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	N046050	A. BUILDING: _____ B. WING _____	01/24/2019

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S 000	INITIAL COMMENTS The following citations represent the findings of an abbreviated survey at the above named assisted living facility conducted on 1-17-19, 1-22-19, 1-23-19 and 1-24-19.	S 000		
S3026 SS=D	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 51 residents (36 assisted living residents and 15 memory care residents). The sample included 3 residents. Based on observation, record review and interview for 1 (#1) of 3 sampled residents, the administrator failed to ensure the cognitively impaired resident was not subjected to neglect when facility staff failed to provide services reasonably necessary to ensure the residents' safety and well-being and to avoid harm when the licensed nurse failed to provide or coordinate services to address the cognitively impaired resident's risk for elopement. Resident #1 left the facility at an unknown time during the night on 12-28-18 without staff knowledge. The resident walked around the corner and into a residential	S3026		

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

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neighborhood 0.5 miles from the facility, where he/she awakened someone who called the police. The facility is one block east of a major 4-lane thoroughfare. There is a stream that runs between the facility and the neighborhood in which the resident was found.

Findings included:

- Record review for Resident #1 revealed admission on 4-19-17 with diagnoses that included Alzheimer's Disease, Dementia, Paranoia, and Hypertension.

The Functional Capacity Screen (FCS) dated 10-5-18 recorded resident required supervision with bathing, dressing, toileting, and eating; independent with transfers, walking/mobility; and unable to perform management of medications and treatments. Cognition: problems with short term memory, long term memory, memory/recall and decision-making. Current problems/risks identified: impaired vision, wandering, socially inappropriate disruptive behavior and impaired decision-making.

The Negotiated Service Agreement/Health Care Service Plan (NSA/HCSP) dated 10-5-18 recorded the following with Administrative Nurse B responsible for implementation of the NSA:
P.M. Care: Requires assistance of one (staff member) for all PM cares. Prefers to go to bed between 10:00 pm and 11:00 pm ...
Night Checks: more than 1 time a night. Requires a night check for safety. Do not wake when checking on him/her.
Mobility/Escort: (resident) ambulates and transfers independently without an assistive device. Requires escorts to and from meals and activities due to his/her memory impairment.

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Cognition: is alert and oriented to person. Has Alzheimer's dementia and paranoia, requires multiple orientations daily to his/her routine and activities.
Behavior: verbal reminder, redirection when behavior is inappropriate ...may require the verbal redirection ...staff to provide verbal redirection until resident becomes more comfortable in new surroundings.
Safety (Monitoring Devices): requires verbal reminders to exit the (facility) safely in the event of an emergency or for drills. Wears a transmitter band monitored 24/7 for safety.

On 1-22-19, the facility provided an unsigned copy of a "Service Plan" dated 11-26-18 which recorded the following: The plan identified Administrative Nurse B as "responsible for implementation of the Negotiated Service Agreement ...will monitor health, cognition and functional status every 180 days and as needed to ensure the NSA reflects (resident's) current needs."
P.M. Care: "Extra assistance due to mobility OR behavior/cognition: (Resident) requires the assistance of 1 (staff) for all PM cares. Prefers to go to be between 10:00 pm and 11:00 pm. (Staff) needs to ensure that (Resident) changes out of his/her clothes into pajamas nightly ..."
Night Checks: "More than 1 time a night. (Resident) requires a night checks for his/her safety Do not wake him/her when checking on him/her."
Cognition: "Multiple orientations to daily routine (may be due to impaired judgement). (Resident) is alert and oriented to person. (Resident) has Alzheimer's dementia and paranoia. (Resident) requires multiple orientations daily to his/her routine for meals and activities."
Behavior: "Specialized interventions needed to

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manage inappropriate behavior. (Resident) is new to (memory care unit) and at times, he/she often requires the verbal redirection that this is his/her new home. Staff to provide this verbal redirection until (Resident) becomes more comfortable in his/her new surroundings. (Resident) has moments of increased exit seeking as well as refusing/spitting out/wiping off medication. (Staff) to redirect (Resident) away from exit doors as needed. (Resident) responds best to the redirection of 1 person versus multiple people at one time when being redirected." Safety (Monitoring Devices): "(Resident) requires verbal reminders to exit the (facility) safely in the event of an emergency or for drills. Wears a transmitter band monitored 24/7 for safety."

