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S 000	INITIAL COMMENTS The following citations represent the findings of the licensure resurvey with attached complaint number 188185 for the above named facility conducted on 07/31/24 and 08/01/24.	S 000		
S3026 SS=J	26-41-101 (f) (1) Staff Treatment of Residents ANE (f)The administrator or operator shall ensure that all of the following requirements are met: (1) No resident shall be subjected to any of the following: (A) Verbal, mental, sexual, or physical abuse, including corporal punishment and involuntary seclusion; (B) neglect; or (C) exploitation. This REQUIREMENT is not met as evidenced by: K.A.R. 26-41-101 (f) (1) (B) The facility reported a census of 30 residents. The sample included 3 "Residents'" (R)'s 1, 2, 3, and one closed record review for R4. Based on record review and interview the Operator failed to protect R4 when she left the building without staff knowledge at approximately 06:00PM on 05/29/24, placing her in immediate jeopardy for 15 hours. R4 was found by the local law enforcement agency approximately half a mile from the facility across a busy four lane highway in front of a car dealership and returned to the facility at approximately 07:05AM on 05/30/24. Findings included:	S3026		

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

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S3026	Continued From page 1 - Record review for R4 revealed an admission date of 01/29/24 with diagnoses of dementia with paranoia and auditory hallucinations and hyperlipidemia. Review of R4's "Functional Capacity Screen" (FCS) dated 01/29/24 revealed R4 required supervision with bathing and dressing. She was independent with toileting, transferring, walking, and eating. She lacked the ability to manage her own medications, she was continent, and had impaired short-term memory and impaired memory recall. She was able to make herself understood and she understood others. She was a fall risk and used no walking mobility device. Review of R4's combined "Negotiated Service Agreement" (NSA) / "Health Service Plan" (HSP) dated 01/29/24 revealed the facility staff would remind R4 three times weekly to shower and assist with turning the shower on and off. Facility staff would remind R4 to dress in the morning and wear pajamas in the evening. R4 was encouraged to use her call light for assistance. The facility would manage R4's medications. In the notes section of the combined NSA/HSP it stated "Resident comes to AL (assisted living) from home where she was living independently with some recent assistance from her family. Resident has had onset of dementia over the last few months which has led to poor medication management, poor diet, anxiety, and insomnia." Resident had recently discharged from a behavioral health unit "after increased anxiety and poor sleep related to her beliefs that someone was trying to get in her house at night. R4 felt unsafe living at home alone and would like to have the safety of knowing someone is near at all times of the day for her safety and assistance.	S3026		

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The combined NSA/HSP lacked services monitoring for anxiety and insomnia.

Review of R4's "Interdisciplinary Progress Notes" dated 01/29/24 to 06/04/24 revealed the following entries:

The note entered on 01/29/24 at 11:00 PM, resident moved into the facility.

The note lacked the actual time the resident arrived at the facility.

On 03/02/24 at 07:45 AM, "Certified Medication Aide" (CMA) F wrote R4 had pushed her call light multiple times due to thinking there were "motorcycles outside her window." The CMA F reassured R4 there was no one outside her window. At 01:50AM the facility received a call from local law enforcement stating they had received a call from R4's personal cell phone about motorcycles being outside her window. The CMA reassured the local law enforcement and told them she would go and check on R4. When the CMA checked on R4 she wrote that R4 called the local police because "she thought something happened" to the staff. The CMA again reassured R4 the facility staff was fine. The CMA continued to write that R4 pushed her call light several more times and they continued to reassure R4 that nothing was outside her window.

On 03/04/24 at 09:30 AM, "Registered Nurse" (RN) A wrote she had been notified that R4 called the local law enforcement "twice" during the night over the prior weekend. A request was sent to the provider for labs and a urinalysis, and this was a change in behavior for R4. The family was notified of R4's change in behavior and the family

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informed the RN that they had come and picked the resident up over the prior weekend and R4 was anxious after she returned the facility, the family member stated the family noticed a change in R4's behavior and wondered if taking R4 back to her home made her move to the facility more difficult. The RN wrote R4's family reported to the RN that R4 stated there was a new staff member at the facility and she was the girlfriend to one of the men who was coming to her home prior to her moving into the facility. The RN wrote that she assured the family that this was normal for someone with a "dementia" diagnosis.

On 03/04/24 at 06:10 PM, RN A wrote R4 voiced concerns to the RN that the "man" from the skating rink had found her and was outside the building in the woods. R4 stated she could hear him talking through her vent and he was stating he was going to rape her. R4 reported that the staff member who worked at the facility the day prior was his girlfriend and had threatened to rape her as well. The incident was reported to the family, the family stated that this had been a cycle for R4, she would feel safe in a new place for a while, but "he would always find her again". The RN wrote that facility staff encouraged the resident to be in the common area around staff and they closed the blinds to the windows, and R4 was very paranoid with hallucinations noted that afternoon and evening. R4 had missed two doses of Seroquel 12.5 milligrams. The RN documented the paranoia started prior to the missed doses of Seroquel.

On 03/05/24 at 01:00 PM, RN A wrote as she approached R4's room R4 was talking to herself, and R4 told the RN that it made her feel safe being upfront with the staff the night prior. The RN noted R4 seemed frazzled and forgetful.

