STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046065	A. BUILDING: _____ B. WING _____	08/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE GARDENS ASSISTED LIVING	5201 W 143RD STREET LEAWOOD, KS 66224

(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 are the result of an abbreviated survey for complaints conducted at the above named assisted living facility in Leawood, Kansas on 7/31/17, 8/1/17, 8/2/17, 8/3/17, 8/7/17, 8/8/17 and 8/9/17.	S 000		
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: 26-42-102(f)(1)(B) The facility reported a census of 62 residents. The sample included 6 residents. Based on record review and interview for 1(#735) of 6 sampled residents, the operator failed to ensure that no resident was subjected to neglect when a resident with a history of wandering and poor decision making, left the fenced outdoor area of memory care through a broken fence, was unaccounted for by staff for at least 15 minutes and returned to the facility by police. The resident continued to be at risk for elopement when he/she continued to reside in the unsecure assisted living unit each night without documented staff observations.	S3026		

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

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S3026	Continued From page 1 Findings included: - Record review for resident #735 recorded admission date of 12/30/15 with diagnoses of: anxiety disorder. Functional Capacity Screen dated 2/9/17 recorded resident had problems with short term and long term memory, memory/recall and decision-making and problems with communication including expressing information and understanding others . He/she had a history of wandering, socially inappropriate/disruptive behavior and impaired decision making. Negotiated Service Agreement/ Health Care Service Plan dated 2/9/17 recorded: Staff will monitor where abouts in evening to ensure he/she is safe and not attempting to exit building. "Does on rare occasion attempt to take [spouse] and leave the building. [resident] will often attempt to provide care for his/her [spouse] against his/her desires .... Staff will listen to [resident's] concerns and redirect him/her to more pleasant things ..." Addendum to Care Plan dated 3/20/17 recorded resident to be assisted to memory care as needed for behaviors and safety. "Elopement Risk Assessment" dated 2/9/17 recorded total score of 18. (risk for elopement if	S3026		

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S3026	Continued From page 2	S3026		

score 10 points or above) "Resident high risk for elopement. Staff to monitor where abouts frequently. Risk increased between 2pm to 6pm. Staff to check every 30 (minutes), unless resident is acting (out) then every 15 minutes till bed."

Resident roster received 7/31/17 recorded resident #735 resided in assisted living unit and shared a room with his/her spouse.

Nurse's notes dated 6/12/17 at 8:30pm recorded "This nurse received a call from [city] police department about a resident found walking outside the building. The name was [resident #736] one of our residents in room (# in Assisted living). Resident was at the memory care unit when he/she was last seen in the facility. The aide took him/her to SCU (memory unit) because the resident was pushing his/her [spouse] up and down the hallway .... It is unknown how the resident walked out of the unit and left the building .... [city] police returned the resident to the facility at 8:05pm ...." Signed by licensed nurse #H.

Wunderground.com documents outside temperature on 6/12/17 at 8p.m. as 83 degrees Fahrenheit with clear skies and a south wind at 10 miles per hour. The notes lacked documentation of how the resident was dressed at the time of the elopement and lacked documentation of a physical assessment upon return.

The facility lacked documentation of an investigation of the elopement.

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S3026	Continued From page 3 Observation during facility tour on 7/31/17 at 12:55pm with administrative staff #D on the memory unit revealed double exterior exit doors leading to a fenced area. The door had a lever handle and a bolt lock on it with both doors chained together at the top. The fenced area was approximately 70 foot long and 20 foot wide and the fence was composed of (approximately) 6 foot tall black metal bar fencing between pillars of red brick with no gate. Private housing was at the bottom of a small hill, west of the fence. Door did not alarm when opened, confirmed by administrative staff #D. Observation on 8/1/17 at 11:45am with licensed nurse #B, asked to view area where resident #735 exited facility from. Observed a metal fence panel on North side of memory unit courtyard between 2 brick pillars that had a white rope tied to the top of each end and looped around the top of the brick pillars. Brackets on the metal panel at each corner had new bolts in place holding the panel to the brick pillars. At the bottom left of the metal panel was a slide bolt lock. Interview on 8/1/17 at 11:45am with licensed nurse #B confirmed resident exited facility from the courtyard to the housing property across the street to the West. The metal panel was found lying on the ground, the connections to the brick pillars had rotted/rusted out. He/she did not know how long the fence had been broken. Interview on 8/1/17 at 12:45pm with licensed nurse #B stated at first it was believed resident	S3026		

