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 _____	01/19/2016

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 are the result of Complaint Investigation #95732 at the above named Assisted Living Facility in Lenexa, Kansas on 01/06/16, 01/07/16, 01/13/16, 01/14/16, and 01/19/16. Revised 2567 sent to facility 1/25/16.	S 000		
S3026 SS=E	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 census equalled 85 with 31 identified residing in the Reminiscence (dementia care) unit of facility. The sample included four Residents from the Reminiscence (REM) unit. Based on observations, interviews, and reviews of records, for one of four sampled (#2), the Administrator failed to ensure no Resident subjected to abuse and neglect, when Resident #2 exposed to repeated contact of a sexual nature by Resident of the opposite sex (#4). Findings included: - Record review revealed #2 admitted to facility 5/29/15 with diagnoses of Anxiety, Alzheimer's,	S3026		

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

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S3026	Continued From page 1 Hypertension, Depression, Insomnia, and Dementia. 5/29/15 functional capacity screen (FCS) assessed #2 in need of physical assistance with dressing, toileting; independent with transfers and mobility; with Impaired decision making, impaired communication (sometimes understood, sometimes understands); and long term, short term, memory recall, and decision making impairments. 5/29/15 Negotiated service agreement (NSA) completed by Registered Nurse (RN) #A documented facility staff to assist with toileting; requires assistance with anything that uses his/her memory (room location, meal times, activities); independent with mobility and transfers. Medical Record notes included: 12/20/15 - 6:23pm - care manager reported that last evening (12/19/15) at approximately 8:20 p.m. entered another Resident's apartment... this Resident (#4) with pants down in process of pulling down #2's pants... separated Residents and escorted #2 from apartment... #2 appeared frightened... care manager notified other staff members to provide frequent checks on both Residents... note documented by Registered Nurse (RN) #F. Incident reported to the Department. The record lacked documentation of steps to prevent further incidents and corrective action taken. The record lacked documentation of other incidents of physical contact between resident #2 and #4.	S3026		

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S3026	Continued From page 2 Record review revealed #4 admitted to facility 3/13/15 with diagnoses of Alzheimer ' s, Gastroesophageal reflux disease, Dementia, Coronary artery disease, Hypercholestrolemia, and Low back pain. 3/11/15 FCS assessed #4 independent with transfers, mobility; unable to perform medication and treatment management; with short term, memory/recall, and decision making impairments, and with wandering. 3/11/15 NSA completed by RN #A documented facility staff to be aware that #4 " sundowns " in the late afternoon/evening and becomes more confused; encourage to engage in activities or allow alone time ... Medical Record notes included: 9/13/15 - 8:00 am - #4 discovered under the bed covers of another Resident in the other Resident ' s room 12/01/15 - 5:41pm - #4 found in another ' s Resident room ... redirected to own room ... 12/20/15 - 7:31pm - care manager reported that last evening at approximately 8:20 p.m., entered #4 ' s room and observed #4 in process of pulling down #2 ' s pants ... care manager separated the two, escorted #2 from room and notified other staff members ... 12/20/15 - 8:31pm - medical care manager reports #4 had to be redirected several times from following Resident of the opposite sex involved in incident last evening ... that Resident relocated to another area ... #4 then found sitting next to a different Resident of opposite sex ... again redirected ... 12/24/15 - 12:45pm - team members reported	S3026		

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S3026	Continued From page 3	S3026		

that last night around 8pm #4 was following a Resident attracted to around and trying to get that Resident in the bathroom with #4 ... team members keep two Residents separated at all times.

On 01/06/16 at 2:30pm, at 3:30pm, at 4:20pm, observed #2 ambulate independently... not oriented to time, place, or person... answers simple questions with unintelligible gibberish.

On 01/06/16 at 5:25pm, evening meal service in progress, #2 and #4 not at dining room tables. At 5:27pm #2 entered dining area from hallway. At this time staff left dining room to find #4, returned with #4 (from his/her room) who sat and began to eat.