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S3026	Continued From page 4 On 03/06/24 at 04:35 PM, RN A wrote that she spoke to the family member and the concern was that R4 was not sleeping and being anxious at night which has been the problem all along, the note continued to state that paranoia and delusions were worse at night. On 03/07/24 at 12:30 PM, RN A wrote that R4 had been to see her provider and increased the Seroquel at night. No other medication changes or orders were noted. On 03/19/24 at 04:00 PM, RN A wrote she spoke to the family member and the family reported R4 is still having paranoia and delusions. The family stated they had R4 at their home over the weekend. R4 called the family the night prior "thinking she could hear someone in her vent." The RN continued she would update the provider and that R4's daughter could be causing "issues", R4's daughter did not realize R4's decline and the daughter wanted R4 to move to her home in another town. On 03/20/24 at 04:10 PM, RN A wrote she spoke to the family about R4 sleeping in the respite room due to increased delusions at times. R4 stated that the "man was still in the woods" or "outside her window." On 04/09/24 at 04:00 PM, RN B wrote that R4 had been more withdrawn over the last couple of weeks. R4 still attended meals and no longer attended activities, and recently R4 had been spending all the time between meals in her room, and staff reported that when they checked on her R4 would be sitting in the room with the television and lights off. A communication had been sent to the provider, who initialed it and sent it back with	S3026		

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no new orders. The note continued that R4 had an appointment with her provider the next day.

On 04/12/24 at 08:00 AM, RN B wrote that R4 had seen her provider the day prior and new orders received with instructions to encourage R4 to engage in activities.

On 04/12/24 at 02:00 PM, RN A wrote R4 had been out of her room most of the day engaging with other residents. R4 asked the RN if she was aware of R4's dementia diagnosis and the RN confirmed she was aware of the diagnosis. R4 told the RN that "the man was outside her window last night talking into her vent, she ignored him, and he got mad, and she thought that it was funny."

On 04/22/24 at 03:34 PM, RN A wrote the family called and reported that R4 was very paranoid and suspicious with them over the prior weekend. The RN wrote that she spoke with the family about how "dementia could be a roller coaster at times ..."

On 04/29/24 at 08:30 AM, RN A wrote that the staff reported R4 was very paranoid of "the man" the night prior and believed a "male resident may be in on it with him." R4 was moved to another room which "had worked in the past." R4 reported that "he followed her there and spent the night in the family dining room but didn't sleep." An update was sent to the family and the provider.

On 04/29/24 at 03:20 PM, RN A wrote that R4 verbalized "the man" talking to her and he knew where she was and who she was talking to and when she was out of her room. R4 knew he could not get in and was just worried that he would not leave her alone. The RN wrote that she talked to

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S3026	Continued From page 6 R4 about using her call button to alert staff is she was scared or had any concerns and encouraged her to come to the television room if she needed to. The provider was notified. On 05/02/24 at 11:10 PM, CMA D wrote R4 had increased paranoia and was seeing and hearing "the man". R4 reported to the CMA that he had a gun and was walking around the building looking for her. The CMA wrote that she reassured R4 that she was ok and that there was nobody with a gun. At 08:25PM the CMA went to R4's room to answer the call light and R4 was not in her room or the sitting areas. The facility staff went room to room and found R4 in an empty room, and R4 stated she had found a good "hiding spot to be safe." On 05/07/24 at 01:10 AM, CMA G wrote that upon arriving to work it was reported by evening staff that R4 had been "very anxious and paranoid", R4 had been going into other residents' rooms and was currently in a resident room sitting with the room's occupant. The occupant told R4 she could stay and sleep in her chair. At 01:00AM R4 rang her call light and the CMA found one of R4's cats in the occupants' room, and R4 was walking back to her room to retrieve the other cat. The CMA informed R4 that she could not take her cats into another resident's room. R4 became angry, the CMA then called R4's family to calm her down. On 05/07/24 at 01:30 AM, CMA G wrote that R4 became irate about "the man" after speaking to her family on the phone and refused to stay in her room because "the man was coming to get her." R4 spent the night on the couch in the common area and agreed to not go into any other residents' rooms.	S3026		

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S3026	Continued From page 7 On 05/07/24 at 02:30 AM, CMA G wrote that R4 was not on the couch in the common room, and they initiated a search of the building. R4 was found in another resident's room sitting in her recliner while the rooms occupant was asleep in her bad. The CMA escorted R4 back to the couch in the common area. At 03:00 AM the resident was observed to not be in the common sitting area and was found in another resident's room sitting in their recliner. R4 was escorted back to the common sitting area where she fell asleep on the couch at approximately 03:30AM. On 05/09/24 at 12:10 PM, RN A wrote that she spoke to R4 and explained to R4 that "the man" was not a "real person" and he had no "physical body" and could not harm her. The RN continued to write that nobody has seen him or heard him and the cameras on the inside and outside of the building have not seen him. The provider was working on adjusting her medications to help what is likely a part of her "dementia." On 05/09/24 at 10:35 PM, CMA D wrote at 08:30PM R4 was checking the outside doors. On 05/10/24 at 10:13 PM, CMA D wrote that R4 had been sitting in the front common areas, roaming the hallways, and peeking out the windows, and refused to go to her room. R4 stated "The man is down there waiting to kill me." R4 requested to sleep in the same room with another resident. R4 had a hard time understanding why she could not go sleep in another resident's room with the occupant in the room. R4 rested in the television room and kept checking the dining room for "the man." On 05/12/24 at 09:45 AM, CMA D wrote that R4	S3026		

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had been sitting in the front room after breakfast and had been incontinent, had increased confusion, and was fearful. R4 refused to stay in her room and stated, "I'm too scared alone." The "Certified Nurse Assistant" (CNA) assisted R4 with changing and escorted her back to the common sitting area.

On 05/12/24 at 02:45 PM, CMA D wrote that R4 went to her room to feed her cats and came back crying and reported "dead people laying on her bed." The CMA offered to go to check R4's room and R4 stated "they are going to kill me, you are crazy for going down there."

On 05/14/24 R 11:00 AM, RN B wrote that R4 saw her provider. New order for Namenda received. The RN wrote that she spoke to R4's family and reported to the family R4 had only shown minimal improvement from the new orders received on 05/06/24 for Depakote. The RN explained to the family that they did not expect to see any improvement from the new order for Namenda. The family reported the provider stated if they wanted to tray out "a bunch of new meds" (medications), they would have to admit R4 to a psychiatric unit and let them start several new medications and then slowly remove then until they could find an effective combination.

