

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046072	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/07/2024
NAME OF PROVIDER OR SUPPLIER SUNRISE ASSISTED LIVING OF LEAWOOD		STREET ADDRESS, CITY, STATE, ZIP CODE 11661 GRANADA AVENUE LEAWOOD, KS 66211		
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S 000	INITIAL COMMENTS The following represents the findings of a resurvey with attached complaints #189570, #187379, #187341, #187074 at the above named assisted living conducted on 08/05/24 - 08/07/24.	S 000		
S3026 SS=J	26-41-101 (f) (1) Staff Treatment of Residents ANE (f)The administrator or operator shall ensure that all of the following requirements are met: (1) No resident shall be subjected to any of the following: (A) Verbal, mental, sexual, or physical abuse, including corporal punishment and involuntary seclusion; (B) neglect; or (C) exploitation. This REQUIREMENT is not met as evidenced by: KAR 26-41-101(f)(1)(B) The facility reported a census of 75 residents with six residents included in the sample and three closed record reviews. Based on observation, interview, and record review the administrator failed to protect cognitively impaired Resident (R)1 from neglect when he attempted to elope from the building on 07/26/24 at 05:49 PM by exiting the secured memory care unit (on the third floor) and staff found him on the ground/basement level. On 07/27/23 at approximately 04:52 AM, he then exited the building by going through the secured memory care unit door, down four flights of stairs to the ground floor/basement and exited the building through a second secured door. Local police found R1 approximately 43 minutes later, approximately 1.3 miles away from the facility.	S3026		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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S3026	Continued From page 1 This placed R1 in Immediate Jeopardy. Findings included: - Record review for R1 revealed an admission date of 07/22/24 with diagnoses of dementia and heart failure. The 07/22/24 "Functional Capacity Screen" (FCS) identified R1 was independent with transfers and walking/mobility and used no assistive devices; he had short-term and long-term memory, memory/recall, and decision-making difficulties; and he was identified at risk for wandering. The 07/22/24 combined "Negotiated Service Agreement/Healthcare Service Plan" (NSA/HSP) documented (unidentified persons) to offer structured activities according to R1's preference for wandering. The combined "NSA/HSP" failed to document guidance for facility staff regarding R1's wandering and failed to describe services provided for cognition. The "date of service" 07/17/24 "History and Physical Information" by Physician C documented R1 had advanced dementia and was unable to care for himself. The 07/23/24 at 10:28 AM late entry "Health Status" note by CNA D documented R1 had packed and expressed a desire to leave the facility. The 07/23/24 at 10:29 AM late entry "Health Status" note by CNA D documented R1 was provided frequent checks. The 07/27/24 at 10:47 AM late entry "Health Status" note by Administrative Nurse B documented R1 exited the building and left facility	S3026		

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S3026	Continued From page 2 property without escort at 04:45 AM. R1's record from admission on 07/22/24 to 07/27/24 failed to document R1's attempt to exit the facility on the evening of 07/26/24 when he left the memory care unit through an alarmed door and staff found him at the bottom of the stairwell. The undated facility's "Investigation" reported the following: R1 resided in the facility's secured memory care with exit doors secured with a keypad code. The doors released after 30 seconds without using the code for life safety reasons. On 07/27/24 Certified Medication Aide (CMA) E last saw R1 in his room during rounds between 02:00 to 03:00 AM. On 07/27/24 at approximately 04:52 AM, R1 activated the door alarm on the back door (Stairwell C) of the memory care unit. The door released and R1 went down the stairs to the basement and set off the door alarm on Stairwell C exit at basement to the outside. CMA E and Certified Nurse Aide (CNA) F were on duty in the memory care. Staff responded to the memory care unit back door alarm. CNA F searched room to room while CMA E went down Stairwell C and searched the facility's grounds outside the building. R1 could not be located. CMA E notified Administrative Nurse B at approximately 05:11 AM that R2 was missing. Administrative Nurse B told CMA E to call local law enforcement for assistance in the search. CMA E called law enforcement at approximately 05:20 AM. The local police department located R1 at an intersection approximately 1.3 miles away at	S3026		

