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| S 000 | INITIAL COMMENTS<br><br>The following citations represent the findings of a resurvey for the above named Assisted Living facility with complaint investigations for 174483, 177963, 178135 conducted on 02/06/23, 02/07/23, and 02/08/23. | S 000 | | |
| S3026 SS=J | 26-41-101 (f) (1) Staff Treatment of Residents ANE<br><br>(f)The administrator or operator shall ensure that all of the following requirements are met:<br>(1) No resident shall be subjected to any of the following:<br>(A) Verbal, mental, sexual, or physical abuse, including corporal punishment and involuntary seclusion;<br>(B) neglect; or<br>(C) exploitation.<br><br>This REQUIREMENT is not met as evidenced by:<br>KAR 26-41-101(f)(1)(A)(C)<br><br>The facility reported a census of 62 residents (R). The sample include three residents and two focused record reviews. Based on observation, interview, and record review, the administrator failed to ensure one of three sampled residents was not subjected to abuse or exploitation when an active employee, "Certified Nurse Aide" (CNA) A, participated in inappropriate physical conduct with R4. Review of video monitoring provided by R4's family revealed on 01/31/23 an on duty, current employee participated in inappropriate hugging, kissing, and other inappropriate activity with R4. On 02/01/23 R4's family contacted the | S3026 | | |

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

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facility three times with concerns that someone was in R4's room and it appeared to the family that inappropriate activity was going on, as each time someone went into R4's room, CNA A hid from view. After the third call, staff found CNA A hiding in the resident's closet, at which time she was escorted out of the facility.

Findings included:

- Review of R4's medical record revealed he moved into the facility on 03/08/22 with diagnoses of diabetes type II, congestive heart failure, and history of cerebral vascular accident in July 2021.

R4's "Functional Capacity Screen" dated 01/11/23 revealed the resident needed physical assistance with showers and dressing as well as management of medications and medical treatments. The resident also had a risk for falls and unsteadiness. It identified the resident had no cognitive impairment or impaired decision-making ability.

R4's "Negotiated Service Agreement/Health Care Service Plan" dated 01/11/23 identified care staff assisted the resident with showers three times per week and provided minimal assistance with dressing.

Review of the electronic monitoring video recordings, provided by R4's family, included the following recordings date stamped 01/31/23:

At 06:31 AM, CNA A (while on duty as a facility employee) walked into the resident's room and immediately walked over to R4, who did not have

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on a shirt, and they hugged. The hug was tight and involved rubbing each other's backs up and down and R4 kissed her on the forehead more than once. The hug lasted a little over 1 minute. The resident then said he better take a shower and went to the bathroom, CNA A made the resident's bed and then sat on the couch.

At 06:43 AM, CNA A walked over to the shower to ask if R4 was ok, R4 opened the bathroom door and CNA A went to the bathroom door. He said, "Did you miss me?" and she responded, "Bad." She remained in the bathroom with the resident and after 30 seconds she said, "Oh my god it is so long" and he said, "I told you it was long." They remained in the bathroom and through the recording one could hear conversation. Thirty-four seconds later, the talking stopped and could hear sounds like kissing and heavy breathing, which started out slow and increased in intensity. At 06:46 AM R4 said, "You alright?" and CNA A responded "yeah, you?" and he said, "I don't know." They remained in the bathroom and there was wet, smacking sounds heard, he called CNA A his "little girl." There were more smacking sounds and CNA A said something to R4, which he did not hear and then she said louder, "I can't get the right angle on it" and then a gagging sound is heard, along with shortness of breath. For two more minutes there is sounds of heavy breathing, slow and then fast, and CNA A made a sighing sound. They had a few seconds of conversation, then it went quiet, then heavy breathing and at 06:50 AM the resident asked CNA A if she was "ok" and she said, "I'm good" and he said "ok." CNA A left out of the bathroom three minutes later, fixed her hair and adjusted her clothing. She let out an audible

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breath/sigh, put on her jacket, went back into the bathroom, and through the audio could be heard a kissing sound and she told the resident to have a good day and then left the room at 06:53 AM.

At 07:10 AM CNA A returned to R4's room and he followed behind her. CNA A removed her shoes and sat on the couch. R4 sat in his recliner. At 07:15 AM, the resident laid stretched back in his chair and CNA A said, "Are you ok?" and he replied "no." She then asked him "What's wrong?" and he said, "I don't know." R4 lowered the feet of his recliner, got out of the chair and sat beside CNA A on the couch. She repositioned herself on the couch and he put his right arm around her, and they hugged each other with her laying her head on his chest. At 07:17 AM there was a knock on R4's door and they both abruptly sat up on the couch and moved apart. An unidentified CMA came into the room and took the resident's vitals, and upon completion, R4 stated "we better go to breakfast" and they all left the room.

