disc, Spondylosis of lumbar region, bilateral hearing loss, obesity, dementia unspecified dementia type, major depressive disorder, anxiety, frequent falls, and dementia with behavioral disturbance.

Review of R1's FCS dated 03/06/24 revealed the date of assessment was entered in as 03/02/24, and R1 was independent with bathing, dressing, toileting, transferring, walking/mobility, and eating. He lacked the ability to manage his own medications and was continent of his bladder. He had impaired short-term memory, impaired long-term memory, impaired memory recall and

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impaired decision making. He was able to make himself understood and he understood others. Under the section titled "Current or Recent Problems and Risks" R1 was marked with impaired decision making and he used no mobility device.

The FCS did not acknowledge in the "Current or Recent Problems and Risks" that R1 had the diagnoses of bilateral hearing loss, frequent falls, and dementia with behaviors.

R1's electronic medical record and the paper medical record lacked a "Negotiated Service Agreement" (NSA) and further lacked a "Health Service Plan" (HSP).

Record review of R1's paper medical record revealed a fax cover sheet sent to the facility on 03/04/24 from R1's medical provider. The record was dated 11/09/23 and was a follow up visit note from the primary care provider. Within the document were the diagnoses for R1 which included dementia with behavioral disturbance and anxiety, on the second page in the "Medications" section were the following medications:

Donepezil Hydrochloride 23 milligram tablet. Take 1 tablet orally once a day at bedtime. Donepezil is used to treat dementia (memory loss and mental changes) associated with mild, moderate, or severe Alzheimer's disease. https://www.mayoclinic.org/drugs-supplements

Lorazepam 0.5 milligram tablet. 1 tablet orally twice a day as needed for anxiety.

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S3171	Continued From page 30 Desvenlafaxine 50 milligram tablet extended release. 1 tablet orally once a day. Desvenlafaxine is used to treat is used to treat depression. https://www.mayoclinic.org/drugs-supplements Meloxicam 7.5 milligram tablets. Take 1 tablet orally one time a day. Meloxicam is a non-steroidal anti-inflammatory medication used to treat the symptoms of arthritis. https://www.mayoclinic.org/drugs-supplements Aspirin 81 milligrams delayed release tablet. Take 1 tablet by mouth one time a day. Levothyroxine 25 micrograms (0.025 milligrams) tablet. Take orally once a day. Acetaminophen-Hydrocodone Bitartrate 325 milligrams - 7.5 milligrams tablet orally every 6 hours. LN C initialed on 03/04/24 with "Noted" written under the date. In the "History of Present Illness" section of the document the following was recorded: Patient's living situation was: "at home with wife requiring assistance with some ADL's" (Activities of Daily Living). He remained living at home with his wife. He continued to "exhibit a slow but significant decline in memory and functionality in the last year" He ambulates without assistance "for the most part but holds onto wife for long distances." R1 was noted with a "considerable decline" in his memory. He was very easily upset when he forgot things and names. He had	S3171		

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difficulty remembering names and dates. He was very paranoid at times and was frequently incontinent of urine and wore briefs. In the "Treatment" Section of the document the following was recorded: R1's memory and functionality had "Significantly declined in the last year." The provider recorded that earlier in the year there were concerns of self - care deficit and worsening memory. The options of home health and hospice were discussed on this visit with R1's DPOA.

Review of R1 electronic medical record under the "Progress" note tab revealed the following entries:

On 03/02/24 at 06:01PM R1 was admitted to the facility and his family was present. R1 was alert times "3" with some confusion. R1 ambulated by himself and was continent of his bowel and his bladder. R1's "wife to assist with administration" of his medications. The entry was initialed by "Licensed Nurse" (LN) C.

On 03/06/24 at 07:03 AM an administration note read "Ativan Oral Tablet 0.5 milligrams. Give 1 tablet by mouth every 12 hours as needed for agitation." and signed by "Certified Medication Aide" D.

On 03/06/24 at 07:54 AM a follow up administration note read the as needed administration of the Ativan 0.5 milligrams administered at 07:03 AM was effective.

The electronic medical record lacked a note in the "Progress Notes" tab of the symptoms or behaviors on 03/06/24 observed, the record and

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the record further lacked notification of the LN prior to the administration of the Ativan by the CMA.