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S3026	Continued From page 3 around 05:35 AM and returned R1 to the facility at approximately 05:40 AM without injury. Facility staff provided R1 one-to-one observation and transferred him to the hospital at approximately 07:00 AM. The 07/27/24 "Statement of Event" by CMA E and included in the facility's "Investigation" reported she exited a resident's room at 04:50 AM and heard a door alarm going off. She and CNA F went towards the back door of the memory care unit and noticed the back door was open. CMA E went down the stairs and did not see anyone. CMA E and CNA F began looking for R1 because he had previously exited the secured memory care unit the evening before. They checked other residents' rooms and searched first and second floors. She asked another staff from the first floor to assist in the search. Together they searched the garage and outside by the creek. CMA E notified Administrative Nurse B and then called the local police department. The police returned R1 to the facility at 05:38 AM. The 07/27/24 "Statement of Event" by CNA F and included in the facility's "Investigation" reported she was on the ground floor to finish laundry. Upon return to the memory care unit (third floor) within five minutes she heard an alarm going off. She and CMA E went to Stairwell C door and identified it was the door that alarmed. CNA F began searching all the rooms in the memory care unit on the third floor while CMA E searched other floors, the stairs, and called other staff members. Review of the facility's "Resident Roster" provided during the survey revealed eight residents in the memory care unit and six residents in the assisted living were marked for wandering.	S3026		

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S3026	Continued From page 4 Observation on 08/05/24 at approximately 01:59 PM revealed a possible route R1 took from his room to exit the building. From his room to Stairwell C door was approximately 280 feet. Stairwell C door had a keypad lock on the wall beside the door. A sign on the door read "push against door for 30 seconds to open." Administrative Staff A pushed the door which immediately activated the alarm. The alarm continued to go off and the door opened in 30 seconds. There were four flights of stairs down to a second door secured with another keypad lock and alarm. Administrative Staff A pushed the bottom door which immediately activated the alarm. The alarm continued to go off and the door opened in 30 seconds. Observation on 08/06/24 at approximately 10:40 AM revealed the intersection where police found R1. One street was a four-lane street with a speed limit of 35 mph. The intersection was a three-way with no traffic lights or stop signs. The intersecting street was a residential street lined with homes on both sides. The area between the facility and the intersection where police found R1 included a small creek, a wide creek lined with wooded areas, a pond, a shopping center, and several neighborhoods. The weather on 07/27/24 at 04:53 AM according to Wunderground.com was 71 degrees Fahrenheit with a wind speed of 17 miles per hour (mph) and it was dark. On 08/05/24 at approximately 01:59 PM CNA M stated R1 went through a secured memory care door and down the stairs on the evening of 07/26/24. Staff responded to the alarm, one took	S3026		

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S3026	Continued From page 5 the elevator while another staff ran down the stairs. R1 did not leave the building and they were able to assist him back to the memory care unit. On 08/06/24 at 11:29 AM Administrative Nurse B stated she became aware of R1's first attempt to elope only after the successful morning elopement occurred. She expected a licensed nurse to implement actions to keep R1 safe from elopement after his first attempt. On 08/06/24 at 12:15 PM Administrative Staff A stated the memory care unit had its own washer and dryer but sometimes staff left the memory care unit to do laundry, leaving one staff alone on the memory care unit. On 08/06/24 at 02:47 PM CMA E stated the training provided her on the door alarm system and phone alert system was inadequate. She had her phone with her the morning R1 eloped and heard it make a noise while she was in a resident's room. She could not access the phone to see the notification because she was in the process of providing care and had on dirty gloves. She heard the door alarm after she exited the room as the alarms could not be heard while in residents' rooms. CMA F had gone downstairs to do laundry leaving her as the only staff member on the unit. There were not enough staff to follow the facility's policy which directed two staff be assigned to each floor during a search. The night R1 eloped, there were only four total staff in the building for three floors the entire night. On 08/06/24 at 03:08 PM CMA G stated R1 exited the memory care unit through a secured door during dinner time on 07/26/24. He found R1 in the stairwell and was able to intercept him before he exited the building and assist R1 back	S3026		

