STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N089045	A. BUILDING: _____ B. WING _____	C 03/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEGEND AT CAPITAL RIDGE	1931 SW ARVONIA PLACE TOPEKA, KS 66615

(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 represent the findings of an abbreviated survey with review of complaints #186180, #186040, #185057, #183379, #183425, and #183328 at the above assisted living conducted on 03/05/24 - 03/07/24.	S 000		
S 135 SS=D	26-39-103 (h) Resident Right Notification of Changes (h) Notification of changes. (1) The administrator or operator shall ensure that designated facility staff inform the resident, consult with the resident's physician, and notify the resident's legal representative or designated family member, if known, upon occurrence of any of the following: (A) An accident involving the resident that results in injury and has the potential for requiring a physician's intervention; (B) a significant change in the resident's physical, mental, or psychosocial status; (C) a need to alter treatment significantly; or (D) a decision to transfer or discharge the resident from the adult care home. (2) The administrator or operator shall ensure that a designated staff member informs the resident, the resident's legal representative, or authorized family members whenever the designated staff member learns that the resident will have a change in room or roommate assignment. This STANDARD is not met as evidenced by: KAR 26-39-103(h)(1)(A)	S 135		

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

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S 135	Continued From page 1 The facility reported a census of 42 residents with two residents and four closed record reviews. Based on interview and record review the administrator failed to ensure licensed staff notified legal representatives or designated family members when Resident (R) 1 exited the locked memory care unit to the outside in 38-degree weather without staff knowledge. Findings included: - Record review for R1 revealed an admission date of 02/27/24 with the following diagnoses: Alzheimer's Dementia, confusion, and disorientation. The 02/27/24 admission "Functional Capacity Screen" (FCS) identified R1 had short-term and long-term memory, memory recall, and decision-making cognitive difficulties and was marked for impaired decision-making. The "FCS" failed to document R1 exhibited wandering behavior. The 02/27/24 combined admission "Negotiated Service Agreement/Healthcare Service Plan" (NSA/HCP) identified facility staff provided cueing, reminders, reorientation, and offered diversion activities for cognitive difficulties. R1 had a Durable Power of Attorney (DPOA) for impaired decision-making. The "NSA/HSP" failed to the describe services facility staff provided for wandering behavior to prevent elopement from the facility. The 02/27/24 "Mini-Mental State Examination" (MMSE) documented R1 scored 8/30 which	S 135		

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S 135	Continued From page 2	S 135		

indicated severe cognitive impairment.

The 02/27/24 (at admission) "Elopement Assessment Risk Tool" for R1 signed by Administrative Nurse B documented a score of 15. A paragraph at the top of the tool read "If the total score is. . . 14 and above [it] is considered high risk for potential elopement and would warrant the need for extra supervision and intervention."

The 02/28/24 at 05:35 PM "Charting Note" for R1 by Administrative Nurse B documented CMA C reported an alarm sounded in the memory care unit. Receptionist D reported R1 entered the front door of the facility. "It was a pleasant, warm day" and R1 wore shoes, long-sleeved shirt, and pants. No injury was found. The resident reported she did not know what she was doing and opened the door because she wanted to go home. Attempted to contact R1's husband but there was no answer and was unable to leave a message.

R1's record lacked evidence of documentation by licensed nursing staff that continued attempts or confirmation that R1's legal representatives or designated family members were notified when she exited the locked memory care unit to the outside in 38-degree weather without staff knowledge.

On 03/05/24 at approximately 05:32 PM Administrative Nurse B confirmed R1's records lacked evidence of documentation that her legal representative or designated family members were notified when she exited the locked memory care unit to the outside in 38-degree weather

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S 135	Continued From page 3 without staff knowledge. The facility's undated "Kansas Resident Rights" documented the adult care home would immediately notify the resident's legal representative or designated family member when there was a significant change in the resident's physical, mental, or psychosocial status. The administrator failed to ensure licensed staff notified legal representatives or designated family members when R1 exited the locked memory care unit to the outside in 38-degree weather without staff knowledge.	S 135		
S 190 SS=D	26-39-102 (e) Admission, Transfer, Discharge (e) Before a resident is transferred or discharged involuntarily, the administrator or operator, or the designee, shall perform the following: (1) Notify the resident, the resident ' s legal representative, and if known, a designated family member of the transfer or discharge and the reasons; and (2) record the reason for the transfer or discharge under any of the circumstances specified in paragraphs (d) (1) through (4) in the resident ' s clinical record, which shall be substantiated as follows: (A) The resident's physician shall document the rationale for transfer or discharge in the resident ' s clinical record if the transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met by the adult care home; (B) the resident's physician shall document the rationale for transfer or discharge in the resident	S 190		