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eloped through the keypad alarm doors, then later resident showed staff where he/she left through the fence. Fence was tied up with cord temporarily until a welder could repair it. He/she stated he/she did not get statements from staff regarding the elopement.

Notarized statement dated 8/1/17 from licensed nurse #H recorded 3 staff worked on the memory unit when the elopement occurred: certified staff #E, #G and #I.

Notarized statement dated 8/2/17 from certified staff #E recorded he/she was on lunch by the time (the elopement) happened. He/she wrote a statement and gave it to his/her supervisor. Interview on 8/2/17 at 11:38am with certified staff #E stated he/she did not remember the exact time he/she went on break that night. He/she stated "I don't remember. It's on the statement I gave [licensed nurse #H] to give to [licensed nurse #B], that night I wrote it."

Notarized statement from certified staff #G stated he/she took his/her break at 7:32pm and resident was with the other residents at that time.

Interview on 8/2/17 at 1:50pm with licensed nurse #B confirmed he/she received a statement about the elopement from certified staff #E that included the time she was on lunch break (when the resident left the facility), but destroyed it because he/she felt it was no longer relevant since the resident did not exit through the alarmed doors.

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S3026	Continued From page 5 Interview on 8/2/17 at 4:45pm with operator #A stated the request to have the fence repaired was made to the former management company prior to May 31st 2017. Notarized statement from maintenance supervisor #F recorded fence panel was broken prior to August 2016, "The 4 eyelets that the bolts went thru attaching it to the brick columns had rusted away, very long lag bolts were used to hold the fence in place. Not a permanent fix." Receipt for welding new clips on fence panel, recorded work was completed on 6/15/17. Interview on 7/31/17 at 1:10pm in memory care unit (a locked unit) with certified staff #C stated 16 residents were currently on the unit. 14 resident who reside there and 2 from the assisted living (AL) unit (#735 and #737), stating they come here during the day because they are elopement risks. Interview on 8/1/17 at 12:45pm with licensed nurse #B stated resident #735 goes to the memory unit when he/she gets up about 7:45am and leaves the unit at bedtime about 8:30pm or 9pm. Resident was observed on the memory care unit (a locked unit) on the following dates and times: 7/31/17 at 1:10pm and 3:22pm, 8/1/17 at 11:45am, 2:45pm, 4:10pm and 6:00pm; and on 8/2/17 at 11:30am, 2:00pm and 5:05pm.	S3026		

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S3026	Continued From page 6 Observation on 8/1/17 at 3:08pm in resident's room revealed exit door to central courtyard, unlocked and easily opened, no alarm sounded. Spouse was on couch, was confused, and stated resident (#735) is in another city "He/she is gone, Medicare." Resident room is located 2 doors away from the front entry. Observation on 7/31/17 at 12:30pm revealed front door unlocked from outside and able to leave from inside without a code to exit. Each resident's assisted living room has an exit door to the outside with a small patio or an exit door to the central courtyard. From the courtyard, residents could enter their apartment or enter doors by the dining room area and living room/main entry area. Observation on 7/31/17 at 1:25pm revealed exit doors near the main kitchen, 1 bolt locked at the top, other unlocked, push bar, opened easily to outside. Observed a visitor enter through this door from outside. Interview on 8/1/17 at 4:55pm with licensed nurse #B, when asked for the current facility plan to keep resident safe from elopement, he/she stated "staff bring resident back to the assisted living unit at bedtime, they monitor his/her whereabouts frequently, all doors are locked to the outside at night by 11ish" In the morning staff dress him/her and take resident back to memory care around 6:15am to 6:30am. He/she confirmed staff do not document when resident is checked on.	S3026		

