STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N063018	A. BUILDING: _____ B. WING _____	11/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREDO SENIOR LIVING OF INDEPENDENCE	2120 N 13TH ST INDEPENDENCE, KS 67301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS The following citations represent the findings of the licensure resurvey for the above named facility conducted on 11/28/22 & 11/29/22.	S 000		
S3081 SS=D	26-41-201 (c) Functional Capacity Screen Reassessment (c) Designated facility staff shall conduct a screening to determine each resident ' s functional capacity according to the following requirements: (1) At least once every 365 days; (2) following any significant change in condition as defined in K.A.R. 26-39-100; and (3) at least quarterly if the resident receives assistance with eating from a paid nutrition assistant. This REQUIREMENT is not met as evidenced by: K.A.R. 26-41-201 (c)(2) The facility reported a census of ten residents. The sample included three "Residents" (R), (R112, R114 and R116). Based on record review and interview the Operator failed to ensure the licensed nurse conducted a "Functional Capacity Screen" (FCS) at the time a resident was exhibiting new socially inappropriate behaviors, after the time of admission, which included wandering/exit seeking behaviors for R112. Findings included: - Record review on 11/29/22 for R112 revealed an admission date of 07/05/22 with diagnoses of	S3081		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S3081	Continued From page 1	S3081		

unspecified dementia, psychotic disturbance, mood disturbance, anxiety, major depressive disorder, deficiency of other vitamins, and pain in unspecified knee.

Record review of R112 "Functional Capacity Screen" (FCS) identified the resident required supervision with bathing, she was independent with dressing, toileting, transferring, and walking/mobility and she lacked the ability to manage her own medications. She had impaired short-term memory and impaired memory recall. She was able to make herself understood and she usually understood others. She was marked has having "none of the above" current or recent problems and risks: wandering, socially inappropriate disruptive behavior and impaired decision making were not marked.

Record review of R112 combined NSA/HSP revealed the following healthcare services provided by the facility staff: her behaviors required monitoring, she required safety checks every two to three hours, and she required set up for showers, dressing and applying lotion.

Record review of R112 electronic progress notes dated 07/05/22 thru 11/28/22 revealed the following entries:

07/05/22 at 07:52 PM as a late entry: "Noticed resident picking at the back of the left arm above the elbow when she was upset this evening"

07/06/22 at 07:54 PM: "noticed red area where resident was pinching at arm when upset. The area measured two-inch width and two-inch length. Resident was unaware that she had even

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S3081	Continued From page 2	S3081		

been doing this."

07/08/22 at 09:14 PM: "she seems to have a lot of anxiety when it comes to night routine and family leaving her".

07/18/22 at 01:14 PM: "R112 has been more confused today than usual. She could not remember her name, and she's still confused about why she's here. I wonder if we could talk to the family about getting her something for anxiety.

07/23/22 at 09:00 PM: "after dinner she started constantly calling people on the phone list that she has to try to get someone to take her home. She was talking to one of her daughters and kept getting upset with her. The daughter was telling her she is here because her house is being remodeled. Then she was telling her that she was losing her mind and no longer had control of her bank account."

08/30/22 at 09:10 PM:" R112 was very confused this evening she was trying to leave and go home. Accused us of keeping her prisoner. Very restless. Going in rooms that are not her room. Very snippy with staff trying to redirect her."

09/15/22 at 04:00 PM: "R112 said she was going out front with another resident. When I checked on them, they were not there. I went outside and found them at the corner of the building. R112 then stated she was going home. I tried redirecting her back to the building and was not successful. At this time, I called her daughter who talked to R112. She was very agitated with her daughter and kept blaming her that his was

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S3081	Continued From page 3	S3081		

all her fault that she was here, it took several attempts from the daughter, the operator and myself to convince her that she needed to return to the building. We finally got her back inside the building at 04:30 PM".

10/25/22 at 07:41 PM: "R112 was exit seeking, aide tried redirecting resident. She went into another resident room and locked the main door and the bathroom door with her in the bathroom. The resident was getting agitated with the aide and being rude while trying to be redirected. I sent the aide to do something else and I tried redirecting the resident. After being unsuccessful several times I called her daughter who talked to her. She stated to the daughter that if she kept his up maybe she would get a padded room. She was talking very loudly and being mean with what she was saying".