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S3026	Continued From page 6 up the memory care unit. Another staff member notified the nurse and facility staff provided R1 frequent checks until the end of their shift. He expected the nurse to notify Administrative Nurse B that R1 attempted to elope. The 11/02/98 facility's "Missing Residents" policy documented the lead care manager would assign two team members to each floor to conduct a building search; team members assigned to search outside areas of the building; and a team member would conduct a quick neighborhood search by van. The administrator failed to protect cognitively impaired Resident (R)1 from neglect when he exited the building through two alarmed doors. The local police found him approximately 43 minutes later approximately 1.3 miles away from the facility. On 08/06/24 the facility's "Abatement Plan - Missing Resident" plan was accepted by the department at 05:44 PM. 1) Facility staff placed R1 on one-to-one observation upon his return to the facility by local police. 2) Administrative Nurse B arranged for R1 to transfer to the hospital on 07/27/24 at approximately 07:00 AM which was 1.5 hours after he returned to the facility. 3) Door alarms were checked weekly with last check on 07/22/24 and were functioning properly. Door alarms were checked on 07/27/24 and were functioning properly. Door alarms would continue to be checked weekly. 4) Elopement policy training began immediately to all team members on all shifts and was completed by 08/01/24.	S3026		

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S3026	Continued From page 7 5) An elopement drill was conducted on 07/30/24 with ten team members. Elopement drills will be conducted monthly on all shifts, with each shift provided a drill at least once per quarter. 6) Education provided to the nurse to report incidents regarding residents exiting the memory care unit immediately to Administrative Staff.	S3026		
S3085 SS=E	26-41-202 (a) Negotiated Service Agreement (a) The administrator or operator of each assisted living facility or residential health care facility shall ensure the development of a written negotiated service agreement for each resident, based on the resident ' s functional capacity screening, service needs, and preferences, in collaboration with the resident or the resident ' s legal representative, the case manager, and, if agreed to by the resident or the resident ' s legal representative, the resident ' s family. The negotiated service agreement shall provide the following information: (1) A description of the services the resident will receive; (2) identification of the provider of each service; and (3) identification of each party responsible for payment if outside resources provide a service. This REQUIREMENT is not met as evidenced by: KAR 26-41-202(a)(1)(2) The facility reported a census of 75 residents with six residents included in the sample and three closed record reviews. Based on interview and	S3085		

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S3085	Continued From page 8 record review the administrator failed to ensure the "Negotiated Service Agreements" (NSA) for Residents (R) 1, R2, R4, R5, R6, R7, R8, and R9 described the services they received based on their "Functional Capacity Screen" (FCS) service needs, and preferences and who was responsible for providing the services. Findings included: - Record review for R1 revealed an admission date of 07/22/24 with diagnoses of dementia and heart failure. The 07/22/24 "Functional Capacity Screen" (FCS) identified R1 required assistance with management of treatments and was identified at risk for wandering. The 07/22/24 combined "NSA/Healthcare Service Plan" (NSA/HSP) documented "I will be offered pleasant activities (SPECIFY: GROUP ACTIVITIES, MUSIC PROGRAM) per my activity preference." The NSA/HSP failed to specify what activities were provided for wandering and to identify the provider of the service. The NSA/HSP failed to describe any services provided for management of treatments and the provider of the services. R1's NSA/HSP failed to describe the services provided and failed to identify the provider of each service. - Record review for R2 revealed an admission date of 09/09/23 with diagnoses of hemiplegia and hemiparesis following cerebral infarction and diabetes mellitus. The 06/04/24 "FCS" identified R2 required	S3085		