On 01/06/16 at 6:41pm observed #2 ambulating hall with #4 trailing behind, no staff within view. #4 attempting to remove hair from #2's sweater on shoulder blade area as they walked... at this time certified staff #G emerged from another Resident room (#6), in process of attempting to bathe that Resident (#6), and happened to see #2 followed by #4 in progress. Certified staff #G approached and intervened by asking #4 questions about his/her shoes.

By confidential interview an individual stated aware of 12/19/15 incident between #2 and #4... touching in various stages of undress... also two more incidents between them on 01/03/16... Individual stated nurses and executive director (ED) #D aware of incidents . . .nothing new in Communication book (no interventions) "just told to keep them apart"...

By confidential interview an individual stated #2 and #4 both wanderers... lately #4 fixated on #2

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S3026	Continued From page 4	S3026		

and will follow #2 around when there is no one to keep them busy or apart... first time found in #4 in hallway with hands on private areas on top of #2 clothes... #2 very distraught, he/she demonstrates that by walking close to walls with hands clenched together... about month ago in #4's room both partially undressed, now keep doors locked. ED #D told staff to redirect them and keep them apart... no other interventions or directions given. Further stated that of the 31 residents, 3 require 2 staff for transfers and have been working with 2 and 3 staff (from usual 4) on a shift.

By confidential interview an individual stated #4 touching #2 inappropriately in public areas on 01/03/16, nurse said to call ED #D... ED #D told staff to keep an eye on them and keep out of room and in common areas. 12/19/15 when residents found partially undressed with #2 crying was not the first time incident with #4 and #2, there had been 5 to 7 times starting around approximately Thanksgiving. Further stated there is no nurse to call, have been instructed to call ED #D and have no new interventions or training yet. Reported staff " have been working with two or three staff instead of four... have two people transfers and #5 who is a really big fall risk... we try to do the best we can. "

On 01/06/16 at 2:30pm, Executive Director (ED) #D reported additional incidents of contact occurred between #4 and #2 on 01/03/16 " both kind of wanderer ' s ... last week end both in hallway touching ... clothes on ... from my understanding flirtations ... both laughing etc. ...we are doing frequent monitoring, multiple times through shift eyes on them ... "

Documents provided by ED #D on 01/07/16, and

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	N046071	A. BUILDING: _____ B. WING _____	01/19/2016

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

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S3026	Continued From page 5	S3026		

identified as the Investigation of the 1/3/16 incidents consisted of written statements by two of the six staff on duty the evening of 01/03/16.

Statement of employee #H: " On 1-3-16 I #H was working on REM at approximately 5:30pm. I was cleaning up the kitchen after dinner when I observed #4 standing face to face with #2 touching #2 on chest and private area above clothes. I went over to stop the situation and re-directed #4 to go down the hallway and #4 did. "

Statement of employee #G: " On January 3rd 2016, I, #G witnessed #4 walking behind #2 with hands under the front side of #2 ' s sweater. I told him/her ' #4, hands to yourself ' ... #4 said OK and moved away. This was in the hall near the bathtique. I told #I (medication aide) who told me to inform #J (licensed nurse) who was already up there for another matter. When I told #J, another care manager reported a second incident involving the two. This was sometime before 5pm, but after 3:45pm. "

Statement of ED #D: " On Sunday January 3, 2016 at approximately 6:00pm I received a call from #H, care manager ...informing me that he/she witnessed an event between #4 and #2 ... #H stated that both #4 and #2 were in the hallway and #4 was touching #2 on breast and private areas outside of clothes ... said he/she separated them immediately and redirected #4 to go down the hallway. I asked if there were any signs from #2 that the actions were uncomfortable to him/her or against his/her will in which #H replied no. I also asked how #2 ' s behavior was after #4 left and there seemed to be no change in behavior. I asked #H to please continue to watch for a change in behavior from #2 and #4 and keep

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	N046071	A. BUILDING: _____ B. WING _____	01/19/2016

