STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N067010	A. BUILDING: _____ B. WING _____	12/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREDO SENIOR LIVING OF CHANUTE	701 OSA MARTIN BLVD CHANUTE, KS 66720

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS The following citations represent the findings of the licensure resurvey with attached complaint number 190129 for the above named facility conducted on 12/09/24 and 12/10/24.	S 000		
S3080 SS=D	26-41-201 (a) (b) Functional Capacity Screen on Admission a) On or before each individual ' s admission to an assisted living facility or residential health care facility, 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 facility, 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 need for health care services. This REQUIREMENT is not met as evidenced by: K.A.R. 26-41-201 (a) The facility reported a census of 27 residents. The sample included 3 "Residents'" (R)'s 1, 2, and 3. Based on record review and interview for one resident, R3, the operator failed to ensure the screening form included the definitions specified by the department. Findings included:	S3080		

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

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S3080	Continued From page 1 - Review of R3's FCS dated 11/03/22 revealed R3 required physical assistance with bathing, and supervision with dressing. She was independent with toileting, transferring, walking/mobility, and eating. She lacked the ability to manage her own medications and medical treatments. R3 was able to make herself understood and R3 understood others. R3 used a walker mobility device. Under the section titled "D. Cognition-Memory Recall (record results from exam in manual)" had the following scores listed; Short Term Memory 2 Long Term Memory 2 Memory/Recall 2 Decision-Making 2 The cognition score on R3's FCS did not match the definitions specified by the department. Review of the departments "Resident Functional Capacity Screen Manual" updated 07/11/2008, under the section titled "D. Cognition, Memory, Recall", instructed the person conducting the screen to "Enter a "0" if the resident was able to recall the information requested, or a "1" if the resident had difficulty recalling the information requested. Interview on 12/10/24 at approximately 09:00 AM with Licensed Nurse B confirmed the scoring documented on R3's FCS under section D. Cognition, did not match the definition specified by the department. The Operator failed to ensure the screening form included the definitions specified by the department for R3.	S3080		

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S3081	Continued From page 2	S3081		
S3081 SS=E	26-41-201 (c) Functional Capacity Screen Reassessment (c) Designated facility staff shall conduct a screening to determine each resident ' s functional capacity according to the following requirements: (1) At least once every 365 days; (2) following any significant change in condition as defined in K.A.R. 26-39-100; and (3) at least quarterly if the resident receives assistance with eating from a paid nutrition assistant. This REQUIREMENT is not met as evidenced by: K.A.R. 26-41-201 (c) (1) (2) The facility reported a census of 27 residents. The sample included 3 "Residents'" (R)'s 1, 2, and 3. Based on record review and interview the Operator failed to ensure a designated staff conducted a screening to determine R1 and R3's "Functional Capacity" (FCS) at least once every 365 days. The operator further failed to ensure a screening was performed for R3 when she experienced a change of condition and was placed on hospice services. Findings included: - Record review for R1 revealed an admission date of 11/01/17 with diagnoses of depression, chronic atrial fibrillation, circadian rhythm sleep disorder, and anemia. Review of R1's FCS assessment date was on 10/10/23 and signed on 12/09/24, revealed R1	S3081		

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S3081	Continued From page 3	S3081		

required physical assistance with bathing, dressing, toileting, transferring, walking/mobility, and eating. He lacked the ability to manage his own medications and treatments and was incontinent. R1 used a wheelchair and mechanical lift for transfers and mobility. R1 was sometimes able to make himself understood and he sometimes understood others.

- Record review for R3 revealed an admission date of 11/02/22 with diagnoses of Rheumatoid arthritis, altered mental status and hypertension.

Review of R3's FCS dated 11/03/22 revealed R3 required physical assistance with bathing, and supervision with dressing. She was independent with toileting, transferring, walking/mobility, and eating. She lacked the ability to manage her own medications and medical treatments. R3 was able to make herself understood and R3 understood others. R3 used a walker mobility device.

The cognition score on R3's FCS did not match the definitions specified by the department.

Interview on 12/10/24 at approximately 09:00 AM with "Licensed Nurse" B confirmed the FCS for R1 and R3 were greater than 365 days old, and she further confirmed the R3's electronic medical record lacked a FCS for R3 when she experienced a significant change of condition and was placed on hospice on 12/05/24. LN B confirmed the FCS for R3 did not accurately reflect R3.