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S 190	Continued From page 4 ' s clinical record if the transfer or discharge is appropriate because the resident's health has improved sufficiently so that the resident no longer needs the services provided by the adult care home; and (C) a physician shall document the rationale for transfer or discharge in the resident ' s clinical record if the transfer or discharge is necessary because the health or safety of other individuals in the adult care home is endangered. This REQUIREMENT is not met as evidenced by: KAR 26-39-102(e)(1)(2)(A) The facility reported a census of 42 residents with two residents included in the sample and four closed record reviews. Based on record review and interview the administrator failed to document in Resident (R) 4's clinical record the reason for an involuntary transfer from the assisted living to the secured memory care unit, the reason for the transfer substantiated by the resident's physician, and the rationale of the transfer. Findings included: - Record review for R4 revealed an admission date of 08/25/23 with a diagnosis of type two diabetes mellitus. The 10/12/23 "FCS" identified R4 required physical assistance with bathing and management of medications and treatments; she had short-term memory, memory recall, and	S 190		

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S 190	Continued From page 5	S 190		

decision-making cognitive difficulties; and was marked for falls and impaired decision-making.

On 03/07/24 at approximately 11:58 AM a signed "NSA" for R4 was requested by email which the facility failed to provide.

The 08/25/23 "Mini-Mental State Examination" (MMSE) documented a score of 19 out of 30 which indicated mild cognitive impairment.

The 10/12/23 "Charting Note" documented R4 was moved to the memory care unit per the administrator. R4's legal representative was notified.

On 03/06/24 at 09:31 AM an unidentified family member for R4 stated during a phone interview that after R4 moved to the memory care unit, the facility had difficulty obtaining a physician's order to move to the memory care unit. They were going to move R4 back to the assisted living and the family had to hire a third party to provide one-on-one care.

On 03/07/24 at 03:03 PM Administrative Nurse B stated R4 made poor decisions like leaving the community. Facility administrative staff identified R4 was at risk for harm and discussed with her family options to keep her safe. An order or rationale to move from the assisted living to the secured memory care unit was requested from R4's physician which he refused to write. The facility director decided to move R4 to the secured memory care unit as a protective measure to keep her safe.

The facility's "Assisted Living Residency

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S 190	Continued From page 6 Agreement" documented "Resident's shall not be involuntarily transferred or discharged unless. . . the transfer or discharge is necessary for the resident's welfare. . . Transfer may be required. . . determined by the Company, in consultation with the Physician and Resident/Responsible Party." The administrator failed to document in R 4's clinical record the reason for an involuntary transfer from the assisted living to the secured memory care unit, the reason for the transfer substantiated by the resident's physician, and the rationale of the transfer.	S 190		
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.	S 230		

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S 230	Continued From page 7 This REQUIREMENT is not met as evidenced by: KAR 26-39-102(b)(1) The facility reported a census of 42 residents with two residents included in the sample and four closed record reviews. Based on interview and record review the administrator failed to ensure a copy of Resident (R) 2's advanced directives were maintained in her medical record. Findings included: - Record review for R2 revealed an admission date of 09/16/22 with a diagnosis of fall risk. The 07/12/23 "Functional Capacity Screen" (FCS) identified R2 required physical assistance with bathing, dressing, toileting, transfers, walking/mobility, management of medications and treatments; was incontinent of urine; had short-term and long-term memory, memory recall, and decision-making cognitive difficulties; and was marked for falls, impaired vision, impaired vision, and impaired decision-making. The 07/12/23 "Negotiated Service Agreement" (NSA) identified facility staff would assist with bathing, dressing, toileting, transfers, management of medication and treatments, bladder incontinence, and provided periodic orientation to complete daily tasks for cognitive difficulties. Services provided for falls, impaired vision, and impaired hearing were not addressed on the "NSA."	S 230		

