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	N046042	A. BUILDING: _____ B. WING _____	11/03/2022

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TRUSTWELL LIVING OF MISSION SPRINGS I	5300 W 61ST PLACE MISSION, KS 66205

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S 000	INITIAL COMMENTS The following citations represent the findings of the licensure resurvey with attached complaint numbers 175507 and 168675 for the above named facility conducted on 11/01/22, 11/02/22 and 11/03/22.	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: KAR 26-41-101(f)(1)(B) The facility reported a census of 34 residents with four residents included in the sample. Based on observation, interview, and record review the administrator failed to protect one resident from neglect by the failure to provide adequate staff elopement training and the failure to secure all exit doors. This failure placed cognitively impaired Resident (R)111 in jeopardy when he left the facility through an egress fire door from the locked memory care unit, went down one flight of stairs to the ground level, exited an unlocked door to the outside, and walked off of the facility property down a side street, crossed a	S3026		

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

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S3026	Continued From page 1	S3026		

bridge over a steep ravine/drainage ditch, and was found on the side street 200 feet from a heavily traveled street.

Findings included:

- Record review for R111 revealed an admission date of 08/17/22 with the following diagnoses: history of transient ischemic attack and cerebral infarction.

The 08/17/22 "Functional Capacity Screen" (FCS) identified R111 required supervision with bathing, transfers, and walking/mobility; physical assistance with dressing and toileting; was unable to perform management of medications and treatments; was usually continent of bladder; was sometimes understandable and sometimes understood during communication; and was marked for falls and impaired decision-making. Section II. D Cognition lines A, B, C, and D were blank with the number 16 entered on the Total Score line which does not meet the department's definitions for the "Functional Capacity Screen."

R111's record lacked evidence of a Negotiated Service Agreement (NSA) and Healthcare Service Plan (HCP).

The 08/17/22" Mini-Mental Status Examination" documented a score of 16 out of 30, which indicated moderate cognitive impairment .

The 10/18/22 at 05:30 PM "Progress Note" documented R111 was found by another resident's family member walking up on the sidewalk near the facility. The family member text messaged Administrative Staff J at 03:46 PM.

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Administrative Staff J drove her car to R111's location and saw other staff were already searching inside and outside the facility building, including the maintenance director who was walking. R111 wore a long-sleeved shirt, 2 pairs of pants, socks, shoes, carried a ball cap in his hand, and had a functioning wander alarm bracelet on his wrist. No injuries were noted.

The 10/19/22 at 01:30 PM "Progress Note" documented R111 continued with exit seeking behaviors.

The 11/01/22 late entry for 10/27/22 "Progress Note" documented the facility transferred R111 out of the facility to a geriatric psych hospital.

R111's record lacked evidence of an elopement risk assessment.

Review of the 10/19/22 facility's incident report to the state agency revealed the following:

16 memory care unit residents were at risk for elopement including R111.

On 10/18/22 at 03:34 PM - R111 tripped the egress fire door. The door alarm and wander alarm bracelet were automatically activated. R111 went down the stairs, exited the building, turned right and walked toward a heavily traveled two-lane street.

On 10/18/22 at 03:39 PM - The alarm was turned off by Certified Nurse Aide (CNA) I.

On 10/18/22 at 03:46 PM - Another resident's family member saw R111 in the street in front of

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Buffalo Funds business and text messaged a photo of R111 to Administrative Staff J. Administrative Staff J drove her car to R111's location put him in her car and took him back to the memory care unit.

The report further documented there was one staff from the activities department, one CMA, and three CNAs on duty at the time of the incident. When the alarms were activated, CNA I opened the door R111 went through from the memory care unit to the stairwell, did not see anyone, and reset the alarm. After the incident, all door alarms were checked to be functioning, the pagers were found not sufficient and new ones were ordered, and all staff were educated on how to respond to alarms.

Review of facility's "Elopement Handbook" revealed one elopement drill conducted on 10/21/22 with six staff in attendance. The notebook documented: "All staff should respond immediately to door alarms, determine why the alarm was sounded, and conduct a head count of residents. Report to supervisor. Never assume a resident did not go out a door." The notebook lacked evidence of training of all staff on all shifts and new staff training.

The 10/25/22 facility's investigation report documented when the alarms were activated and reset, a head count in the memory care unit was not initiated to determine if anyone was missing.