At 08:50 AM, CNA A returned to R4's room where he sat in the recliner. CNA A laid on the couch on her stomach, then moved to her knees on the arm of the couch. R4 and CNA A held hands and rubbed each other's arm for eight minutes.

At 08:59 AM, CNA A said to R4, "You are not upset with me are you" to which he replied "no, do I look upset." CMA A said, " I don't know, it is hard for me to tell sometimes." R4 reached out to hold her hand and then patted his lap and said, "come here." She got up and went over to him and laid across him to where they were face-to-face, he wiped her hair away from her

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face and there were kissing sounds heard. CNA A stood up, leaned to his ear and said, "there's a camera and a window." The resident looked and she repeated it as she sat back down on the couch. R4 took the remote control and tried to cover up the camera while CNA A laughed. R4 moved the camera so the living area was still in view, but R4's face was not. R4 told CNA A "I like you" and she responded with "I'm pretty great, so are you." They remained in the room together, with her leaning on the arm of the couch and the resident in his recliner.

At 09:14 AM CNA A told R4 "You can tell me if I do anything that makes you uncomfortable." R4 raised his hands as if to count on his fingers and laughed, he then reached over to CNA A and said "no" and they started to hold hands again.

At 09:16 AM the resident started to get up out of his recliner and CNA A asked if he was going to exercises and R4 stated "Yes." He walked into his bedroom and CNA A followed. The bedroom door shut and six minutes later at 09:22 AM, it reopened and R4 said "hide in the closet" and then laughed.

On 01/31/23 at 12:11 PM CNA A again entered R4's room, removed her shoes and sat on R4's couch. R4 came out of the bathroom and sat in his recliner. Video observation revealed CNA A was in R4's room for 7 minutes and 43 seconds, when the facility pager (alert for staff to know other residents need assistance) alerted. CNA A looked at the pager, appeared to clear it, placed it on the table, and moved closer to R4 where she rested her head in her right palm and held R4's hand with her left hand. At 12:25 PM, the

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pager sounded again. She looked at it, shook her head, and said, "just a call light" and then repositioned herself on the couch then reached out to hold hands again. At 12:28 PM, there was a sound in the room, and CNA A jerked her hand away momentarily, and then reached back down to hold R4's hand.

At 12:29 PM, while holding hands, CNA A asked R4 if he was alright, he did not verbally respond and then he asked her "Everything alright with you?" and she said "Uh-huh."

At 12:31 PM CNA A let go of R4's hand and stated she "better go and check on room trays." CNA A walked over to R4 and hugged him, which lasted one minute and twenty-six seconds, and there was audible kissing sounds. CNA A stated, "There is a window right there." He said, "No one is out there" and they continued to hug, heavy breathing is heard, and then she stood up and said, "I'll probably see you again later today." CNA A then went into the bathroom for a few seconds and left the room.

CNA A spent 23 minutes in R4's room holding hands, hugging, and kissing the resident, all while on duty for the facility.

Electronic Monitor Recordings date and time stamped 02/01/23 from 07:38 PM to 09:12 PM revealed the following occurrences while facility employee, CNA A, was off duty and visiting R4 in his room.

At 07:38 PM, CNA A walked into R4's room wearing a low-cut top and jeans and walked over to the resident.

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| S3026 | Continued From page 6<br><br>At 07:49 PM, CNA A asked R4 who worked on second shift tonight, and then went into the resident's bathroom. At 07:50 PM she returned from the bathroom, the television was paused, the blinds being closed could be heard and other audible noises could be heard, which were giggling, heavy breathing, sighs, and whispers.<br><br>At 07:57 PM, CNA A started to cough. R4 asked CNA A "Are you doing ok, are you sure?" and she replied "yeah." She then asked, "I'm not crushing you, am I?" and his response was quiet and not understandable. There continued to be smacking and gagging sounds and at 07:59 PM, CNA A made a forceful exhaling sound, and at 08:00 PM R4 stated "that tickles." The smacking and heavy breathing sounds continued and at 08:03 PM CNA A said, "My hair's in the way" and then the smacking and heavy breathing sounds continued until 08:29 PM.<br><br>At 08:29 PM, the phone rang and R4 answered the phone and then hung up. Listening to the audio revealed giggling and CNA A said, "it scared me" after he hung up the phone. At 08:30 PM CNA A asked the resident "can you scoot this way a little?" he said "This way?" to which she repeated twice what direction and position she wanted him to move to. At that point the wet, smacking, and heavy breathing resumed.<br><br>At 08:36 PM CNA A walked over to the door, her top was unbuttoned, she did not have on a bra, and her breasts were exposed. The resident asked if someone was there and she said "no, just heard a knocking." | S3026 | | |

