STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046086	A. BUILDING: _____ B. WING _____	07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADDINGTON PLACE OF PRAIRIE VILLAGE	2700 SOMERSET DRIVE PRAIRIE VILLAGE, KS 66206

(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 represents the findings of a resurvey with attached complaints #189048, #189041, #188802, #188567, #187932, #186488, #184898, and #184423 at the above named assisted living conducted on 07/09/24 - 07/11/24.	S 000		
S 230 SS=D	26-39-102 (b) (c) Admission Advanced Directives Resident Rights b) At the time of admission, adult care home staff shall inform the resident or the resident ' s legal representative, in writing, of the state statutes related to advance medical directives. (1) If a resident has an advance medical directive currently in effect, the facility shall keep a copy on file in the resident ' s clinical record. (2) The administrator or operator, or the designee, shall ensure the development and implementation of policies and procedures related to advance medical directives. (c) The administrator or operator, or the designee, shall provide a copy of resident rights, the adult care home's policies and procedures for advance medical directives, and the adult care home's grievance policy to each resident or the resident's legal representative before the prospective resident signs any admission agreement. This REQUIREMENT is not met as evidenced by: KAR 26-39-102(b)(1) The facility reported a census of 51 total residents with four residents included in the sample and four closed record reviews. Based on interview and record review the administrator failed to	S 230		

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

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S 230	Continued From page 1	S 230		

ensure a copy of Resident (R) 2's advanced directives were maintained in his clinical record.

Findings included:

- Record review for R2 revealed an admission date of 03/11/24 with a diagnosis Alzheimer's disease.

An "FCS" was requested which the facility failed to provide.

An "NSA" was requested which the facility failed to provide.

The facility's "Senior Living Standard Level of Care and Service Plan" documented R2 was resistant to assistance for bathing and showering, dressing, and incontinence of bladder; required assistance and used a manual wheelchair for transfers and mobility; required occasional prompting and orientation for cognitive difficulties; and had a history of "behavioral issues." The "Senior Living Standard Level of Care and Service Plan" Behavior Management section had check boxes for 11 behaviors including "demonstrated sexually inappropriate behaviors" and "history of harming self, others, or property" all were left blank.

The "Senior Living Standard Level of Care and Service Plan" documented under section "GI General Information" Advanced Directive/Code Status R2 had a "Do Not Resuscitate" (DNR) order in place.

Review of the Medication Administration Record (MAR) from 06/01/24 to 07/09/24 revealed the line labeled "Advanced Directive" was left blank.

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S 230	Continued From page 2 R2's record lacked evidence of documentation of advanced directives. On 07/10/24 at approximately 11:39 AM Administrative Nurse C confirmed R2's was not in his record. She stated had a notebook with residents' updated information that documented if a resident was a DNR for full code. Review of notebook provided by Administrative Nurse C revealed the notebook contained face sheets of residents. The notebook lacked an advanced directive for R2. On 07/10/24 at 11:59 AM Administrative Nurse C stated she found a DNR form for R2. She confirmed it was not kept in R2's record and it lacked a signature by R2 or his legal representative. Review of the DNR form revealed it lacked a signature by R2 or his legal representative. The undated facility's "DNR Orders" policy documented "DNR orders will be completed in accordance with all State Regulations." The administrator failed to ensure a copy of R2's advanced directives was maintained in his clinical record.	S 230		
S3026 SS=J	26-41-101 (f) (1) Staff Treatment of Residents ANE (f)The administrator or operator shall ensure that all of the following requirements are met: (1) No resident shall be subjected to any of the following: (A) Verbal, mental, sexual, or physical abuse,	S3026		

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S3026	Continued From page 3 including corporal punishment and involuntary seclusion; (B) neglect; or (C) exploitation. This REQUIREMENT is not met as evidenced by: KAR 26-41-101(f)(1)(B) The facility reported a census of 51 total residents with four residents included in the sample and four closed record reviews. 10 residents lived in the 300-hall memory care unit and nine residents lived in the 400-hall memory care unit. Based on observation, interview, and record review the administrator failed to protect 12 female residents on two separate memory care units within the facility from abuse by failing to ensure all facility staff were provided dementia training and abuse, neglect, and exploitation (ANE) training upon hire and annually. The administrator also failed to ensure a licensed nurse recorded the findings of a "Functional Capacity Screen" (FCS) which included each element and definition specified by the department for Resident (R) 2 and failed to develop a "Negotiated Service Agreement" (NSA) which described services provided and identified the provider of each service based on R2's "FCS," service needs, and preferences. The administrator failed to ensure facility staff documented all incidents for R2 including his inappropriate behaviors, including the date, time of occurrence, action taken and results of the actions. The administrator further failed to ensure facility staff reported to the nurse and administrator when R2 inappropriately touched female residents. This placed eight female residents in one memory care unit in Immediate Jeopardy on 03/17/24 when facility staff	S3026		

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witnessed R2 inappropriately touched two female residents and later placed four other female residents in Immediate Jeopardy in another memory care unit within the facility when R2 moved to that unit on 04/04/24.

Findings included:

- Record review for R2 revealed an admission date of 03/11/24 with a diagnosis Alzheimer's disease.

An"FCS" was requested which the facility failed to provide.

An "NSA" was requested which the facility failed to provide.

The facility's "Senior Living Standard Level of Care and Service Plan" documented R2 was resistant to assistance for bathing and showering, dressing, and incontinence of bladder; required assistance and used a manual wheelchair for transfers and mobility; required occasional prompting and orientation for cognitive difficulties; and had a history of "behavioral issues." The "Senior Living Standard Level of Care and Service Plan" Behavior Management section had check boxes for 11 behaviors including "demonstrated sexually inappropriate behaviors" and "history of harming self, others, or property" all were left blank.

Review of R2's record revealed lack of documentation a licensed nurse completed an "FCS" to determine his functional capacity including each element and definition specified by the department including wandering and socially inappropriate behaviors. R2's record further lacked evidence of documentation an "NSA" was

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developed and signed by all individuals involved, describing the services he would receive, and the provider of the services based on an "FCS" including services for wandering and socially inappropriate behaviors. The "Senior Living Standard Level of Care and Service Plan" failed to direct staff what to do when R2 exhibited wandering and socially inappropriate behavior.

The 03/17/24 at 10:51 AM behavior "Progress Note" by Certified Medication Aide (CMA) E documented R2 "keeps touching the female residents, rubbing their legs" and R2 touched R11's breast.

Review of R2's record from 03/17/24 to 04/04/24 revealed lack of evidence of documentation the nurse or administrator were made aware of R2's inappropriate behaviors. R2 remained in contact with eight female residents for 18 days on the 400-hall memory care unit after CMA E documented his behaviors.

The 04/04/24 at 01:21 PM incident "Progress Note" by Administrative Nurse C documented R2 was found in another female resident (R10)'s room with his hand on her breast while she slept.

The 04/04/24 at 03:44 PM incident "Progress Note" documented a new order was received for trazodone 50 milligrams (mg) (antidepressant/sedative medication).

The 04/04/24 at 04:27 PM communication with family "Progress Note" documented R2's unidentified family member was called, and a message left that R2 would move from the 400-hall memory care unit to the 300-hall memory care unit.

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The 04/08/24 at 11:42 AM "Progress Note" documented R2 slept well throughout the night and had not exhibited inappropriate behaviors since he began taking trazodone 50 mg.

The 05/14/24 "Clinical Physician's Orders" documented a new order to discontinue previous order of trazodone 50 mg and begin trazodone 100 mg daily.

Review of nursing progress notes from 04/08/24 to 05/14/24 lacked evidence of documentation of increased inappropriate behaviors or trouble sleeping including date and time of occurrence, action taken, and results of the action warranting an increase in medication.

The 04/08/24 facility's investigation report to the department documented during the night on 04/03/24 to 04/04/24 facility staff witnessed R2 independently propelled himself in a wheelchair into R10's room where he "fondled" R10's breast while she slept. Facility staff redirected R2 out of R10's room and asked R2 not to touch other residents. Facility staff moved R2 to the other memory care unit, the nurse practitioner prescribed him new medication, and ANE training was provided to facility staff.

The 04/05/24 notarized "Witness Statement" by Certified Nurse Aide (CNA) F and included in the 04/08/24 facility's investigation report documented R2 "strolled" around the unit in his wheelchair. Staff noticed he was out of sight and found R2 in R10's room sitting by her bed in the dark "rubbing" her breast while she slept.

The undated note by Administrative Staff B and included in the facility's 04/08/24 investigation report documented R2 and R10 were immediately

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separated when administration was notified of the incident.