On 05/16/24 at 11:00 AM, The RN wrote that she went to talk to R4 about refusing her medications and meals. R4 refused to talk to the RN.

On 05/16/24 at 11:30 AM, CMA E wrote that R4's son came and R4 ate a snack, took her scheduled medications, and would continue every two-hour checks.

On 5/19/24 at 11:15 PM, CMA D wrote R4

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refused her evening meal and a snack. She did take her medications. She had been observed sitting in the dark for most of the evening. R4 came out of her room at around 09:00PM and refused any snack or drink and stated, "I just want to be left alone." Staff would continue to visually check on R4 every two hours.

On 05/21/24 at 08:00 AM, RN B wrote that she was notified at approximately 12:30AM that R4 had called the local law enforcement stating that "the man was attempting to get inside to rape her." Staff reported that they had checked on R4 at 11:00PM and that R4 showed no signs of distress at that time.

On 05/21/24 at 10:15 AM, RN A wrote that R4 reported she was having difficulty hearing out of her right ear, and she was hearing her daughter yelling in her left ear because she was being hurt. The RN reminded R4 that she saw her provider last week, and that she could call and request something for her allergies, and the RN could speak to R4's family about going back to see the provider. The RN also reminded R4 that her daughter was not there and there "was no way" R4 could hear her. The RN reminded R4 that the voices she heard are not a person and do not have a body and they cannot harm her. The RN explained the voices could be related to the "dementia." The RN sent an update to the provider.

On 05/21/24 at 04:10 PM, RN B wrote that she spoke to R4's family about their concerns related to R4 having a significant change over the "past week" and potential interventions for R4. An update was sent to the provider with no reply. The family reported to the RN that they felt the voices R4 was hearing impaired her quality of life and

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are now constant. The family asked if they should change R4's provider since R4 was "getting worse" and reported the provider told them that R4 should be in memory care. The RN wrote that she agreed that something needed to "happen" to stop the voices and if the provider was not willing to actively work on "that" then they were concerned. The RN wrote that R4's behaviors are worse since a medication change was made to the Seroquel, and R4 was appropriate for the assisted living setting as far as her level of care. The family asked for information on inpatient psychiatric stays and wanted information on what happened in a crises or emergent situation.

On 05/28/24 at 04:00 PM, RN A wrote R4 appeared depressed with flat and minimal interaction with staff and peers. R4 had less paranoia and anxiety noted over the week prior. R4 refused staff assistance with showering, and she refused to change her clothes.

On 05/29/24 at 11:00 PM, RN A wrote that facility staff notified her at 07:18PM they were unable to locate R4 and they had searched the building and the surrounding area. The RN went to the facility and assisted in the search. The RN notified the family at approximately 07:40PM that they were unable to locate R4. Staff reported to the RN that R4 came to the evening meal and after getting her plate the table mate reported "she left in a hurry." At approximately 05:30PM staff reported to the RN that R4 was observed sitting on the front porch, and when they entered her room at 07:00PM they were unable to find her. R4's son arrived at the facility and assisted in the search, and he found her cellular phone in her room. At approximately 09:10PM the RN called the family to advise them the facility staff were not able to find R4 and the family stated the son was at the

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local police department at this time. The RN asked the family if R4's daughter could have picked her up and the family told the RN that the daughter had been in town the weekend prior.

On 05/30/24 at 10:40 AM RN, A wrote that local law enforcement brought R4 back to the building at approximately 07:05AM. R4 was found walking near the car dealership on the north side of town. R4 told the RN she left because "her daughter told her that "they" were taking her baby boy away, she could hear an echo of her in her right ear but she could hear her better the farther away she was mad and upset at the time because of "them" taking the baby." The RN continued to write that R4 told her she made a "bed" out of branches, and she slept in a field but she was unsure where. R4 had her call pendant in place and "she thought" about pushing it. R4 indicated she was not scared or cold because of her faith in God.

05/30/24 at 03:50 PM, RN A wrote resident was to be admitted to the local psychiatric unit on 05/30/24 with no time of admission documented. Review of the facility provided faxed communications to the provider revealed the following:

On 05/16/24 the facility updated the provider That R4 was not eating and being non-compliant with her medications. The provider responded on 05/16/24 That he discussed with the family inpatient stay versus skilled care. "Please consult" the son and decide if she needs more assistance then you can provide."

On 05/21/24 the facility updated the provider that R4 continued to hear the man. The provider responded on 05/22/4 for the facility to monitor

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over the weekend and if the complaint persisted to make an appointment "next week". R4'a Depakote sprinkles were increased to three time a day.

On 05/29/24 the facility updated the provider that R4 was less paranoid, less anxious, and had a flat affect. R4 was spending more time in her room, refused meals, taking her medications, could be struggling with depression, and still hearing the voices. There had been a significant decline since 05/14/24. The provider responded on 05/29/24 no changes today and to follow up in the clinic next week.

Review of the signed and notarized witness statement dated 08/01/24 from CNA C revealed R4 had got to the dining room for the evening meal per her usual at around 04:30 PM on 05/29/24 and was at the table until approximately 05:00 PM when CNA C last saw R4. The CNA C went to R4's room at 07:00PM to assist R4 with her shower and was unable to locate R4 and immediately notified the CMA. CNA C wrote that R4 was within her normal behavior.

Review of the signed and notarized witness statement dated 08/01/24 CMA D wrote that R4 was sitting on the front porch when she arrived for work on 05/29/24 at approximately 04:00 PM, and at 04:15 PM, CMA D went to the front porch and let R4 know it was dinner time. At 04:40 PM CMA D went to check on R4 as she had not come inside from the front porch and R4 stated she needed to use the restroom and then she would come to dinner. At 04:45 PM CMA D wrote R4 was sitting in the front sitting room and then went out to the front porch and was still there at 06:00PM. At approximately 07:00 PM CMA D was informed by CNA C that R4 was not in her room.