Review of the facility provided self-reported incident to the department dated 03/08/24 revealed the following information:

On 03/07/24 at approximately 08:30 AM R1 was being physically combative with facility staff and after numerus failed attempts at redirection, R1's physical aggression escalated, and for safety reasons, Administrator A made the decision to call the emergency number "911" for assistance and for the facility staff to lower R1 to the ground and facility staff provided "physical restraint" until the arrival of the local police department and "Emergency Medical Services" (EMS) for the safety of the other residents and staff. When EMS arrived and started treating R1, they administered Haldol 5 milligrams intramuscularly, Versed 2.5 milligrams intramuscularly, and 2,5 milligrams of Versed intravenously. When the resident was calm the local police officers and the EMS team assisted R1 to the ambulance cot and transported him to the ambulance then to the local hospital where he remained during the survey process.

The electronic medical record lacked a note in the "Progress Notes" tab for the incident on 03/07/24.

Review of the facility provided witness statements related to the incident with R1 on 03/07/24 revealed the following:

CMA F wrote she arrived at work at 05:30 AM

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and was asked by CMA I to assist with R2 because R1 had "already made her cry and has been aggressive." CMA F wrote in her witness statement that she spent time redirecting R1 and was involved in the physical restraint of R1 until law enforcement arrived.

CMA E wrote that he arrived at the facility at 06:00 AM and that he was agitated and had taken some medication to calm down.

Facility staff G wrote that at approximately 08:00 AM R1 was very agitated and stating he wanted out of the facility.

"Director of Nursing" (DON) J wrote that she received a call from CMA E at 08:31Am requesting help in the assisted living for a physically aggressive resident. Upon arrival to the Assisted Living after receiving the call from staff for help she witnessed R1 walking with CMA E and CMA I, DON J wrote she assisted in trying to redirect R1, "he walked out of the dining room towards the courtyard door. While at the door he knocked a picture frame off the window ledge, hit the window and kicked the window frame." DON J continued to write that R1 attempted to "strike/push" CMA E. DON J continued that when R1 saw R2, R1 began yelling and moving towards her. DON J then placed herself between R1 and R2, and when R1 reached DON J he began "striking and pushing" her. The staff removed R2 from the area and CMA E had his back turned and was walking away and R1 started hitting and pushing CMA E repeatedly. DON J wrote that "Multiple attempts to redirect" R1 "were unsuccessful" and they decided to lower him to the floor and provide physical

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restraint until law enforcement could arrive.

R2 witness statement written by facility staff and signed by R2, revealed that R2 and R1 were up at 05:00 AM. R2 could not "remember how it started or what may have triggered it." She remembered eating breakfast and them R1 getting very upset.

Interview on 03/12/24 at 04:55 PM with CMA I by phone with administrator A and Resource Nurse B in the room confirmed that CMA I hear R1 giving R2 "a hard time" at approximately 04:30 AM on 03/07/24. She stated she tried to talk to R1 and that R1 did "settle some". CMA I stated that this was not typical behavior for R1, she continued to state that this was the first time she had seen this behavior from R1. She stated that she called CMA E to see if he would "come up" to redirect R1, she continued that R1 knew who CMA E was, she further confirmed she did not notify the nurse on duty of the newly exhibited behaviors R1 was exhibiting that had caused R2 to cry.

Review of the facility policy titled "Abuse, Neglect and Misappropriation Policy" dated 10/2016 revealed the following statements:

Section 1

Abuse was defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish.

Neglect was defined as a failure to provide goods and services necessary to avoid physical

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harm, mental anfuish, or mental illness.

Section 2 Parties Potentially involved
a. two or more residents.
b. one or more resident(s), family member(s) and/or visitors.
c. one or more resident(s) and associates.

Section 3 Internal Reporting
a. "Associate obligations. Any associate who witnessess or becomes aware of alleged abuse, neglect or misappropriation of resident property, should report such incident to the Administraitor and or Executive Director or supervisor on duty immediately."

"Immediate action will be taken in all cases of abuse or aggressive behaviors..."

"The Administrator / Director of Nursing will be immediately notified when a resident to residnt abuse incident has occured"

Review of the undated facility policy titled "Resident to Resident Altercations" it revealed the following:
"If a resident to resident interaction occurs, the community will do whatever possible to prevent and control resident to resident altercations in order to prevent mental, physical, sexual and verbal abuse or exploitation of personal property from occurring."