Review of the 04/08/24 facility's investigation report lacked evidence of documentation any actions were taken to protect four female residents in 300-hall memory care unit where R2 moved if/when R2 exhibited further inappropriate behaviors.

Review of R2's record from 04/04/24 (date moved to 300-hall memory care unit) to 07/09/24 (date at start of survey) lacked evidence of documentation facility staff monitored R2 for inappropriate behaviors, actions taken if/when they occurred, and results of any actions taken which was 96 days R2 remained in contact with four female residents.

The 04/05/24 (18 days after the first incident) "Staff Meeting Sign-in Sheet" signed by 13 staff documented resident abuse, behaviors, and violence in the workplace were discussed.

Review of five selected staff records lacked evidence of documentation three of the staff were provided dementia training upon hire.

Review of staff roster provided by the facility during the survey revealed 65 staff currently worked at the facility.

Observation on 07/10/24 at approximately 01:09 PM in 300-hall memory care unit revealed R2 and seven other residents sat at tables in the dining area. Four of the residents were females. R2's apartment door was toward the end of long hallway out of direct line of sight from the common area. The nearest apartment entrance door to R2's apartment entrance belonged to a

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female resident with approximately 15 feet between the doors.

On 07/10/24 at 11:39 AM Administrative Nurse C confirmed a CMA reported R2 was found in R10's apartment touching her breast when he lived in the 400-hall memory care unit with eight female residents. He was moved to the 300-hall memory care unit because there were only four female residents.

On 07/10/24 at approximately 12:20 PM Administrative Nurse D stated R2 was moved to another memory care unit away from the female resident (R10) whom he touched. She was not aware R2 touched other female residents before the 04/04/24 incident.

On 07/10/24 at 12:57 PM CMA E stated during a phone interview she witnessed R2 touched R11's breast and rubbed back and forth on her upper legs. He also rubbed another resident's upper legs, but CMA E could not recall which resident. She wrote a note in R2's record and informed direct care staff during shift report. She could not recall reporting the incident to Administrative Nurses C or D or to the administrator.

On 07/10/24 at approximately 01:11 PM R2's unidentified family member stated he moved from previous 400-hall memory care unit to current 300-hall memory care unit because he wandered into other rooms at night and there were too many female residents. Since moving to current memory care unit and with change of medication he was able to rest better at night.

On 07/10/24 at 03:31 PM Administrative Nurse C confirmed R2's record lacked evidence of documentation facility staff provided R2

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monitoring including the date and time, actions taken if/when he exhibited inappropriate behaviors, and results of the action. She did not know the time R2 was found in R10's room because she only overheard staff talking about it. He exhibited inappropriate behaviors during the night even though the two progress notes were written on 03/17/24 at 10:51 AM (when he rubbed R11's upper legs and touched her breast) and 04/04/24 at 01:21 PM (when he touched R10's breast while she slept) and lacked the time the incidents occurred.

The facility's undated "Allegations of Abuse/Neglect/Exploitation Policy and Procedure" documented the facility "has zero tolerance for abuse, neglect, or exploitation of its residents. All allegations of abuse, neglect or exploitation of a resident will be thoroughly investigated by the facility and reported as required to the proper authorities/agencies. . . 'Sexual Abuse' means. . . any sexually oriented behavior between residents that is not fully and freely consented to by both residents involved, any sexually oriented behavior between residents when either or both residents are incapable of consenting to the behavior. . ." The policy listed the following procedures:
1. All staff will be trained on what constitutes ANE and will be able to demonstrate understanding.
2. All staff will be trained on their responsibility to observe for and immediately report any allegation, suspicion, or witness of ANE to the administrator.
3. The administrator will immediately be notified when ANE is suspected.
4. The administrator or designee shall conduct and document a thorough investigation and take immediate and appropriate action to prevent further abuse.

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S3026	Continued From page 10 5. Staff shall attend annual continuing education on ANE to include its definitions and how to report suspected incidents. The administrator failed to protect 12 female residents on two separate memory care units within the facility from abuse by ensuring all facility staff were provided dementia training upon hire, and ANE training upon hire and annually. The administrator failed to ensure a licensed nurse recorded the findings of a "FCS" which included each element and definition specified by the department for R2 and developed a "NSA" which described services provided and identified the provider of each service based on R2's "FCS," service needs, and preferences. The administrator failed to ensure facility staff documented all incidents for R2 including inappropriate behaviors, including the date, time of occurrence, action taken and results of the actions. The administrator further failed to ensure facility staff reported to the nurse and administrator when R2 inappropriately touched female residents. The Immediate Jeopardy was removed on 07/11/24 when the following actions were documented by the facility in the "Abatement Plan" and accepted by the department at 03:24 PM. 1. On 04/04/24 facility staff reported to the Director of Health and Wellness, R2 had inappropriately touched a female resident. R2's Durable Power of Attorney (DPOA) was notified and R2 was relocated to another apartment in a different secured memory care unit at the facility. A new medication order was received from R2's primary care provider to begin trazodone 50 mg one time daily at bedtime. 2. On 04/05/24 ANE training was provided to 13 staff. ANE training scheduled to be provided to	S3026		

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S3026	Continued From page 11 remaining staff by 07/16/24 at 10:00 PM. 3. Nurse note on 04/08/24 documented resident sleeping well throughout the night and no behaviors observed. 4. Previous trazodone order discontinued and new order to increase trazodone to 100 mg one time daily at bedtime for depression. 5. R2 provided 15-minute checks of location and exhibited behaviors during waking hours from 07:00 AM through 09:00 PM starting on 07/10/24 at 07:00 PM. If no behaviors were exhibited during that time 15-minute checks would be discontinued after seven days. 6. R2 provided 30-minute checks of location and exhibited behaviors during sleeping hours from 09:00 PM through 07:00 AM starting on 07/10/24 at 07:00 PM. If no behaviors were exhibited during that time 30-minute checks would be discontinued after seven days. 7. Staff to immediately redirect R2 if he exhibited socially inappropriate behaviors and report behaviors to the nurse. 8. "NSA" updated to included services provided for socially inappropriate behaviors by 07/11/24 at 10:00 PM.	S3026		
S3028 SS=D	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	S3028		

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S3028	Continued From page 12 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 investigation of reported abuse, neglect, or exploitation. This REQUIREMENT is not met as evidenced by: KAR 26-41- 101(f)(3)(D) The facility reported a census of 51 residents. Based on interview and record review the administrator failed to ensure appropriate corrective action to return all personal belongings when they were reported missing from a recently deceased resident's room. Findings included: - Record review for Resident (R)1 revealed an admission date of 04/17/24. Her record lacked evidence of documentation of her diagnoses. R1's record lacked evidence of documentation an "FCS" was conducted on or before admission.	S3028		

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The undated combined "NSA/HCP" failed to describe the services provided R1 based on an "FCS."

The 07/01/24 at 05:48 PM "Progress Note" documented R1's Durable Power of Attorney (DPOA) had been notified of R1's passing and would be in to clean out her room.

The 07/05/24 facility's "Intake Information" report to the department documented R1 passed away on 07/01/24. Her Durable Power of Attorney (DPOA) returned to facility on 07/05/24 and reported some items were missing from R1's room. Facility staff began searching to see if the items were misplaced and an investigation was started by obtaining staff witness statements. The "Intake Information" report further documented "The items have been found."