10/30/22 at 06:42 PM: "R112 was trying to leave to walk home during dinner. After several attempts to redirect her I called her daughter to have her talk to R112. R112 was being very disrespectful and stated that if I did not let her leave she would get abusive with me. Said that we keep her locked up all the time and that is against her rights as a united states resident. She was swearing at her daughter and I."

11/19/22 at 07:35 PM: "R112 got angry out of nowhere. Pushed everything off of desk. Took charger to keep us from using the phone. Told daughter to call the police and have them shoot her in the head. Was very verbally abusive with her language toward staff and her daughter. She refused supper again before bedtime. But was very easily redirected at this time."

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S3081	Continued From page 4 11/23/22 at 10:13 AM: "R112 durable power of attorney came up to me asking if I could contact R112 doctor and see if there was something we could do about controlling her sun downers episodes. I called her doctor and informed them of our concerns, waiting for the doctor to call back letting us know what he would like for us to do". Interview on 11/20/22 at 02:32 PM with Operator D and LN C confirmed there had not been a new FCS to show the resident's significant change related to socially inappropriate disruptive behavior, impaired decision making and wandering. The Operator failed to ensure the licensed nurse conducted a "Functional Capacity Screen" (FCS) at the time resident was exhibiting new socially inappropriate behaviors after the time of admission which included wandering/exit seeking behaviors for R112.	S3081		
S3092 SS=D	26-41-202 (d) Negotiated Service Agreement Revisions (d) Each administrator or operator shall ensure the review and, if necessary, revision of each negotiated service agreement according to the following requirements:(1) At least once every 365 days; (2) following any significant change in condition, as defined in K.A.R. 26-39-100; (3) at least quarterly, if the resident receives assistance with eating from a paid nutrition assistant; and (4) if requested by the resident or the resident ' s	S3092		

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S3092	Continued From page 5	S3092		

legal representative, facility staff, the case manager, or, if agreed to by the resident or the resident ' s legal representative, the resident ' s family.

This REQUIREMENT is not met as evidenced by:
K.A.R. 26-41-202 (d) (2)

The facility reported a census of ten residents. The sample included three "Residents" (R), (R112, R114 and R116). Based on record review and interview the Operator failed to ensure the licensed nurse revised the negotiated service agreement when the resident was identified to be exhibiting new socially inappropriate behaviors after the time of admission which included wandering/exit seeking behaviors for R112.

Findings included:

- Record review on 11/29/22 for R112 revealed an admission date of 07/05/22 with diagnoses of unspecified dementia, psychotic disturbance, mood disturbance, anxiety, major depressive disorder, deficiency of other vitamins, and pain in unspecified knee.

Record review of R112 "Functional Capacity Screen" (FCS) identified the resident required supervision with bathing, she was independent with dressing, toileting, transferring, and walking/mobility and she lacked the ability to manage her own medications. She had impaired short-term memory, and impaired memory recall. She was able to make herself understood and

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S3092	Continued From page 6	S3092		

she usually understood others. She was marked has having "none of the above" current or recent problems and risks. Wandering, socially inappropriate disruptive behavior and impaired decision making were not marked.

Record review of R112 combined NSA/HSP revealed the following healthcare services provided by the facility staff: her behaviors required monitoring, she required safety checks every two to three hours, and she required set up for showers, dressing and applying lotion.

Record review of R112 electronic progress notes dated 07/05/22 thru 11/28/22 revealed the following entries:

07/05/22 at 07:52 PM as a late entry: "Noticed resident picking at the back of the left arm above the elbow when she was upset this evening"

07/06/22 at 07:54 PM: "noticed red area where resident was pinching at arm when upset. The area measured two-inch width and two-inch length. Resident was unaware that she had even been doing this."

07/08/22 at 09:14 PM: "she seems to have a lot of anxiety when it comes to night routine and family leaving her".

07/18/22 at 01:14 PM: "R112 has been more confused today than usual. She could not remember her name, and she's still confused about why she's here. I wonder if we could talk to the family about getting her something for anxiety.

