Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N085009	A. BUILDING: _____ B. WING _____	09/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE SALINA KIRWIN	1200 E KIRWIN AVENUE SALINA, KS 67401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS The following citations represent the findings of a resurvey with a complaints (#123692, #123891, #123893) at the above named assisted living facility conducted on 9/25,26/2018.	S 000		
S3245 SS=F	26-41-102 (a) Staff Qualifications Sufficent Staff (a) The administrator or operator of each assisted living facility or residential health care facility shall ensure the provision of a sufficient number of qualified personnel to provide each resident with services and care in accordance with that resident ' s functional capacity screening, health care service plan, and negotiated service agreement. This REQUIREMENT is not met as evidenced by: KAR 26-41-102(b) The facility reported a census of 29 residents. The sample included 3 residents and 1 focused review. Based on interviews and record review for this assisted living facility and affecting all residents who resided in the facility the operator failed to ensure direct care staff or licensed nursing staff were in attendance at the facility at all times. Findings included: - Review of certified staff A's written statement revealed on the evening of 1/8/17 at approximately 10:37 PM certified staff B reported he/she could not find resident #250. Staff A went to the resident's apartment to double check and upon arriving at the front door at approximately	S3245		

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

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S3245	Continued From page 1 10:48 PM certified staff B was trying to get in the front door. As staff A opened the front door he/she observed the resident sitting in the grass across the street. Staff A and Staff B ran across the street (leaving no staff in the building) and asked the resident if he/she hurt. The resident denied pain and due to the cold staff A and staff B assisted the resident to standing position and walked him/her back to the facility. Review of certified staff B's written statement revealed staff B told staff A he/she was going to look outside for missing resident #250. Staff B went out the front door and noticed the resident across the street on the grass. Staff B turned around to go back in and saw staff A so he/she yelled and waved to get staff A's attention. Both staff B and staff A went to get the resident and helped him/her back across the street to the facility. Staff A then notified administrative nursing staff C who arrived at the facility and did a full assessment. Staff did 15 minute checks throughout the night. Review of administrative nursing staff C's written statement revealed he/she arrived at the facility at 11:50 PM after receiving call at 11:27 PM that resident #250 had walked out the building across the street. Staff C completed assessment and no injuries identified. Staff instructed to start 15 minute checks and needs to be monitored when not resting in his/her bed/room. During an interview on 9/25/18 at 5:16 PM administrative staff D reported there were 2 staff on duty when the resident walked out of the facility and both staff went to get the resident back in the facility which left no staff in the building while staff went to get the resident.	S3245		

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S3245	Continued From page 2 The operator failed to ensure direct care staff or licensed nursing staff were in attendance at the facility at all times.	S3245		