The 07/08/24 "Intake Information" report to the department documented R1 passed away on 07/01/24. Upon arrival at the facility to pick up R1's personal property, it appeared the room had been "ransacked" and several items were "stolen." A list was provided which included:

Two statues
One floor lamp
One desk lamp
One round wood chest
One LL Bean blanket
One shower curtain
One answering machine
One tape recorder

On 07/09/24 at 02:49 PM Administrative Nurse C stated all R1's were found and returned to R1's DPOA. Staff had misunderstood that the items were going to be donated and assumed they

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S3028	Continued From page 14 were "up for grabs" and took them. On 07/09/24 at approximately 02:49 PM a list of items found and returned to R1's DPOA was requested which the facility failed to provide. On 07/11/24 at 10:02 AM R1's DPOA stated during phone interview she had received the two missing statues. She was still expecting the other missing items be returned to her. She had not been provided a list of items that were recovered from the staff who took them from R1's room. On 07/11/24 at approximately 02:30 PM Administrative Staff A confirmed the facility did not have a policy regarding resident's personal property upon death. The administrator failed to ensure appropriate corrective action to return all personal belongings when they were reported missing from a recently deceased resident's room.	S3028		
S3080 SS=E	26-41-201 (a) (b) Functional Capacity Screen on Admission a) On or before each individual ' s admission to an assisted living facility or residential health care facility, a licensed nurse, a licensed social worker, or the administrator or operator shall conduct a screening to determine the individual ' s functional capacity and shall record all findings on a screening form specified by the department. The administrator or operator may integrate the department ' s screening form into a form developed by the facility, which shall include each element and definition specified by the department. (b) A licensed nurse shall assess any resident	S3080		

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S3080	Continued From page 15 whose functional capacity screening indicates the need for health care services. This REQUIREMENT is not met as evidenced by: KAR 26-41-201(a) The facility reported a census of 51 residents with four residents included in the sample and four closed record reviews. Based on interview and record review the administrator failed to ensure evidence of documentation a "Functional Capacity Screen" (FCS) was conducted for four out eight residents sampled. Findings included: - Record review for Resident (R)1 revealed an admission date of 04/17/24. Her record lacked evidence of documentation of any diagnoses. R1's record lacked evidence of documentation an "FCS" was conducted on or before admission. - Record review for R2 revealed an admission date of 03/11/24 with diagnoses of Alzheimer's disease and muscle weakness. R2's record lacked evidence of documentation an "FCS" was conducted on or before admission. - Record review for R7 revealed an admission date of 06/06/23 with diagnoses of dementia and muscle weakness. R7's record lacked evidence of documentation an "FCS" was conducted on or before admission. Record review for R8 revealed an admission date	S3080		

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S3080	Continued From page 16 of 12/06/21 with diagnoses of alcohol abuse and major depressive disorder. R8's record lacked evidence of documentation an "FCS" was conducted on or before admission. On 07/10/24 at 01:13 PM Administrative Staff B confirmed R1, R2, R7, and R8's, records lacked evidence of documentation "FCS's" was conducted on or before admission. The undated facility's "Resident Level of Care Assessment" Policy had a handwritten line near the bottom which read "Functional Capacity Policy." The policy documented a resident should have an initial assessment completed by the Director of Health and Wellness or a designee within 30 days prior to admission in compliance with individual state regulatory guidelines. The administrator failed to ensure evidence of documentation an "FCS" was conducted for R1, R2, R7, and R8 on or before admission to the facility.	S3080		
S3085 SS=E	26-41-202 (a) Negotiated Service Agreement (a) The administrator or operator of each assisted living facility or residential health care facility shall ensure the development of a written negotiated service agreement for each resident, based on the resident ' s functional capacity screening, service needs, and preferences, in collaboration with the resident or the resident ' s legal representative, the case manager, and, if agreed to by the resident or the resident ' s legal representative, the resident ' s family. The negotiated service agreement shall provide the following information:	S3085		

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S3085	Continued From page 17 (1) A description of the services the resident will receive; (2) identification of the provider of each service; and (3) identification of each party responsible for payment if outside resources provide a service. This REQUIREMENT is not met as evidenced by: KAR 26-41-202(a)(1) The facility reported a census of 51 residents with three residents, one focused review, and 4 closed record reviews included in the sample. Based on interview and record review the administrator failed to ensure the development of a "Negotiated Service Agreement" (NSA) for Resident (R) 2 and failed to ensure the "NSA's" for R1, R4, R5, R7, and R8 described the services they received based on their "Functional Capacity Screen" (FCS) service needs, and preferences. Findings included: - Record review for R2 revealed an admission date of 03/11/24 with diagnoses of Alzheimer's disease and muscle weakness. A "Functional Capacity Screen" (FCS) was requested which the facility failed to provide. A "Negotiated Service Agreement" (NSA) was requested which the facility failed to provide. - Record review for R1 revealed an admission date of 04/17/24. Her record lacked evidence of documentation of her diagnoses.	S3085		

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S3085	Continued From page 18 A "FCS" was requested which the facility failed to provide. The undated combined "NSA/Healthcare Service Plan" (HCP) failed to describe the services R1 received based on an "FCS," service needs, and preferences as applicable for bathing, dressing, toileting, transfers, walking/mobility, eating, management of medications and treatments, bladder incontinence, cognition, communication, falls, impaired vision, impaired hearing, impaired decision-making, wandering, and inappropriate behavior. - Record review for R4 revealed an admission date of 06/12/23 with a diagnosis of Alzheimer's disease. The 03/17/24 "FCS" identified R4 required physical assistance with transfers; was sometimes understandable and sometimes understood others during communication and was marked for impaired vision. The undated combined "NSA/HCP" failed to describe services R4 received for transfers, communication and impaired vision." - Record review for R5 revealed an admission date 12/20/22 with diagnoses of dementia and Alzheimer's disease. The 02/01/24 "FCS" identified R5 required physical assistance with dressing and toileting; was frequently incontinent of bladder; was sometimes understandable and sometimes understood others during communication and was marked for impaired vision, impaired hearing, and inappropriate behavior.	S3085		

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S3085	Continued From page 19 The undated combined "NSA/HCP" failed to describe the services R5 received for dressing, toileting, communication, impaired vision, impaired hearing, and inappropriate behavior. The "NSA/HCP" documented R5 was "continent" of bladder which did not match the "FCS" of frequently incontinent. - Record review for R7 revealed an admission date of 06/06/23 with diagnoses of dementia and muscle weakness. A "FCS" was requested which the facility failed to provide. The undated combined "NSA/HCP" failed to describe the services R7 received based on an "FCS," service needs, and preferences as applicable for transfers, management of treatments, communication, impaired vision, impaired hearing, impaired decision-making, wandering, and inappropriate behavior. - Record review for R8 revealed an admission date of 12/06/21 with diagnoses of alcohol abuse and major depressive disorder. A "FCS" was requested which the facility failed to provide. The undated combined "NSA/HCP" failed to describe the services R8 received based on an "FCS," service needs, and preferences as applicable for toileting, transfers, eating, management of treatments, cognitive difficulties, communication, impaired vision, impaired hearing, wandering, and inappropriate behavior. On 07/11/24 at appproximately 02:30 PM Administrative Nurse C confirmed R2's record	S3085		

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S3085	Continued From page 20 lacked an "NSA" and the "NSA's" for R1, R4, R5, R7, and R8 failed to describe the services they received based on their "Functional Capacity Screen" (FCS) service needs, and preferences. On 07/11/24 at approximately 02:30 PM an "NSA" policy was requested which the facility failed to provide. The administrator failed to ensure the development of an "NSA" for R2 and failed to ensure the "NSA's" for R1, R4, R5, R7, and R8 described the services they received based on their "FCS," service needs, and preferences.	S3085		
S3101 SS=E	26-41-202 (h) NSA Signatures (h) Each individual involved in the development of the negotiated service agreement shall sign the agreement. The administrator or operator shall ensure that a copy of the initial agreement and any subsequent revisions are provided to the resident or the resident's legal representative. This REQUIREMENT is not met as evidenced by: KAR 26-41-202(h) The facility reported a census of 51 total residents with four residents included in the sample and four closed record reviews. Based on interview and record review the administrator failed to ensure that each individual involved in the development of the "Negotiated Service Agreement" (NSA) signed the agreement for Residents (R)1, R3, R4, R5, R6, R7, and R8.	S3101		

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S3101	Continued From page 21	S3101		

Findings included:

- Record review for Resident (R)1 revealed an admission date of 04/17/24. Her record lacked evidence of documentation of her diagnoses.

The undated "NSA" for R1 lacked a signature by her and/or her legal representative.

- Record review for R3 revealed an admission date of 10/20/23 with a diagnosis of dementia.

The undated "NSA" for R3 lacked a signature by her and/or her legal representative.

- Record review for R4 revealed an admission date of 06/12/23 with a diagnosis of Alzheimer's disease.

The undated "NSA" for R4 lacked a signature by him and/or his legal representative.

- Record review for R5 revealed an admission date of 12/30/22 with a diagnoses of dementia and Alzheimer's disease.

The undated "NSA" for R5 lacked a signature by him and/or his legal representative.

- Record review for R6 revealed an admission date of 10/02/23 with a diagnosis of dementia.

The undated "NSA" for R6 lacked a signature by her and/or her legal representative.

- Record review for R7 revealed an admission date of 06/06/23 with diagnoses of dementia and muscle weakness.

