STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N023023	A. BUILDING: _____ B. WING _____	08/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ARBORS AT MONTEREY VILLAGE	3905 PETERSON ROAD LAWRENCE, KS 66049

(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 the licensure resurvey for the above named facility conducted on 08/21/23 and 08/22/23.	S 000		
S3085 SS=D	26-41-202 (a) Negotiated Service Agreement (a) The administrator or operator of each assisted living facility or residential health care facility shall ensure the development of a written negotiated service agreement for each resident, based on the resident ' s functional capacity screening, service needs, and preferences, in collaboration with the resident or the resident ' s legal representative, the case manager, and, if agreed to by the resident or the resident ' s legal representative, the resident ' s family. The negotiated service agreement shall provide the following information: (1) A description of the services the resident will receive; (2) identification of the provider of each service; and (3) identification of each party responsible for payment if outside resources provide a service. This REQUIREMENT is not met as evidenced by: K.A.R. 26-41-202 (a) (1)(2)(3) The operator reported a census of 12 residents. The sample included 3 "Residents'" (R's) 1, 2, and 3. Based on record review and interview the operator failed to ensure the "Negotiated Service Agreement" (NSA) for R3 contained a description of the services the hospice provider would	S3085		

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

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S3085	Continued From page 1	S3085		

provide, identification of which company would provide the hospice services, and identification of the party responsible for payment of the outside hospice provider

Findings included:

- Record review for R3 revealed an admission date of 03/28/23 with diagnoses of lumbago with sciatica, pelvic and perineal pain, severe protein calorie malnutrition, atrial fibrillation, and unspecified dementia.

Review of R3 FCS dated 03/28/23 revealed she required physical assistance with bathing, and dressing, she required supervision with toileting, transferring, and she required physical assistance with walking/mobility. She lacked the ability to manage her own medications, she was usually incontinent of here bladder, had impaired short-term memory, impaired long-term memory, impaired memory recall, and impaired decision making. She was able to make herself understood and she usually understood others. She was marked with falls, impaired vision, impaired hearing, wandering, and impaired decision making.

Review of R3 combined "Negotiated Service Agreement" (NSA)/" Health Service Plan" (HSP) dated 03/28/23 identified/instructed facility staff to provide the following health care services: staff to provide physical assistance with bathing, dressing, provide frequent visualization for of R3 for fall preventions, and manage medications. Staff to provide redirection and reassurance when R3 is anxious. Physical therapy/occupational therapy and speech

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S3085	Continued From page 2 therapy will be provided by provider of choice. Facility staff to ensure hearing aides are placed on charger at night. Record review of R3 document titled "Amended Negotiated Service Agreement" dated 05/01/23 revealed R3 would receive home health therapy services from an outside provider. Record review of R3 electronic "Progress" notes dated 06/16/23 revealed the following entry: 06/16/23 at 04:53 PM "Resident was admitted to hospice services today. They will provide nursing and home health visits, incontinent supplies, and a wheelchair". Interview 08/22/23 at 03:00 PM with Licensed nurse A and Operator B, they confirmed R3 NSA lacked the documentation of hospice services. The operator failed to ensure the "Negotiated Service Agreement" (NSA) for R3 contained a description of the services the hospice provider would provide, identification of which company would provide the hospice services, and identification of the party responsible for payment of the outside hospice provider.	S3085		
S3261 SS=F	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	S3261		

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S3261	Continued From page 3 This REQUIREMENT is not met as evidenced by: K.A.R. 26-41-105 (f)(11) The operator reported a census of 12 residents. The sample included 3 "Residents'" (R's) 1, 2, and 3. Based on record review and interview the operator failed to ensure the resident records contained documentation of all incidents, symptoms, and other indications of illness or injury including the date, time of the occurrence, action taken and results of the actions for R's 1, 2, and 3. Findings included: - Record review on 08/21/22 for R1 revealed an admission date of 09/20/20 with diagnoses of Alzheimer's disease, osteomyelitis, syncope and collapse, and abnormalities of gait and mobility. Record review of R1 "Functional Capacity Screen" (FCS) dated 09/15/22 revealed he required physical assistance with bathing, dressing, and toileting. He required supervision with walking/mobility, he lacked the ability to manage his own medications/treatments, was frequently incontinent of his bladder and had impaired short-term memory, impaired long-term memory, impaired memory recall, and impaired decision making. He was usually able to make himself understood and he usually understood others. He was marked with falls, impaired vision, wandering, and impaired decision making. He used a walker mobility device.	S3261		

