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	B085009	A. BUILDING: _____ B. WING _____	10/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REFLECTION RETIREMENT RESORT LLC	626 S 3RD ST SALINA, KS 67401

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S 000	INITIAL COMMENTS The following citations represent the findings of a resurvey with complaints (#187055, #184577, #182000) at the above named facility conducted on 10/29/24.	S 000		
S5028 SS=E	26-42-101 (f) (3) Staff Treatment of Residents Reporting (f) (3) Each allegation of abuse, neglect, or exploitation shall be reported to the administrator or operator of the home 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: (A) An investigation shall be started when the administrator or operator, or the designee, receives notification of an alleged violation. (B) Immediate measures shall be taken to prevent further potential abuse, neglect, or exploitation while the investigation is in progress. (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. (D) Appropriate corrective action shall be taken if the alleged violation is verified. (E) The department ' s complaint investigation report shall be completed and submitted to the department within five working days of the initial report. (F) A written record shall be maintained of each investigation of reported abuse, neglect, or exploitation. This REQUIREMENT is not met as evidenced by:	S5028		

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

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S5028	Continued From page 1 KAR 26-42-101 (f) (3) (A) (B) (C) The facility reported a census of 46 residents. The sample included 3 residents and 1 closed record review resident. Based on record review and interviews for 1 closed record review Resident (R)5, Administrator A failed to ensure each allegation of neglect was reported to the Department within 24 hours, an investigation of each alleged incident was completed to rule out neglect and full investigation was completed within five days, ensure immediate measures were taken to prevent further neglect while investigation in progress, ensure corrective actions taken if allegations verified, submit investigation report to the Department within five days, and maintain a written record of the investigation of any allegation of neglect when R5 was a confused, known wander risk, eloped from the facility on 08/05/23, fell in the parking lot of the facility and sustained injuries. Findings included: Facility report dated 08/07/23 indicated R5 was a known elopement risk and eloped from the facility on 08/05/23 at approximately 01:26 AM. R5 was found in the facility parking lot, sustained a left arm fracture and was transported to the hospital. R5 was last observed by facility staff on 08/05/23 at approximately 12:30 AM. - Review of R5's closed medical record revealed she admitted to the facility on 12/09/20 with diagnosis of amnesia, hypertension and unspecified psychosis. R5's "Functional Capacity Screen" (FCS) dated 07/14/23 recorded the resident required supervision with transfer, walk/ mobility and	S5028		

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S5028	Continued From page 2	S5028		

eating, required physical assistance with bathing and dressing and was unable to perform management of medications and treatments. The FCS recorded the resident was frequently incontinent, had short and long-term memory impairment, memory/recall impairment, impaired decision making and was sometimes understandable/ sometimes understood communication. The FCS further recorded the resident was at risk for falls/ unsteadiness, wandering and was socially inappropriate/ disruptive behavior. The FCS identified R5 used a walker for mobility.

R5's "Negotiated Service Agreement" dated 07/14/23 recorded the resident received physical assistance with bathing, dressing, toileting, transfer, mobility and medication and treatment administration. The NSA further recorded R5 tended to wander throughout the community and was unaware of surrounds. Facility staff were to redirect R5.

Record lacked documentation of a "progress note" related to the 08/05/23 elopement.

Record lacked a facility "Incident Report" related to the 08/05/23 elopement.

R5's record lacked documentation of parties notified including family and physician, injuries sustained from the elopement and interventions put into effect after the elopement occurred.

Record lacked report submitted to the department until 08/07/23, approximately 48 hours after the incident occurred.

Record lacked a completed investigation submitted to the department after the 08/05/23

