STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046072	A. BUILDING: _____ B. WING _____	07/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE ASSISTED LIVING OF LEAWOOD	11661 GRANADA AVENUE LEAWOOD, KS 66211

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S 000	INITIAL COMMENTS The following citations are the result of a licensure for re-survey with attached complaints conducted at the above named assisted living facility in Leawood, KS on 7/10/18, 7/11/18, 7/12/18 and 7/16/18.	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.	S3028		

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

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S3028	Continued From page 1 This REQUIREMENT is not met as evidenced by: 3028 KAR 26-41-101 (f) (1) (3) The facility reported a census of 92 residents. The sample included 6 residents and 3 closed chart review residents. Based on record review and interview for 2 sampled residents (#710, 713) the administrator failed to ensure that allegations of abuse, neglect and exploitation were reported to the department within 24 hours, an investigation was started of the violation and the department's complaint investigation reports were completed and submitted to the department within five working days of the initial report. Findings included: - Record review for resident #710 recorded admission date of 8/21/15 with diagnoses of: allergic rhinitis, depression, dysfunction of the bladder, chronic pain, anxiety, osteoporosis, hyperlipidemia, dementia, chronic obstructive pulmonary disease and hypertension. Functional Capacity Screen (FCS) dated 6/20/18 recorded resident required assistance with bathing, dressing, toileting, transfer, walk/mobility, is incontinent, is unable to perform management of medications and treatments, and had problems with short term memory, long term memory, memory recall and decision making. Negotiated Service Agreement/ Health Care Service Plan (NSA/HCSP) dated 6/26/18 recorded staff to assist resident with bathing, dressing, toileting, transfer (2 staff), walk/mobility, medications and treatments. Cognitive: resident	S3028		

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S3028	Continued From page 2 is unable to remember. Staff to give simple cues. BIMS (Brief interview for mental status) assessment dated 6/20/18 recorded resident at Zero, severe impairment. Progress notes (nurses notes) recorded the following: 5/17/18 at 7:00pm: "Care manager reported that she was getting this resident ready for bed when she noticed [resident] has bruises on his/her left side of his/her back, stomach and left arm. Resident unsure of what happened. Denies pain when asked. Skin around bruises is pink and intact." Signed by licensed nurse #B. 5/22/18 at 11:22am: "Day 1 follow up on bruise to left arm, back and stomach ...." Signed by licensed nurse #D. 5/23/18 5:48pm: "Day 2 follow up on bruise to left arm, back and stomach ...." signed by licensed nurse #D. Interview on 7/12/18 at 12:28pm with licensed nurse #E confirmed report was not sent to the department regarding the bruises, no investigation on record. Bruises of unknown cause on the resident, with the potential for possible abuse or neglect was not reported to the department and an investigation conducted. Department records lacked report of bruises on resident. Record review for resident #713 recorded admission date of 8/21/16 with diagnoses	S3028		

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S3028	Continued From page 3 including: hypothyroidism, diabetes mellitus 2, hyperlipidemia, depression, insomnia, glaucoma, hypertension, atrial fibrillation and osteoarthritis. FCS dated 2/25/18 recorded resident required assistance with bathing and dressing, is unable to administer medications and treatments and has no problems with cognition or communication. NSA/HCSP dated 2/26/18 recorded staff to assist resident with bathing, dressing, medications and treatments. Nurses notes dated 6/15/18 at 3:45pm recorded: "Late entry for 6/14/18. ALC (assisted living coordinator) spoke to resident who said a care manager stole $400 from his/her apartment while the resident and his/her family was visiting .... resident said he/she will call 911 after dinner." signed by administrative staff #C. Interview with resident on 7/12/18 at 10:27am confirmed June theft complaint "yes it was quite a bit of money. $400 and my wallet missing." He/she stated: "I talked to 2 or 3 people who could have done it, they denied it of course. I didn't bring the cops in on it." He/she confirmed it was reported to administrative staff #C. Interview on 7/12/18 at 12:25pm with licensed nurse #E stated "When a resident reports a theft we tell them to call the police. He/she said he/she did." Department records lacked report of allegation of theft from a resident at the facility. Facility policy titled: "internal incident reporting" recorded the following:	S3028		

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S3028	Continued From page 4 "Promptly notify the director of operations. The director of operations must consult with the executive director on the appropriate next steps and follow up including the investigation of the cause and the facts of the incident. Consult with the quality assurance director as needed and direct the timely notification of the following, as applicable, in accordance with law and sunrise procedures,.....regulatory agency law enforcement." "Resident specific incidents: 1 a. Alleged physical, sexual or emotional abuse, h. resident fall with injury or hospitalization, 2b. theft or alleged theft of a resident's funds or property." For residents # 710 and 713, the administrator failed to ensure that allegations of abuse, neglect and exploitation were reported to the department within 24 hours, an investigation was started of the violation and the department's complaint investigation reports were completed and submitted to the department within five working days of the initial report.	S3028		
S3110 SS=F	26-41-203 (a) Range of Services (a) Range of services. The administrator or operator of each assisted living facility or residential health care facility shall ensure the provision or coordination of the range of services specified in each resident ' s negotiated service agreement. The range of services may include the following: (1) Daily meal service based on each resident's needs; (2) health care services based on an assessment by a licensed nurse and in accordance with K.A.R. 26-41-204;	S3110		

