STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087069	A. BUILDING: _____ B. WING _____	06/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENT PARK ASSISTED LIVING AND MEMORY CAF	10600 E 13TH ST NORTH WICHITA, KS 67206

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S 000	INITIAL COMMENTS The following citations represent the findings of an abbreviated survey for the investigation of complaints #93723, #95054, and #95841 of the above assisted living facility on 5/31/16, 6/1/16, 6/2/16, 6/7/16, and 6/8/16.	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: KAR 26-41-101(f)(1)(B) The facility reported a census of 78 residents. The sample included 4 residents and 2 closed resident records reviewed. Based on record review, interview, and observation for 1 (#851) of 6 residents sampled, the administrator failed to ensure no resident was subjected to neglect when a companion was not assigned to monitor this cognitively impaired resident with a known risk for elopement. Resident #851 left the facility without staff knowledge on 5/28/16 and was found approximately 0.7 miles from the facility. This failure placed the cognitively impaired resident with impaired decision-making ability in immediate jeopardy at risk for injury, harm, or death.	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 #851 revealed an admission date of 3/3/16 and diagnoses of Alzheimer's dementia, dyspnea (difficulty breathing), and hypertension (high blood pressure). The functional capacity screen dated 4/12/16 (noted as a 30-day assessment) indicated the resident was independent with transferring and walking; experienced impaired short-term memory, decision-making ability, and memory recall; was at risk for falls; and did not require an assistive device for mobility. The negotiated service agreement/health care service plan (NSA/HCSP) dated 4/12/16 documented resident alert and oriented to person and place and needed occasional redirection and reorientation. The NSA/HCSP contained documentation by health care coordinator H as follows: 5/7/16-Increased frequent safety checks and companion care due to increased confusion and safety. 5/10/16- primary care physician and pharmacy to review medications. Family meeting scheduled 5/26/16. 5/26/16- continue companion care with facility. The record contained an elopement assessment risk tool that scored the resident at 5 points on 3/3/15, 13 points on 5/7/16 (following the 1st elopement), and 16 points on 5/31/16 (3 days following the 2nd elopement). The tool documented that a score of 0-6 points indicated a low risk for elopement, 7-13 points indicated a	S3026		

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moderate risk for elopement, and a score of 14 points and above indicated a high risk for potential elopement and would warrant the need for extra supervision and intervention.

Review of the nurse's notes revealed the following entries:

5/7/16 (entry time documented as 2:00 p.m.) health care coordinator H documented resident was brought back to assisted living front desk by a staff member from a rehabilitation facility at approximately 3:00 p.m. after finding resident in their facility cafe. Resident last seen by staff in assisted living building at 2:15 p.m. Primary care physician notified and antibiotic ordered for urinary tract infection while waiting results of urinalysis. Durable power of attorney notified. Resident placed on increased safety checks and companion care provided by facility staff implemented to provide 1 to 1 until decreased confusion and urinary tract symptoms resolved.

5/10/16 at 10:00 a.m. health care coordinator H documented urinalysis results negative for urinary tract infection. Pharmacist and primary care physician to review medications due to (resident's) confusion and negative urinary tract infection.

5/26/16 at 4:00 p.m. health care coordinator H documented care plan meeting with (durable power of attorney) this afternoon and agreed to continue companion care by facility staff.

5/28/16 at 4:50 p.m. licensed nurse A documented resident #851 "went on a walk. States (he/she) got confused and went into the wrong building. Business associate contacted

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this community to report whereabouts. Resident was picked up by staff and returned to the community at approximately 4:30 p.m.. No signs/symptoms of dehydration, sunburn, or any distress. Resident on visual checks and companion care from 2:00 p.m. to 6:00 p.m." The record lacked documentation of vital signs on return to community.

At 12:20 p.m. on 5/31/16, the health care coordinator H stated resident did leave the facility "over the weekend and was found at the event center."