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S3092	Continued From page 7 07/23/22 at 09:00 PM: "After dinner she started constantly calling people on the phone list that she has to try to get someone to take her home. She was talking to one of her daughters and kept getting upset with her. The daughter was telling her she is here because her house is being remodeled. Then she was telling her that she was losing her mind and no longer had control of her bank account." 08/30/22 at 09:10 PM:" R112 was very confused this evening she was trying to leave and go home. Accused us of keeping her prisoner. Very restless. Going in rooms that are not her room. Very snippy with staff trying to redirect her." 09/15/22 at 04:00 PM: "R112 said she was going out front with another resident. When I checked on them, they were not there. I went outside and found them at the corner of the building. R112 then stated she was going home. I tried redirecting her back to building and was not successful. At this time, I called her daughter who talked to F112. She was very agitated with her daughter and kept blaming her that this was all her fault that she was here, it took several attempts from the daughter, the operator and myself to convince her that she needed to return to the building. We finally got her back inside the building at 04:30 PM." 10/25/22 at 07:41 PM: "R112 was exit seeking, aide tried redirecting resident. She went into another resident room and locked the main door and the bathroom door with her in the bathroom. The resident was getting agitated with the aide and being rude while trying to be redirected. I sent the aide to do something else and I tried	S3092		

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redirecting the resident. After being unsuccessful several times I called her daughter who talked to her. She stated to the daughter that if she kept his up maybe she would get a padded room. She was talking very loudly and being mean with what she was saying".

10/30/22 at 06:42 PM: "R112 was trying to leave to walk home during dinner. After several attempts to redirect her I called her daughter to have her talk to R112. R112 was being very disrespectful and stated that is I did not let her leave she would get abusive with me. Said that we keep her locked up all the time and that is against her rights as a united states resident. She was swearing at her daughter and I."

11/19/22 at 07:35 PM: "R112 got angry out of nowhere. Pushed everything off of desk. Took charger to keep us from using the phone. Told daughter to call the police and have them shoot her in the head. Was very verbally abusive with her language toward staff and her daughter. She refused supper again before bedtime. But was very easily redirected at this time."

11/23/22 at 10:13 AM: "R112 durable power of attorney came up to me asking if I could contact R112 doctor and see if there was something we could do about controlling her sun downers episodes. I called her doctor and informed them of our concerns, waiting for the doctor to call back letting us know what he would like for us to do".

Interview on 11/20/22 at 02:32 PM with Operator D and LN C confirmed there had not been a new NSA revised to provide services to the resident

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S3092	Continued From page 9 who showed after admission behavioral changes related to socially inappropriate disruptive behavior, impaired decision making and wandering. The Operator failed to ensure the licensed nurse revised the negotiated service agreement when the resident was identified to be exhibiting new socially inappropriate behaviors after the time of admission which included wandering/exit seeking behaviors for R112.	S3092		
S3155 SS=D	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 10 residents. The sample included 3 "residents" (R) (112,114, and 116). Based on observation, interview and record review the operator failed to ensure a licensed nurse provided or coordinated the provision of necessary "Health Care Services" (HCS) to meet the needs for R114 in accordance	S3155		

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S3155	Continued From page 10 with the" Functional Capacity Screening/Negotiated Service Agreement" (FCS/NSA) regarding the use of a bed assistive device. Findings included: - On 11/28/22 Operator D provided the resident roster which identified R114 used a bed assist device. Record review on 11/29/22 for R114 revealed an admission date of 03/18/21 with diagnoses of personal history of trans ischemic attack and cerebral infarction, edema, insomnia, heart failure and anxiety. Record review of R114 FCS identified R114 required physical assistance with bathing, dressing, toileting, transferring, and walking/mobility. He lacked the ability to manage his own medications, was usually incontinent of his bladder, he had impaired short -term memory, impaired long-term memory and impaired memory recall. He was marked with falls, and impaired decision making, and he used a walker and wheelchair mobility device. Record review of R114 combined NSA/HSP revealed the following healthcare services provided by facility staff: staff to provide regular assistance in using the bathroom, staff will assist with dressing, toileting, and hospice will provide baths three times a week. He required a one person assist for transfers from the bed to the wheelchair, and a two person assist with bathroom needs.	S3155		