The Operator failed to ensure a designated staff conducted a screening to determine R1 and R3's functional capacity at least once every 365 days.

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S3081	Continued From page 4 The operator further failed to ensure a screening was performed for R3 when she experienced a change of condition and was placed on hospice services.	S3081		
S3092 SS=E	26-41-202 (d) Negotiated Service Agreement Revisions (d) Each administrator or operator shall ensure the review and, if necessary, revision of each negotiated service agreement according to the following requirements:(1) At least once every 365 days; (2) following any significant change in condition, as defined in K.A.R. 26-39-100; (3) at least quarterly, if the resident receives assistance with eating from a paid nutrition assistant; and (4) if requested by the resident or the resident ' s legal representative, facility staff, the case manager, or, if agreed to by the resident or the resident ' s legal representative, the resident ' s family. This REQUIREMENT is not met as evidenced by: K.A.R. 26-41-202 (d) (1) (2) The facility reported a census of 27 residents. The sample included 3 "Residents'" (R)'s 1, 2, and 3. Based on record review and interview the Operator failed to ensure a the review and if necessary the revision o of each "Negotiated Service Agreement" (NSA) at least every 365 days for R1 and R3, and the Operator further failed to ensure the review and in necessary the revision of R3's NSA when she experienced a significant change of condition and was placed on	S3092		

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S3092	Continued From page 5	S3092		

hospice services, and the revision for R1 when he experienced a significant change of condition and was removed from hospice services.

Findings included:

- Record review for R1 revealed an admission date of 11/01/17 with diagnoses of depression, chronic atrial fibrillation, circadian rhythm sleep disorder, and anemia.

Review of R1's "Functional Capacity Screen" (FCS) assessment date was on 10/10/23 and signed on 12/09/24, revealed R1 required physical assistance with bathing, dressing, toileting, transferring, walking/mobility, and eating. He lacked the ability to manage his own medications and treatments and was incontinent. R1 used a wheelchair and mechanical lift for transfers and mobility. R1 was sometimes able to make himself understood and he sometimes understood others.

Review of R1's electronic "Medical Record" revealed under the "Forms" tab, a document titled "Senior Living Level of Care Assessment" dated 10/10/23, identified the facility would provide the following health services: staff assistance with eating, staff escort to meals, "pain management per hospice advice", facility "Certified Medication Aide" (CMA)'s will administer and mange R1's medications, physical assistance with bathing, toileting, and transferring with 2 facility staff and a mechanical lift.

Interview on 12/10/24 at approximately 09:00 AM with "Licensed Nurse" B confirmed the NSA for R1 was greater than 365 days old, R1 was not on skilled nursing services with an outside hospice

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S3092	Continued From page 6 provider, and the document titled "Senior Living Level of Care Assessment" was the facility's NSA. Record review for R3 revealed an admission date of 11/02/22 with diagnoses of Rheumatoid arthritis, altered mental status and hypertension. Review of R3's FCS dated 11/03/22 revealed R3 required physical assistance with bathing, and supervision with dressing. She was independent with toileting, transferring, walking/mobility, and eating. She lacked the ability to manage her own medications and medical treatments. R3 was able to make herself understood and R3 understood others. R3 used a walker mobility device. The cognition score on R3's FCS did not match the definitions specified by the department. Review of electronic "Medical Records" under the "Forms" tab a document titled "Assisted Living Standard Level Of Care and Service Plan" dated 11/2/22, identified the facility would provide the following health services; Facility staff would administer medications, assistance with bathing, toileting, dressing, and stand by assistance with mobility. Interview on 12/10/24 at approximately 09:00 AM with "Licensed Nurse" B confirmed the NSA R3 was greater than 365 days old, and she further confirmed the document titled "Assisted Living Standard Level of Care and Service Plan was the facility's prior document that was used for the NSA. She continued to confirm the medical record for R3 lacked a review and if necessary, a revision of R3's NSA when she experienced a significant change of condition and was placed on	S3092		