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S3110	Continued From page 5 (3) housekeeping services essential for the health, comfort, and safety of each resident; (4) medical, dental, and social transportation; (5) planned group and individual activities that meet the needs and interests of each resident; and (6) other services necessary to support the health and safety of each resident. This REQUIREMENT is not met as evidenced by: KAR 26-41-203 (a)(6) The facility reported a census of 92 residents. The sample included 6 residents and 3 closed review residents. Based on observation, interview and record review for 2 (#713, 715) sampled residents and 15 (#719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733) non-sampled residents, the administrator failed to ensure the provision or coordination of the range of services specified in each resident's negotiated service agreement including other services necessary to support the health and safety of each resident. Findings included: - On 7/11/18 at 3:13pm while passing by resident's room, observed resident #719 in his/her lift recliner, in nearly upright raised position, lift control in his/her hand, attempting to stand. Resident stated he/she wanted to go to the front desk and requested assistance. Resident was unable to stand on own. Call	S3110		

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S3110	Continued From page 6	S3110		

pendant was located inside resident's shirt. Instructed resident to call for assistance with pendant. He/she did so. Resident continued to raise recliner, encouraged him/her to wait for assistance and lowered recliner for resident. He/she raised and lowered recliner repeatedly, while pushing call button repeatedly. No staff was seen passing in hallway. At 3:38pm lowered resident recliner back down and asked resident to wait, entered sales office and requested a Certified Nurse Aide (CNA) be notified resident #719 required assistance. At 3:43pm certified staff #F and #G arrived. (30 minutes time elapsed).

Interview on 7/11/18 at 3:43pm with certified staff #E, confirmed resident call alert was on his/her beeper and alert goes to all the beepers. He/ she stated call light cannot be turned off until staff pendant and resident pendant are pushed at the same time. He/she confirmed resident requires assistance of 2 staff for transfer/toileting.

On 7/11/18 at 3:48pm certified staff #H and #I arrived, confirmed they are assigned to the resident today and received the call alert, but were in with another resident.

Review of call light records for resident #719 recorded the following:

Call light activated (CLA) at 3:16pm, call light cleared (CLC) at 3:42pm, announced 6 times, response time (RT) 26 minutes.

Call light record also recorded resident motion at 3:16pm from a motion detector in the room.

Review of resident call light logs for 7/11/18 recorded call response times of 15 minutes or

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S3110	Continued From page 7 more for 11 other residents. resident #722: CLA at 7:48pm, CLC at 8:09pm. RT 21 minutes. resident #723: CLA at 6:13pm, CLC at 6:38pm. RT 25 minutes. resident 724#: CLA at 5:59m, CLC at 6:22m. RT 23 minutes. resident #715: CLA at 3:25pm, CLC at 3:40pm. RT 15 minutes. resident #725: CLA at2:40 pm, CLC at 3:07pm. RT 27 minutes. resident #713: CLA at 1:57pm, CLC at 2:19pm. RT 22 minutes. resident #726: CLA at 1:40pm, CLC at 1:55pm. RT 15 minutes. resident #721: CLA at 1:12pm, CLC at 1:41pm. RT 29 minutes. resident #721: CLA at 12:44pm, CLC at 1:06pm. RT 22 minutes. resident #729: CLA at 11:54am, CLC at 12:25pm. RT 31 minutes resident #713: CLA at 9:45am, CLC at 10:09am. RT 24 minutes. resident #730: CLA at 8:39am, CLC at 9:15am. RT 36 minutes resident #731: CLA at 7:45am, CLC at 8:01am. RT 16 minutes resident #724: CLA at 7:21am, CLC at 8:00am. RT 39 minutes resident #733: CLA at 6:39am, CLC at 7:23am. RT 44 minutes resident #730: CLA at 6:30am, CLC at 7:04am. RT 34 minutes resident #715: CLA at 5:57am, CLC at 6:25am. RT 28 minutes resident #724: CLA at 4:39am, CLC at 5:01am. RT 22 minutes resident #724: CLA at 12:18am, CLC at 12:36am. RT 18 minutes	S3110		