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S3155	Continued From page 11 The NSA/HSP did not identify the resident used a bed assist device. Record review on 11/29/22 revealed R114 records lacked an assessment of the resident to confirm the device was not a restraint, an assessment of the resident to determine the purpose of the bedrail/assistive device and the resident's ability to safely use the device, an assessment of the bedrail/assistive device to ensure the device was securely attached to the bed or bedframe and posed no risk for entrapment. Observation on 11/29/22 at 03:00 PM revealed R114 had a hospital bed located in his room with the head of the bed against the wall. There was a low air loss mattress in place, and a quarter length, rectangle shaped bed rail in place on each side of the head of the bed. Bed rail release was a pull knob located at the end of the rail. When pulled the rail end at the head of the bed would raise away from the bed. The rails on either side of the bed were securely attached to the bed. Interview on 11/29/22 at 03:00 PM with Operator D and LN C revealed the hospice company placed the bedrails on the bed and R114 record lacked an assessment of the resident to confirm the device was not a restraint, an assessment of the resident to determine the purpose of the bedrail/assistive device and the resident's ability to safely use the device, an assessment of the bedrail/assistive device to ensure the device was securely attached to the bed or bedframe and posed no risk for entrapment.	S3155		

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S3155	Continued From page 12 The operator failed to ensure a licensed nurse provided or coordinated the provision of necessary "Health Care Services" (HCS) to meet the needs for R114 in accordance with the" Functional Capacity Screening/Negotiated Service Agreement" (FCS/NSA) regarding the use of a bed assistive device.	S3155		
S3165 SS=D	26-41-204 (d) Health Care Services (d) The negotiated service agreement shall contain a description of the health care services to be provided and the name of the licensed nurse responsible for the implementation and supervision of the plan. This REQUIREMENT is not met as evidenced by: K.A.R. 26-41-204 (d) The facility reported a census of ten residents. The sample included three resident's (R) (112, 114 and 116). Based on record review and interview the Operator failed to ensure the "Licensed Nurse" (LN) placed on the "Negotiated Service Agreement" (NSA) the name of the nurse responsible for the implementation and supervision of the "Healthcare Service Plan" (HSP) for R112 and R114. Findings included: - Record review on 11/29/22 for R112 revealed an admission date of 07/05/22 with diagnoses of unspecified dementia, psychotic disturbance, mood disturbance, anxiety, major depressive	S3165		

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disorder, deficiency of other vitamins, and pain in unspecified knee.

Record review of R112 "Functional Capacity Screen" (FCS) identified the resident required supervision with bathing, she was independent with dressing, toileting, transferring, and walking/mobility and she lacked the ability to manage her own medications. She had impaired short-term memory, and impaired memory recall. She was able to make herself understood and she usually understood others.

Record review of R112 combined NSA/HSP revealed the following healthcare services provided by the facility staff: her behaviors required monitoring, she required safety checks every two to three hours, and she required set up for showers, dressing and applying lotion.

The NSA/HSP lacked the name of the nurse responsible for the implementation and supervision of the healthcare service plan.

Interview on 11/29/22 at 02:32PM with LN C, she confirmed the NSA/HSP lacked the name of the nurse responsible for the implementation and supervision of the healthcare service plan.

- Record review on 11/29/22 for R114 revealed an admission date of 03/18/21 with diagnoses of personal history of trans ischemic attack and cerebral infarction, edema, insomnia, heart failure and anxiety.

Record review of R114 FCS identified R114 required physical assistance with bathing,

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S3165	Continued From page 14 dressing, toileting, transferring, and walking/mobility. He lacked the ability to manage his own medications, was usually incontinent of his bladder, he had impaired short -term memory, impaired long-term memory, impaired memory recall and impaired memory recall. He was marked with falls, and impaired decision making, and he used a walker and wheelchair mobility device. Record review of R114 combined NSA/HSP revealed the following healthcare services provided by facility staff: staff to provide regular assistance in using the bathroom, staff will assist with dressing, toileting, and hospice will provide baths three times a week. The NSA/HSP lacked the name of the nurse responsible for the implementation and supervision of the healthcare service plan. Interview on 11/29/22 at 02:32PM with LN C, she confirmed the NSA/HSP lacked the name of the nurse responsible for the implementation and supervision of the healthcare service plan. The Operator failed to ensure the "Licensed Nurse" (LN) placed on the "Negotiated Service Agreement" (NSA) the name of the nurse responsible for the implementation and supervision of the "Healthcare Service Plan" (HSP) for R112 and R114.	S3165		
S3248 SS=F	26-41-102 (d) Staff Qualifications Employee Records (d) The employee records and agency staff records shall contain the following	S3248		