On 11/01/22 at 10:14 AM the egress fire door from the memory care unit to the stairwell was pushed for 15 seconds until it alarmed. Administrative Staff A, B, and E with state

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S3026	Continued From page 4 surveyor went through the door and down the stairwell. On 11/01/22 at 10:16 AM Administrative Staff A, B, and E with state surveyor heard the fire door was opened and the alarm was reset. No one went down the stairwell to look if a resident had eloped. On 11/01/22 at 10:20 AM Administrative Staff A, B, and E began looking for the staff who opened the door and reset the alarm without looking down the stairwell for an eloped resident. On 11/01/22 at 10:26 AM CMA F stated she was in the common area and did not hear the door alarm, nor did it show up on her pager. She was not the one who reset the alarm. On 11/02/22 at 10:27 AM CNA G stated the alarm did not show up on her pager. She heard the alarm in the hallway near the door because she was in the area helping a resident. She opened the door, did not see anyone, and reset the alarm. CNA G stated she began working at the facility a week before on 10/25/22 and this was her first shift working on the memory care unit. She received verbal instruction to "look out the door" when the alarms went off but had not received any other education regarding elopement, door alarms, or wander bracelet alarms. On 11/01/22 at 10:33 AM Administrative Staff B activated the egress fire door alarm by pushing on it for 15 seconds. The alarm was not heard in the common area.	S3026		

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S3026	Continued From page 5 On 11/01/22 at 10:33 AM Administrative Staff A confirmed the alarm was not heard in the common area nor did it go the pagers. On 11/01/22 at approximately 10:40 AM requested documentation of staff education regarding elopement at hire. Facility failed to provide documentation of elopement education. On 11/01/22 at 10:41 AM Administrative Staff C confirmed the wander bracelet alarm system was not heard in the common areas and the facility had ordered enunciators to make the alarms audible in the common areas. She stated the pagers were all brand new and maybe had not been programmed correctly. Administrative Staff C stated the facility switched to an online training program for staff training about elopement at hire. On 11/01/22 at approximately 10:41 AM Maintenance Director H stated the wander bracelet alarm system was in the process of being updated to be heard in all areas. On 11/01/122 at 12:02 PM Maintenance Director H stated wander bracelet alarm system was last checked on 10/25/22, one week before. The system had issues and all the bracelets had to be replaced. The facility switched to a new wander bracelet alarm system about five weeks before. There was not a system in place or schedule to routinely check the alarm system nor were there any records of the system being checked. There were about "half a dozen" residents currently using the wander bracelet alarm system and R111 had tried to elope before. The fire door was on a separate system and	S3026		

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alarmed to the pagers as well as to the facility's main system.

On 11/01/22 at 03:31 PM CNA I stated R111 had tried to exit the building before and got to the bottom of the stairs. Staff called the interim executive director (no longer works at the facility) who came and assisted staff to get R111 back up the stairs and back to the memory care unit.

On 11/02/22 at approximately 10:04 AM Administrative Staff J stated R111 was able to get out of the memory care unit and made it down the front grand staircase a week or two before he successfully exited the facility on 10/18/22. She confirmed the previous incident was not documented on his chart.

Observation on 11/02/22 at 11:02 AM revealed the route R111 took to exit the facility was 36 steps from the door to his room to the egress fire door. Then down one flight of stairs and six steps from the bottom of the stairs to the exit door. From the exit door to the location where R111 was found in the street, in front of a local business, was 490 ft measured by Google Maps and took two minutes and 55 seconds to walk. The location where R111 was found was 200 feet estimated by Google Maps from a heavily traveled two-lane street with a center turning lane and a speed limit of 35 miles per hour (MPH). Halfway down the route R111 walked was a steep ravine/drainage ditch that ran parallel to the street for approximately 30-40 feet and was four to five feet from the edge of the street and 30-40 feet deep from the edge to the bottom of the ditch. The exit door was 192 feet estimated by Google Maps to another heavily

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traveled four-lane major roadway with a speed limit of 45 MPH.

The weather on 10/18/22 according to Wunderground.com was 46 degrees Fahrenheit and a wind speed of 12 MPH at 03:53 PM.

On 11/02/22 at approximately 12:03 PM Administrative Staff J stated new staff training was not a formal orientation. The facility was in the process of switching to an online training program which was not fully operational yet. New staff were provided with training on the floor where they shadowed someone for three shifts. In-service staff training was provided monthly, but CNA G was not included because she was recently hired. There was not a list of residents who wander or residents who wear wander alarm bracelets. The new wander bracelet alarm system does not allow for the resident who attempted exit to be named over the pager system. Staff must perform a head count to determine the resident who was missing.

The facility's undated "Elopement Assessment Policy and Procedures" documented: "Staff will be trained on the management of wandering behaviors and elopement risks. . . Periodic missing resident drills will be completed."

