STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087069	A. BUILDING: _____ B. WING _____	12/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENT PARK ASSISTED LIVING AND MEMORY CAF	10600 E 13TH STREET NORTH WICHITA, KS 67206

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS The following citations represent the findings of a resurvey with a complaints #185341,185782, 185994, 187086, 187941, and 189211.at the above named Assisted Living conducted on 12/04/24, 12/09/24 and 12/10/24.	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 70 residents with six residents included in the sample and four closed record reviews. Thirteen residents lived in the secured memory care unit within the facility. Based on observation, interview, and record review the administrator failed to protect one resident from neglect by the failure to ensure staff secured all exit doors and the failure to ensure designated staff provided appropriate interventions when Resident (R) 104 exhibited wandering behaviors. Cognitively impaired R104 exited the facility through an unsecured door to the outside without staff knowledge at	S3026		

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

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approximately 04:30 AM on 07/13/24. Two staff members found him approximately two- and one-half hours later near the entrance to a commercial office building approximately one mile from the facility. This placed the resident in Immediate Jeopardy.

Findings included:

- Record review for R104 revealed an admission date of 07/12/24 with a diagnosis of dementia.

The 07/10/24 "Functional Capacity Screen" (FCS) identified R104 was independent and used no assistive devices for transfers and walking/mobility; had short-term memory, memory/recall, and decision-making cognitive difficulties; and was marked at risk for impaired decision-making and wandering.

The 07/12/24 combined "Negotiated Service Agreement/Healthcare Service Plan" (NSA/HCP) identified the facility provided residence in the locked memory care unit, staff provided frequent night checks, one-on-one redirection, reassurance or validation which may include soothing therapeutic techniques, and encouragement to participate in activities for cognitive difficulties, impaired decision-making, and during episodes of exit-seeking behavior for wandering; and notification to the nurse if they were unable to redirect R104.

The 07/12/24 "Elopement Assessment Risk Tool" documented R104 scored 20 which indicated "high risk for potential elopement" and "warranted extra supervision and intervention."

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S3026	Continued From page 2 The 07/12/24 at 03:25 PM "Resident Note" documented R104 arrived at the facility's memory care unit at 02:30 PM and ambulated independently. He required direction and cueing to complete tasks independently. The 07/14/24 at 07:35 PM "Late Chart Resident Note" documented facility staff reported on 07/13/24 at 05:00 AM they were unable to locate R104. He was located at 06:58 AM and returned to the facility without injury. He wore jeans, short-sleeved shirt, and tennis shoes. Facility staff provided "frequent rounding." The 07/14/24 at 08:55 PM "Resident Note" documented R104 made multiple attempts to elope but staff easily redirected him. He continually stated he was looking for his wife. R104's record lacked evidence of documentation facility staff provided services to meet his needs for cognitive difficulties, impaired decision-making, and wandering according to the services described in his "NSA" when he walked in the hallway at approximately 04:30 AM fully dressed with shoes on and carried a box of personal belongings. The 12/04/24 "Resident Roster" provided during the survey revealed three residents in the memory care unit were marked for wandering behavior. Record review for five sampled staff revealed the facility provided dementia and Alzheimer's Disease with behaviors, elopement, and abuse, neglect, and exploitation training upon hire and at least annually.	S3026		

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S3026	Continued From page 3 Review of the 07/13/24 at 08:28 AM staff education provided by "Broadcast" message revealed 52 of 71 staff read the message. The education message included the expectations staff should not tamper with keypads and door locks. Staff should report to their supervisor immediately if keypads and door locks malfunctioned. Staff should never leave keys in a door, prop doors open, should check all keypads and alarms regularly, and staff should respond to all alarms promptly. Review of the 07/14/24 "Elopement Policy Review" training and in-service attendance sheet revealed 24 staff attended. The 07/16/24 staff education documented the doors were locked when the indicator light on the push bars were green. The definition of Enhanced Visual Observations was staff completed a visual check when walking by a resident's room, when staff noted their attendance in activities and when staff noted their attendance to meals. The education informed staff the "Elopement Risk" binder was located at the front desk. Twenty-two staff members signed they completed the education. Review of "Memory Care Exit Door Function" logs and "Door Check" logs from 01/01/24 to 12/09/24 revealed staff documented they checked the doors once each shift (three times daily). The "Memory Care Exit Door Function" logs from 01/01/24 to 07/16/24 included instructions for designated staff to trigger exit door alarms, reset	S3026		

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door alarms, check that alarms activated to staff pagers, ensure doors were locked each shift, and notify supervisor if there were any malfunctions or issues with door function.