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S3248	Continued From page 15 documentation: (1) Evidence of licensure, registration, certification, or a certificate of successful completion of a training course for each employee performing a function that requires specialized education or training; (2) supporting documentation for criminal background checks of facility staff and contract staff, excluding any staff licensed or registered by a state agency, pursuant to K.S.A. 39-970 and amendments thereto; (3) supporting documentation from the Kansas nurse aide registry that the individual does not have a finding of having abused, neglected, or exploited a resident in an adult care home; and (4) supporting documentation that the individual does not have a finding of having abused, neglected, or exploited any resident in an adult care home, from the nurse aide registry in each state in which the individual has been known to have worked as a certified nurse aide. This REQUIREMENT is not met as evidenced by: K.A.R. 26-41-102 (d)(1)(2) The facility reported a census of ten residents. Based on record review and interview the operator failed to ensure non-certified personnel provided the course completion certificate for the temporary nurse aide course and, complete and place in the newly hired employee records, the required skills competency checklist for the temporary nurse aide prior to providing hands on	S3248		

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S3248	Continued From page 16	S3248		

resident care. The operator further failed to ensure the background check for all staff was submitted to the department at the time of hire.

Findings included:

- Record review on 11/28/22 of the newly hired personnel revealed the facility reported two personnel who provided direct care/hands on assistance to residents who were not yet certified, "Temporary Nurse Aide's" A and B.

Record review on 11/28/22 of the personnel record for newly hired TNA A revealed she began employment on 03/18/22. The personnel file lacked documentation of a temporary nurse aide certificate of completion of the required eight-hour course, and the record further lacked evidence of the completion of the required skills competency checklist attached to the certificate of completion for the temporary nurse aide course.

Record review on 11/29/22 of the facility provided schedules revealed TNA A worked the following days since the time of hire providing direct resident care with no evidence of completion of the required eight-hour temporary nurse aide course and the further lacked the evidence of the required skills competency check list maintained in TNA A personnel file:
03/11/22 thru 03/13/22 TNA A worked the evening shift and trained.
03/22: 15-18, 21-24, 26, 27, 29-31.
04/22: 1, 4-7, 9, 19, 12-15, 18-21, 23, 24, 26-29.
05/22: 2-5, 7, 8, 10-13, 16-19, 21, 22, 24-26, 30,31
06/22: 1, 2, 4, 5, 7-10, 12-16, 18, 19, 21-23,

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S3248	Continued From page 17 28-30 07/22: 2, 3, 5-8, 10-14, 16, 17, 19-22, 25-28, 29 08/22: 2-5, 8-11, 12, 14, 16-19, 22-25, 30, 31 09/22: 1, 3, 4, 6-11, 13-16, 19-22, 24, 25, 27-30 10/22: 3-6, 8, 9, 11-14, 17-20, 22, 23, 25-28, 31 11/22: 1-3, 5, 6, 8-11, 14-17, 19, 20, 22-25, 28-30 Interview on 11/28/22 with Operator D confirmed the personnel record for TNA A lacked the required evidence of completion of the required eight-hour temporary nurse aide course and the further lacked the evidence of the required skills competency check list maintained in TNA A personnel file. Interview on 11/29/22 with Operator D revealed, she provided the course completion certificate for the temporary nurse aide course for TNA A with a completion date of 11/28/22 printed as the completion date. She further provided the required skills competency check list for TNA A with a competency completion date of 11/29/22 and signed by "Licensed Nurse" (LN C). Operator D confirmed TNA A had been providing direct resident care without the required proof of training and documentation. Record review on 11/28/22 of the personnel record for newly hired TNA B revealed he began employment on 08/11/21. The record contained a certificate of completion for the temporary nurse aide eight-hour training completed on 11/10/22. The record lacked evidence of the completion of the required skills competency checklist attached to the certificate of completion for the temporary nurse aide course. Record review on 11/29/22 of the facility	S3248		