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S3110	Continued From page 8 Call light records for 7/11/18 also recorded the following for 9 residents: "Response required but not received as of [time], this alert was never responded to" (RRNR) Resident #720 CLA 8:36pm, announced 9 times, RRNR as of 9:21pm Resident #721, CLA 8:24pm, announced 9 times, RRNR as of 9:09pm Resident #727, CLA 1:39pm, announced 9 times, RRNR as of 2:24pm. Resident #728, CLA 12:37pm, announced 9 times, RRNR as of 1:22pm. Resident #726, CLA 11:58am, announced 9 times, RRNR as of 12:43pm. Resident #724, CLA 10:23am, announced 7 times, RRNR as of 10:53am. Resident #730, CLA 9:14am, announced 9 times, RRNR as of 9:59am. Resident #732, CLA 6:42am, announced 9 times, RRNR as of 7:27am. Resident #712, CLA 4:29am, announced 9 times, RRNR as of 5:14am. Resident #724, CLA 4:28am, announced 9 times, RRNR as of 5:13am. Resident #726, CLA 3:42am, announced 9 times, RRNR as of 4:27am. Interview on 7/12/18 at 1:25pm with administrative staff #C stated the system clears the call alert after 45 minutes. Review of resident council minutes dated July 2, 2018 recorded a complaints of long staff response time: "Don't leave me on the toilet 30 minutes"; "They aren't answering call lights" Interview on 7/12/18 at 1:40pm with facility administrator #A, stated facility does not have a	S3110		

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S3110	Continued From page 9 policy on call lights. He/she stated, "We train them as soon as we can on hire." For 17 residents, the administrator failed to ensure the provision or coordination of the range of services specified in each resident's negotiated service agreement including other services necessary to support the health and safety of each resident.	S3110		
S3215 SS=D	26-41-205 (h) Medication Storage (h) Storage. Licensed nurses and medication aides shall ensure that all medications and biologicals are securely and properly stored in accordance with each manufacturer ' s recommendations or those of the pharmacy provider and with federal and state laws and regulations. (1) Licensed nurses or medication aides shall store non-controlled medications and biologicals managed by the facility in a locked medication room, cabinet, or medication cart. Licensed nurses and medication aides shall store controlled medications managed by the facility in separately locked compartments within a locked medication room, cabinet, or medication cart. Only licensed nurses and medication aides shall have access to the stored medications and biologicals. (2) Each resident managing and self-administering medication shall store medications in a place that is accessible only to the resident, licensed nurses, and medication aides. (3) Any resident who self-administers medication and is unable to provide proper storage as recommended by the manufacturer or pharmacy provider may request that the medication be	S3215		

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S3215	Continued From page 10 stored by the facility. (4) A licensed nurse or medication aide shall not administer medication beyond the manufacturer ' s or pharmacy provider ' s recommended date of expiration. This REQUIREMENT is not met as evidenced by: K.A.R 26-41-205(h)(1) The facility reported a census of 92 residents. The sample included 6 residents and 3 closed chart review residents. By observation for one (#734) resident, the administrator failed to ensure that licensed nurses or medication aides stored non-controlled medications according to each manufacturer's recommendations. Findings included: - During tour of facility's medication cart with certified staff #J, observed in 2nd floor medication cart the following for resident #734. In the top drawer: Latanoprost ophthalmic solution (glaucoma) 0.005/2.5 filled 4/28/18 orders for one drop in each eye at bedtime. Bottle was open, no open date recorded. In the bottom drawer: Latanoprost ophthalmic solution 0.005/2.5 filled 5/20/18. 10 bottles in sealed boxes. Directions on the unopened bottles recorded to store unopened bottles in the refrigerator at 36-46 degrees Fahrenheit and open bottles at room temperature up to 77 degrees Fahrenheit for up	S3215		

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S3215	Continued From page 11 to 6 weeks. For resident #734 the administrator failed to ensure that licensed nurses or medication aides stored non-controlled medications according to manufacturer's recommendations.	S3215		
S3261 SS=D	26-41-105 (f) (11) Resident Record Documentation of Incidents (f) (11) documentation of all incidents, symptoms, and other indications of illness or injury including the date, time of occurrence, action taken, and results of the action This REQUIREMENT is not met as evidenced by: KAR 26-41-105(f)(11) The facility reported a census of 92 residents. The sample included 6 residents and 3 closed review residents. Based on record review and interview for 1 closed review resident (#716), the administrator failed to ensure documentation of all incidents, and indications of illness or injury including date, time of occurrence, action taken and results of the action. Findings included: - Record review for resident #716 recorded admission on 9/10/16 and discharge on 7/19/17.	S3261		

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S3261	Continued From page 12 Progress notes (nurses notes) recorded the last entry on 5/25/17 at 10:10am: may wellness visit. Record lacked entry for resident discharge from facility, location discharged to and condition upon discharge. Facility discharge record recorded resident "moved out, family move/location" on 7/19/18. Interview on 7/11/18 at 5:15pm with facility administrator #A and licensed nurse #E confirmed resident record lacked entry for resident discharge from the facility. For resident #716, the administrator failed to ensure documentation of all incidents, and indications of illness or injury including date, time of occurrence, action taken and results of the action.	S3261		