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S3092	Continued From page 7 hospice on 12/05/24. LN B confirmed the NSA for R3 did not accurately reflect health care services being provided to R3. The Operator failed to ensure a the review and if necessary the revision o of each NSA at least every 365 days for R1 and R3, and the Operator further failed to ensure the review and in necessary the revision of R3's NSA when she experienced a significant change of condition and was placed on hospice services, and the revision for R1 when he experienced a significant change of condition and was removed from hospice services.	S3092		
S3101 SS=E	26-41-202 (h) NSA Signatures (h) Each individual involved in the development of the negotiated service agreement shall sign the agreement. The administrator or operator shall ensure that a copy of the initial agreement and any subsequent revisions are provided to the resident or the resident's legal representative. This REQUIREMENT is not met as evidenced by: K.A.R. 26-41-202 (h) The facility reported a census of 27 residents. The sample included 3 "Residents'" (R)'s 1, 2, and 3. Based on record review and interview the Operator failed to ensure each individual involved in the development of the "Negotiated Service Agreement" signed the agreement for R1 and R3. Findings included:	S3101		

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S3101	Continued From page 8 - Record review for R1 revealed an admission date of 11/01/17 with diagnoses of depression, chronic atrial fibrillation, circadian rhythm sleep disorder, and anemia. Review of R1's FCS assessment date was on 10/10/23 and signed on 12/09/24, revealed R1 required physical assistance with bathing, dressing, toileting, transferring, walking/mobility, and eating. He lacked the ability to manage his own medications and treatments and was incontinent. R1 used a wheelchair and mechanical lift for transfers and mobility. R1 was sometimes able to make himself understood and he sometimes understood others. Review of R1's electronic "Medical Record" revealed under the "Forms" tab, a document titled "Senior Living Level of Care Assessment" dated 10/10/23, identified the facility would provide the following health services: staff assistance with eating, staff escort to meals, "pain management per hospice advice", facility "Certified Medication Aide" (CMA)'s will administer and mange R1's medications, physical assistance with bathing, toileting, and transferring with 2 facility staff and a mechanical lift. Interview on 12/10/24 at approximately 09:00 AM with "Licensed Nurse" (LN) B confirmed the NSA for R1 was greater than 365 days old, R1 was not on skilled nursing services with an outside hospice provider, and the document titled "Senior Living Level of Care Assessment" was the facility's NSA. LN B confirmed the medical record lacked the documentation of signatures of each individual involved in the development of R1's NSA.	S3101		

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S3101	Continued From page 9 - Record review for R3 revealed an admission date of 11/02/22 with diagnoses of Rheumatoid arthritis, altered mental status and hypertension. Review of R3's FCS dated 11/03/22 revealed R3 required physical assistance with bathing, and supervision with dressing. She was independent with toileting, transferring, walking/mobility, and eating. She lacked the ability to manage her own medications and medical treatments. R3 was able to make herself understood and R3 understood others. R3 used a walker mobility device. The cognition score on R3's FCS did not match the definitions specified by the department. Review of electronic "Medical Records" under the "Forms" tab a document titled "Assisted Living Standard Level Of Care and Service Plan" dated 11/2/22, identified the facility would provide the following health services; Facility staff would administer medications, assistance with bathing, toileting, dressing, and stand by assistance with mobility. Interview on 12/10/24 at approximately 09:00 AM with "Licensed Nurse" B confirmed the NSA for R3 was greater than 365 days old, and she further confirmed the document titled "Assisted Living Standard Level of Care and Service Plan was the facility's prior document that was used for the NSA. She continued to confirm the medical record for R3 lacked a review and if necessary, a revision of R3's NSA when she experienced a significant change of condition and was placed on hospice on 12/05/24. LN B confirmed the NSA for R3 did not accurately reflect health care services being provided to R3. LN B confirmed the medical	S3101		

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S3101	Continued From page 10 record lacked the documentation of signatures of each individual involved in the development of R1's NSA. The Operator failed to ensure each individual involved in the development of the "Negotiated Service Agreement" signed the agreement for R1 and R3.	S3101		
S3165 SS=D	26-41-204 (d) Health Care Services (d) The negotiated service agreement shall contain a description of the health care services to be provided and the name of the licensed nurse responsible for the implementation and supervision of the plan. This REQUIREMENT is not met as evidenced by: K.A.R. 26-41-204 (d) The facility reported a census of 27 residents. The sample included 3 "Residents'" (R)'s 1, 2, and 3. Based on record review and interview the Operator failed to ensure the "Negotiated Service Agreement" (NSA) provided the name of the nurse responsible for the implementation and supervision of the health service plan for R3. Findings included: - Record review for R3 revealed an admission date of 11/02/22 with diagnoses of Rheumatoid arthritis, altered mental status and hypertension. Review of R3's FCS dated 11/03/22 revealed R3	S3165		

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S3165	Continued From page 11	S3165		

required physical assistance with bathing, and supervision with dressing. She was independent with toileting, transferring, walking/mobility, and eating. She lacked the ability to manage her own medications and medical treatments. R3 was able to make herself understood and R3 understood others. R3 used a walker mobility device.