03/13/24 at 05:30 PM R1 remained admitted to the local hospital during the survey process.

The Administrator failed to provided health care services to R1 and R2, a married couple who live

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S3171	Continued From page 36 in the same apartment, in accordance with acceptable standards of practice when the night shift "Certified Medication Aide" (CMA) failed to notify the nurse on duty when she noticed a change in behavior in R1 that had a direct effect on R2 at approximately 04:30AM. The day shift staff further failed to notify the day shift nurses of R1's change of condition until R1 exhibited no control over his angry and aggressive behaviors and called the nurse at approximately 08:31 AM, this resulted in R1being lowered to the floor and physically restrained until local law enforcement and "Emergency Medical Services" (EMS) arrived to provide assistance and then transport R1 to the local hospital.	S3171		
S3175 SS=D	26-41-205 (a) (1) Self Administration of Medication (a) Self-administration of medication. Any resident may self-administer and manage medications independently or by using a medication container or syringe prefilled by a licensed nurse or pharmacist or by a family member or friend providing this service gratuitously, if a licensed nurse has performed an assessment and determined that the resident can perform this function safely and accurately without staff assistance. (1) An assessment shall be completed before the resident initially begins self-administration of medication, if the resident experiences a significant change of condition, and annually.	S3175		

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S3175	Continued From page 37 This REQUIREMENT is not met as evidenced by: K.A.R. 26-41-205 (a)(1) The facility reported a census of 31 residents. The sample included 2 "Residents'" (R)1 and R2. Based on interview, and record review, the Administrator failed to ensure the licensed nurse performed an assessment and determined that R2 could safely and accurately without staff assistance self-administer and manage her own medications and administer and manage her husband/R2's medications. Findings included: - Record review for R2 revealed an admission date of 03/02/24 with a diagnosis of Alzheimer's disease. Review of R2's FCS dated 03/06/24 revealed the date of assessment was entered in as 03/02/24, and R2 was independent with bathing, dressing, toileting, transferring, walking/mobility, and eating. She required supervision with the management of her medications and was continent of her bladder. She had impaired short-term memory, impaired memory recall and impaired decision making. She was able to make herself understood and she understood others. Under the section titled "Current or Recent Problems and Risks" R2 was marked with impaired decision making. The section titled Mobility Appliances and Devices" lacked any documentation.	S3175		

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R2's electronic medical record and the paper medical record lacked a "Negotiated Service Agreement" (NSA) and further lacked a "Health Service Plan" (HSP).

Interview on 03/12/23 at approximately 04:55 PM with R2 revealed she could not recall the morning meal or the names of her medications. She stated she took several medications, and she manages her medications herself. She stated she had 3 sons and was able to recall their names.

Interview on 03/13/24 at approximately 12:00 PM with Administrator A she confirmed after watching the facility video on the incident on 03/07/24, and after obtaining permission from R2's DPOA she went to R2's room and asked if she had any medications in her room. Administrator A stated that R2 got in her purse and pulled out a prescription medication bottle and handed it to her. Administrator A then asked R2 if she could look in the bathroom for any more medication bottles and R2 gave permission. Administrator A found another bottle of prescription medication in the bathroom in a holder. Administrator A stated she asked R2 if she had given any medications to R1, she stated R2 confirmed she gave R1 a pill from the bottle in her purse "the day we got here, and then he went home." Administrator A brought both bottles to the interview for observation.

Observation on 03/13/24 at approximately 12:00PM during the Interview with Administrator A confirmed 1 bottle of Hydrocodone-Acetaminophen 5 milligrams/325 milligrams filled on 03/27/20 and expired on

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03/27/21. The bottle was empty and labeled with R1's name.

Interview with Administrator A on 03/13/24 at approximately 11:20 AM, she confirmed per her phone conversation with the DPOA that R1 was to receive his medications from R2, and that R2 could self-administer her own medications.

