STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046086	A. BUILDING: _____ B. WING _____	02/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADDINGTON PLACE OF PRAIRIE VILLAGE	2700 SOMERSET DRIVE PRAIRIE VILLAGE, KS 66206

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S 000	INITIAL COMMENTS The following citations are the result of Complaint Investigations #110661 and #108814 at the above named Assisted Living Facility in Prairie Village, Kansas on 01/23/17, 01/24/17, 01/25/17, 01/30/17, 01/31/17, 02/01/17, and 02/02/17.	S 000		
S3028 SS=E	26-41-101 (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 facility as soon as staff is aware of the allegation and to the department within 24 hours. The administrator or operator shall ensure that all of the following requirements are met: (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.	S3028		

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

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S3028	Continued From page 1 This REQUIREMENT is not met as evidenced by: KAR 26-41-101(f)(3)(B)(C)(D)(E)(F) The census included 43 Assisted Living (AL) Residents, 27 Memory Care (MC) Residents and one Adult Day Care (ADC) Resident who received services in the MC, as identified on the Resident Roster. One MC Resident sampled and six MC Residents focus reviewed. Based on interview and review of record, for 2 of 6 focused reviews (#5 and #2), with allegations of potential abuse or neglect, the Administrator failed to: Report potential abuse or neglect to the department within 24 hours, Thoroughly investigate allegations of potential neglect or abuse, and, Maintain a written record of each investigation. Findings included: - Review of record revealed #5 admitted 3/22/16 with diagnoses of Dementia with behaviors, Hip fracture, Cerebrovascular accident, Atrial fibrillation, Muscle weakness, Depression, and Hypertension. The current functional capacity screen of 3/16/16 assessed #5 in need of supervision with bathing, dressing, toileting, transfers, and mobility; unable to perform medication and treatment management; with bladder incontinence; with short term memory, long term memory, memory recall, and decision making impairments; with communication impairment; used a walker and with falls/unsteadiness. The medical record contained a 3/16/16 Elopement Risk Evaluation Tool - score of "6" (6-15 required Additional Negotiated Risk Agreement). The medical record contained a	S3028		

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S3028	Continued From page 2 3/16/16 Fall Risk Evaluation Tool - score of "19" (6 or more required Additional Shared Risk Agreement. Elopement and Falls not addressed on the 3/16/16 NSA (negotiated service agreement)/HSP. The NSA/HSP documented physical assistance with bathing, physical assistance with dressing, stand by assistance with transfers and ambulation, reminders and redirection for orientation, staff management of medications, and some physical assistance with toileting. The medical record contained hospital admission/evaluation notes dated 12/10/16 and 12/11/16: Patient was found by Police Department walking outside several blocks from his/her assisted living facility ... family feels patient is more confused than baseline ... presents to the Emergency Department after being found wandering outside of Nursing Home with shirt on backwards and more disoriented than baseline ... in week leading up to this ... progressively more confused ... Nurse ' s Notes of medical record documented: 12/10/16 - 12:20 - nurse received phone call from Police Department stating a patient was noticed on the corner and officers would return that patient ... #5 was escorted to facility with two officers ... wearing black coat ... stated went for a walk, no apparent injury noted ... alert and oriented x2 ... family was called and instructed to take to hospital for evaluation ... 12:45 left with family for hospital The medical record lacked evidence of a report to the Department, or of an investigation into cognitively impaired Resident's departure from facility unknown to staff. 12/21/16 - 2155 - aide called... Resident fell out of bed hit head on wall ... got up put self to bed, frontal, hurt right ... emergency medical service	S3028		

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S3028	Continued From page 3	S3028		

came... went to hospital ... Resident seemed very confused ... family, executive director, physician called...
12/30/16 - no time - Resident had unwitnessed fall this morning ... was found on the floor in room by aide ... family, director of nursing, executive director called ...
01/23/17 - no time - fell in bathroom? Has bruising on lower back. Just did remember what happened found out when he/she started having back pain
The medical record lacked evidence of a report to the Department, or of an investigation into unwitnessed falls of Resident.
By interview on 01/24/17 at 2:35pm, Administrator #F stated #5 was an Assisted Living Resident when he/she brought back by police department.... confirmed report not made to Department, and no written investigations completed.
The Administrator failed to report potential neglect or abuse of #5 to the department within 24 hours, failed to thoroughly investigate allegations of potential abuse or neglect, and failed to maintain a written record of an investigation.