The cognition score on R3's FCS did not match the definitions specified by the department.

Review of electronic "Medical Records" under the "Forms" tab a document titled "Assisted Living Standard Level of Care and Service Plan" dated 11/2/22, identified the facility would provide the following health services; Facility staff would administer medications, assistance with bathing, toileting, dressing, and stand by assistance with mobility.

The from lacked documentation of the name of the nurse responsible for the supervision and implementation of the health service plan.

Interview on 12/10/24 at approximately 09:00 AM with "Licensed Nurse" (LN) B confirmed the document titled "Assisted Living Standard Level of Care and Service Plan", was the facility NSA that is no longer in use, LN B further confirmed that "Assisted Living Standard Level of Care and Service Plan" did not provide the name of the nurse responsible for the supervision and implementation of the health service plan.

The Operator failed to ensure the "Negotiated Service Agreement" (NSA) provided the name of the nurse responsible for the implementation and supervision of the health service plan for R3.

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S3171	Continued From page 12	S3171		
S3171 SS=F	26-41-204 (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: K.A.R. 26-41-204 (i) The facility reported a census of 27 residents. The sample included 3 "Residents'" (R)'s 1, 2, 3, and R4. Based on observation, interview and record review the Operator failed to provide healthcare services for R1 in accordance with professional standards of practice when the Operator failed to ensure a periodic review of R1's bed assist device to ensure R1's bed assist device posed no risk for entrapment, confirmed the device was not a restraint, include a description of the device, its purpose and special instructions on use and monitoring in R1's "Negotiated Service Agreement" (NSA), and documentation of periodic reassessments of R1's ability to use the bed assist device safely and document the findings in R1's resident record. The Operator further failed to ensure the facility "Licensed Nurse" (LN) and "Certified Medication Aides" (CMA)'s provided health care services within professional standards of practice when in the facility's medication room, a plastic container was found with 8 bottles and one box labeled as "Overstock", 4 bottles and one box had been labeled with resident names. Findings included:	S3171		

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S3171	Continued From page 13 - Record review for R1 revealed an admission date of 11/01/17 with diagnoses of depression, chronic atrial fibrillation, circadian rhythm sleep disorder, and anemia. Review of R1's "Functional Capacity Screen" (FCS) assessment date was on 10/10/23 and signed on 12/09/24, revealed R1 required physical assistance with bathing, dressing, toileting, transferring, walking/mobility, and eating. He lacked the ability to manage his own medications and was incontinent. He lacked the ability to manage his own medications and medical treatments. R1 used a wheelchair and mechanical lift for transfers and mobility. R1 was sometimes able to make himself understood and he sometimes understood others. Review of R1's electronic "Medical Record" revealed under the "Forms" tab, a document titled "Senior Living Level of Care Assessment" dated 10/10/23, identified the facility would provide the following health services: staff assistance with eating, staff escort to meals, "pain management per hospice advice", facility "Certified Medication Aide" (CMA)'s will administer and mange R1's medications, physical assistance with bathing, toileting, and transferring with 2 facility staff and a mechanical lift. The "Senior Living Level of Care Assessment dated 10/10/23 lacked documentation of R1 having a bed assist device, a description of the device and any special instructions on use and monitoring of the device. Review of R3's electronic "Medical Record" under the "Forms" tab revealed a document titled "Bed Rail Assessment" and was dated 06/06/23.	S3171		

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CREDO SENIOR LIVING OF CHANUTE	701 OSA MARTIN BLVD CHANUTE, KS 66720