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At 08:56 PM there was a knock on the door, CNA A ran into the bedroom and laid on the floor. CNA A then moved out of the view of the camera. Licensed Nurse (LN) B opened the door and told the resident that his family had tried to reach him. LN B did not enter the room completely and would not have seen CNA A in the bedroom.

At 08:57 PM, R4 called his family.

At 08:59 PM, CNA A returned to the living room.

At 09:00 PM, a knock can be heard, and CNA A moved to the corner in the kitchen. LN B entered and is seen in the living room near R4. CNA A could be seen going behind LN B into the bathroom.

At 09:02 PM LN B left R4's room and CNA A could be seen leaving the bathroom.

At 09:11 PM CNA A got up, went to the resident's bathroom and then into the resident's bedroom. There was a knock on the door and CNA D came into the room, asked R4 if she could look around his room. R4 gave her permission. R4 asked if she was looking for something and CNA D stated "yes" then stated softly "unfortunately." CNA D can be seen walking toward the closet and returned with CNA A and they left R4's room at 09:12 PM. CNA A was in R4's room the evening of 02/01/23 for one hour and 54 minutes.

Review of a screen shot of a Facebook message R4's family received from CNA A on 02/01/23 at 09:46 PM read, "I know you probably think I'm either crazy or awful but please let me explain. My # is [phone number] I'm at [facility] now if you

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can talk. Please." The Facebook message was deleted by CNA A after being sent.

On 02/06/23 at 04:22 PM, R4 walked down the hall without an assistive device, looked toward the surveyor and said " hello." Surveyor returned the greeting and spoke to R4 briefly. The resident smiled and stated his day was going pretty good and things were going "so-so" for him here. He denied any concerns at this time.

On 02/06/23 at 09:26 PM, R4's concerned family member family contacted the surveyor and stated he went to the facility to meet with Administrative Licensed Nurse C regarding paperwork for the electronic monitoring. He stated he still had not heard anything from the facility about what happened the evening of 02/01/23 and wanted to make sure she knew what was going on and had been given all the appropriate information. He stated he showed Administrative Nurse C videos on his phone, and she kept saying "why is she doing that," "what is going on," and at one point while watching a video she used the words, "that's exploitation." He said he did not want to influence her or lead her down any specific path, but that is what she said. He also acknowledged that Administrative Nurse C did not know the extent of what was going on until he showed her the videos and did not know staff had tried to contact the family through Facebook.

On 02/07/23 at 08:48 AM R4 sat in his recliner and stated everything was going well. He stated staff treated him with respect and dignity. He stated they helped him with his showers and staff would sit on the couch just to be there and then after he dresses himself, he came out of the

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bathroom and staff would help him button his shirt. The resident was rubbing his face, smiling, and would start to say something and then not finish it. Surveyor reassured him that he was safe, and part of my job was to make staff were not being overtly friendly or taking advantage of him. He shook his head, rubbed his face, and turned slightly red as if embarrassed. He said that he would "say hi to staff and hug them, but apparently he is not supposed to do that." He then looked away, turned back looking directly at surveyor and said, "no one is taking advantage of me and that is all I am going to say," and turned away.

A phone interview on 02/07/23 at 10:26 AM Licensed Nurse (LN) B reported on 02/01/23 she saw CNA A come into the facility and go into R4's room around 07:00 PM. LN B received a call from R4's family wanting to check on him and make sure he was OK. LN B went to the resident's door, knocked, and had to unlock the door. She just stepped in the entry, and he sat in his recliner with his shirt off and looked fine and said he was okay. A little later, R4's family called again saying he thought someone was in R4's room and so she went back again, going into the living room, and looked around and did not see anyone in his room. The family called again, and CNA D answered the phone. CNA D went into R4's room and LN B saw CNA D escort CNA A out of the building. CNA D told LN B she found CNA A in the resident's closet. LN B called Administrative Nurse C and told her what had happened with the son calling and CNA D finding CNA A in the resident's closet and escorted her out of the building.