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S5028	Continued From page 3 elopement within five days. Interview on 10/29/24 at 04:34 PM with Administrator A, LN B and LN C confirmed there was no completed investigation related to R5's elopement from the facility. Administrator A failed to ensure each allegation of neglect was reported to the Department within 24 hours, an investigation of each alleged incident was completed to rule out neglect and full investigation was completed within five days, ensure immediate measures were taken to prevent further neglect while investigation in progress, ensure corrective actions taken if allegations verified, submit investigation report to the Department within five days, and maintain a written record of the investigation of any allegation of neglect when R5 was a confused, known wanderer, eloped from the facility on 08/05/23, fell in the parking lot of the facility and sustained injuries.	S5028		
S5080 SS=D	26-42-201 (a) (b) Functional Capacity Screen on Admission (a) On or before each individual ' s admission to a home plus, a licensed nurse, a licensed social worker, or the administrator or operator shall conduct a screening to determine the individual ' s functional capacity and shall record all findings on a screening form specified by the department. The administrator or operator may integrate the department ' s screening form into a form developed by the home, which shall include each element and definition specified by the department. (b) A licensed nurse shall assess any resident whose functional capacity screening indicates the	S5080		

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S5080	Continued From page 4 need for health care services. This REQUIREMENT is not met as evidenced by: KAR 26-42-201 (a) The census equaled 46 residents. The sample included 3 residents and 1 focused record review resident. Based on record review and interview for 1 focused record review Residents (R)4, the facility failed to ensure designated facility staff conducted a screening on or before admission to the assisted living facility to determine the resident's functional capacity. Findings included: Review of the "Resident Roster" obtained on 10/29/24 included R4. - Record review for R4 revealed an admission date of 04/02/24 with diagnoses of unspecified dementia, chronic obstructive pulmonary disease, hypertension and spinal stenosis. Review of R4's record lacked completion of a "Functional Capacity Screen" (FCS) on admission. R4's FCS was completed on 04/04/24, two days after admission to the facility. Interview on 10/29/24 at 04:45 PM with Administrator A, Licensed Nurse (LN) B and LN C confirmed a FCS for R4 was not completed on	S5080		

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S5080	Continued From page 5 admission and further confirmed a FCS was required to be completed on admission. The facility failed to ensure designated facility staff conducted a screening on or before admission to the assisted living facility to determine the resident's functional capacity for R4.	S5080		
S5115 SS=D	26-42-202 (c) Admission Negotiated Service Agreement (c) Each administrator or operator shall ensure the development of an initial negotiated service agreement at admission. This REQUIREMENT is not met as evidenced by: KAR 26-42-202 (c) The census totaled 46 residents. The sample included 3 residents and 1 focused record review resident. Based on record review and interview for 1 focused record review Residents (R)4, Administrator A failed to ensure the development of an initial negotiated service agreement upon admission. Findings included: - Record review for R4 revealed an admission date of 04/02/24 with diagnoses of unspecified dementia, chronic obstructive pulmonary disease, hypertension and spinal stenosis. The "Resident Functional Capacity Screen" (FCS) dated 04/04/24, two days after admission to the facility, recorded the resident required supervision	S5115		

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S5115	Continued From page 6 with bathing and physical assistance with management of medications and treatments. The FCS further recorded R4 had short- and long-term memory impairment, impaired memory/ recall, impaired decision making and used a mobility device. Record lacked completion of a negotiated service agreement on admission on 04/02/24. Interview on 10/29/24 at 04:45 PM with Administrator A, Licensed Nurse (LN) B and LN C confirmed a NSA for R4 was not completed on admission to the facility. Administrator A failed to ensure the development of an initial negotiated service agreement upon admission for R4.	S5115		
S5171 SS=D	26-42-204 (i) Health Care Services Standards of Practice (i) All health care services shall be provided to residents by qualified staff in accordance with acceptable standards of practice. This REQUIREMENT is not met as evidenced by: KAR 26-42 204 (i) The census totaled 46 residents. The sample included 3 residents. Based on record review, observation and interview, Administrator A failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services in accordance with acceptable standards of practice for the use of bed assistive devices, which met the needs of 1 sampled Resident (R)2.	S5171		