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

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S3026	Continued From page 6	S3026		

checking frequently on both Residents throughout the shift, and to call me with any change in conditions. At this time I was not aware of the previous event that took place between #4 and #2 earlier that afternoon. On Monday I had a message to call #G ... I spoke to #G over the phone when he/she stated that around 3:45pm on 01/03/16 witnessed #4 walking down the hall with #2 ...#4 was walking behind #2 and hands were underneath #2 ' s sweater. I asked what hands were touching and #G stated it looked like #2 ' s stomach. I asked what was the behavior and mood of #2 and #4 and #G stated they were both laughing when I got next to them to redirect #4. #G told the nurse on duty of the situation. On Monday evening I was able to interview #H and get his/her statement from the event that occurred at 5:30pm. After the interview it again seemed like a very consensual action between both #2 and #4. I personally observed #2 and #4 on Monday through Thursday and there seemed to be no change in mood or condition from either Resident. I had a meeting with #2 ' s spouse to explain the situation and to see if spouse had any questions or concerns which spouse did not at that time. On Tuesday afternoon I interviewed #G about the event that occurred around 3:45pm that previous Sunday. #G stated what #G previously told me on the phone and there seemed to be consensual actions between both Residents. "

The medical record lacked evidence of a licensed nurse assessment of either individual immediately after these incidents, and after follow up actions taken. The medical record lacked documentation of preventative or corrective actions to prevent further potential abuse.

On 01/07/16 at 3:55pm, ED #D confirmed

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

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S3026	Continued From page 7 currently no Licensed Nurse on duty in REM for evening shifts... no nurse on call so they contact me... #D stated yes, should have been interventions put into place as result of 01/03/16 incidents between #2 and #4. For Resident #2 with repeat exposures to contact of a sexual nature by #4, the Administrator failed to ensure no Resident subjected to abuse and neglect, when staff not provided with clear, written, planned health care directives to address identified behaviors.	S3026		
S3028 SS=E	26-41-101 (f) (3) Staff Treatment of Residents Reporting (f) (3) Each allegation of abuse, neglect, or exploitation shall be reported to the administrator or operator of the facility as soon as staff is aware of the allegation and to the department within 24 hours. The administrator or operator shall ensure that all of the following requirements are met: (A) An investigation shall be started when the administrator or operator, or the designee, receives notification of an alleged violation. (B) Immediate measures shall be taken to prevent further potential abuse, neglect, or exploitation while the investigation is in progress. (C) Each alleged violation shall be thoroughly investigated within five working days of the initial report. Results of the investigation shall be reported to the administrator or operator. (D) Appropriate corrective action shall be taken if the alleged violation is verified. (E) The department ' s complaint investigation report shall be completed and submitted to the department within five working days of the initial report. (F) A written record shall be maintained of each	S3028		

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

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S3028	Continued From page 8 investigation of reported abuse, neglect, or exploitation. This REQUIREMENT is not met as evidenced by: KAR 26-41-101(f)(3)(B)(C)(D)(E)(F) The census equalled 85 with 31 identified residing in the Reminiscence (dementia care) unit of facility. The sample included four Residents from the Reminiscence (REM) unit. Based on observations, interviews, and reviews of records, for one of four sampled (#2) with repeated unwitnessed falls with injuries and incidents of Resident to Resident contact, the Administrator failed to: report potential abuse or neglect related to unwitnessed falls and resident to resident incidents to the department within 24 hours, ensure immediate measures taken to prevent further potential abuse or neglect while the investigation in progress; and thoroughly investigate allegations of potential abuse and neglect. Findings included: - Record review revealed #2 admitted to facility 5/29/15 with diagnoses of Anxiety, Alzheimer's, Hypertension, Depression, Insomnia, and Dementia. 5/29/15 functional capacity screen (FCS) assessed #2 in need of physical assistance with dressing, toileting; independent with transfers and mobility; with Impaired decision making, impaired	S3028		

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	N046071	A. BUILDING: _____ B. WING _____	01/19/2016

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S3028	Continued From page 9	S3028		

communication (sometimes understood, sometimes understands); long term, short term, memory recall, and decision making impairments. Falls and unsteadiness was not identified as a current or recent problem.

