STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N070007	A. BUILDING: _____ B. WING _____	03/01/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PETERSON ASSISTED LIVING	629 HOLLIDAY STREET OSAGE CITY, KS 66523

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S 000	INITIAL COMMENTS The following citations represent the findings of a resurvey with a complaint (#126600) at the above named assisted living facility conducted on 2/26,27,28/2019.	S 000		
S3028 SS=E	26-41-101 (f) (3) Staff Treatment of Residents Reporting (f) (3) Each allegation of abuse, neglect, or exploitation shall be reported to the administrator or operator of the facility as soon as staff is aware of the allegation and to the department within 24 hours. The administrator or operator shall ensure that all of the following requirements are met: (A) An investigation shall be started when the administrator or operator, or the designee, receives notification of an alleged violation. (B) Immediate measures shall be taken to prevent further potential abuse, neglect, or exploitation while the investigation is in progress. (C) Each alleged violation shall be thoroughly investigated within five working days of the initial report. Results of the investigation shall be reported to the administrator or operator. (D) Appropriate corrective action shall be taken if the alleged violation is verified. (E) The department ' s complaint investigation report shall be completed and submitted to the department within five working days of the initial report. (F) A written record shall be maintained of each investigation of reported abuse, neglect, or exploitation. This REQUIREMENT is not met as evidenced	S3028		

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

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S3028	Continued From page 1 by: KAR 26-41-101(f)(3)(A) The facility reported a census of 15 residents. The sample included 3 residents, 1 focused record review and 1 closed record review. Based on interview and record review the operator failed to report allegations of abuse or neglect within 24 hours of being aware and failed to investigate allegations of abuse or neglect for 1 (#500) of 3 residents. - Review of resident #500's record revealed he/she admitted to the facility 5-2-17 with diagnoses of Alzheimer, congestive heart disease, tremors, hypertension, and peripheral vascular disease. Review of resident #500's functional capacity screen dated 5-2-18 revealed the resident had cognitive impairment, wandering, socially inappropriate disruptive behaviors, and impaired decision making abilities. Review of the residents negotiated service agreement dated 5-2-18 revealed staff needed to provide the resident verbal cues to meals and showers. The negotiated service agreement failed to identify services related to the residents wandering, socially inappropriate behaviors or his/her impaired cognition. Review of the nurses notes revealed the following: 9-20-17 the resident was picking on a couple other resident and took a coffee cup then another resident came over and slapped the resident on his/her shoulder. 9-27-17 the resident took off walking to the store even after staff told him/her it was too hot.	S3028		

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S3028	Continued From page 2	S3028		

Facility staff contacted the residents family and they came and took him/her to the store.
10-29-17 The resident attempted to trip another resident and then grabbed his/her walker and the facility staff intervened. The resident told the staff if he/she didn't leave the resident alone he/she was going to slap him/her.
11-21-17 The resident went to the dining room and went to another resident and pulled on his/her left ear and the other resident turned and slapped the resident.
5-26-18 Resident observed by kitchen staff walk out south exit and head down the alley. Staff followed the resident and was easily redirected to the facility.
6-28-18 certified staff came on duty and the resident was not in his/her room and staff could not find him/her in the facility. Staff contacted the police and staff found the resident later at his/her old house and was taken to the hospital by EMS.
The nurses notes included multiple other times of the resident having inappropriate behaviors and bothering other residents.

Review of a report dated 5-31-18 revealed the resident was pestering another resident and staff asked him/her several times to stop and he/she refused. The other resident walked over to the resident and slapped him/her on the arm.

During an interview on 2-27-19 at 4:30 PM resident #600 reported the resident would stick his/her finger in his/her ears and tug on his/her hair and things like that.

During an interview on 4-27-19 at 4:35 PM certified staff AC reported the resident would grab at other staff and pester them. Staff C stated he/she did not think the resident was safe to be out of the facility alone. Staff C stated the

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S3028	Continued From page 3 resident made a lot of attempts to leave and one time walked and made it to his old house. During an interview on 2-27-19 at 4:44 PM resident #700 reported resident # 500 would walk past him/her and tug on his/her ear or hair or tap him/her on the shoulder but wasn't mean about it. During an interview on 2-27-19 at 4:53 PM administrative staff A reported the resident gave other residents wet-willies and and would occasionally take it too far. Staff A reported the facility would redirect the resident and had arranged a different meal time for him as well as had the physician review his/her medications. Staff A also reported the resident would come and go on the premises and had not given the facility any reason to think he/she would not be able to make it back to the facility without direction. Staff A stated the facility had resident council and resident #500 was there and it was maybe 5-10 minutes later the staff realized the resident was not in the facility. Staff then called the sheriff and went to look for the resident and found him/her at his/her old house. The resident had been gone between 30-45 minutes. The operator failed to report allegations of abuse or neglect related to the "pestering", hitting, and elopement of resident #500 within 24 hours of being aware and failed to investigate the allegations.	S3028		
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	S3085		

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S3085	Continued From page 4 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) (3) The facility reported a census of 15 residents. The sample included 3 residents,1 focused record review, and 1 closed record. Based on record review and interview, the operator failed to ensure that designated facility staff completed the Negotiated Service Agreement to include a description of services to be provided, who would provide the service, and the payment source for outside services provided for 4 (#100, #200, #400, #500) of 5 residents. Findings included: - Review of resident #100's record revealed he/she a;admitted to the facility on 9-30-17 with diagnoses of hypothyroidism and atrial fribulation, hypertension and hyperlipidemia. Review of the functional capacity screen dated	S3085		

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S3085	Continued From page 5	S3085		

9-30-18 revealed the resident needed assistance with bathing, management of medications and medical treatments and had impaired cognition and vision. .