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S5171	Continued From page 7 Findings included: - The "Resident Roster" obtained on 10/29/24 identified no residents as having a bed assistive device. R2's "Medical Record" revealed he admitted to the facility on 12/18/23 with diagnoses of insomnia, diabetes mellitus, hypertension, hyperlipidemia and vitamin deficiency. The current "Resident Functional Capacity Screen" (FCS) dated 10/22/24 recorded the resident as independent with eating, required physical assistance with bathing, dressing, toileting and transfers, and unable to perform walk/mobility and management of medications and treatments. R2 was occasionally incontinent and was at risk for falls/ unsteadiness. The "Negotiated Service Agreement" (NSA) dated 10/22/24 recorded R2 facility staff assisted with bathing, dressing and toileting, transfer and administered medications. The NSA further recorded R2 had two transfer poles in his room for transferring assistance. The NSA failed to identify any additional bed assistive devices used. Observation on 10/29/24 at 04:00 PM in R2's room revealed an unsecured bed assist device to the right side of his bed. R2 stated he used the bed assistive device at times. Record review lacked an annual assessment of the resident to confirm the bed assistive device was not a restraint, an annual assessment of the resident to determine the purpose of the bedrail/assistive device and the resident's ability to safely use the device, an annual assessment	S5171		

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S5171	Continued From page 8 of the bedrail/assistive device to ensure the device was securely attached to the bed or bedframe and posed no risk for entrapment. Interview on 10/29/24 at approximately 04:00 PM with Licensed Nurse (LN) B and LN C confirmed they were unaware R2 had a bed assistive device on his bed and further confirmed no safety checks and bed assistive device assessment for R2 was completed for the bed assistive device to the right side of his bed. The FDA (food and drug administration) Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment dated 3/10/06 listed 4 zones of greatest concern with specific measurements to reduce the risk of entrapment as follows: Zone 1 within the rail should measure less than 4 and 3/4 inches Zone 2 under the rail, between the rail supports or next to a single rail support should measure less than 4 and ¾ inches Zone 3 between the rail and the mattress should measure less than 4 and 3/4 inches Zone 4 under the rail at the ends of the rail should measure less than 2 and 3/8 inches. Administrator A failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services which met the needs of R2 regarding the use of a bed assistive device.	S5171		
S5192 SS=F	26-42-206 (e) Food Preparation (e) Food shall be prepared using safe methods that conserve the nutritive value, flavor, and appearance and shall be served at the proper	S5192		

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S5192	Continued From page 9 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 26-42-206 (e) The census equaled 46 residents. The sample included 3 residents and 1 focused record review resident. Based on record review, interview and observation for all residents living in the facility and receiving meal services, Administrator A failed to ensure the facility staff served food at the proper temperature. Findings included: - During the initial tour of the facility's kitchen on 10/29/24 at 11:08 AM with Dietary Staff G, facility food temperature monitoring logs were requested, and "Food Temperature Log" was obtained from Dietary Staff G. Record lacked breakfast food temperatures for the following dates: 09/29/24, 10/01/24, 10/05/24, 10/06/24, 10/08/24, 10/11/24, 10/12/24, 10/20/24, 10/21/24, 10/22/24,	S5192		

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S5192	Continued From page 10 10/23/24 and 10/26/24 Record lacked lunch food temperatures for the following dates: 10/01/24, 10/04/24, 10/05/24, 10/06/24, 10/08/24, 10/11/24, 10/12/24, 10/19/24, 10/20/24, 10/21/24, 10/22/24, 10/23/24 and 10/26/24 Record lacked supper food temperatures for the following dates: 09/30/24, 10/02/24, 10/03/24, 10/07/24, 10/08/24, 10/09/24, 10/10/24, 10/11/24, 10/13/24, 10/14/24, 10/15/24, 10/16/24, 10/17/24, 10/18/24, 10/19/24, 10/20/24, 10/21/24, 10/22/24, 10/24/24, 10/25/24, 10/26/24 and 10/27/24 Interview on 10/29/24 at 11:03 AM with Dietary Staff G confirmed food temperature monitoring logs were not completed daily at each meal and further confirmed food temperatures were to be completed at breakfast, lunch and dinner every day. Interview on 10/29/24 at 11:23 AM with Resident (R)1 stated food was not served hot at each meal, specifically at breakfast. Observation on 10/29/24 at 12:30 PM revealed residents eating lunch time meal in the dining room of the facility. Kansas Department of Agriculture Food Safety guidelines records hot food must be maintained at a temperature of 135 degrees Fahrenheit or above, cold foods at 41 degrees Fahrenheit or below. Facility's "Food preparation" policy (no date) recorded, "Food shall be prepared using safe methods that conserve the nutritive value, flavor,	S5192		