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S3085	Continued From page 9 physical assistance with dressing, toileting, transfers, and walking/mobility; and he had short term memory, memory/recall, and decision-making difficulties. The 06/05/24 "NSA/HSP" documented "I need physical assistance of one person" for dressing, toileting, transfers, and mobility when moving about in his room; and unidentified persons would offer him limited choices and options so he could continue to make his own decisions for cognitive difficulties. R2's "NSA/HSP" was dated one day before the "FCS" and failed to describe the services provided for dressing, toileting, transfers, and mobility and failed to identify the provider of those services and services provided for cognitive difficulties. - Record review for R4 revealed an admission date of 11/14/22 with a diagnosis of type 2 diabetes mellitus. The 01/03/24 "FCS" identified R4 required physical assistance with bathing, dressing, transfers, walking/mobility, management of treatments, and was identified to have cognitive difficulties and impaired hearing. The 01/03/24 combined "NSA/HSP" documented "I am independent with my mobility" and "I need physical assist of 1 person with mobility". . . I need physical assist of one person" for bathing, dressing, and transfers. The "NSA/HSP" for R4 had conflicting statements which did not correspond to the assistance level identified in the FCS. The "NSA/HSP" failed to identify the provider of the services for bathing,	S3085		

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S3085	Continued From page 10 dressing, transfers, walking/mobility, cognitive difficulties, impaired hearing and failed to identify the provider of the services. The "NSA/HSP" failed to describe the services provided for management of treatments and failed to identify the provider of the services. - Record review for R5 revealed an admission date of 07/22/24 with diagnoses of dementia and heart failure. The 07/10/24 FCS identified R5 required physical assistance with bathing, dressing, toileting, transfers and management of treatments. The 07/10/24 combined "NSA/HSP" documented "I need physical assistance of 1 person" for bathing and dressing. The "NSA/HSP" documented a sit-to-stand lift was required for toileting and transfers. The "NSA/HSP" for R5 failed to identify the services provided for bathing, dressing, toileting, and transfers and failed identify provider of the services. The "NSA/HSP" failed to describe the services provided for management of treatments and failed to identify the provider of the services. - Record review for R6 revealed an admission date of 07/22/24 with diagnoses of visual loss and multiple sclerosis. The 03/13/24 FCS identified R6 required assistance with bathing, transfers, management of treatments and was identified at risk for falls and impaired cognition. The 03/13/24 "NSA/HSP" for R6 documented "I need physical assistance of 2 persons with bathing," "I need a hoier life with transfers," and	S3085		

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S3085	Continued From page 11 to evaluate, remind and provide services for falls. The "NSA/HSP" failed to specify who was to provide the services for bathing, transfers, falls, and impaired cognition. The "NSA/HSP" failed to describe the services provided for management of treatments and the provider of the services. - Record review for R7 revealed an admission date of 06/10/16 with a diagnosis of dementia. The 06/24/24 "FCS" identified R7 was unable to perform management of treatments. The 03/24/24 combined "NSA/HSP" (dated three months before the "FCS") failed to describe services provided for management of treatments and failed to identify the provider of the services. Designated facility further failed to ensure the "NSA/HSP" was based on the "FCS" because it was dated three months before the "FCS" was completed. - Record review for R8 revealed an admission date of 04/20/21 with a diagnosis of dementia. The 07/07/24 "FCS" identified R8 was unable to perform mananagement of treatments; was frequently incontinent of bladder; had short-term and long-term memory, memory/recall, and decision-making difficulties; sometimes understood others during communication; and was identified at risk for falls, impaired decision-making, and inappropriate behavior. The 06/12/24 combined "NSA/HSP" for R8 documented unidentified persons provided needs for bladder incontinence; offered limited choices and options for cognitive difficulties; provided frequent checks for assistance or reassurance for	S3085		