The NSA/HCSP failed to identify and alert staff that resident was a high elopement risk and failed to identify specific interventions to address the resident's elopement risk including resident's tendency to return to the assisted living as desired without adequate staff monitoring. The NSA/HCSP failed to designate staff responsible for monitoring of resident when visiting the assisted living.

Nursing "Progress Notes" stated the following: 7-27-18 at 11:00 am: "(Administrative Staff A) discussed decreased cognitive impairment with family to discuss moving resident to (memory care unit). Resident getting lost in building, lost on elevator, wakes other residents at bedtime asking meal times, clogs toilet multiple times a week. (Nurse) obtained orders for urinalysis with culture and sensitivity and routine labs to rule out infection." Signed by Administrative Nurse C.

(note: the record lacked documentation of date/time resident moved to memory care unit

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and any plan of integration into unit prior to move-in.)

12-7-18 at 9:00 pm: "At approximately 6:00 pm resident exited (memory care) main entry and was found by staff near parking lot sidewalk and escorted back inside through assisted living main entry. Resident observed for injuries, none noted. No pain/discomfort noted. Resident highly agitated and unable to redirect. This (nurse) stayed with resident for concerns of safety ..." Signed by Licensed Staff E.

Note: The licensed nurse failed to revise the NSA/HCSP to include interventions to address resident's elopement risk.

12-11-18 at 7:00 pm: "Resident eloped out of the building through the northeast exit. Resident was dressed appropriately for the weather and was quickly responded to upon pagers going off notifying that he/she was leaving the building ...No injuries noted. Will continue to monitor." Signed by Licensed Staff F.

Note: the NSA/HCSP continued to lack documentation of interventions to address elopement risk or management of behavior.

12-22-18 at 4:30 pm: "Resident has been agitated and aggressive during shift. He/she has been pacing the halls holding a wet towel and swinging it. He/She wiped off the Lorazepam gel from arm and wrist with the wet towel. Ended up walking to assisted living where he/she kept knocking on other resident's doors while threatening to kill people and to call 911. Administrative Nurse B notified. Family planning to come pick up resident to go home with him/her for the evening." Signed by Licensed Staff F.

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S3026	Continued From page 5 Note: The licensed nurse failed to revise the NSA/HCSP to include interventions to address resident's behaviors. 12-26-18 at 5:00 pm: "Resident (with) increased agitation at dinner. Balling up toilet paper and throwing it in (nurse's) face. Attempting to exit building. One on one care started for redirection. Resident continues to need redirection back to dining room table to complete meal." Signed by Administrative Nurse C. 12-26-18 at 6:35 pm: "PRN (as needed medication) not effective. No change in agitation noted at this time. Resident remains one on one." Signed by Administrative Nurse C. 12-28-18: 12:15 am: (Certified Staff H) notified this nurse that resident can't be found in residential room. This nurse and CNA searched for resident on (memory care) side and on premises. 12:35 am: This nurse notified and requested assistance in finding resident on (assisted living side) from certified nurse aides on assisted living side. 1:00 am: Police called and notified this nurse resident was found off (facility) premises. 1:15 am: Police transferred resident back on (facility) premises. No change in range of motion. No concerns noted at this time. Resident resistive to care. Backs away when this nurse attempts to assist. Redirection ineffective. 2:00 am: Resident runs out to courtyard. This nurse unable to locate resident. 2:15 am: Administrative Nurse B and police notified of missing resident. 2:25 am: Resident located by staff on (facility) premises Resident transferred to room. Resident slammed this nurse into a wall. No other concerns at this time." Signed by Licensed Staff D.	S3026		

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S3026	Continued From page 6 Note: Weather Underground history reported the following temperature, events and conditions for 12-28-18: 25 degrees Fahrenheit and overcast. 12-28-18 at 2:00 pm: "Resident has been in and out of my office all day today. He/She is very anxious and agitated. He/she has threatened to kill this writer, others, (staff). He/She hit this writer with a walkie talkie, grabbed papers off desk and crumpled them all up. Threw puzzle pieces at other 9 staff). Grabbed my phone out of my hands and refused to return it. He/she states he/she wants to kill others. But has not made any attempts to kill. Family called to inform of behaviors. Family has called (physician) office to get sleeping pill and anti-anxiety medications. Consulted with (Administrative Staff) He/She suggests being seen for inpatient Geri-psych due to increasing behaviors, inability to be redirected, and need to be evaluated. Administrative Nurse C called (physician) office for order." Signed by Administrative Staff A. 12-28-18 at 4:34 pm: "Resident continues to be aggressive with other resident and (staff). Resident refusing medication (PRN) and will not allow (staff) one on one supervision to promote safety. Call to primary care provider for orders to send to inpatient geri-psych for evaluation and treatment if indicated. Primary care provider denied any new medication orders, lab orders or order to send out. (Administrative Staff A) placed call to (family member) to advise. (family member) did not answer ..." Signed by Administrative Nurse B. 12-28-18 at 10:04 pm: "Resident has been agitated this evening, pacing up and down hallway, exit seeking, yelling to (staff) to get out of	S3026		