Interview on 03/13/24 at 01:13PM by phone with "Licensed Nurse" C, and Administrator A and Resource Nurse B present in the room, LN C stated R2's cognition was not impaired. LN C stated that R2 was going to self-administer her own medications and R1's medications under the family supervision per the DPOA request. She stated that on 03/04/24 the DPOA requested that the facility provide medication management for R1 and R2. LN C then stated she went to R2 and obtained the medications from their room. She stated that R2 kept the medication bottles in her purse. LN C confirmed at the time of admission for R1 and R2 she was aware that R1 and R2 were not successful in self-administration of their own medications when they lived at home per the DPOA. LN C stated she did perform an assessment on R2 for the self-administration of medications in the electronic medical record system on 03/02/24.

Interview on 03/13/24 at approximately 02:20 PM with Administrator A and Resource Nurse B confirmed the electronic medical record lacked the documentation of an assessment for R2 for the self -administration of medications.

The Administrator failed to ensure the licensed nurse performed an assessment and determined

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S3175	Continued From page 40 that R2 could safely and accurately without staff assistance self-administer and manage her own medications and administer and manage her husband/R2's medications.	S3175		
S3200 SS=D	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. This REQUIREMENT is not met as evidenced by: K.A.R 26-41-205 (d) The facility reported a census of 31 residents. The sample included 2 "Residents'" (R)1 and R2. Based on record review and interview the Administrator failed ensure that all medications and biologicals were administered to R1 in accordance with professional standards of	S3200		

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(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
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practice when "Certified Medication Aide" (CMA) D administered Ativan 0.5 milligrams to R1 when he exhibited "agitation" and CMA D did not document that she notified the nurse prior to administration on 03/06/24 at 07:03 AM.

Findings included:

- Record review for R1 revealed an admission date of 03/02/24 with diagnoses of chronic pain, degenerative lumbar disc, Spondylosis of lumbar region, bilateral hearing loss, obesity, dementia unspecified dementia type, major depressive disorder, anxiety, frequent falls, and dementia with behavioral disturbance.

Review of R1's FCS dated 03/06/24 revealed the date of assessment was entered in as 03/02/24, and R1 was independent with bathing, dressing, toileting, transferring, walking/mobility, and eating. He lacked the ability to manage his own medications and was 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. Under the section titled "Current or Recent Problems and Risks" R1 was marked with impaired decision making and he used no mobility device.

The FCS did not acknowledge in the "Current or Recent Problems and Risks" that R1 had the diagnoses of bilateral hearing loss, frequent falls, and dementia with behaviors.

R1's electronic medical record and the paper

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medical record lacked a "Negotiated Service Agreement" (NSA) and further lacked a "Health Service Plan" (HSP).

Record review of R1's paper medical record revealed a fax cover sheet sent to the facility on 03/04/24 from R1's medical provider. The record was dated 11/09/23 and was a follow up visit note from the primary care provider. Within the document were the diagnoses for R1 which included dementia with behavioral disturbance and anxiety, on the second page in the "Medications" section were the following medications:

Donepezil Hydrochloride 23 milligram tablet. Take 1 tablet orally once a day at bedtime.
Donepezil is used to treat dementia (memory loss and mental changes) associated with mild, moderate, or severe Alzheimer's disease.
https://www.mayoclinic.org/drugs-supplements

Lorazepam 0.5 milligram tablet. 1 tablet orally twice a day as needed for anxiety.

Desvenlafaxine 50 milligram tablet extended release. 1 tablet orally once a day.
Desvenlafaxine is used to treat is used to treat depression.
https://www.mayoclinic.org/drugs-supplements

Meloxicam 7.5 milligram tablets. Take 1 tablet orally one time a day.
Meloxicam is a non-steroidal anti-inflammatory medication used to treat the symptoms of arthritis.
https://www.mayoclinic.org/drugs-supplements

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S3200	Continued From page 43 Aspirin 81 milligrams delayed release tablet. Take 1 tablet by mouth one time a day. Levothyroxine 25 micrograms (0.025 milligrams) tablet. Take orally once a day. Acetaminophen-Hydrocodone Bitartrate 325 milligrams - 7.5 milligrams tablet orally every 6 hours. LN C initialed on 03/04/24 with "Noted" written under the date. In the "History of Present Illness" section of the document the following was recorded: Patient's living situation was: "at home with wife requiring assistance with some ADL's" (Activities of Daily Living). He remained living at home with his wife. He continued to "exhibit a slow but significant decline in memory and functionality in the last year" He ambulates without assistance "for the most part but holds onto wife for long distances." R1 was noted with a "considerable decline" in his memory. He was very easily upset when he forgot things and names. He had difficulty remembering names and dates. He was very paranoid at times and was frequently incontinent of urine and wore briefs. In the "Treatment" Section of the document the following was recorded: R1's memory and functionality had "Significantly declined in the last year." The provider recorded that earlier in the year there were concerns of self - care deficit and worsening memory. The options of home health and hospice were discussed on this visit with R1's DPOA. Review of R1 electronic medical record under	S3200		