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S5192	Continued From page 11 and appearance and shall be served at the proper temperature." For all residents of the facility, Administrator A failed to ensure facility staff served food at the proper temperature.	S5192		
S5215 SS=F	26-42-104 (d) Disaster and Emergency Preparedness Education (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 home ' s emergency management plan; (2) education of each resident upon admission to the home regarding emergency procedures; (3) quarterly review of the home ' 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 by: KAR 26-42-104 (d) (3) The census equaled 46 residents. The sample included 3 residents, 1 focused record review resident and review of 5 newly hired employee records. Based on record review and interview, Administrator A failed to ensure disaster and emergency preparedness by ensuring the performance of quarterly review of the facility's	S5215		

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S5215	Continued From page 12 entire "Emergency Management Plan" with residents and staff. Findings included: - Review of the facility "Emergency Management Plan" revealed the plan contained procedures to manage potential emergencies and disasters including fire, flood, severe weather, tornado, explosion, natural gas leak, lack of electrical, or water service, and missing residents. On 10/29/24, surveyor requested the facility's quarterly reviews of the emergency management plan with residents and staff and facility failed to provide documentation of reviews. Interview on 10/29/24 at 03:50 PM with Administrator A confirmed unable to locate documented quarterly reviews of the emergency management plan completed with residents and staff. Facility's "Disaster and Emergency Preparedness" policy (no date) recorded, "(3) quarterly review of the facility's emergency management plan with employees and residents." Administrator A failed to ensure disaster and emergency preparedness by ensuring the performance of quarterly review of the facility's entire "Emergency Management Plan" with residents and staff.	S5215		
S5230 SS=F	26-42-207 (b)(5)(6) (c) Infection Control Policies (b)(5) prohibiting any employee with a communicable disease or any infected skin lesions from coming in direct contact with any	S5230		

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S5230	Continued From page 13 resident, any resident ' s food, or resident care equipment until the condition is no longer infectious; (6) providing orientation to new employees and employee in-service education at least annually on the control of infections in a health care setting; (c) Each administrator or operator shall ensure the home ' s compliance with the department ' s tuberculosis guidelines for adult care homes adopted by reference in K.A.R. 26-39-105. This REQUIREMENT is not met as evidenced by: KAR 26-42-207 (c) The census totaled 46 residents. The sample included 3 residents and review of 5 newly hired employees. Based on record review and interview for 1 sampled Resident (R)1 and 3 newly hired employees (Licensed Nurse (LN) B, Certified Medication Aide (CMA) E and Certified Nurse Aide (CNA) F, the facility failed to ensure compliance with the State Agency's tuberculosis (TB) guidelines. Findings included: - R1's "Medical Record" revealed she admitted to the facility on 03/26/24 and the record lacked completion of TB testing and a TB questionnaire upon admission. R1's TB test and TB questionnaire was initiated on 06/23/24, approximately 3 months after admission to the facility. - Review of LN B's employee record revealed they hired onto the facility on 05/03/24. LN B's	S5230		

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S5230	Continued From page 14 record lacked evidence of completion of TB testing within 7 days of hire. - Review of CMA E's employee record revealed they hired onto the facility on 09/29/23. CMA E's record lacked evidence of completion of TB testing and a TB questionnaire within 7 days of hire. - Review of CNA F's employee record revealed they hired onto the facility on 07/08/24. CNA F's record lacked evidence of completion of TB testing and a TB questionnaire within 7 days of hire. Interview on 10/29/24 at 02:29 PM with LN B confirmed TB testing and a TB questionnaire was not completed upon admission for R1. Facility failed to provide TB testing for LN B, CMA E and CNA F within 7 days of hire. Facility's "Tuberculosis Testing of Residents and Employees Policy" (no date) recorded, "Each new resident or employee shall receive a two-step tuberculin skin test and complete the TB Questionnaire within seven days of residency or employment." The facility failed to follow the State Agency's tuberculosis guidelines for adult care homes adopted by reference in K.A.R. 26-39-105, which had the potential to affect all residents.	S5230		
S5251 SS=E	26-42-105 (f) (11) Resident Records Documentation of Incidents (f) (11) documentation of all incidents, symptoms, and other indications of illness or injury including	S5251		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B085009	A. BUILDING: _____ B. WING _____	10/29/2024