5/29/15 Negotiated service agreement (NSA) completed by Registered Nurse (RN) #A documented facility staff to assist with showers, grooming, dressing, toileting; requires assistance with anything that uses his/her memory (room location, meal times, activities); independent with mobility and transfers.

The medical record recorded unwitnessed incidents of resident found on the floor with no injury on the following dates: 9/12/15 at 2:30pm, 9/13/15 around 4:40pm, 9/26/15 at 6:54pm, and 9/29/15 around 110pm.

6/03/15 - 2:06pm - On 6/02/15 around 9pm staff heard "loud bang"... observed #2 on the floor... hit head... unwitnessed... sent to ER (emergency room).

The record lacked documentation of an investigation; incident not reported to the department.

8/02/15 - 8:47 am - on 8/1/15 at 3:20pm staff witnessed another Resident following #2... punching #2 in the back... also seen being kicked... red marks observed on leg and back... split Residents up... #2 crying and very upset and scared... unable to tell what happened.

The record lacked documentation of an investigation; incident not reported to the

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	N046071	A. BUILDING: _____ B. WING _____	01/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S3028	Continued From page 10 department. 9/03/15 - 10:40am - observed #2 being transported by EMS (emergency medical services) to hospital related to falling in room and hitting head... has bruising/contusion to right side of face near outer eye... awake and alert at time of transfer at about 7:40am. The record lacked documentation of an investigation; incident not reported to the department. 9/14/15 - 10:30am - this morning around 8:35am care manager heard noise like someone had fallen... #2 on floor in hallway next to wall near his/her room holding his/her head... bleeding from head... 911 immediately called... returned from hospital with 3 stitches to laceration on right side of forehead. The record lacked documentation of an investigation; incident not reported to the department. 10/01/15 - 8:33am - on 9/30/15 at 1435 care manager witnessed #2 being grabbed by another Resident on right upper thigh, right forearm, and left upper arm. The record lacked documentation of an investigation; incident not reported to the department. 10/25/15 - 2:55pm - on 10/24 at 2000 care manager heard another Resident holler that a	S3028		

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	N046071	A. BUILDING: _____ B. WING _____	01/19/2016

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

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S3028	Continued From page 11 Resident fell in his/her apartment... when entered found #2 laying on the floor head by night stand... care managers checked #2 and assisted to feet... #2 went limp for brief moment... staff assisted to recliner. The record lacked documentation of an investigation; incident not reported to the department. 10/26/15 11:08am - informed #2 had 2 falls: 1st on 10/25/15 at 11:00pm and 2nd on 10/26/15 at 6:05am... skin tear to right elbow... small abrasion on right temple area and on bottom lip. The record lacked documentation of an investigation; incident not reported to the department. 11/30/15 - 5:45pm - 0913 care manager reports someone calling for help... #2 on floor by Coordinator's office... small skin tear on right eyebrow from fall previous evening... assisted to chair... bruising noted on several nail beds on right hand. The record lacked documentation of an investigation; incident not reported to the department. 12/13/15 - 5:37pm - around 5pm found on floor in another Resident's room... mattress on floor... lying on left side open area noted above left eye. The record lacked documentation of an investigation; incident not reported to the department.	S3028		

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

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S3028	Continued From page 12 12/20/15 - 6:23pm - care manager reported that last evening (12/19/15) at approximately 8:20 p.m. entered another Resident's apartment... this Resident (#4) with pants down in process of pulling down #2's pants... separated Residents and escorted #2 from apartment... #2 appeared frightened... care manager notified other staff members to provide frequent checks on both Residents. The record lacked documentation of steps to prevent further incidents. On 01/06/16 at 2:30pm, Executive Director (ED) #D reported two additional incidents of contact occurred between #4 and #2 on 01/03/16. The medical record lacked documentation of the incidents on 1/3/16. On 1/7/16 ED #D provided written statements by two staff on duty the evening of 01/03/16 as the only evidence of an investigation of the incidents. The Administrator failed to report potential abuse or neglect related to unwitnessed falls and resident to resident incidents to the department within 24 hours, ensure immediate measures taken to prevent further potential abuse or neglect while the investigation in progress; and thoroughly investigate allegations of potential abuse and neglect.	S3028		
S3155 SS=E	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	S3155		