At 12:25 p.m. on 5/31/16 during an interview with the administrator and health care coordinator H, the administrator stated that after resident #851 ' s elopement on 5/7/16 the facility initiated companion care 7 days a week from 12:00 p.m. to 6:00 p.m. Administrator stated at 6:00 p.m. the front door to the assisted living locks and would alarm if resident tried to open door. Health care coordinator H stated he/she met with resident's durable power of attorney on 5/26/16 and due to cost of companion care the hours for companion care were decreased to 2:00 p.m. to 6:00 p.m.. Administrator stated that after the elopement on 5/28/16, additional intervention was put into place for activity person to keep resident with him/her from the time the resident got up in the morning until companion came to be with resident at 2:00 p.m. 7 days a week. Administrator stated resident was on a waiting list to transfer to the facility's memory care.

At 2:30 p.m. on 5/31/16, asked health care coordinator H for a written statement from the companion with resident on 5/28/16. Health care coordinator stated resident did not have an assigned companion on that day. Health care

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coordinator stated (certified nursing assistant B) did not read the schedule correctly and worked the floor.

At 3:20 p.m. on 5/31/16, certified nursing assistant B (CNA B) stated he/she just started working at facility and was marked as "O" on the schedule for orientation on 5/27/16 and 5/28/16 and worked the floor on the 2:00 p.m. to 10:00 p.m. shift on those days. CNA B stated he/she was not aware he/she was to provide companion care to resident on 5/28/16.

Observed resident with CNA B during interview. Resident #851 very pleasant and involved in watching other residents playing cards. CNA B stated resident was very active and liked to be outside.

Review of staff schedule for 5/1/16 through 5/31/16 documented CNA B was marked as "O" for orientation on 5/27/16 and 5/28/16. CNA C was marked on the schedule for companion care for resident on 5/27/16. The schedule lacked the assignment of a companion for the resident on 5/28/16.

During an interview at 4:10 p.m. on 5/31/16, licensed nurse A stated he/she reported for work at 3:30 p.m. on 5/28/16 and shortly after he/she received a call from the facility receptionist (I) that resident was found at the event center. Receptionist I went to the event center and transported the resident back to the facility and licensed nurse A assigned a companion to the resident.

At 4:33 p.m. on 5/31/16, CNA #C stated he/she provided companion care to resident one time

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and resident wanted to go for a walk to go to his/her home in another town.

At 4:40 p.m. on 5/31/16, health care coordinator H stated he/she made out the schedule for companion care for resident #851 and failed to schedule a companion from 2:00 p.m. to 6:00 p.m. on 5/28/16.

On 6/1/16 obtained written witness statements from staff members working the 6:00 a.m. to 2:00 p.m. shift and the 2:00 p.m. to 10:00 p.m. shift on 5/28/16. Review of the written statements revealed certified medication aide (CMA) D was the last staff member to see resident at 1:20 p.m. on 5/28/16.

On 6/1/16 at 11:30 a.m. during an interview with CMA D, he/she stated when going outside for a break at 1:20 p.m. on 5/28/16 resident (#851) and another resident were sitting in front foyer. CMA D stated while on break he/she did not see resident #851 come out the front door and when CMA D came back into the building through the front door resident was no longer sitting in the front foyer.

During an interview at 12:40 p.m. on 6/1/16, administrator stated resident left the facility without staff knowledge due to not having an assigned companion on 5/28/16.

At 1:00 p.m. on 6/1/16, drove to the event center which was 0.7 mile from the facility when driving west on 13th street and turning on Lindberg street. Observed the event center at the end of a dead-end street with no other buildings close by and a body of water close to the building. Observed that resident could have possibly walked through open grassy area if he/she did

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not walk on sidewalk or in street. Went inside the event center and met 3 employees. Employee E stated at approximately 4:45 p.m. on 5/28/16, wedding guest brought resident into the facility and stated resident was not part of the attendees at the wedding. Employee E stated he/she remembered seeing resident dressed in a "jogging suit" sitting on a bench in the sun prior to the guest bringing resident into the building. Employee E stated the resident gave his/her first and last name and said a friend was coming to pick (resident) up and needed to call this person. Employee E gave the phone to resident who did not know how to use the phone. Employee E stated he/she called a nursing facility in the area but they did not have a resident by this name. Employee E stated he/she stayed on phone with that facility while they called the assisted living facility and determined the resident was missing from the assisted living. An employee from the assisted living came to transport resident back to the facility.