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S5251	Continued From page 15 the date, time of occurrence, action taken, and results of the action. This REQUIREMENT is not met as evidenced by: KAR 26-42-105 (f) (11) The census totaled 46 residents. The sample included 3 residents, 1 focused record review resident and 1 closed record review resident. Based on record review and interview for 1 focused record review resident(R)4 and 1 closed record review resident (R)5, Administrator A failed to ensure documentation of all incidents, and indications of illness or injury including date, time of occurrence, action taken and results of the action. Findings included: - Record review for R4 revealed an admission date of 04/02/24 with diagnoses of unspecified dementia, chronic obstructive pulmonary disease, hypertension and spinal stenosis. The "Resident Functional Capacity Screen" (FCS) dated 04/04/24 recorded the resident required supervision with bathing and physical assistance with management of medications and treatments. The FCS further recorded R4 had short- and long-term memory impairment, impaired memory/ recall, impaired decision making and used a mobility device. Resident FCS was not completed upon admission. R4's "Negotiated Service Agreement" (NSA) dated 04/04/24 recorded facility staff stand by assisted with bathing and administered	S5251		

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S5251	Continued From page 16	S5251		

medications and treatments. The NSA failed to address interventions for impaired short- and long-term memory impairment, impaired memory/ recall, impaired decision making and risk for falls/ unsteadiness. Resident NSA was not completed upon admission.

Record lacked a "progress note" by a licensed nurse for R4 upon admission to the facility, on 04/02/24.

Record lacked documentation of a physical assessment of R4 upon admission to the facility on 04/02/24.

Interview on 10/29/24 at 04:45 PM with Administrator A, Licensed Nurse (LN) B and LN C confirmed there was no documentation from a licensed nurse upon R4's admission including a progress note or a physical assessment to indicate a licensed nurse assessed R4 upon admission to the facility.

Administrator A failed to ensure documentation of all incidents, and indications of illness or injury including date, time of occurrence, action taken and results of the action for R4's admission to the facility.

- Facility report to the department, dated 08/07/23 indicated R5 was a known elopement risk and eloped from the facility on 08/05/23 at approximately 01:26 AM. R5 was found in the facility parking lot, sustained a left arm fracture and was transported to the hospital. R5 was last observed by facility staff on 08/05/23 at approximately 12:30 AM.

Review of R5's medical record revealed she admitted to the facility on 12/09/20 with diagnosis

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S5251	Continued From page 17 of amnesia, hypertension and unspecified psychosis. R5's "Functional Capacity Screen" (FCS) dated 07/14/23 recorded the resident required supervision with transfer, walk/ mobility and eating, required physical assistance with bathing and dressing and was unable to perform management of medications and treatments. The FCS recorded the resident was frequently incontinent, had short and long-term memory impairment, memory/recall impairment, impaired decision making and was sometimes understandable/ sometimes understood communication. The FCS further recorded the resident was at risk for falls/ unsteadiness, wandering and was socially inappropriate/ disruptive behavior. The FCS identified R5 used a walker for mobility. R5's "Negotiated Service Agreement" dated 07/14/23 recorded the resident received physical assistance with bathing, dressing, toileting, transfer, mobility and medication and treatment administration. The NSA further recorded R5 tended to wander throughout the community and was unaware of surrounds. Facility staff were to redirect R5. Record lacked a Facility "Incident Report" related to the 08/05/23 elopement. Record lacked documentation of a "progress note" detailing the facts and events of the 08/05/23 elopement R5's record lacked documentation of parties notified including family and physician, injuries sustained from the elopement and interventions put into place after the elopement occurred.	S5251		

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S5251	Continued From page 18 Interview on 10/29/24 at 04:34 PM with Administrator A, LN B and LN C confirmed there was no documentation from a licensed nurse related to R5's elopement from the facility that included a progress notes, incident report, summary of incident, parties notified, injuries sustained and interventions. Administrator A failed to ensure designated staff documented all incidents, symptoms, and other indications of illness including the date and time of occurrence, action taken, and results of the action.	S5251		