- Review of record revealed #2 admitted 3/09/13 with diagnoses of Alzheimer's and Diverticulitis. The current functional capacity screen of 4/01/16 assessed #2 with a need for physical assistance with bathing, dressing, toileting, transfers, mobility; unable to perform medication and treatment management; with frequent bladder incontinence; with impaired communication; with Falls/unsteadiness, Impaired short memory, long term memory, memory recall, and impaired decision making.
The medical record contained a 4/01/16 Elopement Risk Evaluation Tool - score of "8"

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S3028	Continued From page 4	S3028		

(6-15 required Additional Negotiated Risk Agreement). The medical record contained a 4/01/16 Fall Risk Evaluation Tool - score of "13" (6 or more required Additional Shared Risk Agreement.
Elopement and falls not addressed in the current NSA (negotiated service agreement)/HSP of 4/01/16. The NSA/HSP documented physical assistance with bathing, supervision with dressing, stand by assistance with transfers and mobility, reminders and redirection for orientation, staff management of medications, and some physical assistance with toileting.
By interview on 01/24/17 at 11:23am, Administrator #F stated last evening #3's family member came running up the hallway (of Assisted Living)... said somebody had gotten out of MC - #2... had made turn in hall when aide #Q (from MC) got to #2... aide #Q was in bathroom with #3... heard the alarm... never heard door hit wheelchair of #2 (as wheelchair getting through door way auto close door most likely would have hit or come to rest on wheelchair during process)... just heard the alarm...
Administrator #F stated this event not reported because #2 inside the AL, even though he/she left secured MC unit unknown to staff on duty.
By review of written facility investigation on 01/31/17 noted:
No written statement obtained from the alleged witness to the event of elopement.
On 11/23/17 (actual date 01/23/17) at 7:15pm a MC Resident's family member came into Executive Director (ED) office... saying a Resident had escaped MC... ED observed #2 coming around corner... approximately one minute later aide #Q came into AL to get #2... per aide #Q statement the alarm did not sound...
The conflict of an alarm sounded in the initial reported information, no alarm sounded in the

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S3028	Continued From page 5 second statement, and the absence of a witness statement by the family member or any other staff on duty failed to demonstrate a thorough investigation completed. The Medical Record Nurse's Notes lacked any information or reference to this event. The Administrator failed to report potential neglect of #2 to the department within 24 hours, and failed to thoroughly investigate allegations of potential neglect.	S3028		
S3082 SS=D	26-41-201 (d) Functional Capacity Screen Accurate d) Designated facility staff shall ensure that each resident ' s functional capacity at the time of screening is accurately reflected on that resident ' s screening form. This REQUIREMENT is not met as evidenced by: KAR 26-41-201(d) The census included 43 Assisted Living (AL) Residents, 27 Memory Care (MC) Residents and one Adult Day Care (ADC) Resident, as identified on the Resident Roster. One MC Resident sampled and six MC Residents focus reviewed. Based on interview and review of record, for one of one sampled (#3) the Operator failed to ensure designated facility staff completed a functional capacity screen (FCS) that accurately reflected the Residents's functional capacity. Findings included: - Review of record revealed #3 admitted to facility 3/11/16 with a diagnosis of Alzheimer's.	S3082		

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S3082	Continued From page 6 The admission Functional Capacity Screen (FCS) of 3/11/16 lacked the signature of a licensed nurse, and recorded #3 in need of physical assistance with toileting; in need of supervision with transfers, and mobility; with frequent bladder incontinence and impaired communication; unable to perform medication and treatment management; with falls/unsteadiness, wandering, and impaired decision making. The cognition section contained a number value of "9". This code failed to correspond with the required numbering system of the form as described in the instruction manual. Section "D. Cognition" consisted of four boxes, each box to be filled with a "1" if applicable, total score to result from zero to four. A revised FCS dated 4/01/16 recorded #3 now independent with toileting, transfer, mobility. The cognition section contained a number value of "10." This code failed to correspond with the required numbering system of the instruction manual. By interview on 01/25/17 at 12:36pm, Resident Care Director #D stated I have a book they gave me when I came on... not sure what is in it... have done a handful... cognitive section where it refers to test in manual... I don't know what that means... plan to review manual and have all done in facility in 30 days... confirmed a new FCS not completed for #3 when new evaluation tools and negotiated service agreement completed in late December. The Administrator failed to ensure designated facility staff completed an FCS that accurately reflected #3's functional capacity.	S3082		