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S3248	Continued From page 18 provided schedules revealed TNA B worked the following days since the time of hire providing direct resident care with no evidence of completion of the required skills competency check list maintained in TNA B personnel file: 11/22: 12, 13, 26, 27 Interview on 11/28/22 with Operator D confirmed the personnel record for TNA B lacked the evidence of the required skills competency check list maintained in TNA B personnel file. Interview on 11/29/22 with Operator D revealed, she provided the required skills competency check list for TNA B with a competency completion date of 11/29/22 and signed by "Licensed Nurse" (LN C). Operator D confirmed TNA B had provided direct resident care without the required proof of training and documentation maintained in his personnel record. - Record review on 11/28/22 of newly hired Operator D personnel record revealed she began employment on 08/25/22, the record lacked documentation of a criminal background check performed at the time of hire. Interview on 11/29/22 with Operator D confirmed the personnel record lacked documentation of a background check being performed at the time of hire, she confirmed she submitted on 11/29/22 the request for the background check to the department. The operator failed to ensure noncertified personnel provided the course completion certificate for the temporary nurse aide course and, complete and place in the newly hired	S3248		

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S3248	Continued From page 19 employee records, the required skills competency checklist for the temporary nurse aide prior to providing hands on resident care. The operator further failed to ensure the background check for all staff was submitted to the department at the time of hire.	S3248		
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: K.A.R 26-41-105 (f)(11) The facility reported a census of ten residents. The sample included three "Residents" (R), (R112, R114 and R116). Based on record review and interview the Operator failed to ensure the resident records contained documentation of all incidents, symptoms, and other indications of illness or injury including the date, time of the occurrence, action taken, and results of the actions taken for R112. Findings included: - Record review on 11/29/22 for R112 revealed an admission date of 07/05/22 with diagnoses of unspecified dementia, psychotic disturbance, mood disturbance, anxiety, major depressive	S3261		

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disorder, deficiency of other vitamins, and pain in unspecified knee.

Record review of R112 "Functional Capacity Screen" (FCS) identified the resident required supervision with bathing, she was independent with dressing, toileting, transferring, and walking/mobility and she lacked the ability to manage her own medications. She had impaired short-term memory, and impaired memory recall. She was able to make herself understood and she usually understood others.

Record review of R112 combined NSA/HSP revealed the following healthcare services provided by the facility staff: her behaviors required monitoring, she required safety checks every two to three hours, and she required set up for showers, dressing and applying lotion.

Record review of R112 electronic progress notes dated 07/05/22 thru 11/28/22 revealed the following entries:

07/05/22 at 07:52 PM as a late entry: "Noticed resident picking at the back of the left arm above the elbow when she was upset this evening" The note lacked action taken and results of the action taken.

07/06/22 at 07:54 PM: "noticed red area where resident was pinching at arm when upset. The area measured two-inch width and two-inch length. Resident was unaware that she had even been doing this." The note lacked action taken and results of the action taken.

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S3261	Continued From page 21 07/08/22 at 09:14 PM: "she seems to have a lot of anxiety when it comes to night routine and family leaving her". The note lacked action taken and results of the action taken. 07/18/22 at 01:14 PM: "R112 has been mor confused today than usual. She could not remember her name, and she's still confused about why she's here. I wonder if we could talk to the family about getting her something for anxiety." The note lacked action taken and results of the action taken. 07/23/22 at 09:00 PM: "After dinner she started constantly calling people on the phone list that she has to try to get someone to take her home. She was talking to one of her daughters and kept getting upset with her. The daughter was telling her she is here because her house is being remodeled. Then she was telling her that she was losing her mind and no longer had control of her bank account." The note lacked action taken and results of the action taken. 08/30/22 at 09:10 PM:" R112 was very confused this evening she was trying to leave and go home. Accused us of keeping her prisoner. Very restless. Going in rooms that are not her room. Very snippy with staff trying to redirect her." The note lacked action taken and results of the action taken. 09/06/22 at 01:44 PM: "was complaining of her knees hurting her at lunch time. She came out to lunch about ten minutes late". The note lacked	S3261		

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S3261	Continued From page 22 action taken and results of the action taken. 09/15/22 at 04:00 PM: "R112 said she was going out front with another resident. When I checked on them, they were not there. I went outside and found them at the corner of the building. R112 then stated she was going home. I tried redirecting her back to building and was not successful. At this time, I called her daughter who talked to F112. She was very agitated with her daughter and kept blaming her that his was all her fault that she was here, it took several attempts from the daughter, the operator and myself to convince her that she needed to return to the building. We finally got her back inside the building at 04:30 PM. The note lacked documentation of the results of the action for R112 after she refused to come back into the building and was agitated. 10/25/22 at 07:41 PM: "R112 was exit seeking, aide tried redirecting resident. She went into another resident room and locked the main door and the bathroom door with her in the bathroom. The resident was getting agitated with the aide and being rude while trying to be redirected. I sent the aide to do something else and I tried redirecting the resident. After being unsuccessful several times I called her daughter who talked to her. She stated to the daughter that if he kept his up maybe she would get a padded room. She was talking very loudly and being mean with what she was saying.". The note lacked results of the action taken. 10/30/22 at 06:42 PM: "R112 was trying to leave	S3261		

