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S 000	INITIAL COMMENTS The following citations represent the findings of a resurvey and investigation of complaints #67101 and #75530 of the above assisted living facility on 6/10/14, 6/11/14, 6/12/14, 6/16/14, and 6/17/14.	S 000		
S3155 SS=J	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 50 residents. The sample included 4 residents and 2 focus review residents. Based on record review, interview, and observations for 1 (#552) of 4 residents sampled, the operator failed to ensure the licensed nurse accurately assessed and provided or coordinated necessary health care services to the cognitively impaired resident with wandering and exit-seeking behaviors to prevent the resident from eloping from the facility. This failure placed the resident in immediate jeopardy for harm, injury, or death. Resident was identified as an elopement risk according to the resident's functional capacity screen and the negotiated service agreement. The cognitively impaired resident left the facility without staff awareness on 5/18/14, fell, experienced a fractured arm, and required hospitalization for surgery.	S3155		

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

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Findings included:

- Record review for resident #552 revealed an admission date of 3/4/14 and diagnoses of Alzheimer's dementia and osteoporosis.

The functional capacity screen (FCS) dated 3/3/14 indicated the resident was independent with ambulation, transferring, toileting, bathing, dressing, and eating and required physical assistance with management of medications and treatments. The FCS documented the resident experienced impaired long-term and short-term memory and memory recall.

Clinical note entry 5/9/14 licensed nurse #A at 5:17 p.m. documented he/she heard the north door alarm sound, went to door, and observed resident ambulating on sidewalk outside door. Resident stated he/she was going to go get a hamburger. Licensed nurse #A documented he/she redirected resident back into the facility and placed a wander guard on resident's ankle as an additional safety precaution. The nurse documented notification of the resident's family member, the resident care coordinator, and director and completed the addendum to the negotiated service agreement.

The record contained an addendum to the negotiated service agreement dated 5/9/14 of "Wanderguard was placed on resident ankle as an additional safety precaution." (Wanderguard device used to alert staff when resident approaching an exit door.) The addendum lacked additional interventions to manage the resident's wandering and exit-seeking behaviors.

The FCS contained documentation dated 5/9/14

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that the resident did exhibit wandering behavior.

The record contained an elopement risk assessment dated 5/9/14 completed by a licensed nurse that documented the resident was at risk for elopement due to history of wandering with no discernible purpose, attempt to elope, easily distracted, periods of restlessness, and a diagnosis of Alzheimer's dementia.

Clinical note entry 5/12/14 licensed nurse #A at 6:54 p.m. documented resident's family member contacted regarding the resident's increasing pacing and verbalizing desire to go get a hamburger. Food offered to resident but then not hungry and resident had a difficult time remaining at the table during meals. The nurse documented the wanderguard remained in place on the resident. The record lacked additional interventions to address the resident ' s wandering and exit seeking behavior.

Clinical note entry 5/14/14 resident care coordinator (RCC) documented at 10:18 a.m. that the neurologist ordered clonazepam (anti-anxiety medication) 0.5 mg at bedtime as needed for agitation and Seroquel (psychotropic agent) 25 mg at noon daily for agitation.

Clinical note entry 5/16/14 RCC documented at 10:25 a.m. employees were taking resident outside for a daily walk at the request of a family member to help with resident's urge to wander and become agitated. The record lacked additional documentation of interventions to address the resident's wandering and exit seeking behavior

5/18/14 in the morning, Resident #552 refused to change clothes and did not want to take

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medications and got up from table at breakfast 2 times, paced, and tried to exit the building according to written statement by CMA #C. CMA #C further stated he/she redirected the resident and asked nurse about medication to help calm the resident and when the resident's family member came to facility at 11:00 a.m. and CMA #C informed the family member resident had been trying to exit the building. Family member told CMA #C to redirect the resident when trying to exit. CMA #C documented resident continued through day to pace from resident's room to the front of the building with CMA #C last seeing the resident at supper time.