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CMA D wrote that she and CNA C immediately searched the common sitting areas, the porches and all resident rooms and called RN/Operator A at approximately 07:25 PM to report R4 was unable to be located.

Interview on 08/01/24 at approximately 10:15AM with RN/Operator A confirmed the resident was having increased paranoid behavior. She continued to confirm the "Man" mentioned in her note was a hallucination and the family had confirmed this did not occur.

Interview on 08/01/24 at approximately 10:15 AM with RN/Operator A and RN B confirmed R4's family had not identified R4 as an elopement or wandering risk during the initial assessment. They stated that R4's family new the facility was not a secured unit and they would be unable to manage a wandering or at risk for elopement resident. RN/Operator A confirmed R4 had a DPOA that had not been activated and that R4 signed her own facility admission agreements. R4's family encouraged her to be outside to get some "fresh air" and wanted her to use the detached recreation room for the exercise on the treadmill. RN B confirmed that R4's physical address prior to the move into the AL was approximately two blocks south of the facility.

On 08/05/24 at 04:07PM RN/Operator A was notified that R4's leaving the facility without facility staff knowledge on 05/29/24 at approximately 06:00PM placed R4 in immediate jeopardy until her return by the local police department on 05/30/24 at approximately 07:05AM.

The Operator failed to protect R4 when she left the facility property without staff knowledge at

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S3026	Continued From page 14 approximately 06:00PM on 05/29/24, placing her in immediate jeopardy for 15 hours. R4 was found by the local law enforcement agency approximately half a mile from the facility across a busy four lane highway in front of a car dealership and returned to the facility at approximately 07:05AM on 05/30/24. The abatement plan received on 08/05/24 at 05:47PM included the following: On 05/30/24 R4 was in constant view of facility staff from 07:05AM until 11:10 AM when the resident was one on one with her family. On 05/30/24 R4 was admitted to the local psychiatric unit. An elopement risk assessment at the evaluation for admission will be acknowledged on paper by staff, resident, and family. An elopement risk evaluation will be performed every 90 days as well as with any significant change of condition for all residents with a dementia diagnosis. All residents who have a dementia diagnosis when they are on the porch or outside will be monitored every 30 minutes.	S3026		
S3028 SS=D	26-41-101 (f) (3) Staff Treatment of Residents Reporting (f) (3) Each allegation of abuse, neglect, or exploitation shall be reported to the administrator or operator of the facility as soon as staff is aware of the allegation and to the department within 24	S3028		

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S3028	Continued From page 15 hours. The administrator or operator shall ensure that all of the following requirements are met: (A) An investigation shall be started when the administrator or operator, or the designee, receives notification of an alleged violation. (B) Immediate measures shall be taken to prevent further potential abuse, neglect, or exploitation while the investigation is in progress. (C) Each alleged violation shall be thoroughly investigated within five working days of the initial report. Results of the investigation shall be reported to the administrator or operator. (D) Appropriate corrective action shall be taken if the alleged violation is verified. (E) The department ' s complaint investigation report shall be completed and submitted to the department within five working days of the initial report. (F) A written record shall be maintained of each investigation of reported abuse, neglect, or exploitation. This REQUIREMENT is not met as evidenced by: K.A.R. 26-41-101(f) (3) The facility reported a census of 30 residents. The sample included 3 "Residents'" (R)'s 1, 2, 3, and one closed record review for R4. Based on record review and interview the Operator failed to report the incident of when R4 left the facility without staff knowledge and was found by the local law enforcement agency approximately 15 hours later approximately half a mile from the facility across a busy four lane highway in front of a car dealership.	S3028		

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- Findings included:

- Record review for R4 revealed an admission date of 01/29/24 with diagnoses of dementia with paranoia and auditory hallucinations and hyperlipidemia.

Review of R4's "Functional Capacity Screen" (FCS) dated 01/29/24 revealed R4 required supervision with bathing and dressing. She was independent with toileting, transferring, walking, and eating. She lacked the ability to manage her own medications, she was continent, and had impaired short-term memory and impaired memory recall. She was able to make herself understood and she understood others. She was marked as a fall risk and used no walking mobility device.

Review of R4's combined "Negotiated Service Agreement" (NSA) / "Health Service Plan" (HSP) dated 01/29/24 revealed the facility staff would remind R4 three times weekly to shower and assist with turning the shower on and off. Facility staff would remind R4 to dress in the morning and wear pajamas in the evening. R4 was encouraged to use her call light for assistance. The facility would manage R4's medications.

In the notes section of the combined NSA/HSP it stated "Resident comes to AL (assisted living) from home where she was living independently with some recent assistance from her family. Resident has had onset of dementia over the last few months which has led to poor medication management, poor diet, anxiety, and insomnia." Resident had recently discharged from a behavioral health unit "after increased anxiety and

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poor sleep related to her beliefs that someone was trying to get in her house at night. R4 felt unsafe living at home alone and would like to have the safety of knowing someone is near at all times of the day for her safety and assistance.

The combined NSA/HSP lacked services monitoring for anxiety and insomnia.

Review of R4's "Interdisciplinary Progress Notes" dated 01/29/24 to 06/04/24 revealed the following entries:

On 05/29/24 at 11:00 PM The "Registered Nurse" (RN) wrote that facility staff notified her at 07:18PM they were unable to locate R4 and they had searched the building and the surrounding area. The RN went to the facility and assisted in the search. The RN notified the family at approximately 07:40PM that they were unable to locate R4. Staff reported to the RN that R4 came to the evening meal and after getting her plate the table mate reported "she left in a hurry." At approximately 05:30PM staff reported to the RN that R4 was observed sitting on the front porch, and when they entered her room at 07:00PM they were unable to find her. R4's son arrived at the facility and assisted in the search, and he found her cellular phone in her room. At approximately 09:10PM the RN called the family to advise them the facility staff were not able to find R4 and the family stated the son was at the local police department at this time. The RN asked the family if R4's daughter could have picked her up and the family told the RN that the daughter had been in town the weekend prior.

