STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046071	A. BUILDING: _____ B. WING _____	11/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE ASSISTED LIVING OF LENEXA	15055 WEST 87TH ST PARKWAY LENEXA, KS 66215

(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 abbreviated survey for complaints #167204, #167205, #167122, #167168 and #166740 conducted on 11/17/21, 11/18/21, 11/22/21, 11/23/21, 11/24/21 and 11/29/21.	S 000		
S 115 SS=E	26-39-103 (d) Resident Right Inspection of Records (d) Inspection of records. (1) The administrator or operator shall ensure that each resident or resident's legal representative is afforded the right to inspect records pertaining to the resident. The administrator or operator, or the designee, shall provide a photocopy of the resident's record or requested sections of the resident's record to each resident or resident's legal representative within two working days of the request. If a fee is charged for the copy, the fee shall be reasonable and not exceed actual cost, including staff time. (2) The administrator or operator shall ensure access to each resident ' s records for inspection and photocopying by any representative of the department. This STANDARD is not met as evidenced by: K.A.R. 26-39-103 (d)(2) The facility reported a census of 61 residents. The sample included 3 residents. Based on interview and record review the Administrator failed to provide access to each sampled resident's electronic record for inspection in a timely manner delaying the survey. Findings included:	S 115		

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

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S 115	Continued From page 1 - The surveyor entered the facility on 11/17/21 at 11:30 AM to conduct an Abbreviated Survey of 5 complaint investigations. The surveyor informed Administrator A of the reason for the visit, inquired whether they used paper medical records or electronic. Administrator A reported they were all electronic documents. The surveyor requested access to the electronic records to review the items needed in conducting an Abbreviated Survey. On 11/17/21 at approximately 12:45 PM, Administrator A placed a call to the facility's corporate lawyer and put the cell phone on speaker. Administrator A told this person the surveyor was there to do a survey and needed access to the resident's electronic records. The person on the phone asked the surveyor to email a written request for access as she had never heard of giving surveyors access. On 11/17/21 at 01:01 PM the surveyor sent an email to Administrator A reporting most companies have their computer technical people give the surveyor read only access to the record which include; census, contacts, medical diagnosis, orders, weights/vital signs, forms/assessments, progress notes, service plan, Functional Capacity Screening, Negotiated Service Agreements/Health Service Plans and miscellaneous documents scanned into the electronic record. The surveyor noted she would provide a copy of the regulatory requirement. On 11/17/21 at 01:52 PM the surveyor presented Administrator A with a copy of the regulation which required the facility to grant access to the resident's records. A follow-up email was sent to Administrator at 02:15 PM with the Kansas Statue, which also required the facility to grant	S 115		

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S 115	Continued From page 2 access to the surveyor. On 11/17/21 at 02:55 PM, the surveyor requested Administrator A to print, scan, and email resident #1 and #3 documents from the electronic record to the surveyor for review. At this time, Administrator A reported the electronic system was down. However, the surveyor was able to pull up the electronic record keeping system on the surveyor's computer. On 11/17/21 at 03:05 PM, the Assistant Commissioner for Survey, Certification and Credentialing with the Kansas Department for Aging and Disability Services placed a call to Administrator A about the regulatory requirement for the Administrator to grant access to the resident's electronic records. On 11/17/21 at 04:30 PM, Administrator A continued in not granting the surveyor access to the resident's records and had not printed, scanned, and emailed any of the previously requested resident documents. On 11/17/21 at 05:24 PM, Administrator A reported she was working on getting the username and password needed for the surveyor to access the resident's electronic records. Administrator A emailed some of the documents requested for resident #1. On 11/17/21 at 06:38 PM, Administrator A sent the username and password for the electronic record system used for residents' record. She failed to include the suffix needed to log-on. She indicated she would not send any more of the requested documents by email since I should be able to access the records.	S 115		

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S 115	Continued From page 3 On 11/18/21 between 06:04 AM and 08:45 AM several emails were exchanged between the surveyor and Administrator A regarding the surveyor not being able to log on to the electronic record system. On 11/18/21 at approximately 10:00 AM, the surveyor returned to the facility and was able to log on to the electronic system. The Administrator failed to provide access to each sampled resident's electronic record for inspection in a timely manner delaying the survey.	S 115		
S 135 SS=D	26-39-103 (h) Resident Right Notification of Changes (h) Notification of changes. (1) The administrator or operator shall ensure that designated facility staff inform the resident, consult with the resident's physician, and notify the resident's legal representative or designated family member, if known, upon occurrence of any of the following: (A) An accident involving the resident that results in injury and has the potential for requiring a physician's intervention; (B) a significant change in the resident's physical, mental, or psychosocial status; (C) a need to alter treatment significantly; or (D) a decision to transfer or discharge the resident from the adult care home. (2) The administrator or operator shall ensure that a designated staff member informs the resident, the resident's legal representative, or authorized family members whenever the designated staff member learns that the resident will have a change in room or roommate assignment.	S 135		

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S 135	Continued From page 4	S 135		

This STANDARD is not met as evidenced by:
K.A.R. 26-39-103 (h)(1)(A)(D)

The facility reported a census of 61 residents. The sample included 3 residents. Based on record review and interview the Administrator failed to ensure staff informed the resident's legal representative of an accident involving the resident that results in injury with a decision to transfer the resident to a hospital at the time of the accident for 1 of 3 sampled residents (#3) who had a fall on 10/21/21 with facial injuries and laceration requiring stitches.

Findings included:

- Record review for resident #1 revealed an admission date of 12/31/20. He had a diagnosis of Dementia with behavioral disturbance and admitted to a room on the secured memory care unit.

The "Functional Capacity Screen" (FCS) dated 12/29/21 identified the resident with short term memory deficit and impaired memory recall. The FCS indicated the resident's long-term memory was intact and did not identify the resident with impaired decision making. He was identified as at risk for fall/unsteadiness and needed an assistive device. The 06/29/21 FCS included the same cognitive and decision-making abilities, the same activities of daily living abilities and fall risk.

The "Negotiated Service Agreement/Health Service Plan" (NSA/HSP) which began on 12/31/20 and included revision through 02/24/21.

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S 135	Continued From page 5 It included the resident's daily routine as wake up around 08:00 AM, watch TV, sit in the recliner and go to bed around 09:00 PM. Invite, encourage and assist me to activities of interest daily. Allow me adequate time to talk and actively listen when I am withdrawn. Prompt me with simple ye or no questions. Under fall risk was observe and report any changes in my gait and/or balance as well as "I have had an actual fall (but did not identify when). The interventions listed were encourage, invite and assist me to attend activities that promote exercise, strength building, and balance based on my preferences. Provide similar one-on-one activities if I am unable to attend group activities. The resident was independent with mobility, needed a walker and staff to observe and report any changes in mobility. He was to use a walker when transferring between surfaces and could do so independently. The NSA/HSP had one revision on 10/29/21 for the addition of Hospice services. A progress note titled, as a "Fall Note" dated 10/22/21 at 11:28 AM licensed nurse F wrote the resident had a fall on the previous evening shift at approximately 10:15 PM, he hit his head on the floor and was bleeding from the forehead. He was transferred by emergency medical services to the hospital for evaluation. The resident returned to the facility at 07:00 AM his forehead is swollen, and very bruised. Bruising around his eyes. His right eye conjunctiva is red. He has a small laceration between his eyebrows, and beneath his right eye with a skin tear on his right forearm. A request made licensed nurse B on 11/18/21 to review the facility's fall investigation and/or an explanation of the investigation resulted in none provided.	S 135		