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S3026	Continued From page 7 Interview on 8/1/17 at 5:15pm with operator #A confirmed facility does not have a policy for locking doors at night. Observation/interview on 8/1/17 at 5:45pm licensed nurse #B presented alarm panel for resident exit doors. He/she stated the alarm panel was previously set to alarm 8pm to 7am and has now been reset to alarm to pagers 24 hours a day 7 days a week. Exit doors to 2 resident rooms were opened and shut; panel did not register the opened doors. On 8/2/17 received police report (Kansas Standard Offense Report) dated June 12, 2017 at 7:44pm. Location of offense was listed. Route of resident's exit to address on report was walked on 8/2/17 at 4:11pm, taking approximately 4 minutes to complete. Route is in residential area to south west of facility, with duplexes and private homes (some under construction). Busy 4 lane road with speed limit of 45 miles per hour, sits 1 block to West of address where police found resident. Facility policy titled: elopement and safe return included: "3) Elopement drills will be held at least every 3 months on each shift. A record will be kept with the dates and times these drills were held and kept in the Executive Director's office." "10) If the resident cannot be adequately protected, plans must be made for a higher level of care and the resident transferred as soon as possible. In addition it may be necessary to	S3026		

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arrange with the family/responsible party to provide 1:1 supervision until alternative arrangements can be made."

"19) A thorough incident investigation will be conducted and all required notifications made in accordance with the when to call protocol and the entire incident documented. All reports will be filed promptly per State regulations and applicable laws."

Review of facility records documented the most recent facility elopement drill was conducted on 5/25/16 and facility lacked documentation of thorough investigation of 6/12/17 elopement.

For resident #735, the operator failed to ensure that no resident was subjected to neglect when a resident with a history of wandering and poor decision making, left the fenced outdoor area of memory care through a broken fence, was unaccounted for by staff for at least 15 minutes and returned to the facility by police. The resident continued to be at risk for elopement when he/she continued to reside in the unsecure assisted living unit each night without documented staff observations. These failures placed the resident in immediate jeopardy for harm, injury or death.

The jeopardy was removed on 8/1/17 at 6:22 p.m. when operator #A and licensed nurse #B provided a written plan to that included: A one on one staff member for the resident at all times when not in the memory care unit. The one on one will be a Certified nurse aide, certified medication aide or nurse, who is an employee of the community, a

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S3026	Continued From page 9 family member, or a person employed by the family to ensure resident's safety and whereabouts.	S3026		
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 by:	S3028		

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S3028	Continued From page 10 KAR 26-41-101 (f) (1) (3) The facility reported a census of 62 residents. The sample included 6 residents and 1 focus review resident. Based on record review and interview for 3sampled resident (#731,733, 735) the operator failed to ensure that for allegations of abuse and neglect 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 #731 recorded admission date of 2/17/15 with diagnoses of: hypertension, dementia, hyperlipidemia and low vitamin d. Functional Capacity Screen (FCS) dated 2/1/17 recorded resident required assistance with bathing, dressing, toileting, management of medications and treatments, is incontinent of bladder, has problems with cognition (short term memory, long term memory, memory/recall and decision making) and communication (rarely or never understandable, rarely or never understands others) Resident has a history of wandering, impaired decision making and has inappropriate behavior. Negotiated Service Agreement/ Health Care Service Plan (NSA/HCSP) dated 2/2/17 recorded resident to receive staff assistance with bathing, dressing, toileting and medication management. Resident is at risk for elopement thus is on a	S3028		

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special care unit. Resident has a language barrier.

Nurse's notes dated 7/27/17 at 8:00pm recorded "Resident daughter notified this nurse that resident has bruising to his/her right hand, bruises reported to charge nurse of duty. Resident care coordinator notified to initiate investigation." Signed by licensed nurse #H.