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S3200	Continued From page 44 the "Progress" note tab revealed the following entries: On 03/02/24 at 06:01PM R1 was admitted to the facility and his family was present. R1 was alert times "3" with some confusion. R1 ambulated by himself and was continent of his bowel and his bladder. R1's "wife to assist with administration" of his medications. The entry was initialed by "Licensed Nurse" (LN) C. On 03/06/24 at 07:03 AM an administration note read "Ativan Oral Tablet 0.5 milligrams. Give 1 tablet by mouth every 12 hours as needed for agitation." and signed by "Certified Medication Aide" D. On 03/06/24 at 07:54 AM a follow up administration note read the as needed administration of the Ativan 0.5 milligrams administered at 07:03 AM was effective. The electronic medical record lacked a note in the "Progress Notes" tab of the symptoms or behaviors on 03/06/24 observed, the record and the record further lacked notification of the LN prior to the administration of the Ativan by the CMA D. Interview on 03/13/24 at 01:13PM by phone with "Licensed Nurse" (LN) C, and Administrator A and Resource Nurse B present in the room, LN C confirmed she did not receive a phone call on 03/06/24 at approximately from CMA D for the administration of Ativan 0.5 milligrams to R1. Review of the facility provided policy titled "Medications and Treatments" As Needed dated	S3200		

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S3200	Continued From page 45 06/2016 revealed the following statement: in the "State Specific Requirements" As needed procedures in the box for Kansas it stated "If a resident is cognitively impaired had has an as needed order for any mediation, including psychoactive or pain medication the unlicensed community associates should notify the nurse or designated associate before giving the medication. Kansas Only: regardless of parameters in the order; permission must be received in order to administer an as needed medication. The Administrator failed ensure that all medications and biologicals were administered to R1 in accordance with professional standards of practice when CMA D administered Ativan 0.5 milligrams to R1 when he exhibited "agitation" and CMA D did not document that she notified the nurse prior to administration on 03/06/24 at 07:03 AM.	S3200		
S3261 SS=E	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: K.A.R 26-41-105 (f) (11) The facility reported a census of 31 residents.	S3261		

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The sample included 2 "Residents'" (R)1 and R2. Based on record review and interview the Administrator failed to ensure the documentation of all incidents, symptoms and other indications of illness or injury including the date, time, actions taken and results of actions taken for R1 when he was administered Ativan 0.5 milligrams for Agitation on 03/06/24 and an incident on 03/07/24 that involved R1 being lowered to the floor with facility staff providing physical restraint with the involvement of the local police department and the local "Emergency Medical Service" (EMS)'s, and resulting in the transfer of R1 by ambulance the local hospital. The Administrator further failed to ensure the documentation for R1 and R2 when on the morning of 03/07/24 the "Certified Medication Aide" on duty overheard R1 and R2 having an argument and asked the oncoming staff to check on R1 and R2 because R1 had made R2 cry that morning, and the failure to document for R2 witnessing the incident on 03/07/24 for R1.

Findings included:

- Record review for R1 revealed an admission date of 03/02/24 with diagnoses of chronic pain, degenerative lumbar disc, Spondylosis of lumbar region, bilateral hearing loss, obesity, dementia unspecified dementia type, major depressive disorder, anxiety, frequent falls, and dementia with behavioral disturbance.

Review of R1's FCS dated 03/06/24 revealed the date of assessment was entered in as 03/02/24, and R1 was independent with bathing, dressing, toileting, transferring, walking/mobility, and

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eating. He lacked the ability to manage his own medications and was 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. Under the section titled "Current or Recent Problems and Risks" R1 was marked with impaired decision making and he used no mobility device.

The FCS did not acknowledge in the "Current or Recent Problems and Risks" that R1 had the diagnoses of bilateral hearing loss, frequent falls, and dementia with behaviors.