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S 135	Continued From page 6 A confidential interview with a family member of the resident on 11/18/21 revealed the resident's legal representative was not contacted on 10/21/21 at 10:15 PM at the time of the fall. The legal representative received a phone on 10/22/21 at about 10:15 AM to learn resident #1 had an accident with injuries and was sent out by emergency medical services for treatment of the injuries. The resident was already back at the facility before the legal representative knew of the accident. Interview on 11/19/21 at 06:06 AM with certified medication aide L revealed she was on duty and responsible for the resident at the time of the fall on 10/21/21 at about 10:15 PM. She said she called 911 because the resident was screaming and bleeding from his forehead and nose. She confirmed she did not call the resident's legal representative or any family. She did call Licensed Nurse B who was on vacation, so she left a message and called another nurse on the list but could not name them. The Administrator failed to ensure staff informed the resident's legal representative of an accident involving the resident that results in injury with a decision to transfer resident #1 to a hospital at the time of the accident for fall on 10/21/21 with facial injuries and laceration requiring stitches.	S 135		
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;	S3081		

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S3081	Continued From page 7 (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 61 residents. The sample included 3 residents. Based on observation, interview, and record review the Administrator failed to ensure staff conducted a screening to determine each resident's functional capacity following a fall with fracture and a significant change in abilities for 1 of 3 sampled resident's (#3). Findings included: - Record review revealed resident #3 admitted to the memory care unit of the facility on 04/10/21 with diagnoses of unspecified dementia without behavioral disturbances, atrial fibrillation, essential hypertension, osteoarthritis and diabetes type 2. The initial and only "Functional Capacity Screening" dated 04/01/21 identified the resident with short-term memory deficit and impaired memory recall. She was independent with bathing, dressing, toileting, transfers, walking/mobility and eating. She was identified at risk for falls and/or unsteadiness with impaired vision and impaired hearing. A progress note (PN) identified as a "Fall Note" dated 09/03/21 at 04:30 PM documented the care	S3081		

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S3081	Continued From page 8	S3081		

team found the resident lying on her right side, left leg over the right leg and complaining about severe pain. Licensed Nurse (LN) B and F determined the resident must be sent out to the hospital for evaluation ... PN dated 09/07/21 at 12:59 PM LN F wrote she spoke to the resident's daughter, and she stated the resident fractured her right hip and had surgery on 09/4/21.

A PN identified as a "Move-In/Return" note dated 11/11/21 at 01:41 PM indicated the resident returned to the facility on 11/10/21 at approximately 02:00 PM. She had a large dressing on her right heel covering a wound. Orders for dressing changes, Home Health for wound care, Physical and Occupational Therapy ordered. There were no revisions to the FCS to reflect the resident significant change in functional abilities.

Observation on 11/17/21 at 12:35 PM revealed direct care staff C assisted the resident to transfer from the toilet to the wheelchair with the use of a gait belt. The resident was able to stand while direct care staff C provided incontinent care and then needed to sit back down before the transfer to the wheelchair.

Interview on 11/17/21 at 12:35 PM with direct care staff C revealed the resident was mostly independent before the fall when she broke her hip. She needed some supervision before and now she is a one person assist for all activities of daily living (ADLs).

Interview on 11/18/21 at 11:19 AM licensed nurse B confirmed the resident had a significant change in her ADL abilities following the fracture and hospital stay. She confirmed no significant change FCS was completed.

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S3081	Continued From page 9 The Administrator failed to ensure staff conducted a screening to determine resident #3's functional capacity following a fall with fracture and a significant change in her abilities.	S3081		
S3082 SS=E	26-41-201 (d) Functional Capacity Screen Accurate d) Designated facility staff shall ensure that each resident ' s functional capacity at the time of screening is accurately reflected on that resident ' s screening form. This REQUIREMENT is not met as evidenced by: K.A.R 26-41-201 (d) The facility reported a census of 61 residents. The sample included 3 residents. Based on record review and interview the Administrator failed to ensure designated facility staff ensured 2 of 3 sampled resident's Functional Capacity Screening accurately reflected the resident's abilities at the time of screening regarding cognition (#1 and #3). Findings included: - Record review for resident #1 revealed an admission date of 12/31/20. He had a diagnosis of Dementia with behavioral disturbance and admitted to a room on the secured memory care unit. The "Functional Capacity Screen" (FCS) dated 6/29/21 identified the resident with short term memory deficit and impaired memory recall. The	S3082		

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S3082	Continued From page 10 FCS indicated the resident's long-term memory was intact and did not identify the resident with impaired decision making. The 06/29/21 FCS included the same cognitive and decision-making abilities. The 06/29/21 FCS lacked identification of wandering and inappropriate behaviors as indicated in the progress notes. Review of the progress notes revealed an entry by licensed nurse J dated 01/01/21 which indicated the resident admitted to the facility's secured memory care unit on 12/31/20 at 01:45 AM. Resident was alert to self only, no recollection of where he was or had been ... Resident ambulated with a walker but must be reminded to use it as he will walk away and forget it. The progress notes reflected the resident began displaying behaviors of wandering, anxiety and agitation after admission and before the 06/29/21 FCS. For example, wellness visit note dated 03/25/21 at 01:16 PM resident enjoyed visits from spouse, but this often sends the resident into exit seeking behavior. On 05/01/21 at 04:27 PM resident was combative this afternoon with spouse and wanting to go home. On 05/04/21 note left for primary medical care provider regarding resident with increased anxiety and agitation. The medial care provider said to monitor. On 05/05/21 at 05:38 PM resident was arguing with spouse and grabbed her arms. This outburst frightened her. On 05/15/21 at 03:31 PM the resident was shouting at staff and dumped silverware on floor. An entry dated 05/16/21 at 10:22 AM and identified as a behavior note included "this was behavior that occurred on 05/14/21". The note lacked any identification of the behavior. On 05/17/21 at 12:01 PM the resident had behavioral disturbances on 05/16/2021 later in the evening with the visitation from family. On 05/20/21 at 02:30 PM the	S3082		

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S3082	Continued From page 11	S3082		

resident was wandering about the community in a good mood and talking with other residents. On 06/25/21 at 02:48 PM the resident was arguing and had an altercation with another resident in the dining room.

Interview with direct care staff C on 11/17/21 at 01:12 PM revealed the resident could answer yes/no questions but had impaired decision making and needed supervision for safety.

Interview on 11/18/21 at 11:19 AM with licensed nurse B confirmed the initial FCS dated 12/30/20 was inaccurate based on the admission progress note and any resident who needed to be on a secured memory care unit had impaired decision making. She also confirmed the resident had behaviors of wandering and inappropriateness which were not reflected in the 06/29/21 FCS.

The Administrator failed to ensure designated facility staff ensured resident #1's Functional Capacity Screening accurately reflected the resident's abilities at the time of screening regarding cognition and behaviors.

- Record review revealed resident #3 admitted to the memory care unit of the facility on 04/10/21 with diagnoses of unspecified dementia without behavioral disturbances.