The "Door Check" logs from 01/01/24 to 07/16/24 included instructions for designated staff to verify courtyard and back exit were closed with alarms armed and active.

The "Check Exit Door Alarms" logs from 07/17/24 to 12/09/24 lacked instructions for staff to complete the tasks.

The 07/17/24 facility's "Investigation Report" to the department documented Certified Medication Aide (CMA) C last saw R104 on 07/13/24 at 04:30 AM walking in the hallway holding a box of items. He wore a short-sleeved shirt, jeans, and tennis shoes. Ten minutes later at 04:40 AM CMA C was in the process of completing routine wellness rounds and noticed R104 was not in his apartment.

CMA C immediately searched every room and contacted her coworkers to start looking for R104. Facility staff checked all rooms and exits and could not find R104. CMA C notified Licensed Nurse D who notified Administrative Nurse B and Administrative Staff A that R104 was missing. All three of them headed to the community to assist in the search for R104. Facility staff notified Emergency Management Services (EMS) at 05:38 AM for assistance to find R104.

Certified Nurse Aide (CNA) E and CNA F found R104 in the parking lot of another building and

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assisted him back to the facility. Nurse performed assessment and found that R104 did not have any injuries.

Administrative Staff investigated the incident and found that CMA C left her keys in the lock of the door between the memory care and the kitchen. Administrative staff concluded R104 left the memory care unit through the door to the kitchen and left the facility through the kitchen exit door to the outside. The kitchen exit door had a magnetic lock/alarm mechanism that failed to lock. R104 was able to leave the facility freely after he left the memory care unit by turning the key to unlock the door after CMA C left the key in the lock.

The facility's investigation included the following notarized witness statements:

CNA G documented she observed R104 in the facility for the first time around 02:30 PM on 07/12/24. His daughter was in the building off and on throughout the afternoon and evening assisting him in settling into his new apartment. CNA G assisted R104 to bed at 08:55 PM. She completed the last rounds of her shift and observed R104 was in bed at 09:45 PM. CNA G provided shift report to oncoming night shift staff CMA C at approximately 10:05 PM. CNA G included in her report R104 had moved into the facility earlier that day. His family had reported he was "up and down" sometimes so he required frequent checks. CNA G passed the keys to CMA C and left the building at 10:11 PM

CMA C documented the last time she saw R104, he carried a small cardboard box of personal

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belongings. She was doing rounds on 07/13/24 around 04:30 AM and could not find R104. She alerted her coworkers and supervisor and searched around the building.

Licensed Nurse D documented staff notified her on 07/13/24 at 04:50 AM R104 was missing. Staff reported they last saw R104 at 03:30[sic] AM. She instructed staff to check every area of the memory care unit and the assisted living side. Licensed Nurse D notified Administrative Nurse B and Administrative Staff A. The search for R104 continued throughout and around the facility until two staff members located R104 at 06:58 AM and assisted him back to the facility. Licensed Nurse D did not observe any skin issues.

CNA E and CNA F worked at a neighboring building on the same campus as the facility where R104 went missing from. CNA E documented she was taking out the trash at approximately 05:45 AM with a coworker and when a staff member from the neighboring building, who was also outside, informed them R104 was missing. CNA E and her coworker clocked out at 06:05 AM and drove her car around the vicinity, including the nearby car dealership, calling R104's name. They found R104 at approximately 07:00 AM standing near a pole by a commercial office building. CNA E and her coworker took R104 in her car back the facility.

CNA F documented a staff member from the building next door notified her and her coworker a resident had exited the building at an unknown time. After she clocked out, she and her

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coworker joined the search for R104. They found him after an hour of searching, put him in their vehicle and returned him to the facility.

Observation on 12/04/24 at approximately 02:07 PM revealed all exit doors from the memory care unit to the assisted living side of the building and to the outside courtyard and patio (except two, one to the laundry area and one to the kitchen) were keypad locked and had magnetic alarms installed near the top of each door. The door from the memory care to the laundry area was key locked with no door to the outside from the laundry area. The door from the memory care to the kitchen was key locked with another door from the kitchen to outside of the facility facing a street between the two main buildings on the campus.