The undated "NSA" for R7 lacked a signature by

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S3101	Continued From page 22 her and/or her legal representative. - Record review for R8 revealed an admission date of 12/06/21 with diagnoses of alcohol abuse and major depressive disorder. The undated "NSA" for R8 lacked a signature by her and/or her legal representative. On 07/10/24 at 01:57 PM Administrative Staff A confirmed the "NSA's" lacked a signatures by the resident or their legal representative. On 07/11/24 at approximately 02:30 PM an "NSA" policy was requested which the facility failed to provide. The administrator failed to ensure that each individual involved in the development of the "NSA's" signed the agreement for Residents (R)1, R3, R4, R5, R6, R7, and R8.	S3101		
S3155 SS=J	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:	S3155		

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S3155	Continued From page 23 KAR 26-41-204(a) The facility reported a census of 51 total residents with four residents included in the sample and four closed record reviews. Based on observation, interview, and record review the administrator failed to ensure a licensed nurse provided the necessary health care services to keep cognitively impaired Residents (R) 4 and R3 safe from elopement. This failure placed R4 in Immediate Jeopardy on 05/17/24 when he was left unsupervised in the unsecured main section of the building and exited the building to the outside through a back door without staff knowledge. This failure also placed R3 in Immediate Jeopardy on 06/13/24 when she followed a staff member through a locked and alarmed egress door from the secured memory care unit into the unsecured main section of the building and exited the building to the outside through a back door without staff knowledge. Findings included: - Record review for R4 revealed an admission date of 06/12/23 with a diagnosis of Alzheimer's disease. The 03/17/24 "Functional Capacity Screen" (FCS) identified R4 required physical assistance with transfers and walking/mobility; he had short-term and long-term memory, memory/recall, and decision-making cognitive impairments; was sometimes understandable and sometimes understood others during communication and was marked for falls, impaired vision, wandering, and impaired decision making; and used a cane, walker, or crutch device for mobility. The undated combined "NSA/Healthcare Service	S3155		

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Plan" (HCP) identified R4 resided in a secured memory care unit with an egress door and 24-hour supervision. The "NSA/HCP" identified facility staff provided R4 guidance with walking/mobility; cueing for cognitive difficulties; ensure he wore proper footwear and walkways were free of clutter to prevent injury from falls; and reorientation and redirection for wandering. Services provided for transfers, communication and impaired vision were not described on R4's "NSA/HCP."

The 02/09/24 at 02:10 PM "Progress Note" documented R4 wandered everywhere, looked for his wife, and was hard to redirect.

The 02/12/24 at 10:15 AM "Progress Note" documented R4 was anxious, wandered around the unit, looked for his wife, and was hard to redirect.

The 02/15/24 at 11:40 AM "Progress Note" documented R4 anxiously looked for wife all over the unit and was hard to redirect.

The 02/15/24 at 02:02 PM "Progress Note" documented administered as needed medication was ineffective. R4 still anxiously searched for his wife.

The 02/21/24 at 01:05 PM "Progress Note" documented R4 was very anxious and looked for his wife. He was combative during incontinence brief change.

The 02/23/24 at 10:00 AM "Progress Note" documented R4 was combative during toileting, very anxious, looked for his wife, and was hard to redirect.

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The 02/28/24 at 10:07 AM "Progress Note" documented R4 was very anxious, paced around the unit, searched for his wife, and staff unable to redirect him.

The 03/07/24 at 12:30 PM "Progress Note" documented R4 became combative with staff when redirected from hovering over the female residents.

The 03/28/24 at 01:40 PM "Progress Note" documented R4 exhibited exit-seeking behavior and looked for his mother.

The 05/17/24 at 04:30 PM "Progress Note" documented R4 sat in the main dining area of the assisted living portion of the building for happy hour. Staff noticed he was missing and began a search for R4. He was found outside sitting on the curb in the back parking lot.

The 06/23/24 at 03:06 PM "Progress Note" documented R4 was very anxious.

The 05/24/24 facility's "Investigation Report" to the department documented on 05/17/24 at approximately 03:30 PM staff escorted R4 from the memory care unit to the assisted living, main dining area for an activity. He remained seated and was last seen at approximately 03:50 PM when he was served refreshments. Staff noticed soon after being served refreshments, R4 was not in his seat and staff initiated a search. R4 was found outside the building sitting on the curb behind the kitchen area at approximately 04:09 PM.

The 05/17/24 notarized "Witness Statement" by Activities Staff G (included in the facility's investigation) reported she escorted R4 from the

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memory care unit to the assisted living dining room for an activity. She served him refreshments at 03:50 PM. After serving drinks to other residents, she noticed he was not in the dining area and initiated a search for R4. He was found outside at approximately 04:09 PM.

The 05/17/24 notarized "Witness Statement" by Activities Staff H (included in the facility's investigation), reported Activities Staff G escorted R4 to the assisted living dining area at 03:20 PM for an activity that began at 03:30 PM. He was served drinks and snacks at 03:45 PM. Activities Staff G alerted Activities Staff H at 04:00 PM that R4 was missing. They alerted other staff and began a search. R4 was found at 04:07 PM outside in the parking sitting next to a curb.

From 03:45 PM or 03:50 PM when staff reported R4 was last seen to the time he was found outside at 04:07 PM was approximately 17-22 minutes.

The 05/22/24 at 03:30 PM (five days after elopement) second shift "Elopement Drill Sign-In Sheet" was signed by 12 staff.

Review of staff roster provided by the facility during the survey revealed 65 staff currently worked at the facility.

Quarterly reviews of the facility's emergency management plan to include missing resident with residents and staff was requested which the facility failed to provide.

Review of "Test Operation of Doors and Locks" facility weekly log from 05/04/24 to 06/29/24 revealed weekly due date read "no action recorded."

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S3155	Continued From page 27 Observation on 07/10/24 at approximately 02:27 PM revealed a possible route R4 took to exit the building. It was approximately 155 feet from the table where staff pointed out R4 sat in the dining area of the assisted living portion of the building to main hallway door. The door to exit the building was alarmed. It was approximately 95 feet from the exit door to the curb where R4 was found sitting. The weather on 05/17/24 at 03:53 PM according to www.Wunderground.com was 81 degrees Fahrenheit (F) with a wind speed of five miles per hour (mph). On 07/09/24 at approximately 10:48 AM Administrative Nurse C stated the residents' "NSA's" and "HCP's" were combined in one document. On 07/09/24 at 03:35 PM Administrative Staff A confirmed facility records lacked evidence quarterly reviews of the emergency management plan, including missing resident, were completed with residents and staff. On 07/10/24 at 11:56 AM Support Staff I stated she worked at the desk near the front main entrance the day R4 exited the building. She never saw him go through the font lobby or exit the front door. He went out the back door. On 07/10/24 at 01:26 PM Activities Staff G stated she usually sat and supervised memory care residents after they were escorted to the main assisted living for activities. But the day R4 exited the building she was helping serve drinks. On 07/10/24 at approximately 02:27 PM	S3155		

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Administrative Nurse C confirmed the door R4 used to exit the building was not alarmed the day he exited the building. The alarm was installed after the incident.

On 07/10/24 at 02:47 PM maintenance staff J stated door locks and alarms were checked weekly, but he had not completed them for the last two weeks.

On 07/10/24 at 03:44 PM Administrative Staff A confirmed designated facility staff did not document exit doors were locked, and door alarms were in working order.

On 07/11/24 at approximately 02:30 PM Administrative Nurse C confirmed the 05/22/24 elopement drill with 12 staff was the only elopement training provided to facility staff.

The administrator failed to protect cognitively impaired R4 from elopement by the failure to secure all exit doors, the failure to provide staff adequate elopement training, and the failure to provide supervision to R4, a resident identified as an elopement risk, while he was in the unsecured assisted living portion of the building for an activity.

- Record review for R3 revealed an admission date of 10/20/23 with the following diagnoses: dementia, muscle weakness, and unsteadiness.

The 05/23/24 "FCS" identified R3 was independent with transfers and walking/mobility, was unable to perform managment of medications, and was marked for wandering.

The undated combined "NSA/HCP" identified facility staff provided R3, guidance or assistance

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when she ambulated long distances; management of medications; she resided in the memory care unit with egress doors, and staff provided observation of location in the unit and 24-hour/ seven days a week and supervision to keep her safe from elopement.

The 04/25/24 order for alprazolam (sedative/anti-anxiety medication) 0.25 milligrams (mg) directed facility staff to administer once daily by mouth for anxiety.

Review of R3's MAR from 05/01/24 to 06/30/24 revealed alprazolam was not administered from 05/25/24 to 06/13/24 except was documented as administered on 05/26/24, 05/27/24, 05/30/24, 06/01/24, and 06/06/24. Which was 14 days her medication for anxiety was documented as not administered per PCP's order.