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S3085	Continued From page 12 falls, offered limited choices and decisions for impaired decision-making; and offered validation by speaking in calm manner for inappropriate behavior. The "NSA/HSP failed to describe services provided for management of treatments and communication and failed to identify the provider of the services. The "NSA/HSP" failed to identify the provider of the services for falls, impaired decision-making, and inappropriate behavior. Designated facility further failed to ensure the "NSA/HSP" was based on the "FCS" because it was dated one month before the "FCS" was completed. - Record review for R9 revealed an admission date of 06/10/21 with diagnoses of dementia and cognitive communication disorder. The 05/21/24 "FCS" identified R9 was unable to perform management of medications. The 05/29/24 combined "NSA/HSP" failed to describe services provided for management of treatments and failed to identify the provider of the service. On 08/07/24 at approximately 11:05 AM CNA D confirmed R1, R2, R4, R5, R6, R7, R8, and R9 records failed to describe the services they received based on their "FCS's" and failed to identify the provider of the services. On 08/07/24 at approximately 02:49 PM an "NSA" policy was requested which the facility failed to provide. The administrator failed to ensure the "NSA" for R1, R2, R4, R5, R6, R7, R8, and R9 described	S3085		

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(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
S3085	Continued From page 13 the services they received based on their "FCS's" service needs, and preferences and who was responsible for providing the services.	S3085			
S3211 SS=E	26-41-205 (g) (3) OVER THE COUNTER DRUGS (3) A licensed nurse or medication aide may accept over-the-counter medication only in its original, unbroken manufacturer ' s package. A licensed pharmacist or licensed nurse shall place the full name of the resident on the package. If the original manufacturer ' s package of an over-the-counter medication contains a medication in a container, bottle, or tube that can be removed from the original package, the licensed pharmacist or a licensed nurse shall place the full name of the resident on both the original manufacturer ' s medication package and the medication container. This REQUIREMENT is not met as evidenced by: KAR 26-41-205(g)(3) The facility reported a census of 75 residents combined between assisted living and memory care. Based on observation and interview the administrator failed to ensure a licensed pharmacist or licensed nurse placed the full names of residents on the original packages of fourteen over-the-counter (OTC) medications in the nurse's medication cart, seventeen OTC in assisted living, and four OTC in the memory care. Findings included:	S3211			

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S3211	Continued From page 14 - Observation on 08/05/24 at 11:45 AM revealed the first-floor assisted living medication cart contained the following OTC medications were not labeled with residents' full names: One bottle refresh tears, 10ml One bottle Neuriva, 50 gummies One bottle Tums, 150 tabs One bottle ibuprofen 200mg, 100 tabs One tube hydrocortisone cream 2.5%, 2 oz One bottle Tussin DM 236ml On 08/05/24 at approximately 11:48 AM "Certified Medication Aide" (CMA) I confirmed six OTC medications in the first-floor medication cart were not labeled with residents' full names. - Observation on 08/05/24 at 12:20 PM revealed the first of two second-floor assisted living medication carts contained the following OTC medications were not labeled with residents' full names: One bottle melatonin 1mg, 240 tablets One bottle aspirin 81mg, 300 tablets One bottle niacin 500mg, 240 caps One bottle probiotic, 120 tablets One bottle magnesium citrate, 100 caps One bottle acetaminophen 500mg, 500 caps One bottle clearlax, 765 grams On 08/05/24 at approximately 12:22 PM "Certified Medication Aide" (CMA) I confirmed seven OTC medications in the first second-floor medication cart were not labeled with residents' full names. - Observation on 08/05/24 at 01:14 PM revealed the nurse's medication cart contained the following OTC medications were not labeled with residents' full names:	S3211		

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S3211	Continued From page 15 One tube of Zinc oxide paste, 4 oz One tube protective ointment petrolatum 98%, 2.47 oz One tube calmoseptine ointment, 4 oz One shaker container Antifungal powder, 3 oz One tube triamcinolone acetonide 0.1%, 80 g Two tubes silicone cream, 4 oz One tube collagenase Santyl ointment 250 units/gram, 90 grams One tube collagenase Santyl ointment 250 units/gram, 30 grams One tube antifungal ointment, 2.5 oz One tube Curad Vit A and D ointment, 2 oz Two tubes triple antibiotic ointment + pain relief, 1 oz One tube Mupiricin 2%, 22g On 08/05/24 at approximately 01:18 PM Licensed Nurse H confirmed fourteen OTC medications in the nurse's medication cart were not labeled with residents' full names. - Observation on 08/05/24 at 01:25 PM revealed the second of two second-floor assisted living medication carts contained the following OTC medications were not labeled with residents' full names: One bottle Melatonin 1 mg; 90 gummies One bottle refresh tears, 0.5 oz One container daily fiber psyllium husk, 23.3 oz One bottle antacid tabs equate 1000 mg, 160 tablets On 08/05/24 at approximately 01:28 PM "Certified Medication Aide" (CMA) I confirmed four OTC medications in the medication cart were not labeled with residents' full names.	S3211		