The door from the kitchen to the outside was keypad locked. Next to the keypad was a white rectangular unit about the same size as the keypad with a round button with a red checkmark on the button. A sign above the unit read "Reminder. Press the check mark each time that this door is opened. It is connected to the call system and will need to be reset each time that it is opened. All associates are required to enter and exit through the front door for all breaks."

Observation on 12/04/24 at approximately 05:12 PM revealed the vicinity of the facility where R104 may have walked while he was out of the facility without staff supervision for approximately two and one-half hours. A large, luxury multi-brand car dealership was directly east of the facility. A four-lane street with a speed limit of 40 miles per hour (mph) was south of the facility.

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S3026	Continued From page 8 To the north and west of the facility was an area of many curved streets that wound among parking lots of shopping venues, restaurants, and commercial office buildings. There was a large irregularly shaped pond surrounded by a sidewalk in the area between the facility and the commercial office building where two staff found R104. The commercial office building was approximately one mile northwest of the facility. Observation on 12/09/24 at 10:13 AM revealed an exit door to the patio at the end of a hall in the memory care unit. The door alarms were set and activated when the door opened. Observation on 10/09/24 at 10:18 AM revealed state surveyor and Administrative Nurse B entered a resident's apartment, shut the door, and ensured the TV was off to listen for alarms. Staff outside the apartment activated the door alarms, including the recently installed alarm 75 feet down the hallway closer to the common area. The state surveyor and Administrative Nurse B barely heard the alarms while in a resident's apartment bathroom without any background noise. The state surveyor turned the bathroom sink faucet on high to provide background noise simulating if staff were in the bathroom assisting a resident. The state surveyor and Administrative Nurse B could not hear the alarms. On 12/04/24 at 04:03 PM Administrative Nurse B stated the white unit next to the keypad alarmed to the staff pagers. Staff reset the system by pushing the button marked with a red check mark to turn off the alarm at the location the alarm originated from. Administrative Nurse B stated no	S3026		

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staff were in the kitchen at the time R104 exited the building through the kitchen. The door at the time R104 exited the building was also an egress door and would open anyway even if an individual opened the door without entering a code on the keypad.

On 12/09/24 at approximately 09:40 AM Administrative Nurse B stated staff completed dementia training within the last few months. Administrative Nurse B also stated the door alarms had a primary alarm (if an egress door) which beeped for 15 seconds. A secondary alarm utilized a magnetic system that alarmed when the door was open (magnets not connected) and shut off when the door closed (magnets reconnected). The facility also installed one alarm in the hallway of the memory care nearest the end-of-hall exit door. The alarm sounded 75 feet from the door and closer to the common area so staff could hear it better. Door alarms also activated to the pagers carried by staff with a "buzz" sound and vibrated to alert staff if a door was opened.

On 12/04/24 at approximately 10:18 AM Administrative Nurse B confirmed she could not hear the door alarms while in the bathroom of a resident's apartment with the sink faucet turned on and no other noise in the background. Administrative Nurse B stated R104 was provided "enhanced visual checks" which meant the door to his apartment was kept open so every time staff walked by, they could easily check on him. Facility staff did not document they completed "enhanced visual checks." Staff attempted to keep R104 engaged with activities. If he exhibited wandering behavior staff provided

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a hands-on activity. If that didn't work staff called the nurse during the day or night.

On 12/09/24 at 11:39 AM CNA H stated she checked all exit doors every time she walked past them which was about every half hour. She checked to ensure the lights were green which indicated the alarms were armed. She pushed on the door to ensure the alarms sounded and ensured the alarm went to her pager. She had never documented the door and alarm checks anywhere and didn't know where she would do it if she were to document it.

On 12/09/24 at 11:48 AM CMA I stated it was every staff member's responsibility to check the doors and alarms during their shift to ensure they were locked and the alarms worked. The facility provided elopement training to staff a month ago. If a door alarm sounded it was everyone's responsibility to respond. Staff communicated with each other using their pagers. Staff checked outside the door which alarmed, checked outside the building and performed a head count of the residents. They also checked inside the building.

On 12/09/24 at 02:18 PM CNA E stated during a phone interview she was with a coworker searching for R104 when they found him by a pole near the entrance of a commercial office building. He was very confused.