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S 230	Continued From page 8 R2's record lacked evidence of documentation of advanced directives. The 02/22/24 intake report to the department documented R2 was a full code. The 02/10/24 "Charting Note" by Administrative Nurse B documented R2 was found by direct care staff sitting on the side of her bed unresponsive and not breathing. EMS was contacted, care team attempted to get vitals. R2 was Do Not Resuscitate (DNR) On 03/08/24 at 10:52 AM a signed DNR form for R2 was requested by email which the facility failed to provide. The administrator failed to ensure a copy of R2's advanced directives were maintained in her medical 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, 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)	S3026		

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S3026	Continued From page 9 The facility reported a census of 42 residents with two residents included in the sample and four closed record reviews. Based on observation, interview, and record review the administrator failed to protect cognitively impaired Resident (R) 1 from neglect when she exited the locked memory care unit to the outside in 38-degree weather without staff knowledge and staff did not respond to the alarm. This placed the R1 in Immediate Jeopardy for harm or injury. Findings included: - Record review for R1 revealed an admission date of 02/27/24 with the following diagnoses: Alzheimer's Dementia, confusion, and disorientation. The 02/27/24 admission "Functional Capacity Screen" (FCS) identified R1 was independent with bathing, dressing, toileting, transfers, walking/mobility, and eating. She was unable to perform management of medications and treatments; had short-term and long-term memory, memory recall, and decision-making cognitive difficulties; was usually understandable and understood others during communication and had impaired decision-making. The "FCS" failed to document R1 exhibited wandering behavior. The 02/27/24 combined admission "Negotiated Service Agreement/Healthcare Service Plan" (NSA/HCP) identified facility staff provided supervision/assistance with bathing and minimum assistance with every morning and	S3026		

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evening with dressing. Facility staff provided management of medications and treatments; cueing, reminders, reorientation, and offered diversion activities for cognitive difficulties. R1 had a Durable Power of Attorney (DPOA) for impaired decision-making. The "NSA/HSP" failed to the describe services facility staff provided for wandering behavior to prevent elopement from the facility.

The 02/27/24 "Mini-Mental State Examination" (MMSE) documented R1 scored 8/30 which indicated severe cognitive impairment.

The 02/27/24 (at admission) "Elopement Assessment Risk Tool" for R1 signed by Administrative Nurse B documented a score of 15. A paragraph at the top of the tool read "If the total score is. . . 14 and above [it] is considered high risk for potential elopement and would warrant the need for extra supervision and intervention." The last paragraph of the tool read "The staff suggest the following interventions to decrease this risk." The line for the list of interventions was left blank.

The 02/28/24 at 05:35 PM "Charting Note" for R1 by Administrative Nurse B documented CMA C reported an alarm sounded in the memory care unit. Receptionist D reported R1 entered the front door of the facility. "It was a pleasant, warm day" and R1 wore shoes, long-sleeved shirt, and pants. No injury was found. The resident reported she did not know what she was doing and opened the door because she wanted to go home. She was confused at baseline. One attempt to call R1's husband to update but he did not answer and was not able to leave message.

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S3026	Continued From page 11 The weather on 02/28/24 at approximately 04:53 PM according to Wunderground.com was 38 degrees Fahrenheit with a wind speed of three MPH. The facility's intake report to the department documented R1 was last seen at 04:30 PM on 02/28/24 in the memory care unit. At 05:15 PM (45 minutes later) R1 entered the front door of the facility. She exited the facility by pushing open the side door to the memory care unit which was alarmed. CMA C reported to Administrative Nurse B the alarm went off. Administrative Nurse B reported staff did not respond to the door alarm. The facility's investigation report to the department documented the following witness statements: By CMA E: "last seen R1 at 04:30 PM at a table visiting with other residents." By receptionist D: "On 02/28/24, about 05:15 PM while sitting at the reception desk, I saw R1 look in the window of the front door." Receptionist D let R1 inside the facility and walked her to the memory care unit. She saw CMA C at the medication cart. By CMA C: He entered the memory care unit to begin medication administration. "When I entered, the alarm was going off . . . I was in the middle of removing a medication from a medication card when I turned around and the receptionist came into the memory care unit with R1."	S3026		

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By activity assistant F: "I heard the alarm going off, but I thought it was the oven in the kitchen." Observation on 03/05/24 at 04:05 PM revealed a possible route R1 took from the side exit door to re-enter the facility's front door was approximately 50 steps.

