STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087039	A. BUILDING: _____ B. WING _____	12/14/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VINTAGE PARK AT WATERFRONT LLC	900 N BAYSHORE DR WICHITA, KS 67212

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S 000	INITIAL COMMENTS The following citations represent the findings of a resurvey with complaints #117541, #120766, #121536, #121777, #122681, #123079, and #123821 at the above named facility on 12-5-17, 12-6-17, 12-7-17, 12-11-17, 12-12-17, 12-13-17, and 12-14-17.	S 000		
S 110 SS=F	26-39-103 (c) NOTICE OF RIGHTS AND SERVICES (c) Notice of rights and services. (1) Before admission, the administrator or operator shall ensure that each resident or the resident's legal representative is informed, both orally and in writing, of the following in a language the resident or the resident ' s legal representative understands: (A) The rights of the resident; (B) the rules governing resident conduct and responsibility; (C) the current rate for the level of care and services to be provided; and (D) if applicable, any additional fees that will be charged for optional services. (2) The administrator or operator shall ensure that each resident or the resident ' s legal representative is notified in writing of any changes in charges or services that occur after admission and at least 30 days before the effective date of the change. The changes shall not take place until notice is given, unless the change is due to a change in level of care. This STANDARD is not met as evidenced by: KAR 26-41-103(c)(2) The facility identified a census of 31 residents. The sample included 3 residents and 4 focus	S 110		

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

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S 110	Continued From page 1 review residents. Based on all residents, the operator failed to ensure each resident or the resident's legal representative is notified in writing of any changes in charges or service that occur after admission and at least 30 days before the effective date of the change. The changes shall not take place until notice is given, unless the change is due to a change in level of care. Findings included: - Interview on 12-6-17 at 9:40 a.m. stated resident not getting medications since all residents changed to a new pharmacy and was not notified of the change. Interview on 12-6-17 at 1:05 p.m. with operator stated the new pharmacy took over on 12-1-17 and just found out in the middle of November. The operator further stated the new pharmacy was scheduled to come to facility to talk to residents and family members but the new pharmacy representative was a no show. No notifications of pharmacy changes was sent to residents or family members and did not send a 30 day notice of the pharmacy changes. Operator stated he/she put "flyers" out to let everyone know of the pharmacy changes. For all residents that used facility pharmacy provider, the operator failed to ensure each resident or the resident's legal representative is notified in writing of any changes in charges or service that occur after admission and at least 30 days before the effective date of the change. The changes shall not take place until notice is given, unless the change is due to a change in level of care.	S 110		

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S3028	Continued From page 2	S3028		
S3028 SS=F	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 investigation of reported abuse, neglect, or exploitation. This REQUIREMENT is not met as evidenced by: KAR 26-41-101(f)(3)(A)(B)(C)(D)(E)(F) The facility identified a census of 31 residents. The sample included 3 residents and 4 focus review residents. For all residents, the operator	S3028		

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S3028	Continued From page 3	S3028		

failed to report allegations of exploitation to the department within 24 hours of being informed by staff, residents, and family members and take immediate measure to prevent further potential exploitation as evidenced by record review and interview for 2 (#100, #300) of 3 residents sampled and 3 (#411, #412, #413) of 4 focus review residents sampled . The operator further failed to start an investigation upon receipt of an alleged violation, thoroughly investigate each alleged violation within five days of initial report, take corrective action if alleged violation is verified, complete the department's complaint investigation report and submit to department within five working days and maintain a written record of each investigation of reported abuse, neglect, or exploitation.

Findings included:

- Record review for resident #100 revealed an admit date of 5-2-15 with diagnoses of hypertension, hyperlipidemia, chronic pain, and ischemic cardiomyopathy.

Interview on 12-5-17 at 12:00 noon with operator stated a family member for resident #100 reported to him/her someone was trying to get credit cards using resident's name and laundry soap was ordered and delivered to resident's room. The family member refused and sent laundry soap back and notified the police. The operator further stated had not reported misappropriation of resident funds to the Department.