Observation on 7/31/17 at 4:33pm revealed purple bruising on resident right thumb web (approximately 4 cm (centimeters) in diameter) and top of right hand 2cm in diameter purple/yellow.

Interview on 7/31/17 at 4:33pm with certified staff # E stated bruises present about a week and he/she also has bruises on upper arms and back.

Observation on 7/31/17 at 5:00pm with certified staff #G observed additional resident bruises: right forearm 2-1cm round bruises and 1cm round bruise on right back, yellow/purple in color. Resident was wearing long sleeves.

Interview on 7/31/17 at 5:30pm with licensed nurse #B when asked if an investigation had been conducted regarding the resident's bruises was told an investigation had been started, no documentation was available. He/she stated he/she interviewed staff but did not obtain written statements. He/she confirmed bruises were not reported to the department.

On 8/2/17 at 3:40 pm licensed nurse #B confirmed lack of documentation of measurement of bruises. Bruises were measured with licensed nurse #B and certified staff # E, bruises measured as follows:

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S3028	Continued From page 12 Back of upper right arm- 1 bruise, purple with yellow edges, 4cm long by 2 ¼ cm wide; just beneath it a 1cm by 1.5cm purple bruise with yellowed edges. Front right upper arm- 1 bruise purple with yellow edges, 6cm long by 2.5cm wide (appears to be several bruises that have merged together). Inside left upper arm, bruise, pale purple with yellow edges 2cm by 2cm round. Facility failed to report the incident to the department within 24 hours, failed to conduct and document the investigation and submit the investigation to the department within 5 working days. Record review for resident #733 recorded admission date of 2/24/17 with diagnoses of: dementia, depression, anxiety, Coronary artery disease and hypertension. Resident resides on the memory care unit. FCS dated 2/24/17 recorded resident required assistance with bathing, dressing and management of medications and treatments. Resident has problems with long term and short term memory, memory/recall and decision making; he/she is usually understandable and usually understands others. Resident has impaired hearing, and is at risk for wandering. NSA/HCSP dated 2/24/17 recorded resident to receive staff assistance with showers, dressing and management of medications. Resident is at risk for falls. Fall risk assessment dated 2/24/17 recorded	S3028		

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S3028	Continued From page 13 score of 10 (high risk). Nurse's notes dated 6/26/17 (no time recorded) recorded "Resident continues on fall follow up. ST (skin tear) to left elbow and hand ...." Record lacked entry for fall. Interview on 8/3/17 at 10:30am with licensed nurse #B confirmed fall, investigation requested. Interview on 8/3/17 at 12:10pm with licensed nurse #B confirmed record lacked documentation of fall. Stated he/she does not have an investigation or incident report for the fall. He/she stated resident fell in his/her room, on the morning of 6/26/17, cut hand. Fall was not witnessed but resident stated he/she "hit that counter." in kitchenette in room. Confirmed no fall interventions in place. Confirmed incident was not reported to the department. Facility failed to report the incident within 24 hours, failed to conduct and document an investigation and failed to submit documentation to the department within 5 working days. Record review for resident #735 recorded admission date of 12/30/15 with diagnoses of: anxiety disorder. FCS dated 2/9/17 recorded resident has problems with short term and long term memory, memory/recall and decision-making, has problems with communication including expressing information and understanding others . He/she has a history of wandering, socially inappropriate/disruptive behavior and impaired decision making. NSA/HCSP dated 2/9/17 recorded: Staff will	S3028		

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GRACE GARDENS ASSISTED LIVING	5201 W 143RD STREET LEAWOOD, KS 66224

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S3028	Continued From page 14	S3028		

monitor where abouts in evening to ensure he/she is safe and not attempting to exit building. "Does on rare occasion attempt to take [spouse] and leave the building. [resident] will often attempt to provide care for his/her [spouse] against his/her desires .... Staff will listen to [resident's] concerns and redirect him/her to more pleasant things ..."

Addendum to Care Plan dated 3/20/17 recorded resident to be assisted to memory care as needed for behaviors and safety.