According to wunderground.com the temperature was 80 to 83 degrees Fahrenheit during the time the resident was out of the facility. Observed the street directly in front of the facility was a four lane street and well-traveled with a posted speed limit of 40 miles per hour.

The administrator failed to ensure no resident was subjected to neglect when a companion was not assigned to monitor cognitively impaired resident #851 with a known risk for elopement.

At 5:30 p.m. on 5/31/16 the administrator provided a written plan to ensure safety of resident #851 that documented as follows: Upon awakening, resident will be with life enrichment for activities until companion care aide arrives at

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S3026	Continued From page 7 2:00 p.m. Companion care aide will be with resident until 6:00 p.m. when (front) door auto locks, per family request. After 6:00 p.m. companion care aide will report to other aides that he/she will be leaving and where resident is and what resident is doing. Cart 1 certified medication aide will then start 30 minute checks until resident is ready for assistance to bed. After resident is assisted to bed, frequent checks of 30 minutes will be implemented. Cart 1 medication aide will sign in on the sheet that will be located on the medication cart for 30 minute physical checks.	S3026		
S3155 SS=E	26-41-204 (a) Health Care Services . (a) The administrator or operator in each assisted living facility or residential health care facility shall ensure that a licensed nurse provides or coordinates the provision of necessary health care services that meet the needs of each resident and are in accordance with the functional capacity screening and the negotiated service agreement. This REQUIREMENT is not met as evidenced by: KAR 26-41-204(a) The facility reported a census of 78 residents. The sample included 4 residents and 2 closed records reviewed. Based on record review, interview, and observation for 2 (#851 and #854) of 3 residents sampled receiving companion care services, the administrator failed to ensure that a licensed nurse provided or coordinated the provision of necessary health care services that	S3155		

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S3155	Continued From page 8 met the needs of each resident and were in accordance with the functional capacity screening and the negotiated service agreement. Findings included: - Record review for resident #851 revealed an admission date of 3/3/16 and diagnoses of Alzheimer's dementia, dyspnea, and hypertension. The functional capacity screen dated 4/12/16 (noted as a 30-day assessment) indicated the resident was independent with transferring and walking; required supervision with bathing, dressing, toileting, and eating; required physical assistance with management of medications and treatments; experienced impaired short-term memory, decision-making ability, and memory recall; was at risk for falls; and did not require an assistive device for mobility. The negotiated service agreement/health care service plan (NSA/HCSP) dated 4/12/16 documented resident alert and oriented to person and place and needed occasional redirection and reorientation. The NSA/HCSP contained documentation by the health care coordinator as follows: 5/7/16-Increased frequent safety checks and companion care due to increased confusion and safety. 5/10/16- primary care physician and pharmacy to review medications. Family meeting scheduled 5/26/16. 5/26/16- continue companion care with facility. The NSA/HCSP lacked description of the frequency of safety checks, the hour of	S3155		

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S3155	Continued From page 9 companion care and the services to be provided by the companion. Review of the nurse's notes revealed the following entries: 5/7/16 (entry time documented as 2:00 p.m.) health care coordinator H documented resident was brought back to assisted living front desk by a staff member from a rehabilitation facility at approximately 3:00 p.m. after finding resident in their facility cafe. Resident last seen by staff in assisted living building at 2:15 p.m. Primary care physician notified and antibiotic ordered for urinary tract infection while waiting results of urinalysis. Durable power of attorney notified. Resident placed on increased safety checks and companion care provided by facility staff implemented to provide 1 to 1 until decreased confusion and urinary tract symptoms resolved. 5/26/16 at 4:00 p.m. health care coordinator H documented care plan meeting with (durable power of attorney) this afternoon and agreed to continue companion care by facility staff. 5/28/16 at 4:50 p.m. licensed nurse A documented resident "went on a walk. States (he/she) got confused and went into the wrong building. Business associate contacted this community to report whereabouts. Resident was picked up by staff and returned to the community at approximately 4:30 p.m. No signs/symptoms of dehydration, sunburn, or any distress. Resident on visual checks and companion care from 2:00 p.m. to 6:00 p.m." At 12:20 p.m. on 5/31/16, health care coordinator	S3155		