The initial and only "Functional Capacity Screen" dated 04/01/21 identified the resident with short-term memory deficit and impaired memory recall. She was independent with bathing, dressing, toileting, transfers, walking/mobility and eating. She was identified at risk for falls and/or unsteadiness with impaired vision and impaired hearing. The FCS lacked identification of impaired decision making.

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S3082	Continued From page 12 Review of the progress notes revealed a "Move-In" entry dated 04/10/21 at 05:44 PM the resident is pleasant, alert, oriented to self and time. Interview on 11/18/21 at 11:19 AM with licensed nurse B confirmed the initial FCS dated 04/01/21 was inaccurate because any resident who needed to be on a secured memory care unit had impaired decision making. The Administrator failed to ensure designated facility staff ensured resident #3's Functional Capacity Screening accurately reflected the resident's abilities at the time of screening regarding impaired decision making.	S3082		
S3155 SS=G	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 61 residents. The sample included 3 residents. Based on	S3155		

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S3155	Continued From page 13	S3155		

observation, interview, and record review the Administrator failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services to meet the needs for 2 of 3 sampled residents (#1 and #3), which were in accordance with the Functional Capacity Screening and the Negotiated Service Agreement regarding falls and behaviors. The failure to evaluate a fall for causal factors and develop interventions to reduce the risk for further falls on 08/16/21 allowed for resident #3 to have another fall on 09/03/21, which resulted in a fractured right hip with surgical repair.

Findings included:

- Record review revealed resident #3 admitted to the memory care unit of the facility on 04/10/21 with diagnoses of unspecified dementia without behavioral disturbances, atrial fibrillation, essential hypertension, osteoarthritis and diabetes type 2.

The initial and only "Functional Capacity Screening" dated 04/01/21 identified the resident with short-term memory deficit and impaired memory recall. She was independent with bathing, dressing, toileting, transfers, walking/mobility, and eating. She was identified at risk for falls and/or unsteadiness with impaired vision and impaired hearing.

The "Negotiated Service Agreement/Health Service Plan" (NSA/HSP) which began on 04/01/21 included: the resident was independent with transfers and mobility using a walker. She was independent with grooming, dressing, bathing and eating. She needed assistance with meal prep, some assistance or escorts with transportation, medications and treatments. The

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S3155	Continued From page 14 NSA/HSP lacked identification of her fall risk or interventions to reduce the risk for falls. Revision to the NSA/HSP on 04/15/21 included language preference, interventions for communication, daily routine, no problems sleeping, needed reminders to wear her glasses and to monitor and report any complaints of numbness, tingling, tremors etc. Staff would observe for and report if any signs of altered cardiac output or pacemaker malfunction, complaints of dizziness fainting, difficulty breathing, decreased pulse rate or blood pressure lower than what is normal for me. On 04/15/21 Licensed Nurse (LN) K revised the NSA/HSP to reflect the resident's fall risk. There were no further revisions. The interventions included observe and report any changes in my gait and/or balance. The NSA/HSP included an entry dated 04/15/21 which included "I have had an actual fall", but no date of the fall was indicated. The interventions listed were encourage, invite, and assist me to attend activities that promote exercise, strength building, and balance based on my preferences. Provide similar one-on-one activities if I am unable to attend group activities. Also added on 04/15/21 "I am an elopement risk/wander/exit seeking" and interventions of, I will be engaged in pleasant, meaningful, purposeful and enjoyable person-centered activities during moments of exit seeking, restlessness and constant wandering. I live in a secured neighborhood or have a diagnosis of dementia. Revision to the NSA/HSP on 04/19/21 included notify my responsible party and physician of any changes in my clinical status. Impaired cognitive function related to my dementia with revision of give me simple cues, prompts and step-by-step direction to assist me with decision making.	S3155		

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S3155	Continued From page 15 Observe for and report any changes in my cognitive function, specifically changes in my decision-making ability and mental status. Provide me with supervision as needed to ensure that I do not compromise my safety. I require the use of an assistive device (cane) to maximize my independence. Ensure the device is available for use, clean and in good repair. The use of assistive devices shows a revision on 04/20/21, however, there was no clear indicator of what was revised. The bathing assistance, bathing preferences and laundry services had a revision on 05/05/21 with no clear indicator of what was revised. The transferring, and assistance to the bathroom had revision on 06/28/21 with no clear indicator of what was revised. A request for signature pages by all parties participating in the NSA/HSP resulted in one page being provided signed by staff and the resident's responsible party dated 06/10/ 21. There were no other revisions noted to the NSA/HSP after 06/28/21. Review of the progress notes revealed the following entries: 04/10/21 at 05:44 PM, "Move-In note", the resident was alert, oriented to time and self. On 04/20/21 at 10:00 AM the resident was found on the floor sitting just outside of her bathroom on 04/19/21 around 02:15 PM. The resident complained of pain on the back of her head and stated that she hit her head. Vital signs were obtained, which noted elevated blood pressure and the medical care provider was notified. The note lacked causal factors for the fall, nothing about her environment, what she was attempting to do or when staff last observed the resident. The note lacked interventions implemented to reduce the risk for further falls. Fall follow-up notes on 04/20/21, 04/21/21 and 04/22/21 reflected on going monitoring for delayed effects of the fall but lacked any further	S3155		

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information about the cause of the fall or interventions to reduce the risk for falling.

A progress note identified as a "Wellness Visit Note" dated 08/03/21 at 06:55 AM identified the resident as alert and oriented x 2. Resident had complaints of burning with urination and was started on Cephalexin (an antibiotic) due to frequent re-occurring UTI (urinary tract infections), however, results of urine were free from infection.

A progress note identified as a "Fall Note" dated 08/17/21 at 08:42 AM documented on 08/16/21 at approximately 06:15 AM the resident was found lying on the floor in front of her closet. She had her right arm underneath her, and her head on the ground. She stated she was trying to walk to bed and lost her balance. The resident had a noted bump on the right side of her head. Emergency Medical Services (EMS) were called and transported her to the hospital. Her daughter was notified of the fall and subsequent return from the hospital. The resident had a fractured right distal humerus. She returned with a splint on her arm, which she continued to remove. She does not appear to be in pain. The note lacked information on development or implementation of interventions to reduce the risk for further falls. The NSA/HSP lacked revision to reflect the fall or interventions to reduce the risk for further falls.

A progress noted dated 08/17/21 at 04:08 PM the resident continued spending time out in the neighborhood. She had a swollen right eye, and right knuckles with discolorations to her right hand, arm, and face. She denied pain and continued to remove the sling throughout the day. On 08/17/21 at 04:54 PM LN F documented resident seen by medical care provider today and

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recommended the resident follow up with an orthopedic surgeon regarding recent fracture. Staff spoke with the resident's daughter, and she would schedule an appointment. The notes lacked any additional documentation about any treatments for the fractured right distal humerus or interventions implemented to reduce the risk for further falls.

A progress note dated 08/28/21 at 02:02 PM the resident had an unresponsive episode and was sent out with EMS. Blood pressure read 70/40 millimeters of mercury (mmHg) (significantly lower than normal range) with pulse greater than 100 beats per minute (bpm) and thready. The next note 08/29/21 at 08:19 AM indicated she was hospitalized.