On 12/09/24 at 02:21 PM CNA F stated during a phone interview she was with CNA E when they found R104 near the entrance to a commercial office building. She named the company which was on the front of the building and stated there were no other buildings in that area with the

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same name.

The weather per Weather Underground at Wunderground.com on 07/13/24 at 04:53 AM was a temperature of 76 degrees Fahrenheit and wind speed of 9 mph. It was dark outside with a sunrise time of 06:20 AM

The facility's 04/30/19 "Elopement or Missing Resident" policy documented if a resident was missing facility staff would initiate a building search including all locked and unlocked areas and conduct a grounds search including cars parked nearby.

The facility's 09/18/24 "Resident Abuse, Neglect, and Exploitation" policy documented neglect means failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental anguish. The Residence Director or designee who becomes aware of neglect shall immediately act to rectify the problem.

The administrator failed to protect R104 from neglect by the failure to ensure staff secured all exit doors and the failure to ensure designated staff provided appropriate interventions when he exhibited wandering behavior. Cognitively impaired R104 exited the facility through an unsecured door to the outside without staff knowledge at approximately 04:30 AM on 07/13/24. Two staff members found him approximately two- and one-half hours later near the entrance to a commercial office building approximately one mile from the facility.

Jeopardy was removed on 12/10/24 when the

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S3026	Continued From page 12 following actions were documented by the facility in the "Abatement Plan" and accepted by the department at 11:33 AM. 1) A staff member supervised the kitchen exit door until the Maintenance Director arrived to secure it on 07/13/24 at 06:30 AM. 2) On 07/13/24 at 06:30 AM the Maintenance Director evaluated all other exit doors and found they functioned properly. 3) On 07/13/24 at 08:15 the Maintenance Director completed the magnetic lock replacement and verified the alarms sounded to staff pagers. 4) On 07/13/24 at 08:28 Administrative Staff initiated re-education to all staff to be completed prior to working their next shift and was completed by all on 07/25/24. The training including information on elopement procedures, keys left in doors, and proper operation of exterior doors. 5) Elopement drills for each shift completed by 08/27/24. 6) Dementia Challenging Behaviors education completed by staff by 07/31/24. 7) Quality Improvement Process Improvement committee to monitor ongoing elopement and dementia education and determine additional monitoring and frequency.	S3026		
S3085 SS=D	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	S3085		

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S3085	Continued From page 13 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)(2) The facility had a census of 70 residents with six residents sampled and four abbreviated record reviews. Based on record review and interview the administrator failed to ensure the "Negotiated Service Agreement" (NSA) identified the provider for hospice services provided to resident (R)107. Findings included: - R107's medical record revealed he moved into the facility on 02/26/24 with diagnoses of diabetes mellitus and congestive heart failure. The 10/01/24 "Functional Capacity Screen" (FCS) revealed R107 required physical assistance from staff with dressing, management of medications and management of treatments.	S3085		

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	N087069	A. BUILDING: _____ B. WING _____	12/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENT PARK ASSISTED LIVING AND MEMORY CAF	10600 E 13TH STREET NORTH WICHITA, KS 67206

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S3085	Continued From page 14 The 10/01/24 NSA documented R107 received hospice services but did not identify the outside provider for this service. On 12/10/24 at 12:01 PM Licensed Nurse (LN) B stated R107's NSA did not identify the hospice company that provided services to R107 and stated it was her expectation the hospice company be identified on the NSA. The administrator failed to ensure R107's NSA was fully developed to include the provider of each service he received from an outside provider.	S3085		
S3155 SS=E	26-41-204 (a) Health Care Services . (a) The administrator or operator in each assisted living facility or residential health care facility shall ensure that a licensed nurse provides or coordinates the provision of necessary health care services that meet the needs of each resident and are in accordance with the functional capacity screening and the negotiated service agreement. This REQUIREMENT is not met as evidenced by: KAR 26-41-204(a) The facility reported a census of 70 residents. The sample included six residents and four abbreviated record reviews. Based on interview and record review the administrator failed to	S3155		

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REGENT PARK ASSISTED LIVING AND MEMORY CAR	10600 E 13TH STREET NORTH WICHITA, KS 67206

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S3155	Continued From page 15	S3155		

ensure staff provided care in accordance with the "Functional Capacity Screen" (FCS) and "Negotiated Service Agreement" (NSA) when staff failed to respond to R102's call light when she needed to be toileted which resulted in R102 falling when she attempted to transfer herself. Staff also failed to provide frequent checks for R103 who ended up falling out of her wheelchair and was on the floor of her room for an extended period of time.