Interview on 12-6-17 at 11:30 a.m. with operator stated only had one complaint from a family member of credit card/identity theft and that was reported to police from family member for

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S3028	Continued From page 4 resident #100. Written statement from operator dated 12-6-17 at 11:55 a.m. recorded, "(Family member of resident #100)" notified me of mail received in (resident's) name which was a denial letter from a credit card company. (Family member) made a police report of possible identity theft and provided the detectives name and phone number. I contacted the detective and he/she asked questions that I answered. I then sent out a letter to notify all residents and family members that information may have been breached somehow and that it is recommended to contact the three credit bureau's to put a freeze on all credit to prevent any theft occurring. This happened around the end of October. The letter was sent out with the November statements." A written statement from operator with clarified information received on 12-6-17 at 12:40 p.m. recorded. . ."I am aware of more than one resident having accounts compromised from several different stores and talked to families individually. I reported possible identity theft to the police detective." Interview on 12-7-17 with operator stated he/she did not get a case number for reported theft and alleged identity theft for credit cards and did not report the theft or identity theft to the Department within five working days. Telephone interview on 12-12-17 at 10:30 a.m. with detective stated a resident family member reported credit card/identity theft to his/her department. The operator was informed to mail letters to residents/family members with all three credit bureau's to put a freeze on all credit to prevent further possible credit card/identity theft.	S3028		

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S3028	Continued From page 5 The detective state the records of residents were available and open for all staff to look at and further stated the operator only reported one credit card theft and no others. - Record review for resident #300 revealed an admit date of 5-27-16 with diagnoses of insulin dependent diabetic, parkinson's disease, and coronary artery disease. On 6-21-17 the operator reported to the department that family of resident #300 was missing $100.00 in cash and received a case number. Written statement provided on 12-5-17 at 3:35 p.m. recorded on 6-20-17 operator notified by staff of family member asking about $100.00 missing. Operator called family member who stated gave resident $100.00 on Thursday and took resident to dance on Saturday. When arrived to visit resident on Sunday was unable to locate any money. Operator talked to resident who stated went to dance with family member and while in vehicle was going through wallet, arrived at dance, so threw it on floor of the car or maybe just misplaced it. Family member looked in car and unable to find money. Operator talked to staff and no one remembered seeing money. On 12-7-17 at 3:40 p.m. received statements from staff #D, #J, and #K that stated, "Did not see any money". The operator failed to complete a thorough investigation within 5 days, failed to complete the Departments investigation report and send to the Department within 5 business days and failed to maintain a written record of the investigation.	S3028		

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S3028	Continued From page 6 - Record review for focus review resident #411 revealed admit date of 10-3-17 with diagnoses of insomnia, diarrhea, hypertension, and diabetes mellitus. On 12-6-17 at 3:35 p.m. family member came to operator and stated was here to follow up on credit card attempts/hits from phone call last night. Interview on 12-6-17 at 3:45 p.m. with family member stated got things in the mail from credit card companies and a business regarding credit card applications that had been made. Family member stated one company called the resident's phone here at facility while he/she was visiting tried to get information for a credit card. The family member notified the bank and credit bureau's to freeze credit. The family member stated the operator was aware of the attempted credit card/identity theft and detective is working on it. - Record review for focus review resident #412 revealed admit date of 6-9-15 with diagnoses of diabetes mellitus, edema, and hypertension. Confidential interview stated he/she was aware of at least six residents getting denial letters from credit card companies and identity theft. The operator has been notified and is aware. Every time a question was asked about the attempted theft the operator just states ' the detective is working on it. ' A (resident) was charged for an item from a business and reported it to the operator. The operator stated ' the detective is working on it. '	S3028		