On 05/30/24 at 10:40AM The RN wrote that local law enforcement brought R4 back to the building at approximately 07:05AM. They told the RN they

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S3028	Continued From page 18 found her walking near the car dealership on the north of town. R4 told the RN she left because "her daughter told her that "they" were taking her baby boy away, she could hear an echo of her in her right ear but she could hear her better the farther away she was mad and upset at the time because of "them" taking the baby." The RN continued to write that R4 told her she made a "bed" out of branches, and she slept in a field but unsure where. R4 had her call pendant in place and "she thought" about pushing it. R4 indicated she was not scared or cold because of her faith in God. 05/30/24 at 03:50 PM resident was to be admitted to the local psychiatric unit on 05/30/24. Interview on 08/01/24 at approximately 10:30AM with RN/Operator A and RN B confirmed they did not report to the department within 24 hours that R4 left the facility without staff knowledge and was absent from the facility for approximately 15 hours, and then returned to the facility by local law enforcement. The Operator failed to report the incident of when R4 left the facility without staff knowledge and was found by the local law enforcement agency approximately 15 hours later approximately half a mile from the facility across a busy four lane highway in front of a car dealership.	S3028		
S3081 SS=D	26-41-201 (c) Functional Capacity Screen Reassessment (c) Designated facility staff shall conduct a screening to determine each resident ' s functional capacity according to the following requirements:	S3081		

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S3081	Continued From page 19 (1) At least once every 365 days; (2) following any significant change in condition as defined in K.A.R. 26-39-100; and (3) at least quarterly if the resident receives assistance with eating from a paid nutrition assistant. This REQUIREMENT is not met as evidenced by: K.A.R. 26-41-201 (c)(2) The facility reported a census of 30 residents. The sample included 3 "Residents'" (R)'s 1, 2, 3, and one closed record review for R4. Based on record review and interview the Operator failed to ensure the "Functional Capacity Screen" (FCS) was performed for R4 when she experienced a significant change of condition in her cognition. Findings included: - Record review for R4 revealed an admission date of 01/29/24 with diagnoses of dementia with paranoia and auditory hallucinations and hyperlipidemia. Review of R4's "Functional Capacity Screen" (FCS) dated 01/29/24 revealed R4 required supervision with bathing and dressing. She was independent with toileting, transferring, walking, and eating. She lacked the ability to manage her own medications, she was continent, and had impaired short-term memory and impaired memory recall. She was able to make herself understood and she understood others. She was marked as a fall risk and used no walking mobility device.	S3081		

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Review of R4's combined "Negotiated Service Agreement" (NSA) / "Health Service Plan" (HSP) dated 01/29/24 revealed the facility staff would remind R4 three times weekly to shower and assist with turning the shower on and off. Facility staff would remind R4 to dress in the morning and wear pajamas in the evening. R4 was encouraged to use her call light for assistance. The facility would manage R4's medications.

In the notes section of the combined NSA/HSP it stated "Resident comes to AL (assisted living) from home where she was living independently with some recent assistance from her family. Resident has had onset of dementia over the last few months which has led to poor medication management, poor diet, anxiety, and insomnia." Resident had recently discharged from a behavioral health unit "after increased anxiety and poor sleep related to her beliefs that someone was trying to get in her house at night. R4 felt unsafe living at home alone and would like to have the safety of knowing someone is near at all times of the day for her safety and assistance.

The combined NSA/HSP lacked services monitoring for anxiety and insomnia.

Review of R4's "Interdisciplinary Progress Notes" dated 01/29/24 to 06/04/24 revealed the following entries:

On 03/04/24 at 09:30AM the "Registered Nurse" (RN) wrote she had been notified of R4 calling the local law enforcement "twice" during the night over the prior weekend. A request sent to the provider for labs and a urinalysis, and this was a change in behavior for R4. The RN continued to write that the family was notified of R4's change in behavior and the family informed the RN that

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they had come and picked the resident up over the prior weekend and R4 was anxious after she returned the facility, the family member stated the family noticed a change in R4's behavior and wondered if taking R4 back to her home made her move to the facility more difficult. The RN wrote R4's family reported to the RN that R4 stated there was a new staff member at the facility and she was the girlfriend to one of the men who was coming to her home prior to her moving into the facility. The RN wrote that she assured the family that this was normal for someone with a "dementia" diagnosis.

On 03/05/24 at 01:00PM The RN wrote as she approached R4's room she was talking to herself, and R4 told the RN that it made her feel safe being upfront with the staff the night prior. The RN noted R4 seemed frazzled and forgetful.

On 03/06/24 at 04:35 The RN wrote that she spoke to the family member and the concern was that R4 was not sleeping and being anxious at night which has been the problem all along, the note continued to that paranoia and delusions were worse at night.

On 03/07/24 at 12:30PM The RN wrote that R4 had been to see her provider and increased the Seroquel at night. No other medication changes or orders were noted.

On 03/19/24 at 04:00PM The RN wrote she spoke to the family member and the family reported R4 is still having paranoia and delusions. The family stated they had R4 at their home over the weekend. R4 called the family the night prior "thinking she could hear someone in her vent." The RN continued she would update the provider and that R4's daughter could be causing "issues",

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R4's daughter did not realize R4's decline and the daughter wanted R4 to move to her home in another town.

On 04/09/24 at 04:00PM The RN wrote that R4 had been more withdrawn over the last couple of weeks. R4 still attended meals and no longer attended activities, and recently R4 had been spending all the time between meals in her room, and staff reported that when they checked on her R4 would be sitting in the room with the television and lights off. A communication had been sent to the provider, who initialed it and sent it back with no new orders. The note continued that R4 had an appointment with her provider the next day.

On 05/02/24 at 11:10PM The CMA wrote R4 had increased paranoia and was seeing and hearing "the man". R4 reported to the CMA that he had a gun and was walking around the building looking for her. The CMA wrote that she reassured R4 that she was ok and that there was nobody with a gun. At 2025 the CMA went to R4's room to answer the call light and R4 was not in her room or the sitting areas. The facility staff went room to room and found R4 in an empty room, and R4 stated she had found a good "hiding spot to be safe."