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 _____	01/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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
S3155	Continued From page 13 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: KAR 26-41-204(a) The census equalled 85 with 31 identified residing in the Reminiscence (dementia care) unit of facility. The sample included four Residents from the Reminiscence (REM) unit. Based on observations, interviews, and reviews of records, for one of four sampled (#2), the Administrator failed to ensure a licensed nurse provided or coordinated the provision of health care services to address repeated unwitnessed falls with injuries; and for two of four sampled (#2 and #4) the Administrator failed to provide and coordinate the provision of health care services to address repeated incidents of Resident to Resident contact of a sexual nature by #2 and #4. Findings included: - Record review revealed #2 admitted to facility 5/29/15 with diagnoses of Anxiety, Alzheimer's, Hypertension, Depression, Insomnia, and Dementia. 5/29/15 functional capacity screen (FCS) assessed #2 in need of physical assistance (2) with bathing, dressing, toileting; independent (0) with transfers and mobility; in need of supervision (1) with eating; and unable to perform (3) medication and treatment management; with Impaired decision making, no falls or	S3155		

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	N046071	A. BUILDING: _____ B. WING _____	01/19/2016

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S3155	Continued From page 14	S3155		

unsteadiness, impaired communication (sometimes understood, sometimes understands); long term, short term, memory recall, and decision making impairments.

5/29/15 NSA/Health Service Plan (/NSAHSP) completed by Registered Nurse (RN) #A documented facility staff to assist with showers, grooming, dressing, toileting; requires assistance with anything that uses his/her memory (room location, meal times, activities); independent with mobility and transfers.

According to Medical Record Notes:
6/03/15 - 2:06pm - On 6/02 around 9pm staff heard "loud bang"... observed #2 on the floor... hit head... unwitnessed... sent to ER (emergency room).

The NSA/ lacked revision to include interventions to address risk for falls.

September medical record notes documented 4 unwitnessed falls with no injury on 9/12/15 at 2:30pm, 9/13/ around 4:40pm, 9/26/15 at 6:54pm, and on 9/29 around 110pm and the following falls with injuries:

9/03/15 - 10:40am - observed #2 being transported by EMS (emergency medical services) to hospital related to falling in room and hitting head... has bruising/contusion to right side of face near outer eye... awake and alert at time of transfer at about 7:40am.

9/14/15 - 10:30am - this morning around 8:35am care manager heard noise like someone had fallen... #2 on floor in hallway next to wall holding room... bleeding from head... 911 immediately

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S3155	Continued From page 15 called... returned from hospital with 3 stitches to laceration on right side of forehead. The NSA/HSP lacked revision to include interventions to address continued risk for falls. 10/25/15 - 2:55pm - on 10/24 at 8 p.m. care manager heard another Resident holler that a Resident fell in his/her apartment... when entered found #2 laying on the floor head by night stand... care managers checked #2 and assisted to feet... #2 went limp for brief moment... staff assisted to recliner. 10/26/15 11:08am - informed #2 had 2 falls: 1st on 10/25/15 at 11:00pm and 2nd on 10/26/15 at 6:05am... skin tear to right elbow... small abrasion on right temple area and on bottom lip... The NSA/HSP continued to lack interventions to address the resident's risk for falls. 11/30/15 - 5:45pm - 0913 care manager reports someone calling for help... #2 on floor by Coordinator's office... small skin tear on right eyebrow from fall previous evening... assisted to chair... bruising noted on several nail beds on right hand... 12/13/15 - 5:37pm - around 5pm found on floor in another Resident's room... mattress on floor... lying on left side open area noted above left eye... The NSA/HSP lacked revision to include interventions to address risk for falls. 12/20/15 - 6:23pm - care manager reported that last evening (12/19/15) at approximately 8:20 pm	S3155		