The 06/13/24 at 01:30 PM "Progress Note" documented R3 was found in the west parking lot by housekeeping staff. R3 was redirected back into the building and to the memory care unit.

The 06/14/24 at 02:34 PM "Progress Note" documented R3 was triggered to elope when her husband was not present during lunch. Staff were to provide monitoring and reassurance to R3 that her husband would visit soon.

The 06/17/24 at 02:34 PM "Progress Note" documented R3 went outside in the memory care courtyard and into the connecting doors of the assisted living portion of the building. She was seen by a staff member and taken back to the memory care unit.

The 06/18/24 at 01:59 PM "Progress Note" documented R3 continued to wander, and exit

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seek. Staff observed her trying to go through the exit door.

The 06/18/24 facility's "Investigation Report" to the department documented on 06/13/24 during lunch a CMA noticed R3 was not in her seat and began looking for her. R3 was found outside at approximately 12:45 PM by housekeeping staff.

The 06/14/24 signed and notarized "Witness Statement" by CNA F (included in the facility's investigation) reported R3 ambulated per her usual while CNA F assisted residents to the bathroom. Lunch arrived around 12:30 PM and CNA F began to gather the residents to the dining room. She noticed R3 was not in sight and began to search the resident rooms for her. After she realized R3 was not in the memory care unit, CNA F notified Administrative Nurse C R3 was missing. They were on their way to the back parking lot when CNA F and Administrative Nurse C saw staff assisting R3 back to the memory care unit. The facility determined upon investigation that R3 followed Dietary Staff K out of the memory care unit before the door alarmed.

The 06/17/24 signed and notarized "Witness Statement" by Housekeeping Staff L (included in the facility's investigation) reported on 06/13/24 she stepped outside about 12:45 and found R3 standing on the sidewalk by herself.

The 06/18/24 signed and notarized "Witness Statement" by Dietary Staff K (included in the facility's investigation) reported on 06/13/24 at about 12:30 PM she delivered a food cart to the memory care unit and exited. She was unaware R3 was near enough to the door to follow her out of the memory care unit.

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From 12:30 PM when staff reported the food cart was delivered to memory care unit to the time R3 was found outside at 12:45 PM was 15 minutes.

Quarterly reviews of the facility's emergency management plan, including missing resident, with residents and staff was requested, which the facility failed to provide.

Review of "Test Operation of Doors and Locks" facility weekly log from 05/04/24 to 06/29/24 revealed beside weekly due date read "no action recorded."

Observation on 07/10/24 at approximately 01:08 PM on 300-hall memory care unit revealed the exit door from the common area to the outdoor courtyard area was unlocked. A sign was on the door which read "The door to remain locked unless an employee is accompanying a resident into the courtyard." One unidentified resident paced back and forth through the common area using a walker. No staff were observed near the door.

Observation on 07/10/24 at approximately 02:35 PM revealed a possible route R3 took to exit building. It was approximately 92 feet from the table where staff pointed out R3 sat in the dining area of the memory care unit to the keypad locked and alarmed egress door. From the memory care egress door to the door to exit the building was approximately 165 feet. It was approximately five feet from the exit door where R3 was found standing on the sidewalk.

The weather on 06/13/24 at 12:53 PM according to www.Wunderground.com was a temperature of 86 degrees F with a wind speed of 13 mph.

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S3155	Continued From page 32 On 07/09/24 at approximately 10:48 AM Administrative Nurse C stated the residents' "NSA's" and "HCP's" were combined in one document. On 07/09/24 at 03:35 PM Administrative Staff A confirmed facility records lacked evidence of documentation quarterly reviews of the emergency management plan including missing resident was completed with residents and staff. On 07/10/24 at approximately 02:27 PM Administrative Nurse C confirmed the door R3 used to exit the building was not alarmed the day she exited the building. The alarm had been installed after the incident. On 07/10/24 at 02:47 PM maintenance staff J stated routine door locks and alarms were checked weekly but he had not completed them for the last two weeks. On 07/10/24 at 03:44 PM Administrative Staff A confirmed designated facility staff did not document doors were locked, and door alarms were activated and in working order. On 07/11/24 at approximately 02:30 PM Administrative Nurse C confirmed the 05/22/24 elopement drill with 12 staff was the only elopement training provided to facility staff. On 07/18/24 at 08:55 AM during a phone interview Administrative Staff A and Administrative Nurse C confirmed alprazolam was not administered for 19 days in a row because the facility had no supply of alprazolam for R3 during that time. They stated they could not determine why the medication was documented as administered on five days when there was no	S3155		

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S3155	Continued From page 33 supply. The administrator failed to protect cognitively impaired R3 from elopement by the failure to secure all exit doors and the failure to provide adequate staff elopement training to ensure any cognitively impaired residents were not nearby when staff exited the memory care unit. On 07/11/24 at approximately 02:30 PM a missing resident policy was requested which the facility failed to provide. The administrator failed to ensure a licensed nurse provided the necessary health care services to keep cognitively impaired R4 and R3 safe from elopement. This failure placed R4 in Immediate Jeopardy on 05/17/24 when he was left unsupervised in the unsecured main section of the building and exited the building to the outside through a back door without staff knowledge. This failure also placed R3 in Immediate Jeopardy on 06/13/24 when she followed a staff member through a locked and alarmed egress door from the secured memory care unit into the unsecured main section of the building and exited the building to the outside through a back door without staff knowledge. The Immediate Jeopardy for R4 was removed on 07/11/24 when the following actions were documented by the facility in the "Abatement Plan" and accepted by the department at 03:24 PM. 1. On 05/22/24 elopement drill was completed with second shift staff. 2. On 07/10/24 memory care courtyard keys were removed from staff access. A sign that read "keep door locked placed on each memory care courtyard door.	S3155		

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S3155	Continued From page 34 3. On 07/11/24 memory care secured doors code. 4. Elopement training of all staff to be completed by 07/16/24. 5. Dementia training of all staff to be completed by 07/16/24. 6. "NSA" updated to include hourly checks by staff. 7. Secured doors locks and alarms check training provided to Maintenance Director completed by 07/16/24. 8. Memory care courtyard door checks to ensure doors were locked each shift starting 07/12/24. The Immediate Jeopardy for R3 was removed on 07/11/24 when the following actions were documented by the facility in the "Abatement Plan" and accepted by the department at 03:24 PM. 1. On 06/13/24 signs were placed on the interior and exterior of memory care secured doors which read "Stop and ensure door clicks and locks before walking away." 2. On 06/14/24 intervention progress note for staff to reassure R3 that her husband would arrive soon to assist calming R3. 3. On 06/17/24 order received to increase existing alprazolam (medication to treat anxiety and panic disorders) to 0.5 milligrams (mg) three times daily. 4. On 06/18/24 a nurse progress note was written regarding R3 exit seeking and wandering and durable power of attorney (DPOA) was notified. 5. On 07/10/24 memory care courtyard keys were removed from staff access. A sign that read "keep door locked placed on each memory care courtyard door. 6. On 07/11/24 memory care secured doors	S3155		

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S3155	Continued From page 35 code. 7. Elopement training of all staff to be completed by 07/16/24. 8. Dementia training of all staff to be completed by 07/16/24. 9. "NSA" updated to include hourly checks by staff. 10. Secured doors locks and alarms check training provided to Maintenance Director completed by 07/16/24. 11. Memory care courtyard door checks to ensure doors were locked each shift starting 07/12/24.	S3155		
S3165 SS=E	26-41-204 (d) Health Care Services (d) The negotiated service agreement shall contain a description of the health care services to be provided and the name of the licensed nurse responsible for the implementation and supervision of the plan. This REQUIREMENT is not met as evidenced by: KAR 26-41-204(d) The facility reported a census of 51 total residents with four residents included in the sample and four closed record reviews. Based on interview and record review the administrator failed to ensure the "Negotiated Service Agreement" (NSAs) for Residents (R)1, R3, R4, R5, R6, R7, and R8 named the licensed nurse responsible for implementing and supervising their "Healthcare Service Plans" (HSP). Findings included:	S3165		

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S3165	Continued From page 36 - Record review for Resident (R)1 revealed an admission date of 04/17/24. Her record lacked evidence of documentation of her diagnoses. R1's record lacked evidence of documentation an "FCS" was conducted on or before admission. The undated combined "NSA/HCP" failed to describe the services provided R1 based on an "FCS." The "NSA/HCP" further failed to name the licensed nurse responsible for implementing and supervising the "HCP" for R1. - Record review for R3 revealed an admission date of 10/20/23 with a diagnosis of dementia. The 05/23/24 "FCS" identified R3 was unable to perform management of medications and treatments and was incontinent of bladder. The undated combined "NSA/HCP" identified facility staff provided R3 management of medications and treatments and provided assistance for bladder incontinence. The "NSA/HCP" failed to name the licensed nurse responsible for implementing and supervising the "HCP" for R3. - Record review for R4 revealed an admission date of 06/12/23 with a diagnosis of Alzheimer's disease. The 05/17/23 "FCS" identified R4 required physical assistance with bathing, dressing, toileting, transfers, walking/mobility, eating; was unable to perform management of medications and treatments; was frequently incontinent of bladder; had short-term and long-term memory,	S3165		

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memory/recall, and decision-making difficulties; was sometimes understandable and sometimes understood others during communication; and was marked for falls, impaired vision, socially inappropriate behavior, and impaired-decision making.