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S3171	Continued From page 14 Interview on 12/10/24 at approximately 09:00 AM with "Licensed Nurse" B confirmed R1's electronic "Medical Record" lacked a current periodic reassessment and she further confirmed R1's "Senior Living Level of Care Assessment" lacked a description of the device and any special instructions on use and monitoring of the device. Observation on 12/10/24 at approximately 01:00 PM with LN A confirmed bilateral handrails on the top quarter of the hospital bed. They were attached to the frame and measured approx. 14 inches at the top and approximately 4 inches at the bottom. There were no large openings in the device. The FDA (food and drug administration) "Bedrails in Assisted Living, Residential Health Care and Home Plus Facilities" recommended the following: Complete an assessment of the resident to confirm that the device is not a restraint. Complete an assessment of the resident to determine the purpose of the device and the resident's ability to safely use the device and document the findings in the resident's record. Complete an assessment of the device using the recommendations in the FDA guidance to ensure the device is securely attached to the bed or bedframe and poses no risk for entrapment and document the findings in the resident record. If the purpose of the device is to assist the resident with transfers, the FCS should document the resident's functional capacity based on the use of the device and should be listed in the	S3171		

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S3171	Continued From page 15 comments section. Include a description of the device, its purpose and special instructions on use and monitoring in the resident's NSA. Document periodic reassessments of the resident's use of the device and their ability to use it safely and reassessment of the safety of the device in the resident's record. The Operator failed to ensure a periodic review of R1's bed assist device to ensure R1's bed assist device posed no risk for entrapment, confirmed the device was not a restraint, include a description of the device, its purpose and special instructions on use and monitoring in R1's NSA, and documentation of periodic reassessments of R1's ability to use the bed assist device safely and document the findings in R1's resident record. - Observation on 12/09/24 at approximately 01:00 PM, CMA C unlocked the locked medication room, and in the last cabinet on the east wall there sat a small plastic container that was labeled "Overstock Meds" (Medications) and contained the following OTC bottles: 1 bottle of Cetirizine 10 milligrams/antihistamine R4's name had been written on the back of the bottle in black marker and then a black marker was used to draw lines through R4's name and on the top of the bottle "Overstock" was written in black marker. 1 bottle of Natures Blend Vitamin B12 -on the back of the bottle a label with R4's full name.	S3171		

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S3171	Continued From page 16 1 bottle of Major Acetaminophen 500 milligram tablets on the front of the bottle above the label R4's name had been marked through with a black marker, and "overstock" had been written in black marker on the top of the cap. 1bottle of Vitamin D3 and R4's name had been marked through with a black marker, "overstock" had been written on the top of the bottle cap. 1 bottle of Equate Complete Multivitamin Women 50 + that had "overstock" written on the front of the bottle above the label. 1 box of Refresh Optive Advanced lubricating eye drops that had "overstock" written on the front of the box, and on the back of the box you could see the part of the pharmacy sticker which stated "Federal law prohibits transfer of th ...to any person other than patient for whom pres ... 1 bottle of Ferrous Sulfate 325 milligrams 1 bottle of Equate Low Dose Aspirin 81 milligrams. 1 bottle of Melatonin 5 milligrams with "Overstock" written on the cap. Interview on 12/10/24 at approximately 09:00 AM with "Licensed Nurse" (LN) B confirmed that she had recently performed an audit of the facility's medication room and the container of "Overstock" was not present on the shelf at the time of the audit, and she further confirmed that labeling OTC's that had belonged to previous residents was not an acceptable standard of practice. The Operator failed to ensure the facility's LN and CMA's provided health care services within	S3171		

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S3171	Continued From page 17 professional standards of practice when in the facility's medication room, a plastic container was found with 8 bottles and one box labeled as "Overstock", 4 bottles and one box had been labeled with resident names.	S3171		
S3261 SS=E	26-41-105 (f) (11) Resident Record Documentation of Incidents (f) (11) documentation of all incidents, symptoms, and other indications of illness or injury including the date, time of occurrence, action taken, and results of the action This REQUIREMENT is not met as evidenced by: K.A.R. 26-41-105 (f) (11) The facility reported a census of 27 residents. The sample included 3 "Residents'" (R)'s 1, 2, and 3. Based on record review and interview the Operator failed to ensure the documentation of all incidents, symptoms, and other indications of illness and injury including the date, time of occurrence, action taken, and results of the action taken for R1 and R3. Findings included: - Record review for R1 revealed an admission date of 11/01/17 with diagnoses of depression, chronic atrial fibrillation, circadian rhythm sleep disorder, and anemia. Review of R1's "Functional Capacity Screen"	S3261		