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S3211	Continued From page 16 - Observation on 08/05/24 at 01:34 PM revealed the Memory Lane Hall medication cart contained the following OTC medications were not labeled with the resident's full name: One bottle Areds Preservision, 130 gels One bottle aspirin 81 mg, 300 tablets One bottle omeprazole 20 mg, 15 tablets One bottle calcium, magnesium, zinc, vitamin D3, 500 tablets On 08/05/24 at approximately 01:35 PM CMA J confirmed four OTC medications in the Memory Lane medication cart were not labeled with resident's full name. The facility's "Medication Oversight Program" dated April of 2024 states "All medications are kept in their original, properly labeled containers." The administrator failed to ensure a licensed pharmacist or licensed nurse placed the full names of residents on the original packages of 35 OTC medications.	S3211			
S3215 SS=E	26-41-205 (h) Medication Storage (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 provider and with federal and state laws and regulations. (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	S3215			

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S3215	Continued From page 17 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. (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. (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. (4) A licensed nurse or medication aide shall not administer medication beyond the manufacturer ' s or pharmacy provider ' s recommended date of expiration. This REQUIREMENT is not met as evidenced by: KAR 26-41-205(h) The facility reported a census of 75 residents. Based on observation and interview, the administrator failed to ensure medications were stored in accordance with each manufacturer's recommendations. Findings included: - Observation on 08/05/24 at 12:29 PM revealed the nurse's medication cart with opened insulin pens including lispro dated 6/12/24, Tresiba pen dated 07/03/24, and novolog pen dated 06/28/24.	S3215		

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S3215	Continued From page 18 The insulin manufacturer recommendations stated an opened, used pen should be discarded after 28 days. On 08/05/24 at approximately 12:31 PM Licensed Nurse H confirmed the insulin pens were opened and dated longer than 28 days prior. The administrator failed to ensure medications were stored in accordance with each manufacturer's recommendations.	S3215		
S3265 SS=F	26-41-104 (a) Disaster and Emergency Preparedness (a) The administrator or operator of each assisted living facility or residential health care facility shall ensure the provision of a sufficient number of staff members to take residents who would require assistance in an emergency or disaster to a secure location. This REQUIREMENT is not met as evidenced by: KAR 26-41-104(a) The facility reported a census of 75 residents with six residents included in the sample and three closed record reviews. Based on interview and record review the administrator failed to ensure sufficient number of staff members for residents who required assistance in an emergency or disaster were scheduled during all shifts. Findings included: - Record review of the facility's call light log from	S3265		

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S3265	Continued From page 19 08/02/24 through 08/05/24 indicated: Out of 270 total call light activations, 139 call lights were answered in over 30 minutes which was 51% of all call lights. 82 call lights were answered in over one hour which was 30% of all call lights. Record review of resident roster on 08/05/24 revealed memory care unit had seven residents who required two-person assistance to transfer. The assisted living had 14 residents who required two-person assistance to transfer. Review of Evacuation Drill dated 10/03/23 at 10:30 AM revealed the facility completed a full evacuation in 29 minutes with six staff members. The facility failed to ensure night shift staffing levels were used for drill. Interview on 08/05/24 at approximately 01:45 PM of Certified Medication Aide (CMA) N and Certified Nurse Aide M stated there were not enough staff at the time of the interview. They reported that it was just the two of them that day. Both agreed that they had too many two-person assistance residents for their staffing. Interview on 08/07/24 at approximately 12:44 PM of R6 revealed that the resident has had to wait up to three hours for a response to her call light. She stated the staff had excuse of "we have others to take care of." Interview on 08/07/24 at approximately 01:55 PM of R5 revealed that the resident had to wait "sometimes over an hour" for a response to her call light. She stated that one time she had to wait for additional staff that was needed to assist her	S3265		