The undated combined "NSA/HCP" identified facility staff would provide R4 assistance with bathing, dressing, and toileting and bladder incontinence; he was independent with transfers and walking/mobility; staff would provide supervision, cues, and encouragement for eating; facility staff managed medications and treatments; staff would provide cueing for cognitive difficulties; ensure he wore proper footwear and keep walkways free of clutter to prevent injury from falls; was provided 24-hour supervision in secured memory care unit for wandering. The "NSA/HCP" failed to describe services for provided communication.

The "NSA/HCP" failed to name the licensed nurse responsible for implementing and supervising the "HCP" for R4.

- Record review for R5 revealed an admission date of 12/30/22 with diagnoses of dementia and Alzheimer's disease.

The 03/01/24 "FCS" identified R5 required physical assistance with bathing, dressing, toileting, management of medications and treatments; was frequently incontinent of bladder; was sometimes understandable and sometimes understood others during communication; and was marked for impaired vision, impaired hearing, and inappropriate behavior.

The undated combined "NSA/HCP" identified

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facility staff provided R5 stand-by-assistance with as much privacy as possible for bathing; management of medications; he had no treatments; and he was continent of bladder (which did not match "frequently incontinent" on "FCS"). The "NSA/HCP" failed to describe the services provided R5 for communication, impaired vision, impaired hearing, and inappropriate behavior.

The "NSA/HCP" failed to name the licensed nurse responsible for implementing and supervising the "HCP" for R5.

- Record review for R6 revealed an admission date of 10/02/23 with a diagnosis of dementia.

The 10/02/23 "FCS" identified R6 required physical assistance with bathing, dressing, toileting; was unable to perform management of medications and treatments; had short-term memory, memory/recall, and decision-making cognitive difficulties; and was marked for falls, impaired hearing; and impaired decision-making.

The undated combined "NSA/HCP" identified facility staff provided R6 cueing (which did not match "FCS" score she required physical assistance) for bathing; physical assistance with dressing and toileting; management of medications and treatments; cueing for cognitive difficulties; reminders to use assistive device to prevent injury from falls; she wore hearing aids for impaired hearing; and staff provided assistance with decision-making.

The "NSA/HCP" failed to name the licensed nurse responsible for implementing and supervising the "HCP" for R6.

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S3165	Continued From page 39 - Record review for R7 revealed an admission date of 06/06/23 with diagnoses of dementia and muscle weakness. R7's record lacked evidence of documentation an "FCS" was conducted on or before admission. The undated combined "NSA/HCP" identified facility provided management of medications and reminders to use her walked, call for assistance, and keep walkways free of clutter to prevent injury from falls. The "NSA/HCP" failed to name the licensed nurse responsible for implementing and supervising the "HCP" for R7. - Record review for R8 revealed an admission date of 12/06/21 with diagnoses of alcohol abuse and major depressive disorder. R8's record lacked evidence of documentation an "FCS" was conducted on or before admission. The undated combined "NSA/HCP" identified facility provided R8 management of medications; monitoring and assistance for bladder incontinence; she was unable to make her needs known for communication; facility staff ensured she wore proper footwear, kept walkways free of clutter, and left a nightlight on in the bathroom to prevent injury from falls; and she had Durable Power of Attorney (DPOA) for impaired decision-making. The "NSA/HCP" failed to name the licensed nurse responsible for implementing and supervising the "HCP" for R8. On 07/09/24 at approximately 10:48 AM	S3165		

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S3165	Continued From page 40 Administrative Nurse C confirmed R2, R3, and R4's records lacked evidence of quarterly medication regimen reviews by a licensed pharmacist. On 07/11/24 at approximately 02:30 PM Administrative Nurse C confirmed the "NSA's" failed to name the nurse responsible for implementing and supervising the "HCP's." On 07/11/24 at approximately 02:30 PM an "NSA" policy was requested which the facility failed to provide. The administrator failed to ensure the "NSAs" for R1, R3, R4, R5, R6, R7, and R8 named the licensed nurse responsible for implementing and supervising their "HSP's."	S3165		
S3200 SS=E	26-41-205 (d) (1-2) Facility Administration of Medications (d) Facility administration of resident ' s medications. If a facility is responsible for the administration of a resident ' s medications, the administrator or operator shall ensure that all medications and biologicals are administered to that resident in accordance with a medical care provider ' s written order, professional standards of practice, and each manufacturer ' s recommendations. The administrator or operator shall ensure that all of the following are met: (1) Only licensed nurses and medication aides shall administer and manage medications for which the facility has responsibility. (2) Medication aides shall not administer medication through the parenteral route.	S3200		

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ADDINGTON PLACE OF PRAIRIE VILLAGE	2700 SOMERSET DRIVE PRAIRIE VILLAGE, KS 66206

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S3200	Continued From page 41 This REQUIREMENT is not met as evidenced by: KAR 26-41-205(d) The facility reported a census of 51 residents with three residents, one focused review, and 4 closed record reviews included in the sample. Based on interview and record review the administrator failed to ensure facility staff administered all medications to Residents (R) 2 and R3 in accordance with their medical care provider's orders. Findings included: - Record review for R2 revealed an admission date of 03/11/24 with diagnoses of Alzheimer's disease and muscle weakness. A "Functional Capacity Screen" (FCS) was requested which the facility failed to provide. A "Negotiated Service Agreement" (NSA) was requested which the facility failed to provide. The 03/12/24 order for lidocaine patch 4% directed facility staff to apply to affected area topically one time a day. Review of R2's Medication Administration Record" (MAR) from 05/01/24 to 06/30/24 revealed a lidocaine patch was not administered from 05/28/24 to 06/06/24 except for one day on 05/30/24 which was eight days the medication was not administered per Primary Care Provider's (PCP) order. On 07/18/24 at 08:55 AM during a phone	S3200		

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S3200	Continued From page 42	S3200		

interview, Administrative Nurse C confirmed a lidocaine patch was not administered to R2 for eight days per PCP's order.

- Record review for R3 revealed an admission date of 10/20/23 with a diagnosis of dementia.

The 05/23/24 "FCS" identified R3 was unable to perform management of medications.

The undated combined "NSA/HCP" identified facility staff provided R3 management of medications.

The 04/25/24 order for alprazolam 0.25 milligrams (mg) directed facility staff to administer once daily by mouth for anxiety.

Review of R3's MAR from 05/01/24 to 06/30/24 revealed alprazolam was not administered from 05/25/24 to 06/13/24 except was documented as administered on 05/26/24, 05/27/24, 05/30/24, 06/01/24, and 06/06/24. Which was 14 days her medication for anxiety was documented as not administered per PCP's order.

On 07/18/24 at 08:55 AM during a phone interview Administrative Staff A and Administrative Nurse C confirmed alprazolam was not administered for 19 days in a row because the facility had no supply of alprazolam for R3 during that time. They stated they could not determine why the medication was documented as administered on five days when there was no supply.

The administrator failed to ensure facility staff administered all medications to R2 and R3 in accordance with their medical care provider's orders.