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S3261	Continued From page 23	S3261		

to walk home during dinner. After several attempts to redirect her, I called her daughter to have her talk to R112. R112 was being very disrespectful and stated that is I did not let her leave she would get abusive with me. Said that we keep her locked up all the time and that is against her rights as a united states resident. She was swearing at her daughter and I." The note lacked action taken and results of the action taken.

11/19/22 at 07:35 PM: "R112 got angry out of nowhere. Pushed everything off of desk. Took charger to keep us from using the phone. Told daughter to call the police and have them shoot her in the head. Was very verbally abusive with her language toward staff and her daughter. She refused supper again before bedtime. But was very easily redirected at this time." The note lacked action taken and results of the action taken.

11/23/22 at 10:13 AM: "R112 durable power of attorney came up to me asking if I could contact R112 doctor and see if there was something we could do about controlling her sun downers episodes. I called her doctor and informed them of our concerns, waiting for the doctor to call back letting us know what he would like for us to do". There is no follow up note in the progress notes for this entry showing the results of the actions taken.

The documentation lacked all required components of what is required to be included in the resident records related to actions taken and results of the actions taken.

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S3261	Continued From page 24 Interview on 11/20/22 at 02:32 PM with Operator D and LN C, confirmed the resident electronic progress notes lacked the required components of what is required to be included in the resident records related to actions taken and results of the actions taken for R112. The Operator failed to ensure the resident records contained documentation of all incidents, symptoms, and other indications of illness or injury including the date, time of the occurrence, action taken, and results of the actions taken for R112.	S3261		
S3280 SS=F	26-41-104 (d) Disaster and Emergency Preparedness (d) Each administrator or operator shall ensure disaster and emergency preparedness by ensuring the performance of the following: (1) Orientation of new employees at the time of employment to the facility ' s emergency management plan; (2) education of each resident upon admission to the facility regarding emergency procedures; (3) quarterly review of the facility ' s emergency management plan with employees and residents; and (4) an emergency drill, which shall be conducted at least annually with staff and residents. This drill shall include evacuation of the residents to a secure location. This REQUIREMENT is not met as evidenced	S3280		

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S3280	Continued From page 25 by: K.A.R. 26-41-104 (d) (3) The facility reported a census of 10 residents. Based on record review and interview the operator failed to ensure the residents were provided the required review of the facility's emergency management plan with the residents every quarter. Findings included: - Record review on 11/29/22 of the facility provided resident council notes revealed the residents received emergency preparedness training on 03/25/22. Record review on 11/29/22 of the facility provided staff training revealed facility staff received emergency preparedness training on the following dates: 02/16/22 03/16/22 04/22/22 05/22/22 07/21/22 09/28/22 10/19/22 The staff sign in sheets were provided. The record lacked any documentation of the residents receiving the training. Interview on 11/29/22 at 02:20 PM with Operator D, she confirmed the residents had only received the emergency preparedness training the one time on 03/25/22 and could provide no further documentation for resident training.	S3280		

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S3280	Continued From page 26 The operator failed to ensure the residents were provided the required review of the facility's emergency management plan with the residents every quarter.	S3280		
S3296 SS=F	26-41-206 (c) (1) Dietary Services Weekly Menu (c) (1) Menu plans shall be available to each resident on at least a weekly basis. This REQUIREMENT is not met as evidenced by: K.A.R. 26-41-206 (c)(1) The facility reported a census of ten residents. Based on observation and interview the operator failed to ensure the menu plans were available to each resident on a weekly basis. Findings included: - Observation on 11/28/22 at 11:03 AM during the facility tour revealed on a wipe board in the resident dining room that contained the menu for the day. The weekly menu was not observed posted during the facility tour. Interview on 11/28/22 with Operator D confirmed the facility does not post the weekly menu for the residents. The operator failed to ensure the menu plans were available to each resident on a weekly basis.	S3296		