On 05/07/24 at 01:10AM The CMA wrote that upon arriving to work it was reported by evening staff that R4 had been "very anxious and paranoid", R4 had been going into other residents' rooms and was currently in a resident room sitting with the room's occupant. The occupant told R4 she could stay and sleep in her chair. At 01:00AM R4 rang her call light and the CMA found one of R4's cats in the occupants' room, and R4 was walking back to her room to retrieve the other cat. The CMA informed R4 that

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she could not take her cats into another resident's room. R4 became angry, the CMA then called R4's family to calm her down.

On 05/09/24 at 10:35PM The CMA wrote at 08:30PM R4 was checking the outside doors.

On 05/10/24 at 10:13 PM The CMA wrote that R4 had been sitting in the front common areas, roaming the hallways, and peeking out the windows, and refused to go to her room. R4 stated "The man is down there waiting to kill me." R4 requested to sleep in the same room with another resident. R4 had a hard time understanding why she could not go sleep in another resident's room with the occupant in the room. R4 rested in the television room and kept checking the dining room for "the man."

On 05/12/24 at 09:45AM The CMA wrote that R4 had been sitting in the front room after breakfast and had been incontinent, had increased confusion, and was fearful. R4 refused to stay in her room and stated, "I'm too scared alone." The "Certified Nurse Assistant" (CNA) assisted R4 with changing and escorted her back to the common sitting area.

On 05/12/24 at 02:45PM R4 The CMA wrote that R4 went to her room to feed her cats and came back crying and reported "dead people laying on her bed." The CMA offered to go to check R4's room and R4 stated "they are going to kill me, you are crazy for going down there."

On 05/14/24 R 11:00AM The RN wrote that R4 saw her provider. New order for Namenda received. The RN wrote that she spoke to R4's family and reported to the family R4 had only shown minimal improvement from the new orders

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received on 05/06/24 for Depakote. The RN explained to the family that they did not expect to see any improvement from the new order for Namenda. The family reported the provider stated if they wanted to tray out "a bunch of new meds" (medications), they would have to admit R4 to a psychiatric unit and let them start several new medications and then slowly remove then until they could find an effective combination.

On 05/21/24 at 04:10PM The RN wrote that she spoke to R4's family about their concerns related to R4 having a significant change over the "past week" and potential interventions for R4. An update was sent to the provider with no reply. The family reported to the RN that they felt the voices R4 was hearing impaired her quality of life and are now constant. The family asked if they should change R4's provider since R4 was "getting worse" and reported the provider told them that R4 should be in memory care. The RN wrote that she agreed that something needed to "happen" to stop the voices and if the provider was not willing to actively work on "that" then they were concerned. The RN wrote that R4's behaviors are worse since a medication change was made to the Seroquel, and R4 was appropriate for the assisted living setting as far as her level of care. The family asked for information on inpatient psychiatric stays and wanted information on what happened in a crises or emergent situation.

On 05/28/24 at 04:00PM The RN R4 appeared depressed with flat and minimal interaction with staff and peers. R4 had less paranoia and anxiety noted over the week prior. R4 refused staff assistance with showering, and she refused to change her clothes.

On 05/29/24 at 11:00 PM The RN wrote that

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facility staff notified her at 07:18PM they were unable to locate R4 and they had searched the building and the surrounding area. The RN went to the facility and assisted in the search. The RN notified the family at approximately 07:40PM that they were unable to locate R4. Staff reported to the RN that R4 came to the evening meal and after getting her plate the table mate reported "she left in a hurry." At approximately 05:30PM staff reported to the RN that R4 was observed sitting on the front porch, and when they entered her room at 07:00PM they were unable to find her. R4's son arrived at the facility and assisted in the search, and he found her cellular phone in her room. At approximately 09:10PM the RN called the family to advise them the facility staff were not able to find R4 and the family stated the son was at the local police department at this time. The RN asked the family if R4's daughter could have picked her up and the family told the RN that the daughter had been in town the weekend prior.

On 05/30/24 at 10:40AM The RN wrote that local law enforcement brought R4 back to the building at approximately 07:05AM. They told the RN they found her walking near the car dealership on the north of town. R4 told the RN she left because "her daughter told her that "they" were taking her baby boy away, she could hear an echo of her in her right ear but she could hear her better the farther away she was mad and upset at the time because of "them" taking the baby." The RN continued to write that R4 told her she made a "bed" out of branches, and she slept in a field but unsure where. R4 had her call pendant in place and "she thought" about pushing it. R4 indicated she was not scared or cold because of her faith in God.

05/30/24 at 03:50 PM resident was to be admitted

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S3081	Continued From page 26 to the local psychiatric unit on 05/30/24. Interview on 08/02/24 at approximately 10:30AM with Operator/RN A and RN B confirmed the R4's resident record lacked documentation of a FCS being performed when R4 experienced a change of condition with her cognition. The Operator failed to ensure the "Functional Capacity Screen" (FCS) was performed for R4 when she experienced a significant change of condition in her cognition.	S3081		
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 30 residents. The sample included 3 "Residents'" (R)'s 1, 2, 3,	S3092		

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and one closed record review for R4. Based on record review and interview the Operator failed to ensure the combined "Negotiated Service Agreement" (NSA) / "Health Service Plan" (HSP) was reviewed and revised when R4 when she experienced a significant change of condition in her cognition.

Findings included:

- Record review for R4 revealed an admission date of 01/29/24 with diagnoses of dementia with paranoia and auditory hallucinations and hyperlipidemia.

Review of R4's "Functional Capacity Screen" (FCS) dated 01/29/24 revealed R4 required supervision with bathing and dressing. She was independent with toileting, transferring, walking, and eating. She lacked the ability to manage her own medications, she was continent, and had impaired short-term memory and impaired memory recall. She was able to make herself understood and she understood others. She was marked as a fall risk and used no walking mobility device.