Findings included:

- Review of R102's medical record revealed she moved into the facility on 07/28/23 with diagnoses of chronic neck pain and cervical stenosis.

Review of R102's FCS dated 11/27/23 revealed she required physical assistance with transfers and was occasionally incontinent.

Review of R102's NSA dated 11/27/23 revealed staff provided physical assistance with transfers and toileting and were to conduct frequent safety checks. R102 used her call pendant when she needed to be toileted.

Review of the 02/15/24 "Resident Notes" documented, "Care team notified nurse on call a 07:50 AM that resident had rolled out of bed after attempting to get up to go to the bathroom ...Resident was last check and change in bed at 04:00 AM. Call pendant had been activated."

On 12/10/24 at 11:47 AM "Licensed Nurse" (LN) J stated R102 required assistance with transfers.

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S3155	Continued From page 16 LN J stated when a resident activated their call light staff are notified on a pager system. Staff must deactivate the call pendant in person. If staff do not answer the call light the call system will cycle through and re-alert staff. If not answered after 15 minutes the nurse is notified and they are to call staff to check on them. The "Emergency Care" policy revised 04/30/19 documented, "Associates will be trained to respond to a nurse call system when activated by a resident...Prompt response to an activated call system will be provided 24-hours per day." The administrator failed to ensure staff responded to R102's call light and failed to provide frequent safety checks. - Review of R103's medical record revealed she moved into the facility on 05/06/22 with a diagnosis of back pain. Review of R103's FCS dated 01/24/24 revealed she required physical assistance with transfers and toileting. Review of R103's NSA dated 01/24/24 revealed she required assistance of one staff with a toileting program to manage incontinence episodes and mechanics of hygiene and toileting. Staff assisted R103 with toileting upon rising, before and after meals, at bedtime, and as needed throughout the night. Review of the 04/03/24 "Resident Notes" documented, "At 04:51 AM "Certified Medication Aide" (CMA) completed visual check on resident and observed resident lying on her right side	S3155		

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S3155	Continued From page 17 between her wheelchair, nightstand, bed and recliner. The floor surrounding resident was wet with urine. Resident was visibly upset and tearful ....Resident was last seen just prior to 08:30 PM on 04/01 in common area. It was made evident via residents...personal recording device in apartment that resident wheeled herself back to apartment at 08:27 PM. At that time resident was seated in the wheelchair next to the bed when the video recording ends. At 09:35 PM the motion sensor video begins recording and captures resident lying on her right side on the floor between the bed, wheelchair and nightstand." On 12/10/24 at 11:32 AM" Licensed Nurse" (LN) J stated R103 required assistance with transfers and mobility and was a check and change at night. On 12/10/24 at 12:20 PM Administrative Nurse B stated according to nursing notes R103 was on her bedroom floor for an extended period of time. Administrative Nurse B stated it was her expectation that staff checked on R103 more frequently. The administrator failed to ensure staff completed frequent checks on R103 through the night.	S3155		
S3310 SS=E	26-41-207 (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 resident, any resident ' s food, or resident care equipment until the condition is no longer	S3310		

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S3310	Continued From page 18 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; and (c) Each administrator or operator shall ensure the facility ' 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 26-41-207(c) The facility reported a census of 70 residents. The sample included six residents and four abbreviated record reviews. Based on interview and record review for six residents the administrator failed to ensure the facility remained in compliance with the department's tuberculosis (TB) guidelines for adult care homes adopted by reference in K.A.R. 26-39-105. This failure effected all residents who lived in the assisted living facility. Findings included: - Resident (R)107 moved into the facility on 02/26/24 with diagnoses of diabetes mellitus and congestive heart failure. Review of R107's medical record lacked evidence staff completed a TB Symptom Screening Questionnaire for R107 upon	S3310		