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S3261	Continued From page 4 Record review of R1 combined "Negotiated Service Agreement" (NSA)/" Health Service Plan" (HSP) dated 09/15/22 identified/instructed facility staff to provide the following health care services: staff to assist R1 getting into and out of the shower, dressing, provide reminders to go to the bathroom, check on frequently due to falls, remind of mealtimes, and administer all medications and medical treatments. Record review of R1 electronic "Progress Notes" dated 04/27/23 to 08/22/23 revealed the following entries: 06/29/23 at 09:36 PM Incident Note "Resident walked into the resident next doors room and this resident got scratched on upper left arm and started bleeding. Resident was calm the entire time and was not in pain. Resident is now bandaged up and back in his bed. "Director of Nursing" DON notified". The electronic progress notes lacked documentation of actions taken to prevent R1 from going into other residents' rooms, and notes further lacked the effectiveness of those actions taken to prevent R1 from going into other residents' rooms. 08/12/23 at 11:09 AM "Certified Nurse Aide" (CNA)/" Certified Medication Aide" (CMA) Note: "The CNA on duty and this reporter went into resident's room at 08:30 AM to help him get up and dressed for the day. When we opened the door, resident was laying on the floor on his back with his head about a foot away from his bedroom door. He had blankets on top of him	S3261		

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and underneath his head. There was no bedding on his bed. Resident's brief was soiled and taken off and laying next to him. He had a little bit of feces on his bottom and on the ace bandage on his foot. There was bruising on his left arm and his nose was red and swollen. Resident complained of minor pain "all over". This writer immediately notified the on-call nurse and with the assistance of the CNA, resident was gotten up and assisted into the restroom where he was dressed".

The electronic progress notes lacked documentation of actions taken to monitor the resident after he was found on his floor.

- Record review on 08/22/23 for R2 revealed an admission date of 02/11/2019 with diagnoses of essential primary hypertension, dementia, delusional disorders, and major depressive disorder.

Record review of R2 FCS dated 04/17/23 revealed she required physical assistance with bathing, dressing, toileting, and supervision with eating. She lacked the ability to manager her own medications/medical treatments. She was incontinent of bladder and had impaired short-term memory, impaired long-term memory, impaired memory recall and impaired decision making. She was marked with falls, impaired vision, impaired decision making and inappropriate behavior.

Record review of R2 combined "Negotiated Service Agreement" (NSA)/" Health Service Plan" (HSP) dated 04/17/23 identified/instructed facility

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staff to provide the following health care services: staff to assist R2 with bathing, picking out her clothes and the dressing process, and perineal care. Staff to provide redirection when resident wanders, and encouragement to use her walker.

Record review of R2 electronic "Progress" notes dated 03/26/23 to 08/22/23 revealed the following entries:

03/26/23 at 07:54 AM Behavior Note "Another resident went into R2's room, so this writer went in after to go check on the resident and "shoo" the other resident out. Other resident then left the room. R2 was sitting on the toilet with a soaking wet brief and wet pants and this writer went to remove the brief and resident immediately became combative, shouting "You son of a bitch!" R2 pulled this writer's hair and started scratching writer and hitting writer. This writer was able to get residents pants off and resident into a new brief, but resident was combative the whole time. Resident pinched writer on the bottom and then writer left resident in her room".

The record lacked any entries of progress notes from 03/27/23 to 05/02/23.
The electronic progress notes lacked documentation of actions taken and results of the actions taken for R2 to address/redirect the inappropriate behavior. The record further lacked documentation of the writer notifying the nurse, provider, or the durable power of attorney.

06/18/23 at 10:29 AM CNA/CMA note "This writer has attempted to change R2 twice today. The

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first time R2 refused. The second time all this writer said was "R2 can I help you change into some clean pants?", and R2 responded by hitting this writer and calling this writer a "son of a bitch".

The electronic progress notes lacked documentation of actions taken and results of the actions taken for R2 to be redirected when having inappropriate/disruptive behaviors, and the document further lacked documentation of the results of the actions taken for R2 inappropriate / disruptive behaviors.