A progress note identified as a "Wellness Note" dated 09/01/21 at 10:15 AM listed the resident's blood pressure as 102/78 mmHg and pulse of 87 bpm with a narrative of resident alert and oriented x 2. Resident was found to be weak and unresponsive and was transported to the hospital for further evaluation. Resident was diagnosed with AMS (altered mental status) and Leukocytosis. She was sent back to the community on an antibiotic. She was also given orders for physical and occupational therapy. One fall has been reported this month that resulted in a skin tear to her elbow. The note regarding the fall on 08/16/21 lacked identification of a skin tear.

Subsequent notes on 09/01/21, 09/02/21 and 09/03/21 were about her return, order faxed for physical and occupations therapy services, supplies needed from family, wandering behaviors, and staff reporting she seemed more confused than normal, but she answered the

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nurse's questions appropriately.

On 09/03/21 at 04:30 PM the care team found the resident lying on her right side, left leg over the right leg and complaining about severe pain. LN B and F determined the resident must be sent out to the hospital for evaluation ... to notify family when paramedics arrive. The note identified the resident's blood pressure was low 70/50 mmHg and that orthostatic hypotension was a probable cause of frequent falls. The note did not indicate whether the resident had her walker at the time of the fall, when had staff last seen her, or what she was attempting to do. On 09/07/21 at 12:59 PM licensed nurse F wrote she spoke to the resident's daughter, and she stated the resident fractured her right hip and had surgery on 09/4/21.

A progress note identified as a "Move-In/Return" note dated 11/11/21 at 01:41 PM indicated the resident returned to the facility on 11/10/21 at approximately 02:00 PM. She had a large dressing on her right heel covering a wound. Orders for dressing changes, Home Health for wound care, Physical and Occupational Therapy ordered. There were no revisions to the FCS or NSA/HSP.

Observation on 11/17/21 at 12:35 PM revealed direct care staff C assisted the resident to transfer from the toilet to the wheelchair with the use of a gait belt. The resident was able to stand while direct care staff C provided incontinent care and then needed to sit back down before the transfer to the wheelchair.

Interview on 11/17/21 at 12:35 PM with direct care staff C revealed the resident was mostly independent before the fall when she broke her

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hip. She needed some supervision before and now she is a one person assist for all activities of daily living (ADLs). She did not know of any interventions in place to reduce the resident's risk for falls other than the one-person assistance she now received.

Interview on 11/17/21 at 01:05 PM with direct care staff E revealed she was not a direct care provided at the time the resident fell, but knew she was up and about independently with her front wheeled walker. She said the only intervention she knew was they were trying to get the family to purchase her a bed that wasn't so tall, so it would be easier for her to get in and out of the bed.

Interview on 11/18/21 at 11:19 AM LN B reported an expectation for the person who first knew about an incident or injury were required to make an entry in the facility's "Risk Connect" program. They must report to the nurse on duty or Resident Care Director/licensed nurse B immediately. If it is night time the certified medication aide who is responsible for the resident would be the one getting notified and they text licensed nurse B. If it's an emergency, they are to call her. She confirmed the documentation in the progress notes lacked information about causal factors and interventions to reduce the risk for further falls and the NSA/HSP lacked revision after the fall on 08/16/21 and since the return after a hospital stay with a change in her ADL abilities. A request to review the facility's investigations of the falls resulted in none provided.

In an electronic interview on 11/22/21 at 03:17 PM Administrator A responded to questions regarding the falls, investigations into causal factors and any revisions to the NSA/HSP. She

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S3155	Continued From page 20 said for the 04/19/21 fall the resident was getting acclimated to her new surroundings. They moved furniture placement to increase mobility safety and team members encouraged her to use her walker at all times. She said with the 08/16/21 fall, the resident was getting herself dressed and lost her balance with the intervention being the resident was encouraged to notify staff if she needed assistance, was given a call pendant and encouraged to use it. She confirmed the resident with cognitive impairment might not remember to call for assistance. Administrator A confirmed there were no further orders related to the broken right distal humerus or if the daughter followed-up with the orthopedic doctor. She said the resident's functional abilities had not changed as a result of the fracture and the resident continued to take off the sling. She confirmed the NSA/HSP lacked a revision related to the fall or interventions to reduce the risk for further falls. The 09/03/21 fall, they determined she was impatiently looking for something in her purse, staff were with her 5 minutes prior to find something in her purse and she had the purse on the walker with her at the time of the fall. Administrator A confirmed the NSA/HSP lacked revisions after the 06/28/21 revisions. Review of the facility's policy dated 01/19 and titled, Fall Management Program V 2.0 directed the following: The team member who witnesses a fall or has the first encounter with a resident after a fall completes the top section of the Fall Investigation Worksheet and submits the form to a licensed nurse. The licensed nurse completes the remaining sections of the Fall Investigation Worksheet. The licensed nurse, in collaboration with the interdisciplinary team: Determines potential root cause(s) ... Develops and documents targeted interventions using the Falls	S3155		

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Evaluation Intervention Tool. Considers resident-specific, team and/or environmental interventions. Reviews and revises the individual service plan (ISP), as applicable. Educates and trains care managers and department coordinators on any new treatment and interventions. Communicates with the interdisciplinary team (IDT) via stand-up meeting, crossover meetings, and other internal communication methods as appropriate. Through this review process, information is gathered to determine why the resident may have fallen. Once the root cause has been identified, resident-specific interventions can be developed.

The Administrator failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services to meet the needs for residents #3 in accordance with the Functional Capacity Screening and the Negotiated Service Agreement regarding falls. The failure to evaluate a fall for causal factors and develop interventions to reduce the risk for further falls on 08/16/21 allowed for resident #3 to have another fall on 09/03/21, which resulted in a fractured right hip with surgical repair.

- Record review for resident #1 revealed an admission date of 12/31/20. He had a diagnosis of Dementia with behavioral disturbance and admitted to a room on the secured memory care unit.

The "Functional Capacity Screen" (FCS) dated 12/29/21 identified the resident with short term memory deficit and impaired memory recall. The FCS indicated the resident's long-term memory was intact and did not identify the resident with impaired decision making. He was identified as at risk for fall/unsteadiness and needed an assistive

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device. The 06/29/21 FCS included the same cognitive and decision-making abilities, the same activities of daily living abilities and fall risk. The 06/29/21 FCS lacked identification of wandering and inappropriate behaviors as indicated in the progress notes.

The "Negotiated Service Agreement/Health Service Plan" (NSA/HSP) which began on 12/31/20 and included revision through 02/24/21. It included the resident's daily routine as wake up around 08:00 AM, watch TV, sit in the recliner and go to bed around 09:00 PM. Invite, encourage and assist me to activities of interest daily. Allow me adequate time to talk and actively listen when I am withdrawn. Prompt me with simple ye or no questions. Under fall risk was observe and report any changes in my gait and/or balance as well as "I have had an actual fall (but did not identify when). The interventions listed were encourage, invite and assist me to attend activities that promote exercise, strength building, and balance based on my preferences. Provide similar one-on-one activities if I am unable to attend group activities. The resident was independent with mobility, needed a walker and staff to observe and report any changes in mobility. He was to use a walker when transferring between surfaces and could do so independently. The NSA/HSP had one revision on 10/29/21 for the addition of Hospice services. The NSA/HSP did not reflect the resident's wandering/exit seeking or inappropriate behaviors.