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S3215 SS=E	26-41-205 (h) Medication Storage (h) Storage. Licensed nurses and medication aides shall ensure that all medications and biologicals are securely and properly stored in accordance with each manufacturer ' s recommendations or those of the pharmacy provider and with federal and state laws and regulations. (1) Licensed nurses or medication aides shall store non-controlled medications and biologicals managed by the facility in a locked medication room, cabinet, or medication cart. Licensed nurses and medication aides shall store controlled medications managed by the facility in separately locked compartments within a locked medication room, cabinet, or medication cart. Only licensed nurses and medication aides shall have access to the stored medications and biologicals. (2) Each resident managing and self-administering medication shall store medications in a place that is accessible only to the resident, licensed nurses, and medication aides. (3) Any resident who self-administers medication and is unable to provide proper storage as recommended by the manufacturer or pharmacy provider may request that the medication be stored by the facility. (4) A licensed nurse or medication aide shall not administer medication beyond the manufacturer ' s or pharmacy provider ' s recommended date of expiration. This REQUIREMENT is not met as evidenced by: KAR 26-41-205(h)	S3215		

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S3215	Continued From page 44 The facility reported a census of 51 total residents with 10 residents in one of two secured memory care units. Based on observation and interview, the administrator failed to ensure controlled medications in the 300-hall memory care unit were securely and properly stored. Findings included: - Observation on 07/09/24 at 11:49 AM revealed Certified Medication Aide (CMA) unlocked and opened the 300-hall memory care unit medication cart. Controlled medications were stored in a separate locked compartment within the medication cart. The compartment contained medications in bubble pack cards with each card labeled by the pharmacy with the medication it contained and residents' names. Two bubble pack cards had opened bubbles with white pills inside that appeared to look the same as the pills in the unopened bubbles. One bubble pack card had five opened bubbles with three secured with clear tape over the back of the bubbles and two of the bubbles were unsecured with no tape. The other bubble pack had two opened bubbles with one secured with clear tape over back of the bubble and the other bubble was unsecured with no tape. On 07/09/24 at approximately 11:49 AM Administrative Nurse C confirmed three bubbles in two bubble pack cards were unsecured. The 05/10/13 department's "Kansas Certified Medication Aide Curriculum" documented how medications were stored may affect the potency and/or effectiveness. When exposed to air, for example, a bubble pack opened and medication	S3215		

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S3215	Continued From page 45 was not administered, the medication may begin to degrade or chemically change. The 12/01/23 facility's "Medications General ALF Policy and Procedure" documented the facility would ensure safe medication practices for all residents. The administrator failed to ensure controlled medications in the 300-hall memory care unit were securely and properly stored.	S3215		
S3225 SS=E	26-41-205 (l) Medication Regimen Review Frequency (l) Medication regimen review. A licensed pharmacist shall conduct a medication regimen review at least quarterly for each resident whose medication is managed by the facility and each time the resident experiences any significant change in condition. This REQUIREMENT is not met as evidenced by: KAR 26-41-205(l) The facility reported a census of 51 residents with three residents, one focused review, and 4 closed record reviews included in the sample. Based on interview and record review the administrator	S3225		

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S3225	Continued From page 46	S3225		

failed to ensure a licensed pharmacist conducted a medication regimen review at least quarterly for Residents (R) 2, R3, and R4.

Findings included:

- Record review for R2 revealed an admission date of 03/11/24 with diagnoses of Alzheimer's disease and muscle weakness.

A"Functional Capacity Screen" (FCS) was requested which the facility failed to provide.

A "Negotiated Service Agreement" (NSA) was requested which the facility failed to provide.

R2's record lacked evidence of quarterly medication regimen reviews by a licensed pharmacist.

- Record review for R3 revealed an admission date of 10/20/23 with a diagnosis of dementia.

The 05/23/24 "FCS" identified R3 was unable to perform management of medications.

The undated combined "NSA/HCP" identified facility staff provided R3 management of medications.

R3's record lacked evidence of quarterly medication regimen reviews by a licensed pharmacist.

- Record review for R4 revealed an admission date of 06/12/23 with a diagnosis of Alzheimer's disease.

The 05/17/23 "FCS" identified R4 was unable to perform management of medications.

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S3225	Continued From page 47 The undated combined "NSA/HCP" identified facility staff would provide R4 management of medications. R4's record lacked evidence of quarterly medication regimen reviews by a licensed pharmacist. On 07/09/24 at approximately 10:48 AM Administrative Nurse C confirmed R2, R3, and R4's records lacked evidence of quarterly medication regimen reviews by a licensed pharmacist. The administrator failed to ensure a licensed pharmacist conducted a medication regimen review at least quarterly for Residents (R) 2, R3, and R4.	S3225		
S3240 SS=E	26-41-103 (c) Staff Development on Dementia (c) If the facility admits residents with dementia, the administrator or operator shall ensure the provision of staff orientation and in-service education on the treatment and appropriate response to persons who exhibit behaviors associated with dementia. This REQUIREMENT is not met as evidenced by: KAR 26-41-103(c) The facility reported a census of 51 residents. 10 residents lived in the 300-hall memory care unit and nine residents lived in the 400-hall memory care unit. Based on interview and record review the administrator failed to provide dementia training to direct care staff upon hire for four out	S3240		

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S3240	Continued From page 48 of five sampled staff. Findings included: - Record review for Dietary Staff N revealed a hire date of 02/25/23. She was registered for dementia training on 02/25/23 but her record lacked evidence it was completed. Record review for Administrative Nurse C revealed a hire date of 02/13/24. Her record lacked evidence dementia training was provided and completed. Record review for Administrative Nurse D revealed a hire date of 03/25/24. Her record lacked evidence dementia training was provided and completed. Record review for Certified Nurse Aide (CNA) revealed a hire date of 07/01/24. Her record lacked evidence dementia training was provided and completed. On 07/11/24 at 02:00 PM Administrative Staff A confirmed dementia training for staff had not been completed. The administrator failed to provide dementia training to direct care staff upon hire for four out of five sampled staff. The administrator failed to provide dementia training to direct care staff upon hire for four out of five sampled staff.	S3240		
S3261 SS=E	26-41-105 (f) (11) Resident Record Documentation of Incidents (f) (11) documentation of all incidents, symptoms,	S3261		

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S3261	Continued From page 49 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 51 residents with three residents, one focused review, and 4 closed record reviews included in the sample. Based on interview and record review the administrator failed to ensure licensed staff documented all incidents, symptoms, and other indications of illness or injury including the date and time of occurrence, action taken, and results of the action for Resident (R)2 and R3. Findings included: - Record review for R2 revealed an admission date of 03/11/24 with diagnoses of Alzheimer's disease and muscle weakness. A "Functional Capacity Screen" (FCS) was requested which the facility failed to provide. An "Negotiated Service Agreement" (NSA) (was requested which the facility failed to provide. The facility's "Senior Living Standard Level of Care and Service Plan" documented R2 was resistant to assistance for bathing and showering, dressing, and incontinence of bladder; required assistance and used a manual wheelchair for transfers and mobility; required occasional prompting and orientation for cognitive difficulties; and had a history of "behavioral issues." The	S3261		

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"Senior Living Standard Level of Care and Service Plan" Behavior Management section had check boxes for 11 behaviors including "demonstrated sexually inappropriate behaviors" and "history of harming self, others, or property" all were left blank.

The 03/17/24 at 10:51 AM behavior "Progress Note" by Certified Medication Aide (CMA) E documented R2 "keeps touching the female residents, rubbing their legs" and R2 touched R11's breast.

Review of R2's record from 03/17/24 to 04/04/24 revealed lack of evidence licensed staff documented the incident including date and time, actions taken to keep females residents safe, and results of the actions. R2 remained in contact with eight female residents for 18 days on the 400-hall memory care unit after CMA E documented his behaviors.

The 04/04/24 at 01:21 PM incident "Progress Note" by Administrative Nurse C documented R2 was found in another female resident (R10)'s room with his hand on her breast while she slept.

The 04/04/24 at 01:21 PM incident "Progress Note" by Administrative Nurse C failed to document the date and time R2 was in R10's room with his hand on her breast.

The 04/04/24 at 03:44 PM incident "Progress Note" documented a new order was received for trazodone 50 milligrams (mg).

The 04/08/24 at 11:42 AM "Progress Note" documented R2 slept well throughout the night and had not exhibited inappropriate behaviors since he began taking trazodone 50 mg.

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S3261	Continued From page 51 The 05/14/24 "Clinical Physician's Orders" documented a new order to discontinue previous order of trazodone 50 mg and begin trazodone 100 mg daily. Review of nursing progress notes from 04/08/24 to 05/14/24 lacked evidence of documentation of increased inappropriate behaviors or trouble sleeping including date and time of occurrence, action taken, and results of the action warranting an increase in medication. The administrator failed to ensure licensed staff documented all incidents, symptoms, and other indications of illness or injury including the date and time of occurrence, action taken, and results of the action on multiple occasions for R2. - Record review for R3 revealed an admission date of 10/20/23 with the following diagnoses: dementia, muscle weakness, and unsteadiness. The 05/23/24 "FCS" identified R3 was independent with transfers and walking/mobility; and was marked for wandering. The undated combined "NSA/HCP" identified facility staff provided R3 guidance or assistance when she ambulated long distances; she resided in the memory care unit with egress doors; and staff provided observation of location in the unit and 24-hour/ seven days a week, supervision to keep her safe from elopement. The 06/13/24 at 01:30 PM "Progress Note" documented R3 was found in the west parking lot by housekeeping staff. R3 was redirected back into the building and to the memory care unit. The 06/14/24 at 02:34 PM "Progress Note"	S3261		

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documented R3 was triggered to elope when her husband was not present during lunch. Staff were to provide monitoring and reassurance to R3 that her husband would visit soon.