Observation on 03/06/24 at 10:31 AM revealed an alarm activated immediately upon pushing down the bar on the side exit door of the memory care unit. After holding the bar for 15 seconds a second louder alarm activated, and the door unlocked and opened.

Observation on 03/06/24 at 10:34 AM revealed R2 sat in the common area of the memory care unit holding a pacifier to the mouth of a baby doll she held in her arms. She was not wandering or exit-seeking.

On 03/05/24 at 05:17 PM R1's unidentified family member stated R1 liked to go outside because she enjoyed pulling weeds and gardening flowers. While she was still at home, she would peek at him around a corner. If she thought he was asleep, R1 unlocked the door and got out before he had time to stop her.

On 03/06/24 at approximately 01:06 PM Administrative Nurse B confirmed staff did not respond appropriately to the alarm that activated when R1 opened the side door to exit the building. He confirmed the one staff present in the memory care unit for approximately 45 minutes during the time R1 exited the facility was activity assistant F who was not certified.

On 03/06/23 at 01:27 PM CMA E stated she did

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not hear the alarm because she left the memory care unit at 04:30 PM. When she left, the only staff in the memory care unit was an activity staff.

On 03/06/23 at 03:13 PM activity assistant F stated he was in the memory care unit when R1 exited the building. He did not recognize the door alarm because he thought it was the oven. The alarm sounded for about three to five minutes.

The facility's revised 04/30/19 "Elopement or Missing Resident" policy documented: "It is the responsibility of all personnel to report any resident attempting to leave the premises or suspected of being missing to the Residence Director or Healthcare Coordinator as soon as possible."

The administrator failed to protect cognitively impaired R1 from neglect when she exited the locked memory care unit to the outside in 38-degree weather without staff knowledge and staff did not respond to the alarm. Jeopardy was removed on 03/05/24 when the following actions were documented by the facility in the "Abatement Plan" and accepted by the department at 05:42 PM.

1) R1 was assessed after the incident and was found to be without injury.
2) R1's care plan was reviewed and updated with elopement risk interventions on 02/28/24. Re-education provided to Healthcare Coordinator and nurses to put interventions on the care plan to address elopement risk with the move-in assessment.
3) Hands on demonstration of the alarm sounds of the neighborhood and expected response,

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S3026	Continued From page 14 completed with current associates on or before 03/06/24 or prior to working their next shift by Residence Director or designee. 4) Re-education provided regarding elopement risks, monitoring at risk residents, door alarms, and reporting procedures to current associates on or before 03/06/24 or prior to working next shift. 5) Re-education provided regarding a certified associate must always remain in the memory care unit, to current associates by Residence Director or designee. 6) Additional elopement drills will be held on each shift by 03/07/24 including identification of the alarms and where they are located. The results were to be reported to the quality team to determine additional monitoring of the process. 7) Quality Management Process Improvement (QMPI) committee to monitor resident's compliance and make sure the corrections are achieved and permanent. 8) Monthly review of education records and audits for the next quarter. QMPI to determine additional monitoring and frequency.	S3026		
S3080 SS=D	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	S3080		

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S3080	Continued From page 15 each element and definition specified by the department. (b) A licensed nurse shall assess any resident whose functional capacity screening indicates the need for health care services. This REQUIREMENT is not met as evidenced by: KAR 26-41-201(b) The facility reported a census of 42 residents with two residents included in the sample and four closed record reviews. Based on interview and record review the administrator failed to ensure a licensed nurse documented they assessed Residents (R) 2, R3, and R4 when their "Functional Capacity Screen" indicated health care services were required. Findings included: - Record review for R2 revealed an admission date of 09/16/22 with a diagnosis of fall risk. The 07/12/23 "FCS" identified R2 required physical assistance with bathing, dressing, toileting, transfers, walking/mobility, management of medications and treatments; was incontinent of urine; had short-term and long-term memory, memory recall, and decision-making cognitive difficulties; and was marked for falls, impaired vision, impaired vision, and impaired decision-making. The 07/12/23 "FCS" lacked a signature to confirm assessment was completed by a licensed nurse.	S3080		