Nurse's notes dated 6/12/17 at 8:30pm recorded "This nurse received a call from [city] police department about a resident found walking outside the building. The name was [resident #736] one of our residents in room (# in Assisted living). Resident was at the memory care unit when he/she was last seen in the facility. The aide took him/her to SCU (memory unit) because the resident was pushing his/her [spouse] up and down the hallway .... It is unknown how the resident walked out of the unit and left the building .... [city] police returned the resident to the facility at 8:05pm ...." Signed by licensed nurse #H.

Department records recorded elopement reported to the department on 6/16/17. No investigation was received by the department.

On 8/1/17 at 12:45pm received summary document describing elopement dated 6/26/17.

Interview on 8/1/17 at 12:45pm with licensed nurse #B stated at first it was believed resident eloped through the keypad alarm doors, then later resident showed staff where he/she left through the fence. Fence was tied up with cord

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S3028	Continued From page 15 temporarily till a welder could repair it. He/she stated he/she did not get statements from staff regarding the elopement. Facility failed to report the elopement within 24 hours, failed to conduct and document the investigation and failed to submit the investigation to the department within 5 working days. For residents #731,733 and 735 the operator failed to ensure that for allegations of abuse and neglect 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		
S3101 SS=E	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 62 residents. The sample included 6 residents. Based on record review and interview for 2 (#734, 735) the operator failed to ensure each individual involved in the development of the negotiated service	S3101		

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S3101	Continued From page 16 agreement signed the agreement. Findings included: Record review for resident #734 recorded admission date of 9/27/08 with diagnoses of Congestive heart failure, hypertension, neuropathy, irritable bowel syndrome, disorder of cancer metastases, protein calorie malnutrition, and hypercholesterolemia. Functional Capacity Screen (FCS) dated 11/22/16 recorded resident required assistance with bathing, dressing and management of medications and treatments. Negotiated service agreement/ Health care service plan (NSA/HCSP) dated 11/22/16 recorded staff to assist resident with bathing, dressing and management of medications. NSA lacked signatures of those participating in the development of the NSA. Interview on 8/3/17 with licensed nurse #B confirmed lack of NSA signatures, stating family lives out of state. He/she confirmed lack of documentation NSA was sent to responsible party. Record review for resident #735 recorded admission date of 12/30/15 with diagnoses of: anxiety disorder FCS dated 2/9/17 recorded resident required assistance with bathing and management of medications and treatments.	S3101		

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S3101	Continued From page 17 NSA/HCSP dated 2/9/17 recorded staff to assist resident with bathing and medication management. NSA lacked signatures of those participating in the development of the NSA. Interview on 8/3/17 at 11:00am with licensed nurse #B confirmed NSA lacked signatures. For residents #734 and #735) the operator failed to ensure each individual involved in the development of the negotiated service agreement signed the agreement.	S3101		
S3110 SS=E	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; (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.	S3110		

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S3110	Continued From page 18 This REQUIREMENT is not met as evidenced by: 26-41-203 (a)(6) The facility reported a census of 62 residents. The sample included 6 residents. Based on interview and record review for 2 (#732,734) sampled residents and 4(#738, 739,740, 741,) non-sampled residents, the operator 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: - Record review for resident #732 recorded admission date of 5/9/17 with diagnoses of: cystitis, anemia, hypertension, hypomagnesemia, gastroesophogeal reflux disease, glaucoma, squamous cell cancer of right shoulder, gout and neuropathy. FCS dated 5/9/17 recorded resident required assistance with dressing, toileting and transfer. NSA/HCSP dated 5/9/17 recorded resident to receive staff assistance with dressing, toileting and transfer. Observation on 7/31/17 at 1:40pm in resident's room revealed resident activated call assistance button (call light) twice (resident stated he/she wanted to get up from his/her recliner). Staff failed to enter resident's room until 2:03pm when	S3110		