The facility's undated "Elopement Tips/Drills and Reports" policy documented: "Elopement drills should be conducted on each shift quarterly. . . Drills should be scheduled on all shifts. . . All staff should be prepared and know how to search for residents. . . Identify high hazard areas such as . . . stairwells. . . Door alarm maintenance should be part of the preventive maintenance

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S3026	Continued From page 8 program." The administrator failed to protect R111 from neglect when he left the facility without staff knowledge and was found off the facility property down a side street near a heavily traveled street. The administrator further failed to protect the other 15 residents at risk for elopement, when the facility failed to implement interventions including adequate staff training and functioning alarms after the elopement of R111. The following actions were taken by the facility on 11/01/22 to protect the residents: On 11/01/22 at 11:49 AM Administrative Staff C stated she bought very loud door alarms for every door and a back-up alarm for every door. On 12:14 PM the wander bracelet alarm system was checked and functioned appropriately at every door from the memory care unit, except one. The door from the memory care unit to the indoor bridge that connected the north building to the south building did not alarm when tested. On 11/01/22 at 01:31 PM Administrative Staff C stated she had updated the wander bracelet alarm policy and provided a copy to surveyor. The facility's 11/01/22 "Memory Care Door Alarm/Wander Management System" policy documented: " Beginning 11/01/22 memory care unit door alarms and wander management system will be checked daily for two weeks then will be checked weekly. Any malfunctions will be immediately reported to the Executive Director, Health Services Director, and Regional	S3026		

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S3026	Continued From page 9 Operations Manager. The Director of Maintenance will document the testing. The Medication staff will check each shift for placement of the wander band and document that it is blinking red to indicate it is working. This will be documented on the MAR. The Health Services Director will audit the MARs for compliance." Observation on 11/02/22 at 11:01 AM revealed Maintenance Director H had installed an alarm on the door from the memory care unit to the indoor bridge that connected the north building to the south building.	S3026		
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: (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: KAR 26-41-201(c)(1)(2) The facility reported a census of 34 residents with three residents included in the sample. Based on interview and record review the administrator failed to ensure facility staff	S3081		

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S3081	Continued From page 10	S3081		

completed a "Functional Capacity Screen" (FCS) for Resident (R) 111 following a significant change in condition for wandering and exit-seeking behavior.

Findings included:

- Record review for R111 revealed an admission date of 08/17/22 with the following diagnoses: history of transient ischemic attack and cerebral infarction.

The 08/17/22 "FCS" identified R111 required supervision with bathing, transfers, and walking/mobility; physical assistance with dressing and toileting; was unable to perform management of medications and treatments; was usually continent of bladder; was sometimes understandable and sometimes understood during communication; and was marked for falls and impaired decision-making. Section II. D Cognition lines A, B, C, and D were blank with the number 16 entered on the Total Score line which does not meet the department's definitions for the "FCS."

R111's record lacked evidence of a Negotiated Service Agreement (NSA) and Healthcare Service Plan (HCP)

On 11/01/22 at 12:02 PM Maintenance Director H stated R111 had tried to elope before.

On 11/01/22 at 03:31 PM CNA I stated R111 tried to exit the facility before and got to the bottom of the stairs. Staff were unable to redirect him and get him back to the memory care unit. They called the director who came and assisted R111

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S3081	Continued From page 11 back to the memory care unit. On 11/02/22 at 10:04 AM Administrative Staff J R111 had tried to exit the facility one to two weeks before his successful attempt on 10/18/22. On 11/02/22 at approximately 05:50 PM Administrative Staff A, B, C, and D confirmed R111's record lacked a significant change "FCS" after he exhibited wandering and exit-seeking behaviors. The administrator failed to ensure facility staff completed an "FCS" for R111 following a significant change in condition.	S3081		
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.	S3085		

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S3085	Continued From page 12 This REQUIREMENT is not met as evidenced by: K.A.R. 26-41-202 (a)(1)(2)(3) The facility reported a census of thirty-four residents. The sample included three "Resident's" (R's) and one closed record review. Based on record review and interview the administrator failed to ensure a "Negotiated Service Agreement" (NSA) was developed based on the residence functional capacity screening, service needs and preferences in collaboration with the resident, or the resident's legal representative, the resident case manager, and included the description of services the resident will receive, identification of the provider of each service and identification of each party responsible for payment if outside resources provide the service for R111 and R115. Findings included: - Record review on 11/02/22 for R111 revealed an admission date of 08/17/22 with diagnosis of unspecified osteoarthritis, benign prostatic hyperplasia, personal history other malignant neoplasm of the large intestine, personal history of non-Hodgkin lymphoma, personal history of transgenic attack and cerebral infarction. Record review on 11/02/22 for R111 "Functional Capacity Screen" (FCS), identified resident required supervision with bathing, transferring, mobility, and required physical assistance with the dressing and toileting. He was unable to manage his own medications/medical treatments,	S3085		

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he could usually make himself understood and usually understood others. He was marked with falls/unsteadiness and impaired decision making. He used a wheelchair mobility device. Identified under ordered therapies and treatments home health to evaluate is indicated.

The resident record lacked a negotiated service agreement.

- Record review on 11/02/22 for R115 revealed an admission date of 08/17/22 with diagnosis of type 2 diabetes without complications, dementia without behavioral disturbances, major depressive disorder, hemiplegia affecting left nondominant side, chronic pain, hemiplegia, and hemiparesis following unspecified cerebral vascular disease. Identified under ordered therapies and treatments hospice was indicated.