Review of the progress notes revealed an entry by Licensed Nurse (LN) J dated 01/01/21 which indicated the resident admitted to the facility's secured memory care unit on 12/31/20 at 01:45 AM. The resident was alert to self only, no

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recollection of where he was or had been ... The resident ambulated with a walker but must be reminded to use it as he will walk away and forget it. The progress notes (PN) reflected the resident began displaying behaviors of wandering, anxiety and agitation after admission and before the 06/29/21 FCS. For example, a progress noted titled, "Wellness Visit Note" dated 03/25/21 at 01:16 PM resident enjoyed visits from spouse, but this often sent the resident into exit seeking behavior. PN dated 05/01/21 at 04:27 PM resident was combative this afternoon with spouse and wanting to go home. PN dated 05/04/21 a communication note was left for the primary medical care provider regarding the resident's increased anxiety and agitation. The medial care provider said to monitor. PN dated 05/05/21 at 05:38 PM resident was arguing with spouse and grabbed her arms. This outburst frightened her. PN dated 05/15/21 at 03:31 PM the resident was shouting at staff and dumped silverware on floor. A progress note identified as "Behavior Note" dated 05/16/21 at 10:22 AM documented "this was behavior that occurred on 05/14/21". The note lacked any identification of the behavior. PN dated 05/17/21 at 12:01 PM included the resident had behavioral disturbances on 05/16/2021 late in the evening with the visitation from family. PN dated 05/20/21 at 02:30 PM the resident was wandering about the community in a good mood and talking with other residents. PN identified as a "Behavioral Expression Note" dated 06/25/21 at 02:48 PM the resident was arguing and had an altercation with another resident in the dining room. The progress notes reflected he was started on medications to address his dementia with behavior disturbances.

A progress note titled, as a "Fall Note" dated 08/24/21 at 10:53 AM, the resident experienced a

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fall as a result of a resident to resident altercation. The note indicated resident #1 approached a female resident on the unit, grabbed her arm and another male resident pulled resident #1 away and to the ground. A PN identified as a "Wellness Note" dated 09/26/21 at 10:24 AM identified the resident as alert and oriented with confusion present at times. Resident has had an increase in aggressive behaviors. The resident ambulated with no assistive devices and with a steady gait. The notes for August, September and October reflected on going wandering about the unit.

A progress note titled, as a "Fall Note" dated 10/22/21 at 11:28 AM licensed nurse F wrote the resident had a fall on the previous evening shift at approximately 10:15 PM, he hit his head on the floor and was bleeding from the forehead. He was transferred by emergency medical services to the hospital for evaluation. The resident returned to the facility at 7:00 AM his forehead is swollen, and very bruised. Bruising around his eyes. His right eye conjunctiva is red. He has a small laceration between his eyebrows, and beneath his right eye with a skin tear on his right forearm. The note lacked any causal factors for the fall or interventions to reduce the risk for further falls. Fall follow-up notes on 10/23/21, 10/24/21, 10/25/21 and 10/26/21 lacked any further information regarding the causal factors of the fall or interventions to reduce the risk for further falls. The NSA/HSP lacked revision.

A request made licensed nurse B on 11/18/21 to review the facility's fall investigation and/or an explanation of the investigation resulted in none provided.

Interview on 11/17/21 at 01:12 PM with direct care staff C confirmed the resident was a fall risk

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S3155	Continued From page 25 but ambulated independently, had wandering behaviors, was combative and resisted care. Interview with licensed nurse B on 11/18/21 at 11:19 AM confirmed the initial and 06/29/21 FCS were not accurate. The resident had impaired decision making or would not require a secured memory care unit. He did exhibit behaviors and had more than one fall. She confirmed the only revision to the NSA/HSP after 02/24/21 was the addition of Hospice services on 10/29/21. The Administrator failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services to meet the needs for #1 in accordance with the Functional Capacity Screening and the Negotiated Service Agreement regarding falls and behaviors.	S3155		
S3261 SS=E	26-41-105 (f) (11) Resident Record Documentation of Incidents (f) (11) documentation of all incidents, symptoms, and other indications of illness or injury including the date, time of occurrence, action taken, and results of the action This REQUIREMENT is not met as evidenced by: KAR 26-41-105 (f) (11) The facility reported a census of 61 residents. The sample included 3 residents. Based on interview and record review the Administrator failed to ensure the documentation of all incidents, symptoms, and other indications of	S3261		

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SUNRISE ASSISTED LIVING OF LENEXA	15055 WEST 87TH ST PARKWAY LENEXA, KS 66215

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illness or injury including the date, time of occurrence, action taken, and results of the action were documented for 2 of 3 sampled residents (#1 and #3).

Findings included:

- Record review for resident #1 revealed an admission date of 12/31/20. He had a diagnosis of Dementia with behavioral disturbance and admitted to a room on the secured memory care unit.

The "Functional Capacity Screen" (FCS) dated 12/29/21 identified the resident with short term memory deficit and impaired memory recall. The FCS indicated the resident's long-term memory was intact and did not identify the resident with impaired decision making. He was identified as at risk for fall/unsteadiness and needed an assistive device. The 06/29/21 FCS included the same cognitive and decision-making abilities, the same activities of daily living abilities and fall risk. The 06/29/21 FCS lacked identification of wandering and inappropriate behaviors as indicated in the progress notes.

The "Negotiated Service Agreement/Health Service Plan" (NSA/HSP) which began on 12/31/20 and included revision through 02/24/21. It included the resident's daily routine as wake up around 08:00 AM, watch TV, sit in the recliner and go to bed around 09:00 PM. Invite, encourage and assist me to activities of interest daily. Allow me adequate time to talk and actively listen when I am withdrawn. Prompt me with simple ye or no questions. Under fall risk was observe and report any changes in my gait and/or balance as well as "I have had an actual fall (but did not identify when). The interventions listed

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were encourage, invite and assist me to attend activities that promote exercise, strength building, and balance based on my preferences. Provide similar one-on-one activities if I am unable to attend group activities. The resident was independent with mobility, needed a walker and staff to observe and report any changes in mobility. He was to use a walker when transferring between surfaces and could do so independently. Under the section identified as risk for skin integrity impairment which began on 01/13/21 and without any revisions were interventions of observe skin, keep skin clean and dry. Hydrate skin with lotion if indicated. Report any alterations in skin. The NSA/HSP had one revision on 10/29/21 for the addition of Hospice services. The NSA/HSP did not reflect the resident's wandering/exit seeking, inappropriate behaviors or actual skin conditions.

Review of the progress notes (PN) revealed the following entries of incidents, symptoms or other indications of illness or injuries:
On 01/01/21 at 11:11 AM regarding the resident's admission, the resident had old bruising which cover large areas of hands, forearm and upper arm on both sides. Many of these are consistent with senile purpura. No further entries about the resident's skin condition until 01/10/21 at 1:12 PM by "Licensed Nurse" (LN) H, this nurse received report of skin tear to resident's right arm on inside above elbow. This nurse cleaned and put on Steri-strips to prevent opening of tear. This nurse received order to monitor this wound for 7 days daily for signs/symptoms (s/s) of infection. The PN had monitoring on 01/11/21 and 01/12/21 but nothing further.

PN dated 01/19/21 at 7:14 PM by LN H, this nurse was notified the resident was in the

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hospital. No report was given to this nurse. There were no notes before or after this note to indicated the resident had illness or injury which required a hospital visit.