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S3110	Continued From page 19 certified staff #K entered, removed the trash from the bathroom and left. At 2:10pm resident activated call light again, certified staff #L responded at 2:11pm and assisted resident. Review of facility call light logs (device activity report) did not record resident call light activation until 2:09pm, cleared at 2:10pm. Record review for resident #734 recorded admission date of 9/27/08 with diagnoses of Congestive heart failure, hypertension, neuropathy, irritable bowel syndrome, disorder of cancer metastases, protein calorie malnutrition, and hypercholesterolemia. FCS dated 11/22/16 recorded resident required assistance with bathing, dressing and management of medications and treatments. NSA/HCSP dated 11/22/16 recorded staff to assist resident with bathing, dressing and management of medications. Observation on 8/1/17 at 1:30pm in resident's room revealed resident activated bed side call light at 1:30pm, (observed activation and red signal light upon activation by resident) staff did not respond to call light until 1:55pm when informed by this surveyor resident required assistance. Observation on 8/1/17 at 1:53pm of certified staff #M beeper revealed resident's room # not on beeper. Call light was reactivated and appeared on resident's beeper immediately. Review of facility call light logs recorded call light was activated at 1:29pm and cleared at 1:54pm (25 minute response time).	S3110		

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S3110	Continued From page 20 Further review of facility call light logs recorded the following response times: 7/31/17 resident #738: call light activated at 12:45pm, cleared at 1:26pm. Response time 41 minutes. 7/31/17 resident #739 call light activated at 12:25pm, cleared at 1:00pm. Response time 35 minutes. 7/31/17 resident #740 call light activated at 12:42pm, cleared at 12:59pm. Response time 17 minutes. 8/1/17 resident #741 call light activated at 11:50am, cleared at 12:34pm. Response time 44 minutes. Confidential interview on 7/31/17 at 2:03pm with resident family member, he/she stated it is often 15-30 minutes before staff respond to resident's call light. Interview on 8/2/17 at 2:50pm with certified staff #N, stated call lights can only be turned off at resident source by pushing a small pin or ink pen into a small reset button on the back of the call light pendant. (he/she demonstrated). For residents #732, 734, 738, 739,740 and 741, the operator 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 when staff failed to answer call lights in a timely manner.	S3110		
S3200 SS=D	26-41-205 (d) (1-2) Facility Administration of Medications (d) Facility administration of resident ' s	S3200		

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S3200	Continued From page 21 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 reported a census of 62 residents. The sample included 6 residents. Based on record review and interview for 1 resident (#732), the operator failed to ensure all medications and treatments were administered in accordance with a medical care provider's written order, professional standards of practice and each manufacturer's recommendations. Findings included: - Record review for resident #732 recorded admission date of 5/9/17 with diagnoses of:	S3200		

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S3200	Continued From page 22	S3200		

cystitis, anemia, hypertension, hypomagnesemia, gastroesophogeal reflux disease, glaucoma, squamous cell cancer of right shoulder, gout and neuropathy.

Functional Capacity Screen dated 5/9/17 recorded resident required assistance with management of medications and treatments.

Negotiated Service Agreement/ Health Care Service Plan dated 5/9/17 recorded resident to receive staff assistance with management of medications.

Physician's telephone order dated7/14/17 recorded: 0xygen 2 L (liters) keep Sat. (oxygen saturation) equal to or over 90 percent and PRN (as needed) comfort.

Observation on 7/31/17 at 1:40pm in resident's room, revealed resident in recliner with oxygen in place by nasal cannula at 2LPM (liters per minute).

Review of resident's July 2017 MAR/TAR(medication administration record/ Treatment administration record) lacked record of oxygen order.

Observation on 8/2/17 at 5:34pm of resident's electronic MAR/TAR for August 2017 with licensed nurse #H revealed oxygen use not recorded.