Review of R4's combined "Negotiated Service Agreement" (NSA) / "Health Service Plan" (HSP) dated 01/29/24 revealed the facility staff would remind R4 three times weekly to shower and assist with turning the shower on and off. Facility staff would remind R4 to dress in the morning and wear pajamas in the evening. R4 was encouraged to use her call light for assistance. The facility would manage R4's medications.

In the notes section of the combined NSA/HSP it stated "Resident comes to AL (assisted living)

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from home where she was living independently with some recent assistance from her family. Resident has had onset of dementia over the last few months which has led to poor medication management, poor diet, anxiety, and insomnia." Resident had recently discharged from a behavioral health unit "after increased anxiety and poor sleep related to her beliefs that someone was trying to get in her house at night. R4 felt unsafe living at home alone and would like to have the safety of knowing someone is near at all times of the day for her safety and assistance.

The combined NSA/HSP lacked services monitoring for anxiety and insomnia.

Review of R4's "Interdisciplinary Progress Notes" dated 01/29/24 to 06/04/24 revealed the following entries:

On 03/04/24 at 09:30AM the "Registered Nurse" (RN) wrote she had been notified of R4 calling the local law enforcement "twice" during the night over the prior weekend. A request sent to the provider for labs and a urinalysis, and this was a change in behavior for R4. The RN continued to write that the family was notified of R4's change in behavior and the family informed the RN that they had come and picked the resident up over the prior weekend and R4 was anxious after she returned the facility, the family member stated the family noticed a change in R4's behavior and wondered if taking R4 back to her home made her move to the facility more difficult. The RN wrote R4's family reported to the RN that R4 stated there was a new staff member at the facility and she was the girlfriend to one of the men who was coming to her home prior to her moving into the facility. The RN wrote that she assured the family that this was normal for

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someone with a "dementia" diagnosis.

On 03/05/24 at 01:00PM The RN wrote as she approached R4's room she was talking to herself, and R4 told the RN that it made her feel safe being upfront with the staff the night prior. The RN noted R4 seemed frazzled and forgetful.

On 03/06/24 at 04:35 The RN wrote that she spoke to the family member and the concern was that R4 was not sleeping and being anxious at night which has been the problem all along, the note continued to that paranoia and delusions were worse at night.

On 03/07/24 at 12:30PM The RN wrote that R4 had been to see her provider and increased the Seroquel at night. No other medication changes or orders were noted.

On 03/19/24 at 04:00PM The RN wrote she spoke to the family member and the family reported R4 is still having paranoia and delusions. The family stated they had R4 at their home over the weekend. R4 called the family the night prior "thinking she could hear someone in her vent." The RN continued she would update the provider and that R4's daughter could be causing "issues", R4's daughter did not realize R4's decline and the daughter wanted R4 to move to her home in another town.

On 04/09/24 at 04:00PM The RN wrote that R4 had been more withdrawn over the last couple of weeks. R4 still attended meals and no longer attended activities, and recently R4 had been spending all the time between meals in her room, and staff reported that when they checked on her R4 would be sitting in the room with the television and lights off. A communication had been sent to

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the provider, who initialed it and sent it back with no new orders. The note continued that R4 had an appointment with her provider the next day.

On 05/02/24 at 11:10PM The CMA wrote R4 had increased paranoia and was seeing and hearing "the man". R4 reported to the CMA that he had a gun and was walking around the building looking for her. The CMA wrote that she reassured R4 that she was ok and that there was nobody with a gun. At 2025 the CMA went to R4's room to answer the call light and R4 was not in her room or the sitting areas. The facility staff went room to room and found R4 in an empty room, and R4 stated she had found a good "hiding spot to be safe."

On 05/07/24 at 01:10AM The CMA wrote that upon arriving to work it was reported by evening staff that R4 had been "very anxious and paranoid", R4 had been going into other residents' rooms and was currently in a resident room sitting with the room's occupant. The occupant told R4 she could stay and sleep in her chair. At 01:00AM R4 rang her call light and the CMA found one of R4's cats in the occupants' room, and R4 was walking back to her room to retrieve the other cat. The CMA informed R4 that she could not take her cats into another resident's room. R4 became angry, the CMA then called R4's family to calm her down.

On 05/09/24 at 10:35PM The CMA wrote at 08:30PM R4 was checking the outside doors.

On 05/10/24 at 10:13 PM The CMA wrote that R4 had been sitting in the front common areas, roaming the hallways, and peeking out the windows, and refused to go to her room. R4 stated "The man is down there waiting to kill me."

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R4 requested to sleep in the same room with another resident. R4 had a hard time understanding why she could not go sleep in another resident's room with the occupant in the room. R4 rested in the television room and kept checking the dining room for "the man."

On 05/12/24 at 09:45AM The CMA wrote that R4 had been sitting in the front room after breakfast and had been incontinent, had increased confusion, and was fearful. R4 refused to stay in her room and stated, "I'm too scared alone." The "Certified Nurse Assistant" (CNA) assisted R4 with changing and escorted her back to the common sitting area.

On 05/12/24 at 02:45PM R4 The CMA wrote that R4 went to her room to feed her cats and came back crying and reported "dead people laying on her bed." The CMA offered to go to check R4's room and R4 stated "they are going to kill me, you are crazy for going down there."

On 05/14/24 R 11:00AM The RN wrote that R4 saw her provider. New order for Namenda received. The RN wrote that she spoke to R4's family and reported to the family R4 had only shown minimal improvement from the new orders received on 05/06/24 for Depakote. The RN explained to the family that they did not expect to see any improvement from the new order for Namenda. The family reported the provider stated if they wanted to tray out "a bunch of new meds" (medications), they would have to admit R4 to a psychiatric unit and let them start several new medications and then slowly remove then until they could find an effective combination.