R1's electronic medical record and the paper medical record lacked a "Negotiated Service Agreement" (NSA) and further lacked a "Health Service Plan" (HSP).

Record review of R1's paper medical record revealed a fax cover sheet sent to the facility on 03/04/24 from R1's medical provider. The record was dated 11/09/23 and was a follow up visit note from the primary care provider. Within the document were the diagnoses for R1 which included dementia with behavioral disturbance and anxiety, on the second page in the "Medications" section were the following medications:

Donepezil Hydrochloride 23 milligram tablet. Take 1 tablet orally once a day at bedtime. Donepezil is used to treat dementia (memory loss and mental changes) associated with mild, moderate, or severe Alzheimer's disease. https://www.mayoclinic.org/drugs-supplements

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S3261	Continued From page 48 Lorazepam 0.5 milligram tablet. 1 tablet orally twice a day as needed for anxiety. Desvenlafaxine 50 milligram tablet extended release. 1 tablet orally once a day. Desvenlafaxine is used to treat is used to treat depression. https://www.mayoclinic.org/drugs-supplements Meloxicam 7.5 milligram tablets. Take 1 tablet orally one time a day. Meloxicam is a non-steroidal anti-inflammatory medication used to treat the symptoms of arthritis. https://www.mayoclinic.org/drugs-supplements Aspirin 81 milligrams delayed release tablet. Take 1 tablet by mouth one time a day. Levothyroxine 25 micrograms (0.025 milligrams) tablet. Take orally once a day. Acetaminophen-Hydrocodone Bitartrate 325 milligrams - 7.5 milligrams tablet orally every 6 hours. LN C initialed on 03/04/24 with "Noted" written under the date. In the "History of Present Illness" section of the document the following was recorded: Patient's living situation was: "at home with wife requiring assistance with some ADL's" (Activities of Daily Living). He remained living at home with his wife. He continued to "exhibit a slow but significant decline in memory and functionality in the last year" He ambulates without assistance	S3261		

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"for the most part but holds onto wife for long distances." R1 was noted with a "considerable decline" in his memory. He was very easily upset when he forgot things and names. He had difficulty remembering names and dates. He was very paranoid at times and was frequently incontinent of urine and wore briefs. In the "Treatment" Section of the document the following was recorded: R1's memory and functionality had "Significantly declined in the last year." The provider recorded that earlier in the year there were concerns of self - care deficit and worsening memory. The options of home health and hospice were discussed on this visit with R1's DPOA.

Review of R1 electronic medical record under the "Progress" note tab revealed the following entries:

On 03/02/24 at 06:01PM R1 was admitted to the facility and his family was present. R1 was alert times "3" with some confusion. R1 ambulated by himself and was continent of his bowel and his bladder. R1's "wife to assist with administration" of his medications. The entry was initialed by "Licensed Nurse" (LN) C.

On 03/06/24 at 07:03 AM an administration note read "Ativan Oral Tablet 0.5 milligrams. Give 1 tablet by mouth every 12 hours as needed for agitation." and signed by "Certified Medication Aide" D.

On 03/06/24 at 07:54 AM a follow up administration note read the as needed administration of the Ativan 0.5 milligrams administered at 07:03 AM was effective.

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The electronic medical record lacked a note in the "Progress Notes" tab of the symptoms or behaviors on 03/06/24 observed, the record further lacked notification of the LN prior to the administration of the Ativan by the CMA.

Review of the facility provided self-reported incident to the department dated 03/08/24 revealed the following information:

On 03/07/24 at approximately 08:30 AM R1 was being physically combative with facility staff and after numerus failed attempts at redirection, R1's physical aggression escalated, and for safety reasons, Administrator A made the decision to call the emergency number "911" for assistance and for the facility staff to lower R1 to the ground and facility staff provided "physical restraint" until the arrival of the local police department and "Emergency Medical Services" (EMS) for the safety of the other residents and staff. When EMS arrived and started treating R1, they administered Haldol 5 milligrams intramuscularly, Versed 2.5 milligrams intramuscularly, and 2,5 milligrams of Versed intravenously. When the resident was calm the local police officers and the EMS team assisted R1 to the ambulance cot and transported him to the ambulance then to the local hospital where he remained during the survey process.