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S3080	Continued From page 16 - Record review for R3 revealed an admission date of 11/17/23 with a diagnosis of chronic hypoxic respiratory failure. The 11/20/23 "FCS" identified R3 required physical assistance with bathing, toileting, transfers, walking/mobility; was frequently incontinent of urine; had short-term and long-term memory, memory recall, and decision-making cognitive difficulties. The 11/20/23 "FCS" lacked a signature to confirm assessment was completed by a licensed nurse. - Record review for R4 revealed an admission date of 08/25/23 with a diagnosis of type two diabetes mellitus. The 10/12/23 "FCS" identified R4 required physical assistance with bathing and management of medications and treatments; she had short-term memory, memory recall, and decision-making cognitive difficulties; and was marked for falls and impaired decision-making. The 10/12/23 "FCS" lacked a signature to confirm assessment was completed by a licensed nurse. On 03/07/24 at 03:48 PM Administrative Nurse B confirmed R2, R3, and R4's "FCS's" lacked signatures to confirm assessments were completed by a licensed nurse. The facility's 07/01/12 "Personal Care Assessment" policy documented "The Healthcare Coordinator or designee will conduct the	S3080		

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S3080	Continued From page 17 Personal Care Assessment during the move-in process." The administrator failed to ensure a licensed nurse documented they assessed R2, R3, and R4 when their "Functional Capacity Screen" indicated health care services were required.	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: (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)(2) The facility reported a census of 42 residents with two residents included in the sample and four closed record reviews. Based on interview	S3085		

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S3085	Continued From page 18	S3085		

and record review the administrator failed to ensure the "Negotiated Service Agreement" (NSA) for Resident (R) for R4 was completed; the "NSA's" for R1, R2, R3, and R6 described the services they received based on their "Functional Capacity Screens" (FCS); and the "NSA" for R3 identified the hospice provider.

Findings included:

- Record review for R4 revealed an admission date of 08/25/23 with a diagnosis of type two diabetes mellitus.
The 10/12/23 "FCS" identified R4 required physical assistance with bathing and management of medications and treatments; she had short-term and long-term memory, memory recall, and decision-making cognitive difficulties; and was marked for falls and impaired decision-making.

Review of clinical record for R4 revealed lack of evidence of documentation an "NSA" was completed.
On 03/07/24 at approximately 11:58 AM a signed "NSA" for R4 was requested by email which the facility failed to provide.

On 03/07/24 at approximately 03:15 PM Administrative Nurse B confirmed R4's record lacked evidence of documentation an "NSA" was completed.

- Record review for R1 revealed an admission date of 02/27/24 with the following diagnoses: Alzheimer's Dementia, confusion, and disorientation.

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S3085	Continued From page 19 The 02/27/24 admission "Functional Capacity Screen" (FCS) identified R1 was independent with bathing, dressing, toileting, transfers, walking/mobility, and eating. She was unable to perform management of medications and treatments; had short-term and long-term memory, memory recall, and decision-making cognitive difficulties; was usually understandable and understood others during communication and had impaired decision-making. The "FCS" failed to document R1 exhibited wandering behavior. The 02/27/24 combined admission "Negotiated Service Agreement/Healthcare Service Plan" (NSA/HCP) identified facility staff provided supervision/assistance with bathing and minimum assistance with every morning and evening with dressing. Facility staff provided management of medications and treatments; cueing, reminders, reorientation, and offered diversion activities for cognitive difficulties. R1 had a Durable Power of Attorney (DPOA) for impaired decision-making. The "NSA" failed to the describe services facility staff provided for wandering behavior to prevent elopement from the facility. The 02/27/24 "Mini-Mental State Examination" (MMSE) documented R1 scored 8/30 which indicated severe cognitive impairment. The 02/27/24 (at admission) "Elopement Assessment Risk Tool" for R1 signed by Administrative Nurse B documented a score of 15. A paragraph at the top of the tool read "If the total score is. . . 14 and above [it] is considered high risk for potential elopement and would	S3085		

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warrant the need for extra supervision and intervention." The last paragraph of the tool read "The staff suggest the following interventions to decrease this risk." The line for the list of interventions was left blank.