Record review on 11/ 02/22 of R115 FCS identified the resident required physical assistance with bathing, dressing, toileting. He was identified to be unable to transfer, walk, or manage his own medications. He could sometimes make himself understood, and he sometimes understand others. He was marked with falls/unsteadiness and impaired hearing. He required a wheelchair and mechanical left for mobility devices.

The resident record lacked a negotiated service agreement.

Interview on 11/02/22 at 05:50 PM with administrative staff A, B, and C; confirmed the resident records for R111 and R115 lacked the

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S3085	Continued From page 14 required NSA. The administrator failed to ensure a "Negotiated Service Agreement" (NSA) was developed based on the residence functional capacity screening, service needs and preferences in collaboration with the resident, or the resident's legal representative, the resident case manager, and included the description of services the resident will receive, identification of the provider of each service and identification of each party responsible for payment if outside resources provide the service for R111 and R115.	S3085		
S3155 SS=D	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 thirty-four residents. The sample included three "Resident's" (R's) and one closed record review. Based on record review and interview the administrator failed to ensure a licensed nurse	S3155		

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S3155	Continued From page 15 provided or coordinated the provision of necessary healthcare services that meet the needs of each resident and are in accordance with the "Functional Capacity Screen" (FCS) and the "Negotiated Service Agreement" (NSA) for R111 and R115. Findings included: - Record review on 11/02/22 for R111 revealed an admission date of 08/17/22 with diagnosis of unspecified osteoarthritis, benign prostatic hyperplasia, personal history other malignant neoplasm of the large intestine, personal history of non-Hodgkin lymphoma, personal history of transgenic attack and cerebral infarction. Record review on 11/02/22 for R111 "Functional Capacity Screen" (FCS), identified resident required supervision with bathing, transferring, mobility, and required physical assistance with the dressing and toileting. He was unable to manage his own medications/medical treatments, he could usually make himself understood and usually understood others. He was marked with falls/unsteadiness and impaired decision making. He used a wheelchair mobility device. Identified under ordered therapies and treatments home health to evaluate is indicated. The resident record lacked a negotiated service agreement. - Record review on 11/02/22 for R115 revealed an admission date of 08/17/22 with diagnosis of type 2 diabetes without complications, dementia without behavioral disturbances, major depressive disorder, hemiplegia affecting left	S3155		

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S3155	Continued From page 16 nondominant side, chronic pain, hemiplegia, and hemiparesis following unspecified cerebral vascular disease. Identified under ordered therapies and treatments hospice was indicated. Record review on 11/ 02/22 of R115 FCS identified the resident required physical assistance with bathing, dressing, toileting. He was identified to be unable to transfer, walk, or manage his own medications. He could sometimes make himself understood, and he sometimes understand others. He was marked with falls/unsteadiness and impaired hearing. He required a wheelchair and mechanical left for mobility devices. The resident record lacked a negotiated service agreement. Interview on 11/02/22 at 05:50 PM with administrative staff A, B, and C; confirmed the resident records for R111 and R115 lacked the required NSA. Interview on 11/02/22 at 10:30 AM with administrative staff J, she confirmed the NSA and the "healthcare service plan" are a combined document. Interview on 11/02/22 at 05:50 PM with administrative staff A, B, and C confirmed that R111 and R115 resident records lacked healthcare service plans. The administrator failed to ensure a licensed nurse provided or coordinated the provision of necessary healthcare services that meet the needs of each resident and are in accordance	S3155		

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S3155	Continued From page 17 with the "Functional Capacity Screen" (FCS) and the "Negotiated Service Agreement" (NSA) for R111 and R115.	S3155		
S3165 SS=D	26-41-204 (d) Health Care Services (d) The negotiated service agreement shall contain a description of the health care services to be provided and the name of the licensed nurse responsible for the implementation and supervision of the plan. This REQUIREMENT is not met as evidenced by: KAR 26-41-204(d) The facility reported a census of 34 residents with three included in the sample. Based on interview and record review the administrator failed to ensure Residents (R) 113 and 119's Negotiated Service Agreements (NSA) named the licensed nurse responsible for implementing and supervising their Healthcare Service Plans (HSP). Findings included: - Record review for R113 revealed an admission date of 02/15/22 with the following diagnoses: Parkinson's disease, dementia, major depressive disorder, and insomnia. The 04/09/22 "Functional Capacity Screen" (FCS) identified R113 required supervision with bathing; physical assistance with dressing; was unable to perform management of medications	S3165		