Review of the May 1-May 31, 2014 medication administration record revealed certified medication aide (CMA) #C administered clonazepam 0.5 mg to resident at 10:15 a.m. on 5/18/14 due to "anxious, wandering." Documentation for the clonazepam on the medication administration record indicated the medication was to only be given at bedtime if needed for agitation. The resident record lacked an assessment by the licensed nurse and contact of the resident's physician to administer the medication at 10:15 a.m. At 11:00 a.m. on 5/18/14, licensed nurse #B documented "Less agitated." on the medication administration record.

The record lacked documentation by licensed nurse #B of an assessment of the resident and interventions implemented to reduce the resident's wandering and exit-seeking behavior.

5/18/14 around 4:30 p.m. CMA #E was on the second floor of the facility and observed another resident leaving the building (on the first floor) and resident #552 was trying to exit the building

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also according to written statement by CMA #E. CMA #E further documented he/she notified CNA #D and licensed nurse #B that resident was trying to leave and CMA #E got to resident first and redirected the resident.

The record lacked documentation of an assessment by the nurse or interventions to address the residents increased wandering and exit seeking behavior.

Clinical note entry 5/18/14 11:12 p.m. Licensed nurse #B documented " about 1900 (7:00 p.m.) resident's family member called to report he/she received a call from someone stating resident was found "at McAllister and Huntoon and they were following behind the ambulance to the hospital." Licensed nurse # B documented he/she had last seen the resident walking in the first floor hall around 6:30 p.m. The nurse also documented the resident required redirection earlier (no time identified) when wanting to go to the car to get a hamburger and "this nurse redirected (resident) to the interior for various reasons." Nurse documented contacting director and RCC.

Clinical note entry 5/19/14 Director documented at 9:09 a.m. that resident was in the hospital for treatment of a fractured humerus.

Clinical note entry 5/20/14 RCC documented at 10:59 a.m. that he/she talked with a nurse at the hospital who reported resident had shoulder replacement surgery due to 4 fractures of arm.

Per telephone interview on 6/11/14 at 12:45 p.m., CNA # D stated he/she was providing care to a resident (#556) the evening of 5/18/14 in the

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southeast hall and came to the front of the building to get hygiene supplies for that resident and heard the north door alarm. CNA #D stated he/she reset the door to silence the alarm because needed to get back to care for resident #556 who was in the bathroom. CNA #D stated that licensed nurse #B was sitting in the RCC's office and he/she told the nurse that the north door alarm had sounded. CNA #D stated licensed nurse #B should have heard the alarm to the north door sounding. The RCC's office is located on the first floor in close proximity to the north door.

At 9:55 a.m. on 6/11/14 the office manager stated according to review of the 5/18/14 video recording the resident left the facility through the north door. Office manager explained that each exit door was monitored with a camera and all doors except the front door would alarm and open after pushing on the door for 15 seconds. Office manager explained that the wanderguard the resident wore would alarm and lock the front door if resident tried to go out that door but the north door where the resident exited would only alarm when opened. Office manager stated the door alarms were audible only and did not alert staff unless staff members were where they could hear an alarm.

At 12:25 p.m. on 6/11/14, office manager stated he/she reviewed the video recording of the north door and resident exited the building at 5:59 p.m. on 5/18/14 and CNA #D entered the code on the keypad to reset the door and silence the alarm at 6:05 p.m. on 5/18/14 without checking outside to see if a resident left the building.