PN dated 01/27/21 at 03:47 PM resident's skin tear on the right arm are in the healing process with no s/s of infection. The subsequent PN through to 02/06/21 at 10:44 AM lacked any information about the resident's skin condition. On 02/06/21 at 10:44 AM, LN J documented the resident's two skin tears on left arm were re-bandaged. The subsequent PN through to 03/08/21 at 02:29 PM lacked any further information about the resident's skin condition.

PN dated 03/08/21 at 02:29 PM the resident reported his left great toe hurt. LN H assessed the resident and described the area as appeared to be a possible ingrown toe nail. LN H attempted to cut his nail and gently try to pull out pointed edge along the right edge of the left toe. The resident took the clippers from LN H and attempted to dig at toe. LN H noted bleeding, so she took the clippers. LN H cleaned the wound with wound cleaner and covered with band aid. LN H contacted the resident's responsible party to inform them the resident may need to go to podiatrist to get toe nail removed. Will monitor. However, there were no further notes about the toe.

The next PN about the resident's skin dated 03/21/21 at 12:47 PM by LN H which documented skin tear on top of left hand two inches long. LN H cleaned with wound cleanse, applied three small Steri-strips and covered with an adhesive bandage. PN notes on 03/23/21 and 03/24/21 indicated the resident refused treatment. The PN on 03/25/21 indicated the resident had a skin tear

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on the left hand where senile purpura was present. The next note about his skin condition was recorded on 04/01/21 at 02/25 PM reflecting the skin tear as old and healing. From that PN until 04/29/21 there were no notes about the resident skin condition. On 04/29/21 at 03:00 PM LN J recorded a skin tear to the top of the left hand which was less than half an inch. LN J cleansed the wound and applied a bandage. The next entry dated 04/30/21 indicated the resident refused to let the nurse change bandage to the skin tear on the left hand. The subsequent notes through 05/12/21 at 03:05 PM lacked any further information about skin tears, dressing changes or refusals.

A PN dated 05/14/21 at 10:03 AM made by LN H documented Resident returned from Hospital no new orders". There were no notes before or after explaining why the resident went to the hospital, actions taken and outcome of actions. A PN dated 05/16/21 at 10:22 PM made by LN J documented "This was a behavior that occurred on 5/14/2021". There is a link noted in the notes, but the surveyor was not able to access the link. The note lacked any further information about the behavior, actions taken or outcome of the actions.

There were no further PN about the resident skin condition. On 05/24/21 at 01:27 PM LN J documented a half dollar sized skin tear to the left forearm. She applied a triple antibiotic ointment, petrolatum dressing and non-adhesive dressing then wrapped in gauze. The PN for 05/25/21 and 05/26/21 indicated the resident refused treatment. On 05/27/21 a medical care provider's note included large skin tear to left forearm currently covered with a dressing. He has mild tenderness but no erythema and directed for staff to monitor

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the skin tear for s/s of infection. The next note dated 06/06/21 at 04:56 PM had no mention of skin tears. All entries between 06/06/21 and 07/03/21 had no information about the resident's skin condition, dressing or refusal of treatment.

On 07/03/21 at 12:52 PM LN H documented she went to check on resident's skin tear on the left hand and right forearm. The bandage on left hand looked clean. The resident made a bandage and put scotch tape on it which looked dry. The resident refused to let LN H even touch the bandage. The next PN which talked about the resident's skin was recorded by a medical care provider on 07/15/21 at 12:29 PM and noted the resident's skin as xerosis (abnormal dryness) throughout and a skin tear on the left hand. There were no further notes about the resident's skin condition through 08/21/21 at 08:39 AM.

PN on 08/24/21 at 10:53 AM made by LN F regarding a resident to resident altercation and un-witnessed fall. Resident #1 had multiple skin tears on the left hand, middle finger, arm and right elbow because of the fall. LN F indicated she put dressing on all areas. The PN through 08/28/21 reflected monitoring of the area or the resident's refusal. Between 08/28/21 and 09/08/21 the PN lacked information on the resident's skin conditions. On 09/08/21 at 02:09 PM the resident is not showing signs of infection at this time - no dressing change was done. The PN indicated there was another document linked to this entry, but the surveyor could not access this document.

PN dated 09/13/21 at 01:34 PM by LN F documented the resident had skin tears on his right forearm which have re-opened. She indicated they were almost healed but failed to

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record the cause for the areas to re-open. She received an order for Home Health wound care. On 09/16/21 at 02:20 PM the medical care provider documented the resident's skin tear to the right forearm reopened. His skin was very thin, fragile and tears easily. Home Health nursing to evaluate and treat for full healing. No s/s of infection at this time. The subsequent notes reflect wound care by an outside provider with weekly note by facility staff.

Interview on 11/18/21 at 11:19 AM with Licensed Nurse B confirmed the above documentation regarding hospitalization on 01/19/21 and 05/14/21 were lacking details of an incidents or s/s of illness. She confirmed the record lacked follow through on his skin conditions and details when there was a new injury or a reopening. She reported some nurses are better at documentation than others and confirmed she needed to do some training on what the regulation required for documentation.

The Administrator failed to ensure the 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 were documented for resident #1 regarding multiple skin tears, hospital visits and an ingrown toe nail.

- Record review revealed resident #3 admitted to the memory care unit of the facility on 04/10/21 with diagnoses of unspecified dementia without behavioral disturbances, atrial fibrillation, essential hypertension, osteoarthritis and diabetes type 2.

The initial and only "Functional Capacity Screening" dated 04/01/21 identified the resident

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with short-term memory deficit and impaired memory recall. She was independent with bathing, dressing, toileting, transfers, walking/mobility, and eating. She was identified at risk for falls and/or unsteadiness with impaired vision and impaired hearing.

The "Negotiated Service Agreement/Health Service Plan" (NSA/HSP) which began on 04/01/21 included: the resident was independent with transfers and mobility using a walker. She was independent with grooming, dressing, bathing and eating. She needed assistance with meal prep, some assistance or escorts with transportation, medications and treatments. The NSA/HSP lacked identification of her fall risk or interventions to reduce the risk for falls. Revision to the NSA/HSP on 04/15/21 included language preference, interventions for communication, daily routine, no problems sleeping, needed reminders to wear her glasses and to monitor and report any complaints of numbness, tingling, tremors etc. Staff would observe for and report if any signs of altered cardiac output or pacemaker malfunction, complaints of dizziness fainting, difficulty breathing, decreased pulse rate or blood pressure lower than what is normal for me.

On 04/15/21 Licensed Nurse (LN) K revised the NSA/HSP to reflect the resident's fall risk. There were no further revisions. The interventions included observe and report any changes in my gait and/or balance. The NSA/HSP included an entry dated 04/15/21 which included "I have had an actual fall", but no date of the fall was indicated. The interventions listed were encourage, invite, and assist me to attend activities that promote exercise, strength building, and balance based on my preferences. Provide similar one-on-one activities if I am unable to

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attend group activities. Also added on 04/15/21 "I am an elopement risk/wander/exit seeking" and interventions of, I will be engaged in pleasant, meaningful, purposeful and enjoyable person-centered activities during moments of exit seeking, restlessness and constant wandering. I live in a secured neighborhood or have a diagnosis of dementia.