On 03/05/24 at 05:17 PM R1's unidentified family member stated R1 liked to go outside because she enjoyed pulling weeds and gardening flowers. While she was still at home, she would peek at him around a corner. If she thought he was asleep, R1 unlocked the door and got out before he had time to stop her.

On 03/06/24 at approximately 01:06 PM Administrative Nurse B confirmed services provided R1 for wandering and to prevent elopement were not described on her admission "NSA."

- Record review for R2 revealed an admission date of 05/12/29 with a diagnosis of fall risk.

The 07/12/23 "FCS" identified R2 was marked for falls, impaired vision, and impaired hearing.

The 07/12/23 "NSA" lacked a description of services provided to prevent injury from falls and for impaired vision and hearing.

On 03/07/24 at approximately 03:15 Administrative Nurse confirmed R2's "NSA" lacked a description of the services provided based on her "FCS" for falls, impaired vision, and impaired hearing.

- Record review for R3 revealed an admission date of 11/17/23 with a diagnosis of chronic

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S3085	Continued From page 21 hypoxic respiratory failure. The 11/20/23 "FCS" identified R3 required physical assistance with bathing, toileting, transfers, walking/mobility; was frequently incontinent of urine; had short-term and long-term memory, memory recall, and decision-making cognitive difficulties. The 11/20/23 "NSA" identified R3's husband provided assistance with bathing and dressing. Facility staff provided assistance with toileting, transfers, she used a wheelchair for long distances for walking/mobility; and staff assisted with bladder incontinence. The "NSA" documented services including home health services provider. The 11/20/23 "NSA" lacked the name of the home health provider and services provided by them for R3. On 03/07/24 at approximately 03:15 Administrative Nurse confirmed R3's "NSA" lacked the name of the home health provider and services provided. - Record review for R6 revealed an admission date of 03/17/23 with a diagnosis of dementia with agitation. The 06/06/23 "FCS" identified R6 was marked for falls, impaired vision, and impaired hearing. The 06/06/23 "NSA" failed to identify the services provided R6 for falls, impaired vision, and impaired hearing.	S3085		

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S3085	Continued From page 22 On 03/07/24 at approximately 03:15 Administrative Nurse confirmed R6's "NSA" lacked a description of the services provided based on her "FCS" for falls, impaired vision, and impaired hearing. The facility's 07/01/12 "Negotiated Service Agreement" policy documented the Negotiated Service Agreement shall describe the services to be provided and identify the provider of each service. The administrator failed to ensure the "NSA" for R4 was completed; the "NSA's" for R1, R2, R3, and R6 described the services they received based on their "FCS;" and the "NSA" for R3 identified the hospice provider.	S3085		
S3101 SS=D	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 42 residents with two residents included in the sample and four closed record reviews. Based on interview and record review the administrator failed to	S3101		

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S3101	Continued From page 23 ensure that each individual involved in the development of the "Negotiated Service Agreement" (NSA) signed the agreement for Residents (R) 1 and R3. Findings included: - Record review for R1 revealed an admission date of 02/27/24 with the following diagnoses: Alzheimer's Dementia, confusion, and disorientation. The 02/27/24 admission "Functional Capacity Screen" (FCS) identified R1 was independent with bathing, dressing, toileting, transfers, walking/mobility, and eating. She was unable to perform management of medications and treatments; had short-term and long-term memory, memory recall, and decision-making cognitive difficulties; was usually understandable and understood others during communication and had impaired decision-making. The "FCS" failed to document R1 exhibited wandering behavior. The 02/27/24 combined admission "Negotiated Service Agreement" NSA identified facility staff provided supervision/assistance with bathing and minimum assistance with every morning and evening with dressing. Facility staff provided management of medications and treatments; cueing, reminders, reorientation, and offered diversion activities for cognitive difficulties. R1 had a Durable Power of Attorney (DPOA) for impaired decision-making. The "NSA/HSP" failed to the describe services facility staff provided for wandering behavior to prevent elopement from the facility.	S3101		