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S3155	Continued From page 6 Review of the statement written by licensed nurse #B who described resident's behavior on 5/18/14 as "moving in the halls in usual manner." Licensed nurse #B documented that at mid-morning staff reported resident pacing more than usual and resident needing redirection as he/she went near the doors. Staff inquired about the use of a medication due to resident being agitated and uncooperative. Medication was given. Licensed nurse #B documented that he/she last saw the resident on 5/18/14 after dinner in the hallway walking toward the resident's room. Telephone interview at 1:40 p.m. on 6/12/14 with licensed nurse #B who stated resident walked in the halls in the morning of 5/18/14 and around 10:00 a.m. was given clonazepam when CMA reported resident was agitated. Licensed nurse #B stated he/she did not call the resident's physician, the facility director, or the RCC when CMA reported resident was agitated. Licensed nurse #B stated he/she did not hear a door alarm at 6:00 p.m. and that an employee did not report the alarm had sounded. At 3:55 p.m. on 6/12/14, licensed nurse #B came to the facility and provided a written statement. Licensed nurse #B stated he/she did not assess the resident prior to instructing CMA #C to administer clonazepam on 5/18/14. Licensed nurse #B stated he/she saw the resident earlier in the morning and resident seemed a little agitated. Licensed nurse #B stated he/she documented resident's reaction to the medication as "less agitated" on the medication administration record as his/her assessment of the resident. Licensed nurse #B stated sometime during the morning (unable to give time) he/she did hear the door alarm and reset the door. Licensed nurse #B	S3155		

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stated he/she did not do a perimeter check of the building and did not check on residents at risk for elopement because he/she found resident #552 in the front lobby. Licensed nurse #B stated employees did not inform her of resident trying to exit at 4:30 p.m. or a door alarming at 6:00 p.m. on 5/18/14.

Approximately 30 minutes after leaving the facility, Resident #552 was found in the street at Huntoon and McAllister where he/she had fallen. If resident had walked from facility to 10th street and followed sidewalk on Gage and turned right on Huntoon and proceeded on Huntoon to the intersection with McAllister, resident had walked 1.3 miles from the facility through a high traffic area with multiple businesses. Observed the speed limit on 10th street at 35 miles per hour (mph) dropping to 30 mph at the corner shopping center. Observed speed limit on Gage at 40 mph and Huntoon at 30 mph.

Observed that if resident had headed west or southwest from facility he/she would have passed by 3 small ponds of water with thick brush and small trees covering a sloping bank to the water. Observed a fence to the south of the property that resident could have gone around or through a gate to get to McAllister.

According to weather underground the temperature at 6:00 p.m. was around 78 degrees F.

The ambulance report documented a call was received at 6:28 p.m. on 5/18/14 to respond to Huntoon and McAllister due to a person falling and emergency medical technician and paramedic on scene with resident at 6:39 p.m. Report documents resident #552 complained of

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S3155	Continued From page 8 pain in right shoulder and upper arm and had a small abrasion to the left hand. Resident #552 was able to tell emergency personnel his/her name and birthday and emergency personnel contacted the hospital to get records of resident #552's emergency contacts. Resident transported to hospital 7:30 p.m. Review of hospital discharge documents dated 5/23/2014 document resident #552 suffered a Right humerus fracture at the humeral neck and part of the greater tubercle and had a hemiarthroplasty (shoulder replacement). For resident #552, the operator failed to ensure the licensed nurse accurately assessed and provided or coordinated necessary health care services to the cognitively impaired resident with wandering and exit-seeking behaviors to prevent the resident from eloping from the facility. This failure placed the resident in immediate jeopardy for harm, injury, or death. This cognitively impaired resident left the facility without staff awareness on 5/18/14 when staff failed to respond to a door alarm, fell, experienced a fractured arm, and required hospitalization for surgery.	S3155		
S3200 SS=D	26-41-205 (d) (1-2) Facility Administration of Medications (d) Facility administration of resident ' s 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	S3200		

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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 50 residents. The sample included 4 residents and 2 focus review residents. Based on record review and interview for 1 (#552) of 4 residents sampled, the operator failed to ensure the resident received medications in accordance with a medical care provider's written order and standards of practice.

Findings included:

- Record review for resident #552 revealed an admission date of 3/4/14 and diagnoses of Alzheimer's dementia and osteoporosis.

The functional capacity screen dated 3/3/14 indicated the resident required physical assistance with management of medications.

The negotiated service agreement dated 3/3/14 documented the service of all medications administered to resident by facility staff.