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S3165	Continued From page 18 and treatments; was occasionally incontinent of bladder; had short-term, long-term, memory/recall, and decision-making impairments; was usually understandable and sometimes understood others during communication, and was marked for impaired hearing, wandering, and impaired decision making. The 04/09/22 combined "Negotiated Service Agreement/Healthcare Service Plan" (NSA/HCP) directed facility staff to provide R113 with assistance with a shower twice weekly; dressing morning and evening; frequent night checks for safety and incontinence care; facility staff administered medications; and provided reminders of daily routine up to four times a week. R113's record lacked documentation of the licensed nurse responsible for implementing and supervising his HCP. - Record review for R119 revealed an admission date of 05/25/21 with the following diagnoses: dementia, insomnia, major depressive disorder, anxiety, and hypertension. The 12/25/21 "FCS" identified R119 required physical assistance with management of medications and treatments and was marked for impaired decision making. The 05/17/22 combined "NSA/HSP" directed facility staff to provide R119 management of medications and impaired decision making was not addressed.	S3165		

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S3165	Continued From page 19 R119's record lacked documentation of the named licensed nurse responsible for implementing and supervising his HSP. On 11/02/22 at 05:50 PM Administrative Staff A, B, and C confirmed R113 and R119's NSA lacked documentation of the licensed nurse responsible for implementing and supervising their HCP's. The administrator failed to ensure each resident's NSA named the licensed nurse responsible for implementing and supervising the HSP.	S3165		
S3210 SS=D	26-41-205 (e) (f) Medication Verbal Orders and Standing Orders (e) Medication orders. Only a licensed nurse or a licensed pharmacist may receive verbal orders for medication from a medical care provider. The licensed nurse shall ensure that all verbal orders are signed by the medical care provider within seven working days of receipt of the verbal order. (f) Standing orders. Only a licensed nurse shall make the decision for implementation of standing orders for specified medications and treatments formulated and signed by the resident ' s medical care provider. Standing orders of medications shall not include orders for the administration of schedule II medications or psychopharmacological medications. This REQUIREMENT is not met as evidenced by: K.A.R. 26-41-205 (e)	S3210		

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S3210	Continued From page 20 The facility reported a census of thirty-four residents. The sample included three residents (R) and one closed record review. Based on record review and interview the administrator failed to ensure the licensed nurse obtained the provider signature on two telephone orders for R111 and two telephone orders for R113. Findings included: - Record review on 11/02/22 for R111 revealed an admission date of 08/17/22 with diagnosis of unspecified osteoarthritis, benign prostatic hyperplasia, personal history other malignant neoplasm of the large intestine, personal history of non-Hodgkin lymphoma, personal history of transgenic attack and cerebral infarction. Record review on 11/02/22 for R111 "Functional Capacity Screen" (FCS), identified resident required supervision with bathing, transferring, mobility, and required physical assistance with the dressing and toileting. He was unable to manage his own medications/medical treatments, he could usually make himself understood and usually understood others. He was marked with falls/unsteadiness and impaired decision making. He used a wheelchair mobility device. Identified under ordered therapies and treatments home health to evaluate is indicated. The resident record lacked a negotiated service agreement. Record review on 11/02/22 of the "Physician/Prescriber Telephone Orders" revealed the following two unsigned orders:	S3210		

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S3210	Continued From page 21 09/08/22: Clindamycin (antibiotic) 300 milligrams by mouth every eight hours for ten days for wound infection. The order lacked the provider signature within seven days of receipt of the verbal order. 08/19/22: 20 milliequivalent of Potassium daily. The order lacked the provider signature within seven days of receipt of the verbal order. - Record review on 11/02/22 for R113 revealed an admission date of 02/15/22 with diagnoses of Parkinson's disease, Insomnia, gastro-esophageal reflux disease, dementia, major depressive disorder and urinary incontinence. Record review on 11/02/22 of R113 FCS identified the resident required supervision with dressing, and physical assistance with dressing. He was independent with toileting, transferring, walking and eating. He lacked the ability to manage his own medications and was occasionally incontinent. He 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 sometimes understood others. He used a walker mobility device. Record review on 11/02/22 of the "Physician/Prescriber Telephone Orders" revealed the following two unsigned orders: 05/18/22: Doxycycline Hyclate (antibiotic) 100 milligrams twice daily for ten days, and Probiotic	S3210		

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S3210	Continued From page 22 one by mouth daily for twenty days for left posterior knee wound. The order lacked the provider signature within seven days of receipt of the verbal order. 05/10/22: Home health nursing for wound care to right posterior calf. Home health physical therapy, occupational therapy, and speech therapy for Parkinson's disease. The order lacked the provider signature within seven days of receipt of the verbal order. The administrator failed to ensure the licensed nurse obtained the provider signature on two telephone orders for R111 and two telephone orders for R113.	S3210		
S3261 SS=D	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: KAR 26-41-105(f)(11) The facility reported a census of 34 residents with three residents included in the sample. Based on interview and record review the administrator failed to ensure staff provided documentation of all incidents including date, time of occurrence, action taken, and results of	S3261		

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S3261	Continued From page 23	S3261		

the action when Resident (R) 111 successfully exited the memory care unit through a locked door, went down the front grand staircase, and made it to the front common area/foyer of the facility.