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S3101	Continued From page 7	S3101		
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: KAR 26-41-202(h) The census included 43 Assisted Living (AL) Residents, 27 Memory Care (MC) Residents and one Adult Day Care (ADC) Resident who received services in the MC, as identified on the Resident Roster. One MC Resident sampled and six MC Residents focus reviewed. Based on interview and review of record, for one of one sampled (#3) and for 1 of 6 focused reviews (#7), the Administrator failed to ensure each individual involved in the development of the negotiated service agreement/health service plan (NSA/HSP) signed the agreement. Findings included: - Review of record revealed #7 admitted to facility 8/20/13 with diagnoses of Mild Alzheimer's, Moderate dementia, and Osteoarthritis of right knee. The current functional capacity screen (FCS) of 8/12/16 assessed #7 in need of physical assistance with bathing and toileting; in need of supervision with dressing; unable to perform	S3101		

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S3101	Continued From page 8	S3101		

medication and treatment management; with occasional incontinence of bladder; with short term memory impairment, with memory recall and decision making impairment; sometimes understands and sometimes understood.

The current NSA/HSP dated 01/01/16 (signed by previous facility nurse 7/28/16) documented interventions to address Resident needs. The NSA lacked the signature of Resident or the Resident's legal representative.

- Review of record revealed #3 admitted to facility 3/11/16 with a diagnosis of Alzheimer's.

The admission Functional Capacity Screen (FCS) of 3/11/16 lacked the signature of a licensed nurse, and recorded #3 in need of physical assistance with toileting; in need of supervision with transfers, and mobility; with frequent bladder incontinence and impaired communication; unable to perform medication and treatment management; with falls/unsteadiness, wandering, and impaired decision making. The cognition section contained a number value of "9". This code failed to correspond with the required numbering system of the form as described in the instruction manual, but indicated impaired short term and long term memory, memory recall, and decision making.

A revised FCS dated 4/01/16 recorded #3 now independent with toileting, transfer, mobility. The cognition section again indicated impaired short term and long term memory, memory recall, and decision making.

The current 4/01/16 NSA/HSP documented #3 to receive services from facility to address these identified needs.

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S3101	Continued From page 9 A newer NSA/HSP in medical record dated on front as 12/23/16. This NSA/HSP not yet signed by anyone. By interview on 01/24/17 11:14am, Executive Director #F stated we did a new NSA/HSP on 12/23/16... but when we sat down with spouse to review, form printed blank... had another meeting "about a week later" with spouse to review the NSA/HSP... he/she attended... took forms home... has not returned a signed copy in spite of contacts and attempts to get these signed and in the chart... #F stated all attempts have been verbal... have no documentation of attempts to get NSA/HSP signed. By interview on 01/25/17 at 2:03pm, Executive Director #F and Resident Care Director #D confirmed NSA/HSP for #7 completed before we started by previous staff... no review or signing of the NSA/HSP since then. The Administrator failed to ensure each individual involved in the development of the NSA/HSP's for #3 and #7 signed the agreements.	S3101		
S3130 SS=F	26-41-203 (d) Special Care Services (d) Special care. Any administrator or operator of an assisted living facility or residential health care facility may choose to serve residents who do not exceed the facility ' s admission and retention criteria and who have special needs in a special care section of the facility or the entire facility, if the administrator or operator ensures that all of the following conditions are met: (1) Written policies and procedures are developed and are implemented for the operation of the special care section or facility.	S3130		

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S3130	Continued From page 10 (2) Admission and discharge criteria are in effect that identify the diagnosis, behavior, or specific clinical needs of the residents to be served. The medical diagnosis, medical care provider ' s progress notes, or both shall justify admission to the special care section or the facility. (3) A written order from a medical care provider is obtained for admission. (4) The functional capacity screening indicates that the resident would benefit from the services and programs offered by the special care section or facility. (5) Before the resident ' s admission to the special care section or facility, the resident or resident's legal representative is informed, in writing, of the available services and programs that are specific to the needs of the resident. (6) Direct care staff are present in the special care section or facility at all times. (7) Before assignment to the special care section or facility, each staff member is provided with a training program related to specific needs of the residents to be served, and evidence of completion of the training is maintained in the employee's personnel records. (8) Living, dining, activity, and recreational areas are provided within the special care section, except when residents are able to access living, dining, activity, and recreational areas in another section of the facility. (9) The control of exits in the special care section is the least restrictive possible for the residents in that section. This REQUIREMENT is not met as evidenced by: KAR 26-41-203(d)	S3130		