Interview on 8/2/17 at 5:34pm with licensed nurse #J confirmed Oxygen is not recorded on MAR/TAR, resident uses oxygen stating "We put his oxygen on at night. Wife sometimes says to put it on." He/she stated SPO2 (blood oxygen saturation level) is checked. He/she confirmed

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S3200	Continued From page 23 SPO2 is not recorded anywhere. For resident #732, the operator failed to ensure all medications and treatments were administered in accordance with a medical care provider's written order, professional standards of practice and each manufacturer's recommendations.	S3200		
S3261 SS=E	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 62 residents. The sample included 6 residents. Based on record review and interview for 4 sampled residents (#731, 733, 734 and 735), the operator 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:	S3261		

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S3261	Continued From page 24 - Record review for resident #731 recorded admission date of 2/17/15 with diagnoses of: hypertension, dementia, hyperlipidemia and low vitamin d. Functional Capacity Screen (FCS) dated 2/1/17 recorded resident required assistance with bathing, dressing, toileting, management of medications and treatments. Negotiated Service Agreement/ Health Care Service Plan (NSA/HCSP) dated 2/2/17 recorded resident to receive staff assistance with bathing, dressing, toileting and medication management. Nurse's notes dated 7/27/17 at 8:00pm recorded "Resident daughter notified this nurse that resident has bruising to his/her right hand, bruises reported to charge nurse of duty. Resident care coordinator notified to initiate investigation." Signed by licensed nurse #H. Record lacked assessment by licensed nurse including size, color and location of bruising. On 8/2/17 at 3:40 pm licensed nurse #B confirmed lack of documentation of measurement of bruises. Nurse's note dated 5/18/17 recorded "Resident seen by [nurse practitioner]..". Entry lacked time of entry. Record review for resident #732 recorded admission date of 5/9/17 with diagnoses of: cystitis, anemia, hypertension, hypomagnesemia, gastroesophogeal reflux disease, glaucoma, squamous cell cancer of right shoulder, gout and neuropathy.	S3261		

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S3261	Continued From page 25 FCS dated 5/9/17 recorded resident required assistance with bathing, dressing, toileting, transfer and management of medications and treatments. NSA/HCSP dated 5/9/17 recorded resident to receive staff assistance with bathing, dressing, toileting, transfer and management of medications. Nurse's notes lacked time of entry for 14 entries from admission on 5/9//17 to most recent entry on 7/27/17. Record review for resident #733 recorded admission date of 2/24/17 with diagnoses of: dementia, depression, anxiety, Coronary artery disease and hypertension. Resident resides on the memory care unit. FCS dated 2/24/17 recorded resident required assistance with bathing, dressing and management of medications and treatments NSA/HCSP dated 2/24/17 recorded resident to receive staff assistance with showers, dressing and management of medications. Nurse's notes dated 6/26/17 (no time recorded) recorded "Resident continues on fall follow up. ST (skin tear) to left elbow and hand ...." Record lacked time of entry and lacked entry for date and time of fall including assessment by a licensed nurse and notification of family and physician. Interview on 8/3/17 at 12:10pm with licensed nurse #B confirmed record lacked documentation of fall.	S3261		

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S3261	Continued From page 26 Record review for resident #734 recorded admission date of 9/27/08 with diagnoses of Congestive heart failure, hypertension, neuropathy, irritable bowel syndrome, disorder of cancer metastases, protein calorie malnutrition, and hypercholesterolemia. FCS dated 11/22/16 recorded resident required assistance with bathing, dressing and management of medications and treatments. NSA/HCSP dated 11/22/16 recorded staff to assist resident with bathing, dressing and management of medications. Nurse's notes dated 3/24/17 to most recent entry on 7/28/17 lacked time of entry 6 times. Record review for resident #735 recorded admission date of 12/30/15 with diagnoses of: anxiety disorder FCS dated 2/9/17 recorded resident required assistance with bathing and management of medications and treatments. NSA/HCSP dated 2/9/17 recorded staff to assist resident with bathing and medication management. Nurse's notes 2/22/17 to most recent entry on 6/23/17 lacked time of entry 11 times. Interview on 8/3/17 at 12:20pm with licensed nurse #B confirmed lack of entry times on nurse's notes stating "I know, I've talked to them about that." Facility policy on documentation recorded: "These	S3261		