Findings included:

- Record review for R111 revealed an admission date of 08/17/22 with the following diagnoses: history of transient ischemic attack and cerebral infarction.

The 08/17/22 "Functional Capacity Screen" (FCS) identified R111 required supervision with bathing, transfers, and walking/mobility; physical assistance with dressing and toileting; was unable to perform management of medications and treatments; was usually continent of bladder; was sometimes understandable and sometimes understood during communication; and was marked for falls and impaired decision-making. Section II. D Cognition lines A, B, C, and D were blank with the number 16 entered on the Total Score line which does not meet the department's definitions for the "Functional Capacity Screen."

R111's record lacked evidence of a Negotiated Service Agreement (NSA) and Healthcare Service Plan (HCP)

R111's record lacked evidence of documentation of an exit-seeking incident prior to his successful attempt on 10/18/22 including the date, time of the occurrence, actions taken and the results of the action(s).

On 11/01/22 at 12:02 PM Maintenance Director

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S3261	Continued From page 24 H stated R111 had tried to elope before. On 11/01/22 at 03:31 PM CNA I stated R111 tried to exit the facility before and got to the bottom of the stairs. Staff were unable to redirect him and get him back to the memory care unit. They called the director who came and assisted R111 back to the memory care unit. On 11/02/22 at 10:04 AM Administrative Staff J confirmed R111 had tried to exit the facility one to two weeks before his successful attempt on 10/18/22. On 11/02/22 at approximately 05:50 PM Administrative Staff A, B, C, and D confirmed R111's record lacked documentation. The administrator failed to ensure staff provided documentation of all incidents including date, time of occurrence, action taken and results of the action when R111 successfully exited the memory care unit through a locked door, went down the front grand staircase, and made it to the front common area/foyer of the facility.	S3261		
S3265 SS=J	26-41-104 (a) Disaster and Emergency Preparedness (a) The administrator or operator of each assisted living facility or residential health care facility shall ensure the provision of a sufficient number of staff members to take residents who would require assistance in an emergency or disaster to a secure location.	S3265		

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S3265	Continued From page 25 This REQUIREMENT is not met as evidenced by: 26-41-104 (a) The facility reported a census of 34 residents. Based on observation, interview and record review the administrator failed to ensure adequate staffing was provided during the overnight hours for residents who required a two person assist for all transfers, and who resided on two different floors/units of the same building. The administrator further failed to staff the building to accommodate the identified two person assist resident's when the staff was scheduled to work one shift between two buildings that do not hold the same license number. This left the building inadequately staffed in the event of an emergency evacuation Findings included: - Record review on 11/01/22 of the facility provided resident roster revealed four residents who required a two person assist. One resident who was identified as a two person assist and resided on the first floor, which was identified as an assisted living unit, and three residents who were identified as a two person assist on the second floor, which was identified as the secured memory care unit. Observation on 11/01/22 at 02:00 PM - two buildings sat on opposite sides of the street that went between the two buildings. From the ground looking up to what appeared to be a second story is a covered /enclosed walkway connecting the two buildings. The "sister facility" is the south building.	S3265		

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S3265	Continued From page 26 Interview on 11/01/22 at 02:30 PM with Administrative Staff C, she confirmed the two buildings are "sister facilities" and have separate licensure. Interview on 11/01/22 at 02:08 PM with Administrative Staff C gave the following definitions as it related to the staffing schedule: "North Cart" (NC) "Memory Care Cart" (MCC) "North building staff position 1" (N1) "Memory Care unit staff positions 1 and 2" (MC1 and MC2) "South building Cart 1 and 2" (SC1 and SC2) "South building staff positions 1 and 2" (S1 and S2) "Cart" is the medication cart. Record review of the facility night shift staffing schedule for 08/28/22 thru 09/10/22 revealed the following staff scheduled in the two units on: 08/28- 9/19/22: NC, M1 and M2 for a total of 3 staff. One staff for the assisted living and 2 staff for the secured memory care unit. 09/13 -9/19/22: NC, M1 and M2/SC the facility scheduled one staff for the assisted living and one staff for the memory care unit with the second memory care unit staff being shared with the south building. 09/20 NC, M1 and M2/SC the facility scheduled one staff for the assisted living and one staff for the memory care unit with the second memory care unit staff being shared with the south building.	S3265		