The 06/17/24 at 02:34 PM "Progress Note" documented R3 went outside in the memory care courtyard and into the connecting doors of the assisted living portion of the building. She was seen by a staff member and taken back to the memory care unit. Order received to increase alprazolam to 30 mg three times daily. Staff called R3's unidentified family member, left a message, and waited for a call back.

The 06/18/24 at 01:59 PM "Progress Note" documented R3 continued to wander, and exit seek. Staff observed her trying to go through the exit door. Staff called R3's unidentified family member to report behavior and discuss interventions, left a message, and waited for a call back.

Review of "Progress Notes" for R3 from 06/18/24 to 07/07/24 revealed licensed staff failed to document results of increased alprazolam on R3's wandering/exit seeking behaviors and when/if R3's family member called back including new actions discussed to keep her safe from wandering/exit seeking, and results of the actions.

The administrator failed to ensure licensed staff documented all incidents, symptoms, and other indications of illness or injury including the date and time of occurrence, action taken, and results of the action for R3 as well as results of increased alprazolam on R3's wandering/exit seeking behaviors and when/if R3's family member called back in addition to new actions

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S3261	Continued From page 53 discussed to keep her safe from wandering/exit seeking, and results of the actions. On 07/11/24 at approximately 02:30 PM Administrative Nurse C confirmed R2 and R3's records lacked documentation of all incidents, symptoms, and other indications of illness or injury including the date and time of occurrence, action taken, and results of the action for R2 and R3. The 01/2022 facility's "Documentation Policy" documented the Director of Health and Wellness and/or designee will chart in the resident's record services and situations exceptional to the resident which may include: behaviors, change of condition, communication with responsible parties, incidents, and others. The administrator failed to ensure licensed staff documented all incidents, symptoms, and other indications of illness or injury including the date and time of occurrence, action taken, and results of the action for R2 and R3.	S3261		
S3280 SS=F	26-41-104 (d) Disaster and Emergency Preparedness (d) Each administrator or operator shall ensure disaster and emergency preparedness by ensuring the performance of the following: (1) Orientation of new employees at the time of employment to the facility ' s emergency management plan; (2) education of each resident upon admission to the facility regarding emergency procedures; (3) quarterly review of the facility ' s emergency management plan with employees and residents;	S3280		

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S3280	Continued From page 54 and (4) an emergency drill, which shall be conducted at least annually with staff and residents. This drill shall include evacuation of the residents to a secure location. This REQUIREMENT is not met as evidenced by: KAR 26-41-104(d)(3) The facility reported a census of 51 residents. Based on interview and record review the administrator failed to provide evidence of documentation quarterly reviews of the facility's emergency management plan were completed with staff and residents. Findings included: - Review of the facility's emergency plan records lacked evidence of documentation quarterly reviews were completed with staff and residents. On 07/09/24 at 03:35 PM Administrative Staff A confirmed the facility's record lacked documentation reviews of the emergency management plan were completed quarterly with staff and residents. On 07/11/24 at approximately 2:30 PM an Emergency Management Plan quarterly reviews policy was requested which the facility failed to provide. The administrator failed to provide evidence of documentation quarterly reviews of the facility's emergency management plan were completed	S3280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046086	A. BUILDING: _____ B. WING _____	07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADDINGTON PLACE OF PRAIRIE VILLAGE	2700 SOMERSET DRIVE PRAIRIE VILLAGE, KS 66206

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S3280	Continued From page 55 with staff and residents.	S3280		
S3299 SS=F	26-41-206 (e) (1) Facility Food Storage (e) Food storage. Facility staff shall store all food under safe and sanitary conditions. (1) Containers of poisonous compounds and cleaning supplies shall not be stored in the areas used for food storage, preparation, or serving. This REQUIREMENT is not met as evidenced by: KAR 26-41-206(e)(1) The facility reported a census of 51 residents. The facility had a main kitchen where food was stored, prepared, and served and two satellite kitchens where food was stored and served. Based on observation and interview the administrator failed to ensure food items were stored under safe conditions. Findings included: - Observation on 07/09/24 at 11:12 AM of the common snack area revealed one refrigerator that contained the following food items that lacked labels identifying the date the food was opened: One gallon container of milk One plastic sleeve of sliced cheese On 07/09/24 at approximately 11:12 AM Administrative Nurse C confirmed the food items lacked date labels.	S3299		

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S3299	Continued From page 56 Observation on 07/09/24 at 11:20 AM of the facility's main kitchen revealed a two-door refrigerator that contained the following food items that lacked labels identifying the date the food was opened: One gallon container of milk One bottle of chocolate syrup Observation on 07/09/24 at 12:05 PM of the 300-hall memory care satellite kitchen revealed a refrigerator that contained the following food items that lacked labels identifying the date the food was opened: One gallon container of milk One bottle of chocolate syrup One individual sized yogurt with half missing One bottle of liquid coffee creamer One pitcher of orange juice Two pitchers of red liquid One pitcher of tea The refrigerator also contained the following items: One bottle of prune juice dated 04/09/24 which was three months prior The freezer above the refrigerator contained a one-pint sized package of ice cream with lid cracked open. The remaining one-fourth amount of ice cream had visible ice crystals covering the top which indicated freezer burn. On 07/09/24 at approximately 12:05 AM Administrative Nurse C confirmed the food items lacked date labels, the prune juice was dated three months prior, and the ice cream was	S3299		

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S3299	Continued From page 57 freezer burned. The August 2017 Kansas Department of Agriculture's "Focus on Food Safety" booklet documented food items must be date marked after the original container was opened and can be held up to seven days if refrigeration was adequate at 41 degrees Fahrenheit or less. The administrator failed to ensure foods were stored under safe conditions.	S3299		
S3310 SS=F	26-41-207 (b) (5-6) (c) Infection Control Policies (b) (5) prohibiting any employee with a communicable disease or any infected skin lesions from coming in direct contact with any resident, any resident ' s food, or resident care equipment until the condition is no longer infectious; (6) providing orientation to new employees and employee in-service education at least annually on the control of infections in a health care setting; and (c) Each administrator or operator shall ensure the facility ' s compliance with the department ' s tuberculosis guidelines for adult care homes adopted by reference in K.A.R. 26-39-105 This REQUIREMENT is not met as evidenced by: KAR 26-41-207(c) The facility reported a census of 51 residents with three residents, one focused review, and 4 closed record reviews included in the sample. Based on	S3310		

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S3310	Continued From page 58	S3310		

interview and record review the administrator failed to ensure the facility remained in compliance with the department's tuberculosis (TB) guidelines for adult care homes adopted by reference in KAR 26-39-105 for three residents.

Findings included:

- Record review for R2 revealed an admission date of 03/11/24 with diagnoses of Alzheimer's disease and muscle weakness.

R2's record lacked evidence of documentation an initial TB symptom screen and a TB skin test was administered within seven days of residency, and a second step of the two-step TB skin test was administered.

- Record review for R3 revealed an admission date of 10/20/23 with a diagnosis of dementia.

R3's record lacked evidence of documentation an initial TB symptom screen and a TB skin test was administered within seven days of residency, and a second step of the two-step TB skin test was administered.

- Record review for R4 revealed an admission date of 06/12/23 with a diagnosis of Alzheimer's disease.

R4's record lacked evidence of documentation an initial TB symptom screen and a TB skin test was administered within seven days of residency, and a second step of the two-step TB skin test was administered.

On 07/10/24 at approximately 03:18 PM Administrative Nurse D confirmed R2, R3, and R4's records lacked evidence of TB screening

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S3310	Continued From page 59 and testing. The June 2013 department's "Tuberculosis (TB) Guidelines for Adult Care Homes" documented each new employee and each new resident shall receive a two-step TB skin test and symptom screen questionnaire within seven days of employment or admission. On 07/11/24 at approximately 02:30 PM an "TB" policy was requested which the facility failed to provide. The administrator failed to ensure the facility remained in compliance with the department's tuberculosis guidelines for adult care homes adopted by reference in KAR 26-39-105.	S3310		