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S3101	Continued From page 24 The 02/27/24 "NSA" lacked signatures by those involved in its development. - Record review for R3 revealed an admission date of 11/17/23 with a diagnosis of chronic hypoxic respiratory failure. The 11/20/23 "FCS" identified R3 required physical assistance with bathing, toileting, transfers, walking/mobility; was frequently incontinent of urine; had short-term and long-term memory, memory recall, and decision-making cognitive difficulties. The 11/20/23 "NSA" identified R3's husband provided assistance with bathing and dressing. Facility staff provided assistance with toileting, transfers, she used a wheelchair for long distances for walking/mobility; and staff assisted with bladder incontinence. The 11/20/23 "NSA" lacked signatures by those involved in its development. On 03/07/24 at 03:48 PM Administrative Nurse B confirmed R1 and R3's "NSAs" were not signed. The facility's 07/01/12 "Negotiated Service Agreement" policy documented "Each individual involved in the development of the Negotiated Service Agreement shall sign the agreement." The administrator failed to ensure that each individual involved in the development of the "NSA" signed the agreement for Residents (R) 1 and R3.	S3101		

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S3130	Continued From page 25	S3130		
S3130 SS=E	26-41-203 (d) Special Care Services (d) Special care. Any administrator or operator of an assisted living facility or residential health care facility may choose to serve residents who do not exceed the facility ' s admission and retention criteria and who have special needs in a special care section of the facility or the entire facility, if the administrator or operator ensures that all of the following conditions are met: (1) Written policies and procedures are developed and are implemented for the operation of the special care section or facility. (2) Admission and discharge criteria are in effect that identify the diagnosis, behavior, or specific clinical needs of the residents to be served. The medical diagnosis, medical care provider ' s progress notes, or both shall justify admission to the special care section or the facility. (3) A written order from a medical care provider is obtained for admission. (4) The functional capacity screening indicates that the resident would benefit from the services and programs offered by the special care section or facility. (5) Before the resident ' s admission to the special care section or facility, the resident or resident's legal representative is informed, in writing, of the available services and programs that are specific to the needs of the resident. (6) Direct care staff are present in the special care section or facility at all times. (7) Before assignment to the special care section or facility, each staff member is provided with a training program related to specific needs of the residents to be served, and evidence of completion of the training is maintained in the	S3130		

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S3130	Continued From page 26 employee's personnel records. (8) Living, dining, activity, and recreational areas are provided within the special care section, except when residents are able to access living, dining, activity, and recreational areas in another section of the facility. (9) The control of exits in the special care section is the least restrictive possible for the residents in that section. This REQUIREMENT is not met as evidenced by: KAR 26-41-203(d)(6) The facility reported a census of 42 residents with five residents in the secured memory care unit. Based on observation, interview, and record review the administrator failed to ensure direct care staff were always present in the memory care unit. Findings included: - Record review for R1 revealed an admission date of 02/27/24 with the following diagnoses: Alzheimer's Dementia, confusion, and disorientation. The 02/27/24 admission "Functional Capacity Screen" (FCS) identified R1 had short-term and long-term memory, memory recall, and decision-making cognitive difficulties and was marked for impaired decision-making. The "FCS" failed to document R1 exhibited wandering behavior.	S3130		

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S3130	Continued From page 27 The 02/27/24 combined admission "Negotiated Service Agreement/Healthcare Service Plan" (NSA/HCP) identified facility staff provided cueing, reminders, reorientation, and offered diversion activities for cognitive difficulties. R1 had a Durable Power of Attorney (DPOA) for impaired decision-making. The "NSA/HSP" failed to the describe services facility staff provided for wandering behavior to prevent elopement from the facility. The 02/27/24 "Mini-Mental State Examination" (MMSE) documented R1 scored 8/30 which indicated severe cognitive impairment. The 02/27/24 (at admission) "Elopement Assessment Risk Tool" for R1 signed by Administrative Nurse B documented a score of 15. A paragraph at the top of the tool read "If the total score is. . . 14 and above [it] is considered high risk for potential elopement and would warrant the need for extra supervision and intervention." The 02/28/24 at 05:35 PM "Charting Note" for R1 by Administrative Nurse B documented CMA C reported an alarm sounded in the memory care unit. Receptionist D reported R1 entered the front door of the facility. "It was a pleasant, warm day" and R1 wore shoes, long-sleeved shirt, and pants. No injury was found. The resident reported she did not know what she was doing and opened the door because she wanted to go home. She was confused at baseline. On 03/06/24 at approximately 01:06 PM Administrative Nurse B confirmed the one staff	S3130		