Review of the Negotiated Service Agreement dated 9-30-18 revealed staff assisted the resident with bathing and managed his/her medications. The negotiated service agreement failed to identify any services related to impaired cognition, low vision, who provided lab services, and payment source for outside services of oxygen.

- Review of resident #200's record revealed the resident admitted into the facility on 2/28/13 with diagnoses of hypertension, anxiety, reflux disease, paralysis of lower extremities, and contracture of left neck.

Review of the functional capacity screen dated 2-28-18 revealed the resident was unable to manage his/her medications and medical treatments, had impaired vision with blindness in his/her right eye, and had impaired vision.

Review of the negotiated service agreement dated 2-28-18 lacked services related to the residents blindness in his/her right eye, services related to use of bed raills, failed to identify appropriate services related to outside services for lab, and durable medical equipment.

- Review of resident #400's record revealed the resident admitted to the facility on 9-5-18 with diagnoses of anxiety, colon cancer, hypertension and osteopenia.

Review of the residents functional capacity screen dated 9-6-18 revealed the resident needed assistance with bathing, management of

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S3085	Continued From page 6	S3085		

medications and medical treatment, had bladder incontinence, impaired cognition, and current problems with falls, unsteadiness, impaired vision and hearing and impaired decision making.

Review of the negotiated service agreement dated 9-6-19 lacked services related to falls and unsteadiness, and lacked payment sources for outside services provided to the resident.

- Review of resident #500's record revealed he/she admitted to the facility 5-2-17 with diagnoses of Alzheimer, congestive heart disease, tremors, hypertension, and peripheral vascular disease.

Review of resident #500's functional capacity screen dated 5-2-18 revealed the resident had cognitive impairment, wandering, socially inappropriate disruptive behaviors, and impaired decision making abilities.

Review of the residents negotiated service agreement dated 5-2-18 revealed staff needed to provide the resident verbal cues to meals and showers. The negotiated service agreement failed to identify services related to the residents wandering, socially inappropriate behaviors or his/her impaired cognition.

During an interview on 2-27-19 with licensed nursing staff B reported he/she did not realize all the information that needed to be included in the negotiated service agreement.

The operator failed to ensure designated staff completed the Negotiated Service Agreement to include the appropriate information regarding services to be provided to residents including outside services.

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S3186 SS=E	26-41-205 (b) Administration of Selected Medications (b) Administration of select medications. Any resident who self-administers medication may select some medications to be administered by a licensed nurse or medication aide. The negotiated service agreement shall reflect this service and identify who is responsible for the administration and management of selected medications. This REQUIREMENT is not met as evidenced by: KAR 26-41-205(b) The facility reported a census of 15 residents. The sample included 3 residents, 1 focused record review, and 1 closed record review. Based on record review and interview for 2 (#100 and #300) of 3 residents the administrator failed to ensure a resident who self-administered medications was identified in the negotiated service agreement this service and identify who is responsible for the administration and management of selected medications. Findings included: - Review of resident #100's record revealed he/she a;admitted to the facility on 9-30-17 with diagnoses of hypothyroidism and atrial fibrillation, hypertension and hyperlipidemia. Review of the functional capacity screen dated	S3186		

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S3186	Continued From page 8 9-30-18 revealed the resident needed assistance management of medications and medical treatments and had impaired cognition and vision. . Review of the Negotiated Service Agreement dated 9-30-18 revealed staff assisted the resident with bathing and managed his/her medications. The negotiated service agreement revealed the facility managed medications and the resident self administered some medications. The negotiated service agreement failed to identify what medications the resident self administered. Review of resident #300's record revealed he/she admitted to the facility on 3-1-15 with diagnoses of bilateral lower extremity amputee, heart disease, and diabetes. Review of the resident's functional capacity screen revealed the resident needed assistance with management of medications. Review of the resident negotiated service agreement revealed the facility managed the resident's medications and the resident self administered medications but did not identify what medications the resident self administered. During an interview on 2-27-19 at 2:05 PM licensed nursing staff B reported he/she did not realize it needed to identify who was responsible for the administration and management oaf selected medications. The administrator failed to ensure the negotiated service agreement for residents who self-administered some of their medications included the selected medications the resident/facility would administer.	S3186		

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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; 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 15. The sample included 3 residents, 1 focused record review, and 1 closed record review. Based on interview for all residents and all facility employees, the administrator failed to ensure disaster and emergency preparedness by ensuring performance of quarterly review of the facility's emergency management plan with employees and residents. Findings included: - During an interview on 2-26-19 at 2:08 PM	S3280		

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S3280	Continued From page 10 administrative staff A reported he/she discussed the disaster plan at each resident council but only covered the most common disasters and not the whole emergency management plan. Staff A also reported they had an annual inservice over the disaster plan but did not cover it quarterly. For all residents and employees, the administrator failed to ensure emergency preparedness by ensuring quarterly review of the emergency management plan with all staff and residents.	S3280		