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S3155	Continued From page 16 entered another Resident's apartment... this Resident (#4) with pants down in process of pulling down #2's pants... separated Residents and escorted #2 from apartment... #2 appeared frightened... care manager notified other staff members to provide frequent checks on both Residents. The NSA/HSP lacked interventions to address physical contact between #2 and #4 of a sexual nature. 01/02/16 NSA/HSP completed by RN #F documented #2 at risk of falls, facility staff to keep floors and pathways clear of clutter to avoid trips and falls... adequate lighting... ensure wearing glasses... team members to provide frequent safety/environmental checks to verify location... redirect from another Resident's room - engage in activity of choice (walk with resident in the hallways) offer finger foods and fluids of choice. For resident #2, the administrator failed to ensure a licensed nurse provided or coordinated the provision of health care services to address repeated unwitnessed falls with injuries; and further failed to provide and coordinate the provision of health care services to address repeated incidents of Resident to Resident contact of a sexual nature by #2 and #4. Record review revealed #4 admitted to facility 3/13/15 with diagnoses of Alzheimer's, Gastroesophageal reflux disease, Dementia, Coronary artery disease, Hypercholestrolemia, and Low back pain.	S3155		

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S3155	Continued From page 17 3/11/15 FCS assessed #4 independent with transfers, mobility; unable to perform medication and treatment management; with short term, memory/recall, and decision making impairments, and with wandering. 3/11/15 NSA/HSP completed by RN #A documented facility staff to be aware that #4 " sundowns " in the late afternoon/evening and becomes more confused; encourage to engage in activities or allow alone time . The NSA/HSP lacked interventions to address resident's physical contact of a sexual nature with other residents. Medical Record notes included: 9/13/15 - 0800 - #4 discovered under the bed covers of another Resident in the other Resident ' s room 12/01/15 - 5:41pm - #4 found in another ' s Resident room ... redirected to own room ... 12/20/15 - 7:31pm - care manager reported that last evening at approximately 8:20 p.m. entered #4 ' s room and observed #4 in process of pulling down #2 ' s pants ... care manager separated the two, escorted #2 from room and notified other staff members ... 12/20/15 - 8:31pm - medical care manager reports #4 had to be redirected several times from following Resident of the opposite sex involved in incident last evening ... that Resident relocated to another area ... #4 then found sitting next to a different Resident of opposite sex ... again redirected ... 12/24/15 - 12:45pm - team members reported that last night around 8pm #4 was following a Resident attracted to around and trying to get that Resident in the bathroom with #4 ... team	S3155		

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S3155	Continued From page 18 members keep two Residents separated at all times and there were no other behaviors ... On 01/06/16 at 2:30pm, Executive Director (ED) #D reported additional incidents of contact occurred between #4 and #2 on 01/03/16 " both kind of wanderers' ... last week end both in hallway touching ... clothes on ... from my understanding flirtations ... both laughing etc. ...we are doing frequent monitoring, multiple times through shift eyes on them ... " On 01/06/16 at 2:30pm, at 3:30pm, at 4:20pm, observed #2 ambulate independently... not oriented to time, place, or person... answers simple questions with unintelligible gibberish. On 01/06/16 at 5:25pm, evening meal service in progress, #2 and #4 not at dining room tables. At 5:27pm #2 entered dining area from hallway. At this time staff left dining room to find #4, returned with #4 (from his/her room) who sat and began to eat. On 01/06/16 at 6:41pm observed #2 ambulating hall with #4 trailing behind, no staff within view. #4 attempting to remove hair from #2's sweater on shoulder blade area as they walked... at this time certified staff #G emerged from another Resident room (#6), in process of attempting to bathe that Resident (#6), and happened to see #2 followed by #4 in progress. Certified staff #G approached and intervened by asking #4 questions about his/her shoes. By confidential interview an individual stated aware of 12/19/15 incident between #2 and #4... touching in various stages of undress... also two more incidents between them on 01/03/16... Individual stated nurses aware of incidents...	S3155		