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S3310	Continued From page 19 admission to the facility. On 12/10/24 at 12:01 PM "Licensed Nurse" (LN) B stated she was not able to locate a TB Symptom Screening Questionnaire completed for R107 upon admission to the facility. The 06/2013 "Tuberculosis (TB) Guidelines for Adult Care Homes" documented, "Each new resident...shall have an initial TB symptom screen that includes the components of the Tuberculosis Symptom Screen Questionnaire within 7 days of residency." The administrator failed to ensure compliance with the department's tuberculosis guidelines for adult care homes adopted by reference in K.A.R. 26-39-105. - R105 moved into the facility on 01/29/24 with a diagnosis of Meniere's Disease. Review of R105's medical record lacked evidence staff completed a TB Symptom Screening Questionnaire for R105 upon admission to the facility. On 12/10/24 at 12:24 PM LN B stated she was not able to locate a TB Symptom Screening Questionnaire completed for R105 upon admission to the facility. The 06/2013 "Tuberculosis (TB) Guidelines for Adult Care Homes" documented, "Each new resident...shall have an initial TB symptom screen that includes the components of the Tuberculosis Symptom Screen Questionnaire within 7 days of residency."	S3310		

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S3310	Continued From page 20 The administrator failed to ensure compliance with the department's tuberculosis guidelines for adult care homes adopted by reference in K.A.R. 26-39-105.	S3310		
S3320 SS=F	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)	S3320		

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S3320	Continued From page 21 The facility reported a census of 70 residents with 13 residents in the memory care unit. Based on observation, record review, and interview the administrator failed to ensure direct care staff could hear the exit door alarms throughout the memory care unit while providing care to residents which put three cognitively impaired residents marked for wandering at risk. Findings included: - Record review for Resident (R) 106 revealed an admission date of 09/26/21 with diagnoses of dementia and aphasia. The 10/31/24 "Functional Capacity Screen" (FCS) identified R106 required supervision for transfers and walking/mobility; had short-term and long-term memory, memory/recall, and decision-making cognitive difficulties; and was marked at risk for wandering. The 10/31/24 "Negotiated Service Plan" (NSA) identified facility staff provided R106 supervision during transfers; she was independent and used no devices for walking/mobility; staff provided periodic orientation or redirection for cognitive difficulties; and residence in locked memory care unit, reassurance or validation during episodes of exit-seeking behavior, and monitoring of keypad doors every shift. - Record review for Resident (R) 108 revealed an admission date of 03/19/24 with diagnoses of dementia and amnesia. The 05/24/24 "FCS" identified R108 was independent with transfers and walking/mobility;	S3320		

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S3320	Continued From page 22	S3320		

had short-term and long-term memory, memory/recall, and decision-making cognitive difficulties; and was marked at risk for wandering and inappropriate behavior.

The 05/24/24 "NSA" identified facility staff provided R108 residence in locked memory care unit and supervision daily for cognitive difficulties redirection, reassurance or validation during episodes of exit-seeking behavior, and one-on-one intervention for re-orientation, therapeutic techniques to soothe or reassure R108 for inappropriate behavior.
Review of the "Resident Roster" provided by the facility during the survey revealed three residents were marked for wandering behavior: R106, R108, and R111, who was not selected for review.

Observation on 10/09/24 at 10:18 AM revealed state surveyor and Administrative Nurse B entered a resident's apartment, shut the door, and ensured the TV was off to listen for alarms. Staff outside the apartment activated the door alarms, including the recently installed alarm 75 feet down the hallway closer to the common area. The state surveyor and Administrative Nurse B barely heard the alarms while in a resident's apartment bathroom without any background noise. The state surveyor turned the bathroom sink faucet on high to provide background noise simulating if staff were in the bathroom assisting a resident. The state surveyor and Administrative Nurse B could not hear the alarms.

On 12/09/24 at approximately 09:40 AM Administrative Nurse B stated the facility

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S3320	Continued From page 23 installed an alarm in the hallway of the memory care nearest the end-of-hall exit door. The alarm sounded 75 feet from the door and closer to the common area so staff could hear it better. On 12/04/24 at approximately 10:18 AM Administrative Nurse B confirmed she could not hear the door alarms while in the bathroom of a resident's apartment with the sink faucet turned on and no other noise in the background. On 12/11/24 at 03:14 PM a policy regarding alarms being adequately heard by staff was requested by email which the facility failed to provide. The administrator failed to ensure direct care staff could hear the exit door alarms throughout the memory care unit while providing care to residents which put three residents marked for wandering at risk.	S3320		