Revision to the NSA/HSP on 04/19/21 included notify my responsible party and physician of any changes in my clinical status. Impaired cognitive function related to my dementia with revision of give me simple cues, prompts and step-by-step direction to assist me with decision making. Observe for and report any changes in my cognitive function, specifically changes in my decision-making ability and mental status. Provide me with supervision as needed to ensure that I do not compromise my safety. I require the use of an assistive device (cane) to maximize my independence. Ensure the device is available for use, clean and in good repair. The use of assistive devices shows a revision on 04/20/21, however, there was no clear indicator of what was revised. The bathing assistance, bathing preferences and laundry services had a revision on 05/05/21 with no clear indicator of what was revised. The transferring, and assistance to the bathroom had revision on 06/28/21 with no clear indicator of what was revised. A request for signature pages by all parties participating in the NSA/HSP resulted in one page being provided signed by staff and the resident's responsible party dated 06/10/ 21. There were no other revisions noted to the NSA/HSP after 06/28/21.

Review of the progress notes revealed an entry on 09/03/21 at 4:30 PM by licensed nurse (LN) F regarding a fall and was sent out by emergency

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medical services. Later note the resident was found to have a fractured right hip with subsequent hospital stay following surgical repair. An entry on 11/11/21 at 01:41 PM regarding the resident's return the previous day (11/10/21) at approximately 02:00 PM. The note indicated the resident had a large dressing on her right heel, which covered. The orders included a dressing change three times a week. She was to have Home Health for wound care. Subsequent notes until 11/15/21 at 01:15 PM lacked any further information about the wound, no evaluation, no description or if healing or not. On 11/15/21 at 01:15 PM LN F wrote the resident had a wound on her right heel and with a planned dressing change three times a week, by home health. The record lacked any evaluation with description of the wound, type of treatment and outcome of those treatments. Subsequent notes through 11/18/21 at 08:48 AM failed to include any further information regarding the wound on the resident's right heel. An entry made on 11/16/21 at 03:25 PM by LN F read, "large bruise on her left hip. No reported falls. Resident cannot tell me how this happened." The note lacked any description of the bruise to include an approximate size, coloring or probable cause. The note lacked any actions taken.

Observation on 11/17/21 at 12:35 PM revealed the resident assisted to the toilet by direct care staff C. The resident had a large discolored area approximately 6 inches in diameter on her left lateral hip. The coloration was mostly dark blue with light purple and splotchy in places. Direct care staff C did not know when or how the resident received the injury.

Interview on 11/18/21 at 11:19 AM with Licensed Nurse B confirmed the resident's record lacked

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S3261	Continued From page 35 details regarding a description of the resident's wound and she was not aware of the injury to the resident's left hip. The Administrator failed to ensure the 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 were documented for resident #3 regarding a wound on her right heel and large bruise on the left hip.	S3261		
S3320 SS=J	28-39-254 CONSTRUCTION (a) The assisted living facility or residential health care facility shall be designed, constructed, equipped and maintained to protect the health and safety of residents, personnel and the public. (b) All new construction, renovation, remodeling and changes in building use in existing buildings shall comply with building and fire codes, ordinances and regulations enforced by city, county, and state jurisdictions, including the state fire marshal. (c) New construction, modifications and equipment shall conform to the following codes and standards: (1) Title III of the Americans with disabilities act, 42 U.S.C. 12181, effective as of January 26, 1992; and (2) "Food Service Sanitation Manual," health, education, and welfare (HEW) publication no. FDA 78-2081, as in effect on July 1, 1981.	S3320		

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S3320	Continued From page 36 This REQUIREMENT is not met as evidenced by: K.A.R. 28-39-254 (a) The facility reported a census of 61 residents. Administrator A reported 24 of the 27 residents on the memory care unit were independently mobile and cognitively impaired on 11/13/21. Based on observation, interview, and record review on 11/13/21 the Administrator failed to protect the health and safety of one resident (#1) regarding hazardous chemicals when direct care staff D poured an industrial strength chemical for the dish washing machine into a plastic drinking cup and then left it unsupervised on the kitchen counter by the sink and juice machine. Cognitively impaired and independently mobile resident #1 with known wandering behavior entered the kitchen area, obtained the unsupervised/unsecured plastic cup of red colored liquid dish washing chemical and took a drink thinking it was juice. The resident cried out alerting direct care staff C who discovered the resident drank the red liquid from the plastic cup left sitting on the counter. EMS (emergency medical services) were called and transported the resident to the hospital where he later died. This deficient practice placed cognitively impaired and independently mobile resident #1 in immediate jeopardy for harm, injury or death on 11/13/21. Findings included: - Record review for resident #1 revealed an admission date of 12/31/20. He had a diagnosis of Dementia with behavioral disturbance. The "Functional Capacity Screen" (FCS) dated 6/29/21 identified the resident with short term memory deficit and impaired memory recall. He	S3320		

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was independent with transfer, walking, and mobility.

The "Negotiated Service Agreement" included the following services and directions to staff: the resident lacked the ability to remember times of day, events, and where he may be. Assist the resident to all activities and meals, reminding him what time of day it is and current events. Provide him with cues, reorientation, supervision or assistance as needed. The resident was independent with transfers, mobility, grooming, dressing, bathroom, and dining. A focus titled, "Housekeeping" with a start date of 12/31/20 directed staff to ensure all hazardous materials were kept secured and out of harm's way.

Review of the "Progress Notes" revealed an entry dated 01/01/21 at 11:11 AM, which noted the resident moved in on 12/31/20 at 1:45 AM from a named hospital. Resident was alert to self only and had no recollection of where he was or had been. The resident was easily distracted and liked to rummage through items in room. He ambulated with a walker, but needed be reminded to use it as he would walk away and forget it. An entry dated 05/27/21 at 02:38 PM about a medical care provider's visit included a past medical history of dementia with behavioral disturbance, cardiac arrhythmia, aphasia, and peripheral vascular disease. The note identified the resident as awake, alert, oriented x 1, and aphasic. An entry on 11/11/21 at 01:28 PM from the medical care provider included the same information for past medical history and orientation.

An entry by licensed nurse F in the "Progress Notes" dated 11/13/21 at 02:33 PM included the resident accidentally drank dishwasher detergent.

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S3320	Continued From page 38 It was on the counter in a plastic cup. "Staff was there doing dishes, and he walked up behind her and drank a small amount of the liquid". He immediately sought the help of another staff member. He was given milk to drink and this nurse was notified. The resident sat in a chair in the dining/activity area with his lower lip visibly swollen. He was spitting up mucus and milk. He did not appear to be in respiratory distress, 911 was called, and his family was notified. Resident taken via ambulance to a named emergency room. Observation on 11/17/21 at 12:22 PM revealed a locked memory care unit where resident #1 had resided. The unit include an open area, centralized kitchen with sink, counters, cabinets, a table with 4 chairs in the center of the room, refrigerator, and a below counter commercial dish washing machine. On the counter approximately 5 inches to the right of the sink sat an automatic juice dispensing machine and directly under the counter was the commercial dish washing machine. Observation and interview with direct care staff C on 11/17/21 at 01:12 PM revealed the juice machine dispensed juice when the surveyor pushed the button. Direct care staff C reported the residents can get juice on their own and resident #1 frequently got the cranberry juice, which he preferred. She reported the dish machine was not working properly a couple days before the incident on 11/13/21. She reported maintenance was notified and came and looked at the dishwasher thinking there was a clogged hose. He called the company, which owns and services the dish machine. During the interview and observation direct care staff C opened the dish machine, which had clear water in the	S3320		