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| S3026 | Continued From page 10<br><br>On 02/07/23 at 11:50 AM Administrative Staff F stated he had not received any allegations of abuse, neglect, or exploitation during the time frame requested. He stated that as far as he knew CNA A worked at the facility and provided R4 care.<br><br>02/07/23 at 01:57 PM Administrative Licensed Nurse C reported CNA A and R4 were "really good friends." She acknowledged CNA A came and visited R4 frequently. She denied anyone reporting to her that CNA A had inappropriate relations with R4, or other concerns about them.<br><br>On 02/07/23 at 02:56 PM Administrative Nurse C confirmed LN B called her on the night of 02/01/23 and told her R4's family called about someone in R4's room, but she did not find anyone. CNA D went in after LN B had already been in twice and CNA D found CNA A hiding in the resident's closet. Administrative Nurse C thought it had to do with it being late and the family wanted the resident to not have company, as it was close to bedtime. She stated it was not unusual for CNA A to come and visit R4 in the evenings.<br><br>On 02/07/23 at 03:20 PM Certified Nurse Aide" (CNA) D confirmed on the evening of 02/01/23 she found CNA A hiding in R4's closet. CNA D did not know why CNA A was hiding but she was very "panicked and anxious" when found. As CNA D walked CNA A out of the facility, she did not say why she was hiding in the closet. When CNA D came back into the facility, she explained what had happened to LN B, who then contacted Administrative Nurse C and told her. CNA D reported CNA A visited R4 a lot, and as far as | S3026 | | |

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she knew there was not a problem with her visiting in the evening.

On 02/08/23 at 02:00 PM Surveyor met with Administrative Staff F, Administrative Staff G, and Administrative Nurse C to continue investigation. Administrative Nurse C reported she did not start an investigation when LN B called her with information that CNA A was found hiding in R4's bedroom closet, because LN B acted like she did not really know anything. Administrative Nurse C contacted CNA D the morning of 02/02/22 to get her side of what happened, regarding CNA A being in R4's room and hiding in the closet. Administrative Nurse C said she just thought CNA A was joking with staff and did not think it was a concern. She also stated when R4's family showed her a video on 02/06/23 on his phone, it was hard to see but the video showed CNA A and R4 holding hands.

At 02:19 PM on 02/08/23, the surveyor explained to Administrative Staff F, Administrative Staff G, and Administrative Nurse C the facility was is in Immediate Jeopardy related to an employee who was still on their payroll, having inappropriate relations with a resident.

Review of the "Associate Handbook" dated 2020 included the following employee rules:
"Resident and Associate Interactions" - "
...Please refrain from sharing personal information or concerns about the workplace with residents."
"Flagrant Infraction Examples" - "Flagrant infractions are severe and may lead to investigation, suspension, and or immediate separation ... Taking part in any conduct which

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may endanger associates, residents ...committing immoral or indecent acts on company property ...unauthorized use of company time ... any other serious or flagrant infraction the company feels impacts the quality and smooth operation of the business of negatively affects resident care ..."

Review of the "Resident Abuse, Neglect and Exploitation" policy and procedure dated 04/30/19 revealed "an employee must report to the Residence Director immediately any allegations of abuse, neglect, or exploitation of residents ..."

The administrator failed to ensure R4 was not subjected to further abuse or exploitation when an active employee participated in inappropriate physical conduct with the resident, and administrative staff failed to investigate and report the situation when concerns were brought to Administrative Nurse C the evening of 02/06/23.

The Immediate Jeopardy was removed on 02/08/23 at 05:39 PM when Administrative Staff F developed an abatement plan which included the following:
Report CNA A to Wichita Police Department
Report CNA A to Kansas Department of Aging and Disabilities Registry.
CNA A will be suspended until completion of the investigation
Facility will work with the family and resident for no contact with CNA A.
Will Immediately initiate all staff training for Abuse, Neglect, and Exploitation. Will train all staff currently on duty and then train all staff prior

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| S3026 | Continued From page 13<br>to coming onto their shift. This will also include all dietary staff, maintenance, and housekeeping staff. There will also be an all-staff in-service conducted on 02/08/23. | S3026 | | |
| S3028 SS=D | 26-41-101 (f) (3) Staff Treatment of Residents Reporting<br><br>(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:<br>(A) An investigation shall be started when the administrator or operator, or the designee, receives notification of an alleged violation.<br>(B) Immediate measures shall be taken to prevent further potential abuse, neglect, or exploitation while the investigation is in progress.<br>(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.<br>(D) Appropriate corrective action shall be taken if the alleged violation is verified.<br>(E) The department ' s complaint investigation report shall be completed and submitted to the department within five working days of the initial report.<br>(F) A written record shall be maintained of each investigation of reported abuse, neglect, or exploitation. | S3028 | | |