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S3028	Continued From page 7 - Record review for focus review resident #413 revealed an admit date of 10-10-15 with diagnoses of encephalopathy, depression, osteoarthritis, hypertension and macular degeneration. Interview on 12-12-17 at 3:10 p.m. with resident stated the bank notified him/her of fraud investigation due to $18,000.00 missing from bank account. Resident stated bank confirmed fraud and refunded $14,000.00 and at this time unable to locate $4,000.00. Resident stated he/she had numerous denial letters from credit card companies and received a glock gun holster from a local gun shop that he/she did not order. The resident called the gun shop and they had it picked up from the facility. The resident stated that these places had his/her social security number, address, date of birth. Resident stated he/she reported this to the operator and was told he/she reported it to the detective. The resident was tearful and stated he/she just needed to rest and was very upset and did not know what to do. Telephone interview with detective on 12-12-17 at 4:45 p.m. stated the operator provided information about a gun holster being sent to (resident #413) but was not informed of the resident's bank account being compromised and theft of money. For all residents, the operator failed to report allegations of abuse, neglect or exploitation to the department within 24 hours of being informed by staff, residents, and family members. The operator further failed to start an investigation upon receipt of an alleged violation, implement	S3028		

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S3028	Continued From page 8 immediate measures to prevent further potential abuse, neglect, or exploitation while the investigation is in progress, thoroughly investigate each alleged violation within five days of initial report, take corrective action if alleged violation is verified, complete the department's complaint investigation report and submit to department within five working days and maintain a written record of each investigation of reported abuse, neglect, or exploitation.	S3028		
S3105 SS=D	26-41-202 (j) Negotiated Service Agreement Outside Resource (j) If a resident's negotiated service agreement includes the use of outside resources, the designated facility staff shall perform the following: (1) Provide the resident, 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, with a list of providers available to provide needed services; (2) assist the resident, if requested, in contacting outside resources for services; and (3) monitor the services provided by outside resources and act as an advocate for the resident if services do not meet professional standards of practice This REQUIREMENT is not met as evidenced by: KAR 26-41-KAR 202(j)(3) The facility identified a census of 31 residents. The sample included 3 residents. Based on record review, interviews, and observation for 1 (#100) of 3 residents sampled, the designated	S3105		

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S3105	Continued From page 9	S3105		

facility staff failed to monitor the service provided by outside resources and act as an advocated for the resident if services do not meet the professional standards of practice.

Findings included:

- Record review for resident #100 revealed an admit date of 5-2-15 with diagnoses of diabetes mellitus, hypertension, hyperlipidemia, chronic pain, and ischemic cardiomyopathy.

The annual Functional Capacity Screen (FCS) dated 7-10-16 and 8-7-17 recorded resident independent with bathing, toileting, transfer, walking/mobility, eating, cognition, required supervision with dressing, unable to manage medications/treatments, and experienced falls/unsteadiness.

The annual Negotiated Service Agreement (NSA)/Health Care Service Plan (HCSP) dated 7-10-16 and 8-7-17 recorded resident independent with ambulation, eating, dressing, toileting, cognition, and staff to administer medications/treatments. Hospice to provide skilled nursing care and maintain optimal cardiac function, provide oxygen and incontinent supplies.

The significant change FCS dated 10-20-17 recorded resident unable to assist with bathing, dressing, toileting, transfer, walking/mobility, bladder incontinence, experienced falls/unsteadiness, impaired hearing, and decision making.

The significant change NSA/HCSP dated 10-20-17 recorded resident is in bed most of time, turn and reposition, hospice and family to assist with feeding, hospice to provide bed baths

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S3105	Continued From page 10	S3105		

two times a week (no dates identified), resident to have a clean gown on, incontinent care provided by facility staff and hospice staff, resident confused and alert at times.

The NSA/HCSP lacked documentation to identify a home health agency comes to the facility two times a day to get resident up in am and returns in the evenings to provide night time care.

The treatment records 10-1-17 through 12-1-17 recorded hospice to shower resident "see nursing care plan". The treatment records are blank and no other records available to identify resident received a shower or bed bath.

Interview on 12-5-17 at 3:45 p.m. with licensed nurse A stated, "(A home health agency) comes to facility in mornings, feeds resident breakfast, assist with getting resident up, and returns in the evening to feed resident supper and returns resident back to bed. Licensed nurse A stated and confirmed services provided by the home health agency not in the NSA/HCSP.

On 12-5-17 at 3:55 p.m. observed resident sleeping in bed.