On 05/21/24 at 04:10PM The RN wrote that she spoke to R4's family about their concerns related

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to R4 having a significant change over the "past week" and potential interventions for R4. An update was sent to the provider with no reply. The family reported to the RN that they felt the voices R4 was hearing impaired her quality of life and are now constant. The family asked if they should change R4's provider since R4 was "getting worse" and reported the provider told them that R4 should be in memory care. The RN wrote that she agreed that something needed to "happen" to stop the voices and if the provider was not willing to actively work on "that" then they were concerned. The RN wrote that R4's behaviors are worse since a medication change was made to the Seroquel, and R4 was appropriate for the assisted living setting as far as her level of care. The family asked for information on inpatient psychiatric stays and wanted information on what happened in a crises or emergent situation.

On 05/28/24 at 04:00PM The RN R4 appeared depressed with flat and minimal interaction with staff and peers. R4 had less paranoia and anxiety noted over the week prior. R4 refused staff assistance with showering, and she refused to change her clothes.

On 05/29/24 at 11:00 PM The RN wrote that facility staff notified her at 07:18PM they were unable to locate R4 and they had searched the building and the surrounding area. The RN went to the facility and assisted in the search. The RN notified the family at approximately 07:40PM that they were unable to locate R4. Staff reported to the RN that R4 came to the evening meal and after getting her plate the table mate reported "she left in a hurry." At approximately 05:30PM staff reported to the RN that R4 was observed sitting on the front porch, and when they entered her room at 07:00PM they were unable to find

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her. R4's son arrived at the facility and assisted in the search, and he found her cellular phone in her room. At approximately 09:10PM the RN called the family to advise them the facility staff were not able to find R4 and the family stated the son was at the local police department at this time. The RN asked the family if R4's daughter could have picked her up and the family told the RN that the daughter had been in town the weekend prior.

On 05/30/24 at 10:40AM The RN wrote that local law enforcement brought R4 back to the building at approximately 07:05AM. They told the RN they found her walking near the car dealership on the north of town. R4 told the RN she left because "her daughter told her that "they" were taking her baby boy away, she could hear an echo of her in her right ear but she could hear her better the farther away she was mad and upset at the time because of "them" taking the baby." The RN continued to write that R4 told her she made a "bed" out of branches, and she slept in a field but unsure where. R4 had her call pendant in place and "she thought" about pushing it. R4 indicated she was not scared or cold because of her faith in God.

05/30/24 at 03:50 PM resident was to be admitted to the local psychiatric unit on 05/30/24.

Interview on 08/02/24 at approximately 10:30AM with Operator/RN A and RN B confirmed R4's resident record lacked documentation of her NSA/HSP being reviewed and revised when R4 experienced a change of condition with her cognition.

The Operator failed to ensure the combined "Negotiated Service Agreement" (NSA) / "Health Service Plan" (HSP) was reviewed and revised

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S3092	Continued From page 34 when R4 when she experienced a significant change of condition in her cognition.	S3092		
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 30 residents. Based on observation and interview the Operator failed to ensure the "Certified Medication Aide" (CMA) prepared and passed medications in accordance with professional standards of practice. Findings included: - Observation on 07/31/24 at approximately 01:00PM with "Registered Nurse" RN/Operator A and CMA E in the facility's medication room revealed a small plastic square container that contained 6 clear plastic medication cups. The cups contained the following: The first clear plastic medication cup was labeled with the first name only of a female resident and the time of 02:00PM and contained 2 round white pills. The second clear plastic medication cup was	S3171		

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labeled with the first name only of a female resident and the time of 02:00PM and contained ½ of a small round orange pill.

The third clear plastic medication cup was labeled with the first name only of a female resident and the time of 02:00PM in the top of the clear round plastic medication cup was a paper medication cup which contained two dark red gummies. The clear plastic medication cup contained 2 white capsules, 1 dark gel capsule, 1 pink oval pill, 1 round orange pill, and 1 white pill.

The fourth clear plastic medication cup was labeled with the first name only of a female resident and the time of 02:00PM and contained 1 white capsule.

The fifth clear plastic medication cup was labeled with the first name only of a female resident and the time of 02:00PM and contained 2 round white pills.

The sixth clear plastic medication cup was labeled with the first name only of a female resident and the time of 02:00PM and contained 3 small round pills.

Interview on 08/01/24 at approximately 10:30AM with RN/Operator A confirmed pre-popping resident medications was not the standard of practice for the facility.

Review of the "Kansas Certified Medication Aide Curriculum" dated 02/2011 revealed on page 169 under the section titled "Medication Administration Record (MAR)" under the "Third Method" it stated "The medication aide sets up the mediations for a group of residents. Medication cards are available for each differed medication. Medication is placed

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S3171	Continued From page 36 in a medication cup and the appropriate medication cards are placed on the tray in a slot or under the cup." The Operator failed to ensure the "Certified Medication Aide" (CMA) prepared and passed medications in accordance with professional standards of practice.	S3171		
S3296 SS=F	26-41-206 (c) (1) Dietary Services Weekly Menu (c) (1) Menu plans shall be available to each resident on at least a weekly basis. This REQUIREMENT is not met as evidenced by: K.A.R. 26-41-206 (c) (1) The facility reported a census of 30 residents. Based on observation and interview the Operator failed to ensure the weekly dietary menu was available for resident on at least a weekly basis. Findings included: - Observation on 07/31/24 at approximately 11:45AM with "Registered Nurse" RN/Operator A during the initial facility tour of the dining room, revealed a medium sized white writing board that contained that day's menu sitting next to the entrance of the kitchen. The dining area lacked a weekly menu. Interview on 07/31/24 at approximately 11:45AM with RN/Operator A confirmed the facility does not post a weekly menu, the provide a seasonal and	S3296		

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S3296	Continued From page 37 daily menu at this time. The Operator failed to ensure the weekly dietary menu was available for resident on at least a weekly basis.	S3296		