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| S3028 | Continued From page 14<br><br>This REQUIREMENT is not met as evidenced by:<br>KAR 26-41-101(f)(3)(A)<br><br>The facility reported a census of 62 residents (R). The sample included 3 residents and 2 focused record reviews. Based on interview and record review the "Administrative Licensed Nurse" C failed to report an allegation of potential abuse, neglect, exploitation to the administrator to ensure each allegation of abuse, neglect or exploitation was reported to the Kansas Department for Aging and Disabilities (KDADS) within 24 hours for R4.<br><br>Findings included:<br><br>- Review of R4's medical record revealed he moved into the facility on 11/24/42 with diagnosis of diabetes type II.<br><br>On 02/06/23 at 09:26 PM, R4's concerned family member family contacted the surveyor and stated he went to the facility to meet with Administrative Licensed Nurse C regarding paperwork for the electronic monitoring. He stated he still had not heard anything from the facility about what happened the evening of 02/01/23 and wanted to make sure she knew what was going on and had been given all the appropriate information. He showed "Administrative Nurse" C videos on his phone, and she kept saying "why is she doing that", "what is going on", and at one point while watching a video she used the words, "that's exploitation". He said he did not want to influence her or lead her down any specific path, but that is what she said. He also acknowledged | S3028 | | |

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| S3028 | Continued From page 15 | S3028 | | |

that Administrative Licensed Nurse C did not know the extent of what was going on until he showed her the videos and did not know that staff had tried to contact the family through Facebook.

On 02/07/23 at 11:50 AM "Administrative Staff" F stated he had not received any allegations of abuse, neglect, or exploitation during the time frame requested. He stated that as far as he knew "Certified Nurse Aide" (CNA) A worked at the facility and provided R4 care.

On 02/07/23 at 01:57 PM "Administrative Licensed Nurse" C reported CNA A and R4 were "really good friends". She acknowledged that CNA A came and visited R4 frequently. She denied anyone reporting to her that CNA A had inappropriate relations with R4. or other concerns about them.

On 02/08/23 at 02:00 PM Surveyor met with "Administrative Licensed Nurse" C, "Administrative Staff" F, and "Administrative Staff" G. "Administrative Licensed Nurse" C reported she did not start an investigation when "Licensed Nurse" (LN) B called her with information that CNA A was found hiding in R4's bedroom closet because LN B acted like she didn't really know anything. "Administrative Licensed Nurse" C reported she contacted CNA D the morning of 02/02/22 to get her side of what happened regarding CNA A being in R4's room and hiding in the closet. "Administrative Licensed Nurse" C said she just thought CNA A was joking with staff and did not think it was a concern. She also stated that when R4's family showed her some videos on 02/06/23 on his

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| S3028 | Continued From page 16<br>phone, it was hard to see but the video showed CNA A and R4 holding hands.<br><br>On 02/08/23 at 02:30 PM "Administrative Staff" G commented "Administrative Licensed Nurse" C should have said something to "Administrative Staff" F after a concerned family member came in and talked to her and showed her videos that were concerning to him.<br><br>Review of the "Resident Abuse, Neglect and Exploitation" policy and procedure dated 04/30/19 revealed "an employee must report to the Residence Director immediately any allegations of abuse, neglect, or exploitation of residents ... An investigation shall be conducted by the Residence Director Administrator or designee...An employer shall report to the department and/or appropriate state or local agency any allegation of client or resident abuse, neglect, exploitation, mistreatment... An employer shall report to the department by telephone within 24 hours after receiving the allegation and in writing within 5 working days after receiving an allegation..."<br><br>"The administrator failed to report the family's concerns brought to Administrative Nurse C on 02/06/23 related to potential abuse or exploitation to the department within 24 hours | S3028 | | |
| S3215 SS=E | 26-41-205 (h) Medication Storage<br><br>(h) Storage. Licensed nurses and medication aides shall ensure that all medications and biologicals are securely and properly stored in accordance with each manufacturer ' s recommendations or those of the pharmacy | S3215 | | |