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S3265	Continued From page 20 to come from upstairs. R2 stated that her opinion was there should have been two staff on each floor of the building. Interview on 08/07/24 at 02:28 PM of Licensed Nurse H revealed that she consistently did not feel she had enough time to complete the tasks she needed to do each shift. Interview on 08/06/24 at 12:15 PM of Administrative Staff A revealed if staff left unit to do laundry the facility did not have staff from another floor cover. Interview on 08/06/24 at 02:24 PM of Administrative Nurse B revealed staffing was two staff in memory care (third floor) at night and two staff in assisted living (first and second floors) with sometimes a float. Four to five total staff for whole building. Interview on 08/06/24 at 02:47 PM of CMA E revealed there were not enough staff during an emergency when a resident went missing. The policy stated two staff were assigned to each floor during a search. That night there were only 4 staff in the whole building with three floors. Interview on 08/06/24 at 05:45 PM with Administrative Nurse B revealed her goal for call light response was within 15 minutes. She stated they needed more staff. Interview on 08/07/24 at approximately 02:52 PM Administrative Staff A stated call light response time goal was 15-20 minutes. The administrator failed to ensure sufficient number of staff members for residents who required assistance in an emergency or disaster	S3265		

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S3265	Continued From page 21 were scheduled during all shifts.	S3265		
S3298 SS=F	26-41-206 (d) Food Preparation (d) Food preparation. Food shall be prepared using safe methods that conserve the nutritive value, flavor, and appearance and shall be served at the proper temperature. (1) Food used by facility staff to serve to the residents, including donated food, shall meet all applicable federal, state, and local laws and regulations. (2) Food in cans that have significant defects, including swelling, leakage, punctures, holes, fractures, pitted rust, or denting severe enough to prevent normal stacking or opening with a manual, wheel-type can opener, shall not be used. (3) Food provided by a resident ' s family or friends for individual residents shall not be required to meet federal, state, and local laws and regulations. This REQUIREMENT is not met as evidenced by: KAR 26-41-206(d) The facility reported a census of 75 residents. The facility had a main kitchen where food was stored, prepared and served and an additional kitchen in memory care where food was served. Based on interview and record review, the administrator failed to ensure food was served at the proper temperature. Findings included:	S3298		

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S3298	Continued From page 22 - Observation on 08/05/24 at 01:43 PM of the main kitchen revealed clipboards on the wall above the prep area which contained weekly food temperature logs for the current week. Review of the food temperature logs for the month of July 2024 revealed designated staff failed to obtain temperatures for foods served 71 out of 93 meals. On 08/06/24 at 03:45 PM Dietary Staff K confirmed the food temperature logs were not completed for every meal every day of the month. On 08/05/24 at 02:20 PM Dietary Staff L confirmed the expectation was that food temperature logs were completed for every meal every day of the month. She stated the main kitchen and memory care kitchen staff should both have completed temperature logs. The Kansas Department of Agriculture's "Focus on Food Safety" booklet page 14, 18 and 19 documented "minimum hot holding temperature is 135 degrees Fahrenheit (F)." and "maximum cold holding temperature is 41 degrees F." The facility's "Food Storage, Preparation and Service" policy revised 07/08/24 documented food temperatures were "to be taken 15 minutes prior to service in the main kitchen and all satellite locations." The administrator failed to ensure food was served at the proper temperature.	S3298		
S3299 SS=F	26-41-206 (e) (1) Facility Food Storage (e) Food storage. Facility staff shall store all food	S3299		