On 12-7-17 at 2:00 p.m. observed licensed nurse A turn resident with difficulty on side to observe skin. Resident unable to assist with repositioning.

The NSA/HCSP lacked services to be provided by hospice and home health agency and further lacked documentation from hospice and home health agency of services provided.

For resident #100, the designated facility staff failed to monitor the service provided by outside resources and act as an advocated for the

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S3105	Continued From page 11 resident if services do not meet the professional standards of practice.	S3105		
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 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 facility identified a census of 31 residents. The sample included 3 residents and 4 focus reviewed residents. Based on record reviews interview, and observations for 2 (#200, #100) of 3 residents sampled, the operator failed to ensure a licensed nurse provided or coordinated the provision of necessary Health Care Services (HCS) that meet the needs of each resident and are in accordance with the Functional Capacity Screen (FCS) and the Negotiated Service Agreement (NSA). Findings included: - Record review for resident #200 revealed an admit date of 2-10-11 with diagnoses of dementia, anxiety and gastro esophageal reflux	S3155		

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disease.

The FCS dated 5-18-17 recorded resident required physical assistance with bathing, toileting, transfer, walking/mobility, experienced short term memory loss, memory recall, and falls/unsteadiness.

The NSA dated 5-18-17 recorded resident required physical assistance with personal care.

The HCS dated 5-18-17 recorded resident required physical assistance in and out of the shower two times weekly.

The HCS lacked the days of the week to get showers.

The treatment record that records showers to be administered on Tuesday's and Friday's. The record revealed one shower given 12-1-17 through 12-6-17. On 11-1-17 through 11-30-17 revealed total of 4 showers administered on 11-10-17, 11-17-17, 11-22-17 and 11-24-17. On 8-1-17 through 8-31-17 revealed total of 5 showers administered on 8-4-17, 8-11-17, 8-18-17, 8-22-17 and 8-29-17.

Confidential interview on 12-6-17 at 10:05 a.m. revealed resident not getting showers except maybe one time a week and should be getting them two times a week. The director of nurses, operator, and regional manager had been notified of resident not getting showers as scheduled nothing has changed.

Interview with certified staff M stated residents are not getting showers when scheduled.

For resident #200, the licensed nurse failed to

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ensure the provision of health care services to ensure shower provided two times a week.

- Record review for resident #100 revealed an admit date of 5-2-15 with diagnoses of diabetes mellitus, hypertension, hyperlipidemia, chronic pain, and ischemic cardiomyopathy.

The annual FCS dated 7-10-16 and 8-7-17 recorded resident independent with bathing, toileting, transfer, walking/mobility, eating, cognition, required supervision with dressing, unable to manage medications/treatments, and experienced falls/unsteadiness.

The annual NSA/HCSP dated 7-10-16 and 8-7-17 recorded resident independent with ambulation, eating, dressing, toileting, cognition, and staff to administer medications/treatments. Hospice to provide skilled nursing care and maintain optimal cardiac function, provide oxygen and incontinent supplies.

The significant change FCS dated 10-20-17 recorded resident unable to assist with bathing, dressing, toileting, transfer, walking/mobility, bladder incontinence, experienced falls/unsteadiness, impaired hearing, and decision making.

The significant change NSA/HCSP dated 10-20-17 recorded resident is in bed most of time, turn and reposition, hospice and family to assist with feeding, hospice to provide bed baths two times a week (no dates identified), resident to have a clean gown on, incontinent care provided by facility staff and hospice staff, resident confused and alert at times.