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| S3215 | Continued From page 17<br>provider and with federal and state laws and regulations.<br>(1) Licensed nurses or medication aides shall store non-controlled medications and biologicals managed by the facility in a locked medication room, cabinet, or medication cart. Licensed nurses and medication aides shall store controlled medications managed by the facility in separately locked compartments within a locked medication room, cabinet, or medication cart. Only licensed nurses and medication aides shall have access to the stored medications and biologicals.<br>(2) Each resident managing and self-administering medication shall store medications in a place that is accessible only to the resident, licensed nurses, and medication aides.<br>(3) Any resident who self-administers medication and is unable to provide proper storage as recommended by the manufacturer or pharmacy provider may request that the medication be stored by the facility.<br>(4) A licensed nurse or medication aide shall not administer medication beyond the manufacturer ' s or pharmacy provider ' s recommended date of expiration.<br><br>This REQUIREMENT is not met as evidenced by:<br>KAR 26-41-205 (h) (4)<br><br>The facility reported a census of 62 residents (R). Based on observation and interview the operator failed to ensure licensed nurses and certified medication aides could not administer | S3215 | | |

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| S3215 | Continued From page 18 | S3215 | | |

medications beyond the medication manufacturer's or pharmacy provider's recommended date of expiration by a failure to ensure staff dated insulin pens once opened.

Findings included:

- Review of the resident roster provided by "Administrative Licensed Nurse" C, revealed the facility had six residents whom the facility was responsible for administering their insulin.

Observation of the 100/200 hall medication cart on 02/06/23 at 04:00 PM revealed a divider section with multiple insulin pens. Two of the insulin pens did not include a date opened for staff to know when it expired and one of those two did not have a resident's name on it. A Toujeo pen, without name or date had five units remaining in it and the Humalog pen had 20 units remaining in it.

On 02/06/23 at 04:10 PM, "Administrative Licensed Nurse" C acknowledged the insulin pens should all include a date they were opened.

The Toujeo insulin manufacture recommended storage guide indicates an opened insulin pen can be stored at room temperature for 28 days and to discard even if insulin remained in the pen.

The Humalog Kwickpen manufacture recommended to store the opened insulin at room temperature for 28 days and discard even if insulin remained in the pen.

The administrator failed to ensure licensed

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| S3215 | Continued From page 19<br>nurses and certified medication aides could not administer medications beyond the medication manufacturer's or pharmacy provider's recommended date of expiration by a failure to ensure staff dated insulin pens once opened. | S3215 | | |
| S9999 | Final Observations<br><br>Scope and Severity of F.<br><br>Kansas Statute 39-981.<br><br>Authorized electronic monitoring; reasonable accommodations; notice; consent; use as evidence; prohibitions.<br>(d) A resident, or such resident's guardian or legal representative, who wishes to conduct authorized electronic monitoring shall notify the adult care home on a form prescribed by the secretary for aging and disability services.<br>(i) Each adult care home shall post a conspicuous notice at the entrance to the adult care home and each resident's room stating that the rooms of some residents may be monitored electronically by or on behalf of the room's resident or residents.<br><br>This Requirement is not met as evidenced by:<br><br>The facility reported a census of 62 residents(R). Based on observation, record review, and interview, the Administrator failed to ensure the proper paperwork was completed for the use of a recording electronic monitoring device in one (R4) of one resident's room, failed to post a conspicuous notice at the entrance to the adult | S9999 | | |

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care home and failed to post at the entrance to each resident's room a notice, stating that the rooms of some residents may be monitored electronically by or on behalf of the room's resident or residents.

Findings included:

- Upon entering the facility on 02/06/23 at 03:50 PM the facility did not have a posting at the entrance of the facility that identified the rooms of some residents may be monitored electronically on their behalf.

Observation on 02/06/23 at 04:46 PM surveyor went into the resident R4's room and observed on the table by the resident's chair a picture frame type device which had the capability of electronic monitoring.

During entrance review on 02/06/23 at 05:55 PM "Administrative Staff" F reported one resident, R4 had a video monitoring device that family had put in the resident's room.

At 05:57 PM "Administrative Licensed Nurse" C reported the posting for the video monitoring was at the nurse's station.

On 02/07/23 review of R4's medical record included "Authorized Electronic Monitoring" paperwork that was signed on 02/06/23 but the device had been in the room prior to 02/06/23.

The facility failed to ensure the proper paperwork was completed for the use of an electronic monitoring device in one resident's room and failed to post required notification outside each

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| S9999 | Continued From page 21<br>resident's room that "some residents rooms may be monitored electronically." | S9999 | | |