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S3299	Continued From page 23 under safe and sanitary conditions. (1) Containers of poisonous compounds and cleaning supplies shall not be stored in the areas used for food storage, preparation, or serving. This REQUIREMENT is not met as evidenced by: KAR 26-41-206(e) The facility reported a census of 75 residents. The facility had a main kitchen where food for all residents were stored, prepared, and served and an additional kitchen in memory care where food was served. Based on observation and interview the administrator failed to ensure food items were stored under safe conditions. Findings included: - Observation on 08/05/24 at 02:17 PM in the main kitchen revealed a salad refrigerator that contained food items for the residents. The salad refrigerator contained two trays of double stacked cups with individual serving sizes of dressings and one gallon of milk that lacked labels identifying a date the food was opened or prepared. On 08/05/24 at approximately 02:21 PM Dietary Staff L confirmed the food items were undated. A food storage area contained all non-perishable items contained a dented can of pears, one opened and unsealed bag of mousse mix, two opened and unsealed packages of instant pudding mix and one opened and unsealed package of frosting mix.	S3299		

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S3299	Continued From page 24 On 08/05/24 at approximately 02:24 PM Dietary Staff L confirmed the food items were dented or unsealed. A walk-in refrigerator contained the following items; one cardboard box of uncooked bacon on a shelf above vegetables and prepared dessert, one eight ounce container of fresh mushrooms unsealed, and 14 gallons of various dressings (including Ranch flavor), sauces, salsa, and mayo were opened and undated. On 08/05/24 at approximately 02:30 PM Dietary Staff L confirmed the food items were not correctly placed, unsealed and undated. The facility's "Food Storage, Preparation and Service" policy revised 07/08/24 documented all food items are labeled, dated and rotated to maintain system and "all canned products must be in good condition. Cans that are dented may not be used and are discarded immediately." The policy stated safe internal cooking and holding temperatures as defined by the Food and Drug Administration Food Code "are met and recorded on the productions sheets." The Kansas Department of Agriculture's "Focus on Food Safety" booklet Page 13 documented that cooked, ready-to-eat foods were to be stored above raw animal foods. Page 19 stated that cold foods must be covered to maintain cold holding temperature. Page 20 explained commercially prepared foods must be date marked after the original container was opened or if it was held for more than 24 hours. The administrator failed to ensure foods were stored under safe conditions.	S3299		

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S3320 SS=E	28-39-254 CONSTRUCTION (a) The assisted living facility or residential health care facility shall be designed, constructed, equipped and maintained to protect the health and safety of residents, personnel and the public. (b) All new construction, renovation, remodeling and changes in building use in existing buildings shall comply with building and fire codes, ordinances and regulations enforced by city, county, and state jurisdictions, including the state fire marshal. (c) New construction, modifications and equipment shall conform to the following codes and standards: (1) Title III of the Americans with disabilities act, 42 U.S.C. 12181, effective as of January 26, 1992; and (2) "Food Service Sanitation Manual," health, education, and welfare (HEW) publication no. FDA 78-2081, as in effect on July 1, 1981. This REQUIREMENT is not met as evidenced by: KAR 28-39-254(a) The facility reported a census of 75 total residents with 25 residents in the memory care unit. Based on observation and interview the administrator failed to ensure the facility was maintained to protect the health and safety of the residents and visitors by ensuring all chemicals were stored within locked areas in the memory care unit. Findings included:	S3320		

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S3320	Continued From page 26 - Observation on 08/05/24 at approximately 01:43 PM of the memory care kitchen, which was accessible to residents, revealed an unlocked cabinet under the kitchen sink. The cabinet contained four one-gallon sized plastic containers of automatic dishwashing liquid and one 16-ounce spray bottle of disinfectant cleaner with labels that read "Keep out of reach of children." On 08/05/24 at approximately 01:43 PM Certified Medication Aide (CMA) N confirmed the chemicals were stored in an unlocked area that was accessible to the residents. The administrator failed to ensure the building was maintained to protect the health and safety of the residents and visitors by ensuring all chemicals were stored within a locked areas in the memory care unit.	S3320		