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present in the memory care unit for approximately 45 minutes during the time R1 exited the locked memory care was activity assistant F who was not a certified direct care staff.

On 03/06/24 at 01:27 PM CMA E stated she did not hear the alarm because she left the memory care unit at 04:30 PM. When she left, the only staff in the memory care unit was an activities staff.

Observation on 03/06/24 at approximately 03:14 PM revealed CNA F left the memory care unit. A minute later CMA E entered the memory care unit.

On 03/06/24 at 03:16 PM CMA E and CNA F confirmed they were both off the unit at the same time a minute ago and the only staff on the unit for about one minute was an activity person. CMA E and CNA F stated they had been provided education to practice face-to-face hand off to ensure certified staff were present in memory care unit all times. They thought the activity person was certified.

The KAR 26-39-100 departments "Definitions" defined direct care staff as the individuals employed by or working under contract for an adult care home who assist in activities of daily living.

On 03/07/24 at approximately 11:58 AM policy regarding direct care staff presence on the special care unit was requested by email which the facility failed to provide.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N089045	A. BUILDING: _____ B. WING _____	C 03/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEGEND AT CAPITAL RIDGE	1931 SW ARVONIA PLACE TOPEKA, KS 66615

(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
S3130	Continued From page 29 The administrator failed to ensure direct care staff were always present in the memory care unit.	S3130		
S3165 SS=D	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 42 residents with two 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 and R3 named the licensed nurse responsible for implementing and supervising their "Healthcare Service Plans" (HSP). Findings included: - Record review for R1 revealed an admission date of 02/27/24 with the following diagnoses: Alzheimer's Dementia, confusion, and disorientation. The 02/27/24 admission "Functional Capacity Screen" (FCS) identified R1 was independent with bathing, dressing, toileting, transfers,	S3165		

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S3165	Continued From page 30	S3165		

walking/mobility, and eating. She was unable to perform management of medications and treatments; had short-term and long-term memory, memory recall, and decision-making cognitive difficulties; was usually understandable and understood others during communication and had impaired decision-making.

The 02/27/24 combined admission "Negotiated Service Agreement" NSA identified facility staff provided supervision/assistance with bathing and minimum assistance with every morning and evening with dressing. Facility staff provided management of medications and treatments; cueing, reminders, reorientation, and offered diversion activities for cognitive difficulties. R1 had a Durable Power of Attorney (DPOA) for impaired decision-making.

The 02/27/24 "NSA" for R1 lacked the name of a licensed nurse responsible for implementing and supervising the "HSP."

- Record review for R3 revealed an admission date of 11/17/23 with a diagnosis of chronic hypoxic respiratory failure.

The 11/20/23 "FCS" identified R3 required physical assistance with bathing, toileting, transfers, walking/mobility; was frequently incontinent of urine; had short-term and long-term memory, memory recall, and decision-making cognitive difficulties.

The 11/20/23 "NSA" identified R3's husband provided assistance with bathing and dressing. Facility staff provided assistance with toileting, transfers, she used a wheelchair for long

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S3165	Continued From page 31 distances for walking/mobility; and staff assisted with bladder incontinence. The 11/20/23 "NSA" for R3 lacked the name of a licensed nurse responsible for implementing and supervising the "HSP." On 03/06/24 at approximately 01:06 PM Administrative Nurse B confirmed the nurse responsible was not named on the "NSAs" for R1 and R3. The facility's 07/01/12 "Negotiated Service Agreement" policy lacked a statement addressing the nurse responsible for implementing and supervising the "HSP" for residents. The administrator failed to ensure R1 and R3's "NSAs" named the licensed nurse responsible for implementing and supervising their "HSPs."	S3165		