The NSA/HCS lacked the provision of services

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S3155	Continued From page 14 for side rails on bed or physical assessment for use of side rails on bed. The NSA/HCSP lacked documentation to identify a home health agency comes to the facility two times a day to get resident up in am and returns in the evenings to provide night time care. The treatment records 10-1-17 through 12-1-17 recorded hospice to shower resident "see nursing care plan". The treatment records are blank and no other records available to identify resident received a shower or bed bath. Interview on 12-5-17 at 3:45 p.m. with licensed nurse A stated, "(A home health agency) comes to facility in mornings, feeds resident breakfast, assist with getting resident up, and returns in the evening to feed resident supper and returns resident back to bed. Licensed nurse A stated and confirmed services provided by the home health agency not in the NSA/HCSP. On 12-5-17 at 3:55 p.m. observed resident sleeping in bed with half side rails up on both sides of bed. On 12-7-17 at 2:00 p.m. observed licensed nurse A turn resident with difficulty on side to observe skin. Resident unable to assist with repositioning. Licensed nurse A stated didn't realize resident had side rails on bed The NSA/HCSP lacked services to be provided by hospice and home health agency and further lacked documentation from hospice and home health agency of services provided and lacked provision of services for side rails on bed. For resident #200 and #100, the operator failed to	S3155		

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S3155	Continued From page 15 ensure a licensed nurse provided or coordinated the provision of necessary HCS that meet the needs of each resident and are in accordance with the FCS and the NSA.	S3155		
S3200 SS=D	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. This REQUIREMENT is not met as evidenced by: KAR 26-41-205(d) The facility identified a census of 31 residents. The sample included 3 residents and 4 focus reviewed residents. Based on record review, interview, and observations for 1 (#412) of 4 focus reviewed residents, the operator failed to ensure all medications administered to resident in accordance with a medical care provider's written	S3200		

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S3200	Continued From page 16 order, professional standards of practice, and each manufacture's recommendations. Findings included: - Focus record review for resident #412 revealed an admit date of 6-9-15 with diagnoses of insulin dependent diabetic, hypertension, and edema. The functional capacity screen recorded facility to administer medications. The negotiated service agreement/health care service plan recorded facility to administer medications. The physician orders dated 8-10-17 recorded lantus 100 units/solo star insulin inject 60 units daily at bedtime for diabetes mellitus. The medication administration record dated 12-1-17 recorded 60 units lantus solo star insulin administered daily at 9:00 p.m. Confidential written statement recorded resident had 45 units of insulin left in insulin pen and notified licensed nurse A who instructed to give 15 units of resident #300's insulin to equal 60 units. Confidential interview stated notified licensed nurse A and was instructed to give the rest of insulin and use resident #300's insulin to make it a total of 60 units and he/she would take care of it in the morning. Interview on 12-6-17 at 4:30 p.m. with certified staff L stated resident #412 ran out of insulin last night and unable to locate an insulin pen for resident to administer at this time and further stated licensed nurse A stated it was coming in	S3200		

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S3200	Continued From page 17 tonight. Interview on 12-6-17 at 4:35 p.m. with licensed nurse A stated, "Instructed certified staff D to administer 45 units insulin that was left to resident #412 and understood resident was to get 60 units. Licensed nurse A confirmed 45 units not documented as being administered and informed certified staff D he/she would handle it in the morning. Licensed nurse A stated, "Did not notify the physician or family member." Written statement provided 12-7-17 at 12:45 p.m. from licensed nurse A recorded, "Certified staff D informed him/her resident did not have enough insulin for night injection and had 35 units left. The order is for 60 units. . .I instructed certified staff D to administer what was available and I will handle the situation in the morning. . .On 12-6-17 it was brought to my attention about 5:00 p.m. I had not notified the physician. I sent a nurse communication by fax." For resident #412, the operator failed to ensure all medications administered to resident in accordance with a medical care provider's written order, professional standards of practice, and each manufacture's recommendations.	S3200		
S3201 SS=D	26-41-205 (d) (3) Facility Administration of Medication (3) A licensed nurse or medication aide shall perform the following: (A) Administer only the medication that the licensed nurse or medication aide has personally prepared; (B) identify the resident before medication is administered;	S3201		

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(C) remain with the resident until the medication is ingested or applied; and

(D) document the administration of each resident ' s medication in the resident ' s medication administration record immediately before or following completion of the task. If the medication administration record identifies only time intervals or events for the administration of medication, the licensed nurse or medication aide shall document the actual clock time the medication is administered.