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S3155	Continued From page 19 Executive Director (ED) #D aware... nothing new in Communication book (no interventions) "just told to keep them apart"... By confidential interview an individual stated #2 and #4 both wanderers... lately #4 fixated on #2 and will follow #2 around when there is no one to keep them busy or apart... first time found in #4 in hallway with hands on private areas on top of #2 clothes... #2 very distraught, he/she demonstrates that by walking close to walls with hands clenched together... about month ago in #4's room both partially undressed, now keep doors locked... there is no nurse to call... ED #D told staff to redirect them and keep them apart... no other interventions or directions given. By confidential interview an individual stated #4 touching #2 inappropriately in public areas on 01/03/16, nurse said to call ED #D... ED #D told staff to keep an eye on them and keep out of room and in common areas. Further stated 12/19/15 when residents found partially undressed with #2 crying was not the first incident with #4 and #2, there had been 5 to 7 times starting around approximately Thanksgiving. Further stated there is no nurse to call, have been instructed to call ED #D and have no new interventions or training yet. On 01/07/16 at 3:55pm, ED #D stated yes, should have been interventions put into place on NSA/HSP as result of 01/03/16 incidents between #2 and #4. For resident #4 the Administrator failed to ensure a licensed nurse provided or coordinated the provision of health care services to address physical contact of a sexual nature between two cognitively impaired Residents of the facility.	S3155		

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S3167 SS=E	26-41-204 (f) Health Care Services (f) Each administrator or operator shall ensure that a licensed nurse is available to provide immediate direction to medication aides and nurse aides for residents who have unscheduled needs. This REQUIREMENT is not met as evidenced by: KAR 26-41-204(f) The census equalled 85 with 31 identified residing in the Reminiscence (dementia care) unit of facility. The sample included four Residents from the Reminiscence (REM) unit. Based on observations, interviews, and reviews of records, for all Residents of facility, the Administrator failed to ensure a licensed nurse available to provide immediate direction to medication aides and nurse aides for Residents with unscheduled needs. Findings included: - On 01/06/16 at 2:30pm, Executive Director (ED) #D reported there was an incident on 12/19/15... additional incidents of contact occurred between #4 and #2 on 01/03/16... "both kind of wanderer's ... last week end both in hallway touching ... clothes on ... from my understanding flirtations ... both laughing etc. ...we are doing frequent monitoring, multiple times through shift eyes on them ..." - By confidential interview an individual stated #2	S3167		

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S3167	Continued From page 21	S3167		

and #4 are both wanderers... lately #4 fixated on #2... and will follow #2 around when there is no one to keep them busy or apart... hands on #2 above clothes... in #4's room both partially undressed... there is no nurse to call... ED #D told staff to redirect them and keep them apart... no other interventions or directions given...

- By confidential interview an individual stated #4 touching #2 inappropriately in public areas on 01/03/16, nurse on during day said to call ED #D... ED #D told staff to keep an eye on them and keep out of room and in common areas... between #4 and #2, further stated there is no nurse to call, have been instructed to call ED #D and have no new interventions or training yet...

Medical Record notes of #2's chart and of #4's chart each corroborated events of inappropriate contact.
Medical record notes of #2's chart described multiple falls, with and without injuries, witnessed and non-witnessed.
Each medical record lacked evidence of licensed nurse assessment after these incidents.
Each medical record lacked evidence of licensed nurse review and revision of health care services to address the identified needs of #2 and #4.

On 01/07/16 at 3:55pm, ED #D confirmed currently no Licensed Nurse on duty in REM for evening shifts... no nurse on call so they contact me...

For all Residents, the Administrator failed to ensure a licensed nurse available to provide immediate direction to medication aides and nurse aides for Residents with unscheduled needs.