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his/her way and hitting with a pillow. He/She is on one on one care ..." Signed by Licensed Staff F.

Note: Resident was transferred to the hospital on 12-28-18 around 2:45 pm; he/she did not return to the facility. No observation of resident performed during the survey.

Review of staffing scheduled on 12-27-18 on the evening shift revealed Licensed Staff F, Certified Staff I and Certified Staff J worked on the memory care unit. On the night shift beginning at 11:00 pm, Licensed Staff D and Certified Staff H worked on the memory care unit.

Interview on 1-22-19 at 3:11 pm with Licensed Staff F confirmed his/her written statement dated 12-28-18 which stated, I ...walked (Resident #1) from assisted living to his/her room with the help of (Licensed Staff K) around 8:30 pm on Thursday, December 27th, 2018. He/She was very tired and just wanted to go to sleep. When he/she went to bed, his/her door was closed. I later checked on him/her around 9:30 pm during the night to make sure he/she was still in his/her room and he/she was still in there. To the best of my knowledge, he/she was still in his/her room at the end of the shift at 11:00 pm when I left." Licensed Staff F stated he/she went over to the assisted living to "check on" the resident and found him/her on the 2nd floor sitting in a chair dosing off. Resident didn't want to get up because he/she was very tired. Licensed Staff F stated he/she escorted resident back to the memory care and "made sure he/she was lying on his/her bed." Further stated, "I checked on him/her around 9:30 pm in his/her room and he/she was still in bed sleeping." Stated the aides did round and since he/she observed the aides completing their rounds, he/she felt the

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resident "was still in there." Confirmed he/she did not actually visually see the resident after 9:30 pm. Licensed Staff F confirmed he/she worked on the memory care unit and he/she would go over to the assisted living to check on the resident but there was not a designated time frame to check and no one on the assisted living was assigned to monitor the resident.

Interviews on 1-24-19 at 9:15 am and 9:26 am with Licnesed Staff D and Certified Staff H: Certified staff H confirmed he/she noticed resident was not in his/her room around 12:15 am and notified Licensed Staff D who stated they began to search the unit and were unable to locate the resident. Both staff confirmed resident was resistant to care at times, combative with staff, known to exhibit exit seeking behaviors and freely walked back and forth from the memory care unit to the assisted living unit. Licensed Staff D confirmed the resident returned to the facility with police around 1:15 am. While he/she was talking with police and assisted living staff, the resident took off running and exited the building into the courtyard. Resident was found in the assisted living building. Confirmed he/she failed to notify Administrative Staff A of the events on 12-28-18 per facility policy.

Interview on 1-22-19 at 12:35 pm with Administrative Staff A and Administrative Nurse B confirmed the NSA/HCSP lacked specific interventions to address the resident's elopement risk and failed to designate staff responsible for monitoring of resident when he/she left the memory care unit and went unaccompanied to the assisted living. Administrative Staff A confirmed the resident moved from the assisted living to the memory care unit on 9-22-18 and the record failed to document the move or the

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S3026	Continued From page 9 resident's adjustment to living on the memory care unit. Administrative Staff A and Administrative Nurse B confirmed the resident's behaviors of exit seeking, aggressiveness and medication refusal escalated after moving to the memory care unit. For Resident #1, who had eloped from the facility and exhibited repeated exit seeking behavior, the administrator failed to ensure the resident was not subjected to neglect when the licensed nurse failed to identify and implement interventions to address residents' behaviors and elopement risk. Resident #1 left the facility at an unknown time on 12-28-18 without staff knowledge and was found at a neighbor's home around 1:15 am, 0.5 mile from the facility when that neighbor called the police to report the resident was at his/her home.	S3026		