Comparison of the 5/1/14 through 5/31/14 medication administration record (MAR) and the

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medical care provider's written orders revealed the resident received Namenda to treat dementia 10 milligrams (mg) two times a day from 5/1/14 until discontinued after the 8:00 a.m. dose by the medical care provider on 5/7/14. The MAR contained an entry for the resident to start receiving Namenda XR 28 mg daily on 5/8/14. The MAR lacked documentation that the resident received Namenda XR 28 mg daily. The MAR contained documentation that the resident received Namenda 10 mg two times a day starting with the 8:00 a.m. dose on 5/15/14. The record lacked an order by the medical care provider for the resident to not receive Namenda XR 28 mg daily and to restart Namenda 10 mg two times a day 5/15/14.

The MAR contained documentation of a medical care provider's order 5/14/14 for the resident to receive clonazepam (anti-anxiety medication) at bedtime as needed for agitation. The MAR contained documentation by CMA #C at 10:15 a.m. on 5/18/14 that the resident received the medication for "anxious, wandering."

The MAR contained documentation of a medical care provider's order 5/14/14 for Seroquel (psychotropic agent) 25 mg one tablet at noon daily. The MAR contained documentation that resident did not receive the medication due to "not available being held by family." The record lacked documentation of contact with the medical care provider to inform the resident did not receive the Seroquel as ordered.

At 4:40 p.m. on 6/11/14, the resident care coordinator (RCC) stated resident's family wanted resident to finish taking Namenda 10 mg two times a day to use the supply of medication before starting the Namenda XR 28 mg daily.

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S3200	Continued From page 11 This did not get communicated to certified medications aides or the medical care provider. RCC confirmed resident did not receive Namenda as ordered by the medical care provider. RCC confirmed the resident received clonazepam at a time that was not ordered for the resident to receive the medication. RCC confirmed the resident's record lacked documentation of notification of the medical care provider that the resident did not receive Seroquel as ordered. The operator failed to ensure resident #552 received medications in accordance with a medical care provider's written order and standards of practice.	S3200		
S3400 SS=F	28-39-255 DIETARY AREAS (d) Dietary areas. A dietary area or areas shall provide for sanitary meal preparation or service for residents. (1) The facility shall provide disposal of waste by incineration, mechanical destruction, removal or a combination of these. The facility shall use containers with tightly fitting lids to store waste. (2) Ceilings in the dietary areas shall be cleanable by dustless methods, such as vacuum cleaning or wet cleaning. These areas shall not have exposed or unprotected sewer lines. This REQUIREMENT is not met as evidenced by: KAR 28-39-255(d) The facility reported a census of 50 residents.	S3400		

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S3400	Continued From page 12 The sample included 4 residents and 2 focus review residents. Based on observation and interview for all residents, the operator failed to ensure the dietary area provided for sanitary meal preparation and service for residents. Findings included: - At 1:00 p.m. on 6/12/14, observed the following in the kitchen: Vent in ceiling directly over steam table covered with dust hanging off the vent. Dust hanging off ceiling tile over the refrigerator in the kitchenette area. Ceiling above cabinets in kitchenette area covered with dust. Plastic covering over florescent lights dirty on each side of the cover. Ceiling vent by doorway from kitchenette area to dishwashing area covered with hanging dust. Black substance on caulk around dishwashing machine and area. Dish rack for the dishwasher sitting on floor. Produce room with dead bugs on floor. Dry wall in produce room with a 1/2 inch gap between dry wall and concrete floor. Dead bugs on floor by the 3 door freezer. Ceiling tile between the food prep area and refrigerator/freezer area and a ceiling tile just	S3400		

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S3400	Continued From page 13 outside pantry each with water damage. Ceiling tiles throughout all areas of the kitchen covered with dust buildup between the tile and the ceiling tile supports. At 1:15 p.m. on 6/12/14, the dietary manager stated there was no schedule for cleaning areas of the kitchen. Dietary manager stated "We just clean up as we go. We have tried to clean sections of the ceiling tiles but we cannot keep up with it." At 2:00 p.m. on 6/12/14, the office manager confirmed the kitchen needed cleaning. For all residents, the operator failed to ensure the dietary area provided for sanitary meal preparation and service for residents.	S3400		