This REQUIREMENT is not met as evidenced by:
KAR 26-41-205(d)(3)(c)

The facility identified a census of 31 residents. The sample included 3 residents and 4 focus review resident. Based on observation, interview and record review for 1 (#414) of 4 focus reviewed residents, the licensed nurse or Certified Medication Aide failed to remain with the resident until the medication is ingested.

Findings included:

- Focus record review for resident #414 revealed admit 8-11-14 with diagnoses of parkinson's disease, hypothyroidism, depression, and constipation.

On 12-5-17 at 2:35 p.m. observed CMA (D) pour medication carbidopa 100 milligram tablet (for parkinson's disease) in medication cup. Resident came to medication cart and took medication in cup from CMA D, and stated, "He/she was taking it to his/her room and would take the medication in room." CMA allowed

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S3201	Continued From page 19 resident to walk off with out observing him/her taking medication, then recorded medication administered. For resident #414, the licensed nurse or CMA failed to remain with the resident until the medication is ingested.	S3201		
S3256 SS=F	26-41-105 (c) Resident Records Safeguards (c) Each administrator or operator shall ensure the safeguarding of resident records against the following:(1) Loss; (2) destruction; (3) fire; (4) theft; and (5) unauthorized use. This REQUIREMENT is not met as evidenced by: KAR 26-41-105(c)(4) The facility identified a census of 31 residents. The sample included 3 residents. Based on observations and interviews for all residents, the operator failed to ensure the safeguarding of resident records against theft. Findings included: - On 12-5-17 at 2:37 p.m. observed all resident records kept in an open cabinet in copy room where door to copy room is kept open. The resident records were not secured.	S3256		

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S3256	Continued From page 20 On 12-6-17 at 1:55 p.m. went to operator's office and observed resident charts in open cabinet inside copy room. The copy room door open and cabinet where charts are kept open. Interview on 12-12-17 at 10:30 a.m. with detective stated the records for residents with all the information needed for identity theft was open for anyone to look at. The records are not secured and the operator stated the staff needed access to records. Interview on 12-12-17 at 2:35 p.m. with operator stated the copy room where the resident records are located is not locked and available to all staff. For all residents, the operator failed to ensure the safeguarding of resident records against theft.	S3256		
S3265 SS=F	26-41-104 (a) Disaster and Emergency Preparedness (a) The administrator or operator of each assisted living facility or residential health care facility shall ensure the provision of a sufficient number of staff members to take residents who would require assistance in an emergency or disaster to a secure location. This REQUIREMENT is not met as evidenced by: KAR 26-41-104(a) The facility identified a census of 31 residents. The sample included 3 residents. Based on record review, observations, and interviews for all	S3265		

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residents, the operator failed to ensure the provision of a sufficient number of staff member to take residents who would require assistance in an emergency or disaster to a secure location when he/she failed to document the ability to safely evacuate residents with the least number of staff on duty.

Findings included:

- Resident roster provided on 12-5-17 at 1:15 p.m. identified one resident as a two person transfer, five residents required transfer assist to toilet, and twelve residents identified with impaired cognition.

Review of annual evacuations of residents to a secure location with operator on 12-6-17 at 2:30 p.m. revealed last two evacuations conducted on 5-2016 (no date) and 5-18-17. The evacuation on 5-2016 was conducted with 8 staff members (no time it took to complete evacuation). The evacuation conducted on 5-18-17 was conducted with 14 staff members (no time or how long it took to complete evacuation).

Interview on 12-5-17 at 1:35 p.m. with licensed nurse A stated from 2:00 p.m. to 10:00 p.m. and 10:00 p.m. to 6:00 a.m. two staff on duty. A licensed nurse is usually at facility Monday through Friday from 8:00 a.m. to 5:00 p.m.

Interview on 12-6-17 at 2:30 p.m. with operator stated, "Has not conducted an evacuation with only two staff members and confirmed only two staff members on duty on evenings and night shifts."

For all residents, the operator failed to ensure the

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S3265	Continued From page 22 provision of a sufficient number of staff member to take residents who would require assistance in an emergency or disaster to a secure location when he/she failed to document the ability to safely evacuate residents with the least number of staff on duty.	S3265		