- Record review for R3 revealed an admission date of 3/28/23 with diagnoses of lumbago with sciatica, pelvic and perineal pain, sever protein calorie malnutrition, atrial fibrillation, and unspecified dementia.

Review of R3 FCS dated 03/28/23 revealed she required physical assistance with bathing, and dressing, she required supervision with toileting, transferring, and she required physical assistance with walking/mobility. She lacked the ability to manage her own medications, she was usually incontinent of here bladder, had impaired short-term memory, impaired long-term memory, impaired memory recall, and impaired decision making. She was able to make herself understood and she usually understood others. She was marked with falls, impaired vision, impaired hearing, wandering, and impaired decision making.

Record review of R3 combined "Negotiated Service Agreement" (NSA)/" Health Service Plan"

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(HSP) dated 03/28/23 identified/instructed facility staff to provide the following health care services: staff to provide physical assistance with bathing, dressing, provide frequent visualization for of R3 for fall preventions, and manage medications. Staff to provide redirection and reassurance when R3 is anxious. Physical therapy/occupational therapy and speech therapy will be provided by provider of choice. Facility staff to ensure hearing aides are placed on charger at night.

Record review of R3 electronic "Progress" notes dated 07/06/23 to 08/22/23 revealed the following entries:

07/06/23 at 05:38 PM "Resident had cried off and on today, she had resisted cares of toileting and transferring. She had refused her medications, food, and fluids. She had very little to eat or drink today. She will start Morphine this evening for severe pain. Hospice was aware and had guided staff on her care. R3 daughter had been updated and was visiting at the time. Will continue to offer support."

The electronic progress notes lacked an entry until 07/09/23.
The electronic progress note lacked documentation of actions taken for redirection of R3 cares, and further lacked follow up on actions of the new order for Morphine and documentation of the results of how R3 responded to the actions of the Morphine.

07/09/23 at 06:11 PM "Evening shift CMA reported that resident stood up from her wheelchair, threw her shoes, attempted to sit

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back down and the wheelchair rolled out from under her. No apparent injury, hospice was notified, and a hospice nurse was sent out to assess R3. R3's daughter was notified."

The electronic progress note lacked documentation of the results of the actions taken after the witnessed resident fall.

07/25/23 at 03:17 AM "R3 was found on the ground of bedroom floor. She seemed calm and was not in pain".

The electronic progress notes lacked an entry until 08/04/23.
The electronic progress notes lacked documentation of actions taken, and further lacked the results of actions taken after being found on the floor.

08/13/23 at 01:27 PM "This writer was walking past R3 room at 08:10 to administer medications to another resident when R3 was heard to be yelling "Help Me" from her room. The writer opened the door and observed R3 to be crying and laying on her back on the floor a few feet from her bed. This writer went to get the CNA on duty and called the on-call nurse and got R3's vital signs, R3 complained of minor back pain and had a small abrasion to her back that resembled a rug burn. She also had a small skin tear to her right elbow. R3 had no other signs of symptoms of pain or further visible injuries. Staff assisted her into her wheelchair and helped her get dressed. Hospice and her family were contacted".

The electronic progress notes lacked an entry

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until 08/14/23.
The electronic progress notes lacked documentation of results of the actions taken after being found on the floor.

08/20/23 at 12:42 PM "R3 had a fall in the living room while this writer was at the assisted living facility. R3 was placed on her back with a pillow under her head. CNA notified DON and this writer obtained R3 vital signs. Range of motion was assessed, and right leg was a little stiff. R3 had pain in her lower back this writer gave as needed Morphine for her pain. Administration was notified. Physician was notified".

The electronic progress notes lacked any entry after 08/20/23.
The electronic progress notes lacked documentation of the results of the actions taken to monitor R3 after she had a witnessed fall.

Interview on 08/22/23 at 03:00 PM with Licensed Nurse A and Operator B, they confirmed the electronic "Progress" Notes for R's 1, 2, and 3 lacked the required documentation for actions taken and results of the actions taken.

The operator failed to ensure the resident records contained documentation of all incidents, symptoms, and other indications of illness or injury including the date, time of the occurrence, action taken and results of the actions for R's 1, 2, and 3.