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S3261	Continued From page 18 (FCS) assessment date was on 10/10/23 and signed on 12/09/24, revealed R1 required physical assistance with bathing, dressing, toileting, transferring, walking/mobility, and eating. He lacked the ability to manage his own medications and treatments and was incontinent. . R1 used a wheelchair and mechanical lift for transfers and mobility. R1 was sometimes able to make himself understood and he sometimes understood others. Review of R1's electronic "Medical Record" revealed under the "Forms" tab, a document titled "Senior Living Level of Care Assessment" dated 10/10/23, identified the facility would provide the following health services: staff assistance with eating, staff escort to meals, "pain management per hospice advice", facility "Certified Medication Aide" (CMA)'s will administer and mange R1's medications, physical assistance with bathing, toileting, and transferring with 2 facility staff and a mechanical lift. Interview on 12/10/24 at approximately 09:00 AM with "Licensed Nurse" B confirmed the document titled "Senior Living Level of Care Assessment" was the facility's NSA. Review of R1's electronic "Medical Records" under the progress notes tab revealed the following entry; On 10/17/24 at 03:13 PM on 10/16/13 at 04:30 PM a technician from the pacemaker company "came and turned off defibrillator portion" of the combined defibrillator/pacemaker device. This was done per family request and physician ordered after "extensive telehealth visit on 09/18/24 with the resident, cardiologist and family."	S3261		

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S3261	Continued From page 19 R1's electronic medical record lacked documentation of the results of the action of turning off the defibrillator portion of R1's combined defibrillator/pacemaker. - Record review for R3 revealed an admission date of 11/02/22 with diagnoses of Rheumatoid arthritis, altered mental status and hypertension. Review of R3's FCS dated 11/03/22 revealed R3 required physical assistance with bathing, and supervision with dressing. She was independent with toileting, transferring, walking/mobility, and eating. She lacked the ability to manage her own medications and medical treatments. R3 was able to make herself understood and R3 understood others. R3 used a walker mobility device. The cognition score on R3's FCS did not match the definitions specified by the department. Review of electronic "Medical Records" under the "Forms" tab a document titled "Assisted Living Standard Level Of Care and Service Plan" dated 11/02/22, identified the facility would provide the following health services; Facility staff would administer medications, assistance with bathing, toileting, dressing, and stand by assistance with mobility. Review of R3's electronic "Medical Records" under the progress notes tab revealed the following entries; On 05/14/24 at 01:47 PM R3's physician was contacted regarding R3 having an increase in tearfulness, sad demeanor, and an increase in	S3261		

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S3261	Continued From page 20	S3261		

anxiety since starting a new medication for depression.

R3's record lacked documentation of the results of the results of contacting the physician for possible adverse reaction to a new medication.

On 08/15/24 at 02:36 PM staff reported R3 having dark color in stools. R3's medical provider was notified and a hemoccult stool sample was obtained.

R3's record lacked documentation of the actions taken to monitor R3 for symptoms of illness.

On 08/21/24 at 03:20 PM R3 was found sitting on her bed screaming and grabbing her right hip. R3 was sent to the local emergency room. "On 08/20/24 resident underwent procedure to put right hip back into place and then was transferred back to residence at 05:30 PM on 08/20/24 with hip precaution measures and also wearing an immobilizing hip brace."

R3's record lacked actions taken to monitor R3 upon return from the hospital.

Review of the facility provided document titled "Routine Admission Orders" dated 12/5/24 from a local hospice agency.

Interview on 12/10/24 at approximately 09:00 AM with "Licensed Nurse" B confirmed the document titled "Assisted Living Standard Level of Care and Service Plan was the facility's prior document that was used for the NSA. She continued to confirm the medical record for R3 lacked a review and if necessary, a revision of R3's NSA when she experienced a significant change of condition and was placed on hospice on 12/05/24. LN B

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S3261	Continued From page 21 confirmed the NSA for R3 did not accurately reflect health care services being provided to R3. She further confirmed R3's record lacked documentation showing the change of condition for R3. The Operator failed to ensure the documentation of all incidents, symptoms, and other indications of illness and injury including the date, time of occurrence, action taken, and results of the action taken for R1 and R3.	S3261		