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	N046071	A. BUILDING: _____ B. WING _____	11/29/2021

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bottom holding area. She pushed the button marked priming and no detergent dispensed. She tried several times with no evidence of soap dispensing. She opened the locked under sink cabinet which held 2 different gallon bottles of chemicals (a red one and a blue one). She identified the red one as the dish washing detergent "Ecotemp Ultra Klene" and the blue one as a drying agent. The gallon bottles had a plastic tube with an attached hose down inside the bottle opening. The hose went to the dish machine for dispensing of the liquid. She reported on 11/13/21 resident #1 was his normal self and after lunch at about 12:30 PM she sat at the table in the kitchen with resident #1 while direct care staff D washed the dishes. Then direct care staff D said she was going to the bathroom and she left the area. At that time resident #1 wanted to go outside to sit on the patio. Direct care staff C told the resident it was cold out, but the resident got up from the table and walked to the patio (which is adjacent to the kitchen area and through the French style doors). The resident said it was too cold, so the resident and direct care staff C came back inside. When they came in from the patio direct care staff C went down the hall to start cares with other residents and resident #1 went walking about the unit like normal. A few minutes later she heard resident #1 screaming like he was in an altercation or something, so she came back down the hall towards the common area to find out what had happened. As she approached the sitting area off of the kitchen area, resident #1 came around the corner of the kitchen, approached her, grabbed her arm, saying come here, come here and took her to the kitchen sink. He showed her a cup with red liquid in it and said, "I drunk this and I'm going to die". She then called out for direct care staff D who was coming out of the bathroom and asked her what was in the cup

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by the sink because the resident drank it. Direct care staff D said it was the dish washing detergent for the dishes. Direct care staff C had the resident sit in the chair while direct care staff D got some milk. The resident said he drank the liquid thinking it was juice. The nurse was summoned who was already present on the unit in another resident's room. Direct care staff C described the resident's condition after discovering he drank from the unsupervised/unsecured cup of dish washing detergent. She said he was spitting out red colored liquid, his mouth was blistering, voice was altering, and sounding gravely. She reported direct care staff D gave the resident some milk to drink and both of them went to get the nurse.

Interview on 11/17/21 at 01:53 PM with maintenance coordinator M revealed he was available 24/7 and 365 days a year for facility maintenance needs. He reported on or about 11/10/21 he received notice the dish machine in the memory care unit was not working properly. He reported calling Ecolab out and they came the same day. He did not know what they did or if repairs were made just that it was working when the Ecolab technician left that day. He did not report doing any follow up testing of the machine or getting any reports from staff of it not working properly after 11/10/21.

Interview with direct care staff D on 11/17/21 at 02:28 PM revealed she worked the overnight shift and then stayed over to work the day shift. She said the facility's dish washing machine was not working properly and failed to dispense the liquid chemical "Ecotemp Ultra Klene". She reported the dishes were not coming out clean even after she manually rinsed the dishes before loading and running the cycle 2 times. She reported

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opening the machine and finding no color change to the water in the bottom or soap suds. She reported removing the dispensing tube from the gallon bottle of liquid detergent to pour some of the red colored liquid dishwashing detergent into a clear plastic drinking cup, which she obtained from the medication cart. She indicated she planned to pour the dish washing detergent into the bottom of the dish machine, but had to wait for it to finish filling with water before opening. She suddenly had a bathroom need and sat the cup at the back of the counter behind the juice machine which is directly adjacent to the kitchen sink. She confirmed the cup was probably still visible if a person was standing at the sink. She said she was in the bathroom when she heard direct care staff C calling out in distress asking what was in the cup on the counter because resident #1 drank some. Direct care staff D reported she placed her finger into the liquid dish washing detergent and her finger felt hot. She reported putting a little on her tongue, which burned and blistered. She said the resident kept saying Hot, Hot and spitting. She gave him a glass of milk to drink. She confirmed she did not lock the chemical back up or alert direct care staff C of the plastic cup with the dish washing detergent being on the counter. Direct care staff D reported she had worked at the facility for 1 year and 2 months. She did not remember having training on the chemicals or the function of the dish machine. She said she may have but was over a year ago and we get some much in the beginning she could not say for sure. She said she gave the milk because that was what she believed you should do when drink poison.

Phone interview with emergency room (ER) licensed nurse G on 11/17/21 at 04:04 PM revealed resident #1 came into the ER on

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S3320	Continued From page 42 11/13/21 after ingestion of industrial strength dishwashing liquid. The ER nurse said it was reported the dishwashing liquid was left out in the open in the unit's day room. The ER nurse read the medical care provider's note to the surveyor, which included a preliminary cause of death as corrosive ingestion of caustic alkali, respiratory distress, and hypoxia. Review of the "Safety Data Sheet" for Ecotemp Ultra Klene dishwashing detergent revealed the chemical product as sold (directly from the bottle) was a pure substance/mixture with a chemical name of sodium hydroxide (lye) in a 10-30% concentration. For first aid it listed if swallowed: rinse mouth with water. Do not induce vomiting. Get medical attention immediately. The facility's policy dated 11/11/05 and titled, "Chemical Safety: Resident Risk Reduction" directed, all team members will properly mix, dispense, use and store chemicals. All team member must successfully complete the "OSHA" required hazard communication program training before starting their normal job duties. Reinforce chemical safety training ... Randomly quiz team members on chemical safety processes and reward proper responses and safe work practices. Compliance monitoring process directed ... chemicals are always supervised by a facility team member when in use. Chemicals are not accessible to residents. Chemicals are always in approved containers and proper labeled. Chemical control process: ensure Ecolab concentrate chemicals (formulary products) are dispensed through approved close-loop systems. Malfunctioning dispenser protocol: when a system is not working properly, team members must notify the appropriate person immediately ... dining service coordinator for dishwasher	S3320		

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chemical dispenser. The team member responsible for the dispensing system immediately places an "out of service" sign on the dispenser and remove all chemicals ... contacts Ecolab to report the broken dispenser and coordinate repairs. Restocks the dispenser, tests the unit and authorized it's return to service.

The Administrator failed to protect the health and safety of residents regarding hazardous chemicals when direct care staff C poured an industrial strength chemical for the dish washing machine into a plastic drinking cup and then left it unsupervised on the kitchen counter by the sink and juice machine. This deficient practice placed the 24 cognitively impaired and independently mobile residents in immediate jeopardy for harm, injury or death on 11/13/21.

The jeopardy was removed on 11/17/21 at 5:16 PM when the Administrator provided an abatement plan of the following:
Training of current staff on chemical safety and storage conducted on 11/15/21 and 11/16/21 with evidence of such provided to the surveyor. The 3rd floor (memory care unit) staff were retrained on how the dishwasher machine functions, what chemical the dishwasher uses, safe storage and handling. All PRN (as needed) and part-time staff will be trained before they work a shift.
If the dish machine is out of order the dishes will be taken to the main kitchen for cleaning. Staff to be trained.
A key to the cabinet where the dish soap is stored is located on the medication cart for the 3rd floor so only a designated person can get access. Team members are not given keys to the cabinet.

The alleged perpetrator was put on Administrative leave immediately and corrective/disciplinary

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S3320	Continued From page 44 action will be given at the completion of the investigation.	S3320		