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S3261	Continued From page 27 guidelines should be followed when making entries in resident care notes: 6 b) for every entry, record the date (including the month, day, year and time of the occurrence.)" For residents #731, 733, 734 and 735, the operator 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		
S3320 SS=F	28-39-254 CONSTRUCTION (a) The assisted living facility or residential health care facility shall be designed, constructed, equipped and maintained to protect the health and safety of residents, personnel and the public. (b) All new construction, renovation, remodeling and changes in building use in existing buildings shall comply with building and fire codes, ordinances and regulations enforced by city, county, and state jurisdictions, including the state fire marshal. (c) New construction, modifications and equipment shall conform to the following codes and standards: (1) Title III of the Americans with disabilities act, 42 U.S.C. 12181, effective as of January 26, 1992; and (2) "Food Service Sanitation Manual," health, education, and welfare (HEW) publication no. FDA 78-2081, as in effect on July 1, 1981. This REQUIREMENT is not met as evidenced	S3320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046065	A. BUILDING: _____ B. WING _____	08/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE GARDENS ASSISTED LIVING	5201 W 143RD STREET LEAWOOD, KS 66224

(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
S3320	Continued From page 28 by: KAR 28-39-254(a) The facility reported a census of 62 residents. The sample included 6 residents. Based on observation and interview for all residents, the operator failed to ensure the facility was maintained to protect the health and safety of the residents when resident use areas were found to lack proper housekeeping and maintenance. Findings included: - On 7/31/17 during facility tour from 12:30pm to 1:38pm with administrative staff #D, observed the following: Throughout assisted living hallways, fans blowing on the carpeted floors, East hall (100 hall) warm, carpet in main living room area has large areas that are stained. In the facility memory care unit: large amount of white food debris noted on living room floor. Carpet badly stained (black and red spots) in living room, dining room and hall areas. Outside main kitchen: tile dirty with black scuffs and food debris. Exit doors black at edges. West hall (200 hall) carpet wet near entry to dining room, fan blowing on carpet. Interview on 7/31/17 during facility tour with administrative staff #D confirmed roof leaks, stating "we are getting a new roof." He/she confirmed air conditioner in 100 hallway is not	S3320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046065	A. BUILDING: _____ B. WING _____	08/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE GARDENS ASSISTED LIVING	5201 W 143RD STREET LEAWOOD, KS 66224

(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
S3320	Continued From page 29 working but resident room air conditioners are functioning. Observations throughout rest of building: On 7/31/17 at 2:24pm in resident room #205, water damage to inside wall near ceiling above window, carpet has large stains. On 7/31/17 at 3:35pm in resident room #6, with licensed nurse #B, urine in toilet, toilet paper holder empty, wet briefs in trash can. Certified staff # G observed leaving room just prior. On 7/31/17 at 4:45pm in memory care unit living room: debris under couches including food, plastic medication cups, 2 pills (unidentifiable one white, one peach colored, have been moistened), a zebra slipper, a shoe, a box of vinyl gloves and an empty jelly packet. On 8/1/17 at 11:45am with licensed nurse #B, in hallway near courtyard exit, strong urine smell (confirmed by licensed nurse #B), glass exit doors dirty, black smear on North wall behind a chair. On 8/1/17 at 12:05pm East hall (100 hall) temperature 79.1F (degrees Fahrenheit). On 8/1/17 at 6:07pm in public restroom, toilet seat worn, black edges, dirt debris on floor behind toilet and sink, sink faucet drips water and base of faucet badly corroded in front. At dining room entry, interior wall at ceiling, warped/ swollen, stained from water damage. For all residents, the operator failed to ensure the facility was maintained to protect the health and safety of the residents when resident use areas	S3320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046065	A. BUILDING: _____ B. WING _____	08/09/2017

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GRACE GARDENS ASSISTED LIVING	5201 W 143RD STREET LEAWOOD, KS 66224

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S3320	Continued From page 30 were found to lack proper housekeeping and maintenance.	S3320		