The electronic medical record lacked a note in the "Progress Notes" tab for the incident on 03/07/24.

Review of the facility provided witness statements related to the incident with R1 on

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S3261	Continued From page 51 03/07/24 revealed the following: CMA F wrote she arrived at work at 05:30 AM and was asked by CMA I to assist with R2 because R1 had "already made her cry and has been aggressive." "Director of Nursing" (DON) J wrote upon arrival to the Assisted Living after receiving the call from staff for help she witnessed R1 walking with CMA E and CMA I, DON J wrote she assisted in trying to redirect R1, "he walked out of the dining room towards the courtyard door. While at the door he knocked a picture frame off the window ledge, hit the window and kicked the window frame." DON J continued to write that R1 attempted to "strike/push" CMA E. DON J continued that when R1 saw R2, R1 began yelling and moving towards her. DON J then placed herself between R1 and R2, and when R1 reached DON J he began "striking and pushing" her. The staff removed R2 from the area and CMA E had his back turned and was walking away and R1 started hitting and pushing CMA E repeatedly. DON J wrote that "Multiple attempts to redirect" R1 "were unsuccessful" and they decided to lower him to the floor and provide physical restraint until law enforcement could arrive. R2 witness statement written by facility staff and signed by R2, revealed that R2 and R1 were up at 05:00 AM. R2 could not "remember how it started or what may have triggered it." She remembered eating breakfast and them R1 getting very upset. Interview on 03/12/24 at 04:55 PM with CMA I by phone with administrator A and Resource Nurse	S3261		

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S3261	Continued From page 52 B in the room confirmed that CMA I hear R1 giving R2 "a hard time" at approximately 04:30 AM on 03/07/24. She stated she tried to talk to R1 and that R1 did "settle some". She stated that she called CMA E to see if he would "come up" to redirect R1, she continued that R1 knew who CMA E was. 03/13/24 at 05:30 PM R1 remained admitted to the local hospital during the survey process, and the electronic medical record under the "Progress Notes" tab lacked an entry for the incident involving R1 and R2. - Record review for R2 revealed an admission date of 03/02/24 with a diagnosis of Alzheimer's disease. Review of R2's FCS dated 03/06/24 revealed the date of assessment was entered in as 03/02/24, and R2 was independent with bathing, dressing, toileting, transferring, walking/mobility, and eating. She required supervision with the management of her medications and was continent of her bladder. She had impaired short-term memory, impaired memory recall and impaired decision making. She was able to make herself understood and she understood others. Under the section titled "Current or Recent Problems and Risks" R2 was marked with impaired decision making. R1's electronic medical record and the paper medical record lacked a "Negotiated Service Agreement" (NSA) and further lacked a "Health Service Plan" (HSP).	S3261		

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Record review of R2's electronic medical records under the "Progress Notes" tab revealed the following entries:

On 03/02/24 at 06:07PM R2 admitted to the facility with her "spouse". R2 was independent with all ADL's, she ambulated by herself without an assistive device, and her family was present.

The electronic medical records under the "Progress Notes" tab lacked the documentation for the following: that R2 would self-administer her own medications and further lacked documentation that she would administer R1's medications, "Progress Notes lacked documentation related to the incidents on 03/07/24 involving R1.

Interview on 03/13/24 at approximately 04:30 PM with Administrator A and Resource Nurse B confirmed R1 and R2 electronic and paper medical records lacked documentation of all incidents, and other indications of illness or injury including the date, time, actions taken, and results of actions taken related to the events on 03/07/24.

The Administrator failed to ensure the documentation of all incidents, symptoms and other indications of illness or injury including the date, time, actions taken and results of actions taken for R1 when was administered Ativan 0.5 milligrams for Agitation on 03/06/24 and an incident on 03/07/24 that involved R1 being lowered to the floor with facility staff providing physical restraint with the involvement of the local police department and the local EMS, and

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S3261	Continued From page 54 resulting in the transfer of R1 by ambulance the local hospital. The Administrator further failed to ensure the documentation for R1 and R2 when on the morning of 03/07/24 the "Certified Medication Aide" on duty overheard R1 and R2 having an argument and asked the oncoming staff to check on R1 and R2 because R1 had made R2 cry that morning, and the failure to document for R2 witnessing the incident on 03/07/24 for R1.	S3261		