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S3155	Continued From page 10 H stated resident did leave the facility "over the weekend and was found at the event center." At 12:25 p.m. on 5/31/16 during an interview with the administrator and health care coordinator H, the administrator stated after resident #851's elopement on 5/7/16 the facility initiated companion care for 7 days a week from 12:00 p.m. to 6:00 p.m. Health care coordinator H stated he/she met with resident's durable power of attorney on 5/26/16 and due to cost of companion care the hours for companion care decreased to 2:00 p.m. to 6:00 p.m. Administrator stated that after the elopement on 5/28/16, additional intervention was put into place for activity person to keep resident with him/her from the time the resident got up in the morning until companion came to be with resident 7 days a week. Administrator stated resident was on a waiting list to transfer to the facility's memory care. The NSA/HCSP lacked a description of services to include activity person with resident from waking until companion arrived. Observed resident with CNA B during interview. Resident #851 very pleasant and involved in watching other residents playing cards. CNA B stated resident was very active and liked to be outside. The administrator failed to ensure that a licensed nurse provided or coordinated the provision of necessary health care services that met the needs of resident #851 and were in accordance	S3155		

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with the functional capacity screening and the negotiated service agreement.

- Record review for resident #854 revealed an admission date of 2/19/16 and a diagnosis of dementia.

The functional capacity screen dated 2/19/16 indicated the resident was independent with transferring, walking, eating, and management of medications; required supervision with bathing, dressing, and toileting; physical assistance with management of treatments; experienced impaired short-term memory, long-term memory, decision making, and memory recall; impaired ability to communicate and understand communication; and was at risk for falls.

The negotiated service agreement/health care service plan (NSA/HCSP) dated 2/19/16 documented the facility services of one-person assistance with bathing and dressing, cue to toilet, redirect and reorient, and a nurse added on 3/2/16 companion care by an outside provider 3:00 p.m. to 9:00 p.m. The NSA/HCSP lacked a description of services provided by companion care.

The nurse's notes contained an entry by licensed nurse A at 1:25 p.m. on 5/23/16 that he/she spoke with resident's family member regarding facility to begin providing companion care service on 6/1/16 when companion care services by the outside provider were discontinued.

At 3:35 p.m. on 6/1/16 in the memory care, certified medication aide G stated the resident's companion did not start until 4:00 p.m.

At 4:50 p.m. on 6/1/16 in the memory care unit

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S3155	Continued From page 12 met facility employee certified nursing assistant (CNA) J who stated he/she was providing companion care services to resident. Observed CNA J in the commons area of the facility visiting with 2 facility certified staff members. CNA J stated resident was in bed in his/her room and did not want to get up. When asked CNA J what care he/she provided to resident CNA J replied "usual" activities of daily living and resident required a companion due to being combative with some staff members. CNA J stated this was his/her first time to care for resident. During an interview at 3:45 p.m. on 6/2/16 with administrator and health care coordinator H, administrator stated the companion was to be 1 to 1 with resident during the specified hours due to resident being aggressive with staff and "mouthy" toward other residents. Health care coordinator H confirmed he/she did not describe companion care services in the NSA/HCSP and did not instruct CNA J on care and services to be provided for resident. The administrator failed to ensure that a licensed nurse provided or coordinated the provision of necessary health care services that met the needs of resident #854 and were in accordance with the functional capacity screening and the negotiated service agreement.	S3155		