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S3265	Continued From page 27 09/21: NC, M1 and M2 scheduled 3 staff, one staff for the assisted living and 2 staff for the secured memory care unit. 09/22 NC, M1 and M2/SC the facility scheduled one staff for the assisted living and one staff for the memory care unit with the second memory care unit staff being shared with the south building. 09/23: NC, M1 and M2 the facility scheduled three staff, one staff for the assisted living and 2 staff for the secured memory care unit. 09/24: M1/NC and M2 for a total of 2 people the facility scheduled one staff for the memory care and north building cart and the second person for the memory care. 09/25-9/27/22: N1/SC, MC1/NC, and MC2 for a total of 3 staff. The first staff was scheduled to be shared with the north assisted living and the south building medication cart, the second staff was to be shared with the memory care unit and the assisted living, and the third staff would remain in the memory care unit. 09/28: N1/SC, MC1/NC, and MC2 for a total of 3 staff. The first staff was shared between two buildings, the second staff was shared between the secured memory care unit and the north building cart, and the third staff would remain in the memory care unit. 09/29: N1/SC and MC1/NC for a total of 2 staff. The first staff was shared between two buildings, and the second staff was shared between the secured memory care unit and the north building	S3265		

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S3265	Continued From page 28 medication cart. 09/30-10/6/22: N1/SC, MC1/NC, and MC2 for a total of 3 staff. The first staff was scheduled to be shared with the north assisted living and the south building medication cart, the second staff was to be shared with the memory care unit and the assisted living, and the third staff was for the memory care unit. 10/07: N1/SC (NC/SC), MC1/NC, MC2 for a total of 3 staff. The first staff was scheduled for the north building assisted living medication cart and the south building cart as well as being the staff for north building, the second person was the memory care cart and second north person staff, and the third person was for the memory care unit. 10/08-10/10/22: N1/SC, MC1/NC, and MC2 for a total of 3 staff. The first staff was scheduled to be shared with the north assisted living and the south building medication cart, the second staff was to be shared with the memory care unit and the assisted living, and the third staff was scheduled for the memory care unit. 10/11: N1/SC (no one scheduled), MC1/NC, and MC2 for a total of 2 staff. The first staff was not assigned, the second staff was shared between the secured memory care unit and the north building assisted living medication cart, and the third staff was for the memory care unit. There were only 2 staff on the schedule. 10/12-10/14/22: N1/SC, MC1/NC, and MC2 for a total of 3 staff. The first staff was scheduled to be in the assisted living in the north building and	S3265		

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	N046042	A. BUILDING: _____ B. WING _____	11/03/2022

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shared for the south building medication cart, the second staff was shared between the secured memory care unit and the north building assisted living medication cart, and the third staff was for the memory care unit.

10/15: N1/SC, MC1/NC, and MC2 (no one scheduled) for a total of 2 staff. There were only 2 staff on the schedule.

The first staff was shared between the north building assisted living and the south building medication cart, the second staff was not assigned, and the third staff was scheduled for the memory care unit.

10/16-10/17/22: N1/SC, MC1/NC, and MC2 for a total of 3 staff. The first staff was scheduled to be in the assisted living in the north building and shared for the south building medication cart, the second staff was shared between the secured memory care unit and the north building assisted living medication cart, and the third staff was for the memory care unit.

10/18: N1/SC, MC1/NC (NC/SC), and MC2 for a total of 3 staff. The first staff was shared between the north building assisted living and the south building medication cart, the second staff was shared between the secured memory care unit and the north building assisted living medication cart (but was assigned on this day to the north building medication cart and the south building medication cart), and the third staff was scheduled for the memory care unit.

10/19-10/21/22: N1/SC, MC1/NC, and MC2 for a total of 3 staff. The first staff was scheduled to be

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in the assisted living in the north building and shared for the south building medication cart, the second staff was shared between the secured memory care unit and the north building assisted living medication cart, and the third staff is for the memory care unit.

10/22: N1/SC, MC1/NC (NC/SC), and MC2 for a total of 3 staff. The first staff was shared between the north building assisted living and the south building medication cart, the second staff was shared between the secured memory care unit and the north building assisted living medication cart (but was assigned on this day to the north building medication cart and the south building medication cart), and the third staff is for the memory care unit.

10/23: N1 (NC), MC1 and MC2 for a total of 3 staff. 1 staff on the north building assisted living medication cart and working the floor, and 2 staff on the memory care unit.

10/24: N1 (NC), MC1 and MC2 for a total of 3 staff. 1 staff on the north building assisted living medication cart and working the floor, and 2 staff on the memory care unit.

10/25: N1, MC1(NC/S) and MC2 for a total of 3 staff. 1 staff on the north assisted living unit, 1 shared staff from memory care coming down to the medication cart on the north assisted living unit and in the south building, and one staff on the memory care unit.

10/26: N1, MC1(NC) and MC2 for a total of 3 staff. 1 staff on the north assisted living unit, one shared staff from memory care coming down to

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S3265	Continued From page 31 the north assisted living medication cart, and one staff on the memory care unit. 10/27: N1, MC1 and MC2 for a total of three staff. One staff member on the north building assisted living unit floor and two staff members on the memory care unit. 10/28: N1, MC1 and MC2 for a total of 3 staff. One staff member on the north assisted living unit building floor and two staff members on the memory care unit. 10/29: N1, MC1 and MC2 for a total of 3 staff. One staff member on the north assisted living unit building floor and two staff members on the memory care unit. 10/30: N1 (NC/SC), MC1 and MC2 for a total of 3 staff. One staff on the north building assisted living unit floor and cart and shared with the south building medication cart, and 2 memory care staff. 10/31: N1 (SC), MC1 (NC), and MC2 for a total of 2 staff. One staff member on the north assisted living unit floor shared to the south building medication cart, 1 memory care staff member scheduled to go down to the assisted living unit for the medication cart, and one staff member for the memory care. 11/01: N1, MC1 (NC/S) MC2 for a total of 3 staff, one staff for north assisted living unit, 1 shared memory care staff for the north assisted living unit medication cart and further shared with the south building, and one memory care staff.	S3265		

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S3265	Continued From page 32 Interview on 11/02/22 at 12:57 PM with Administrative Staff J revealed the current staffing plan was "1 "Certified Nurse Aide" (CNA) and 1 "Certified Medication Aide" (CMA) that goes between floors, and 1 CNA that floats between floors". Record review of on 11/02/22 of Administrative Staff J's signed witness statement revealed the following: "Current staffing model was 1 CMA/" Licensed Nurse" (LN), for N1/MC medication carts, 1 CNA on N1 and 2 CNAs on MC with 1 CMA/LN and 2 CNA's. This changed back to the current model due to staff complaints of the memory care CMA/LM not assisting between medication passes. Upon my return, staffing was decreased from 3 CNAs to 2 CNAs on memory care. I decided to go back to 3 CNAs in memory care due to behaviors". Interview on 11/02/22 at 03:27 PM with Administrative Staff D confirmed the time system the facility used did not show what location the staff clocked in and out from. It only showed that the staff had clocked in and out. Interview with CMA K on 11/03/22 at approximately 11:00 AM revealed there were 3 residents who used a mechanical lift that did not require a sling. She continued to state there were to be two staff to assist residents when this equipment was being used. She confirmed that since she had been an employee of the facility, she had not worked with less than two staff members on the memory care unit during her shift. Observation on 11/04/22 at 10:41 AM an	S3265		

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apartment in the assisted living unit with a mechanical lift, which required a sling for transfer.

Observation on 11/04/22 at 10:55 AM revealed a mechanical lift, which did not require a sling, in a room on the second floor, which was identified as the locked/secured memory care unit, and was confirmed there were three residents on the secured unit that required a mechanical lift.

Interview 11/06/22 at approximately 12:30 PM with Administrative Staff C, confirmed the facility did not have a mechanical lift policy.

Record review on 11/02/22 of the facility provided emergency preparedness training, revealed the documents lacked documentation of an annual emergency drill that included the evacuation of the residents to a secure location.

Record review of electronic mail sent on 11/03/22 at 04:29 PM from administrative staff C confirmed the facility did not have record of an annual emergency preparedness drill that would have included evacuation of the residents to a secure location.

The administrator failed to ensure adequate staffing during the overnight hours for residents who required two staff assistance for all transfers, and who resided on two different floors/units of the same building. The administrator further failed to staff the building to accommodate the identified two person assist residents when the staff was scheduled to work one shift between two buildings that did not hold the same license number. This left the building

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S3265	Continued From page 34 inadequately staffed in the event of an emergency evacuation.	S3265		
S3280 SS=F	26-41-104 (d) Disaster and Emergency Preparedness (d) Each administrator or operator shall ensure disaster and emergency preparedness by ensuring the performance of the following: (1) Orientation of new employees at the time of employment to the facility ' s emergency management plan; (2) education of each resident upon admission to the facility regarding emergency procedures; (3) quarterly review of the facility ' s emergency management plan with employees and residents; and (4) an emergency drill, which shall be conducted at least annually with staff and residents. This drill shall include evacuation of the residents to a secure location. This REQUIREMENT is not met as evidenced by: K.A.R.26-41-104 (d)(4) The facility reported a census of thirty-four residents. The sample included three residents and one closed record review. Based on record review and interview the administrator failed to ensure an emergency drill was conducted at least annually with staff and residents that included the evacuation of the residents to a secure location.	S3280		

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S3280	Continued From page 35 Findings included: - Record review on 11/02/22 of the facility provided emergency preparedness training revealed the documents lacked documentation of an annual emergency drill that included the evacuation of the residents to a secure location. Record review of electronic mail sent on 11/03/22 at 04:29 PM from administrative staff C confirmed the facility did not have record of an annual emergency preparedness drill that would have included evacuation of the residents to a secure location. The administrator failed to ensure an emergency drill was conducted at least annually with staff and residents that included the evacuation of the residents to a secure location.	S3280		