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S3130	Continued From page 11 The census included 43 Assisted Living (AL) Residents, 27 Memory Care (MC) Residents and one Adult Day Care (ADC) Resident who received services in the MC, as identified on the Resident Roster. One MC Resident sampled and six MC Residents focus reviewed. Based on interview and review of record, for one of one sampled (#3) for 6 of 6 focused reviews, and for all Residents of MC unit, the Administrator failed to: 1) Ensure written policies and procedures were developed and were implemented for the operation of the special care section 2) Ensure admission and discharge criteria were in effect that identified the diagnosis, behavior, or specific clinical needs of the Resident to be served. 3) Ensure a written order from a medical care provider was obtained for admission 4) Inform in writing the Resident or Resident's representative of the available services and programs specific to the needs of the Resident 5) Ensure before staff assigned to special care section, each staff member is provided with training specific to needs of special care Residents, and records of training maintained in employee's personnel records. Findings included: - Review of record revealed #5 admitted to AL 3/22/16 with diagnoses of Dementia with behaviors, Hip fracture, Cerebrovascular accident, Atrial fibrillation, Muscle weakness, Depression, and Hypertension. The current functional capacity screen of 3/16/16 assessed #5 in need of supervision with bathing, dressing, toileting, transfers, and mobility; unable	S3130		

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S3130	Continued From page 12	S3130		

to perform medication and treatment management; with occasional bladder incontinence; with short term memory, long term memory, memory recall, and decision making impairments; with communication impairment; used a walker and with falls/unsteadiness.
The current NSA (negotiated service agreement)/ISP (individual service plan)/HSP (health service plan) of 3/16/16 documented #5 to receive physical assistance with bathing (help with washing and drying back), physical assistance with dressing (getting my clothes and putting them on and taking them off), stand by assistance with transfers and ambulation, reminders and redirection for orientation, staff management of medications, and some physical assistance with toileting.
The medical record contained an Elopement Risk Evaluation Tool - score of "6" (6-15 score required "Additional Negotiated Risk Agreement regarding elopement risk"). The "Negotiated Risk Agreement (elopement risk)" of 3/22/16, Exhibit B, identified "Potential Risks" as: Unknown whereabouts, Physical injury, Loss of life. The section for alternatives considered or attempted, and the section for agreement regarding actions to be taken, persons participating, and signature lines all left blank. Elopement not addressed on the 3/16/16 NSA/HSP.
The medical record contained a Fall Risk Evaluation Tool - score of "19" (6 or more score required "Additional Shared Risk Agreement regarding fall risk").The "Negotiated Risk Agreement (fall risk)" of 3/22/16 Exhibit B, identified "Potential Risks" as Physical Injury, Loss of Life. The section for alternatives considered or attempted, and the section for agreement regarding actions to be taken, persons participating, and signature lines all left blank. Falls not addressed on the 3/16/16

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S3130	Continued From page 13 NSA/HSP. Nurse's Notes of medical record documented: 12/10/16 - 12:20 - #5 was escorted to facility with two officers ... stated went for a walk, no apparent injury noted ... alert and oriented x2 ... family was called and instructed to take to hospital for evaluation ... 12:45 left with family for hospital The Nurse's Notes failed to document the date and time of Resident's return to facility from the hospital. 12/12/16 - 1027 - Resident in his/her apartment this morning... assisted with dressing... reported Resident with increased confusion... will continue to monitor for confusion alert and oriented x1... 12/13/16 - 1010 - Resident remains in MC room... alert and oriented... increased confusion... will see medical care provider today... will continue to monitor for change in condition... 12/14/16 - 0922 - Resident adjusting well to MC room... 12/15/16 - 1028 - Resident sitting in a chair of MC common area... will continue to monitor... The medical record lacked documentation of the date and time #5 admitted to the MC unit. The medical record lacked a physician's order to admit #5 to the MC unit. The medical record lacked evidence the FCS or the NSA/HSP reviewed or revised to demonstrate the need for #5 to move to the MC unit. By interview on 01/25/17 at 1:20pm, at 1:31pm, and at 1:44pm, Administrator #F reviewed computer data and Resident Care Director #D searched office, each confirmed: No physician's order obtained for admission of #5 to MC unit... FCS and NSA/HSP not reviewed or revised for indication #5 in need of MC services... No available policies and procedures available for the MC unit... No admission criteria available...	S3130		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046086	A. BUILDING: _____ B. WING _____	02/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S3130	Continued From page 14 Administrator #F stated I have made a note Corporate needs to provide MC policies and procedures... provided two "point scoring" sheets that tallied care point values for AL and for MC... stated these would help determine level of care needs, but no criteria to identify which service area of facility appropriate. On 02/01/17 at 10:27am, requested documentation regarding specific training of staff for Special care (Memory Care). Requested documentation of any staff orientation/ training/inservices, topics covered with videos, the talking points or itinerary of training sessions, and a signature list or at least list of attendees. As of 02/01/17 at 4:37pm this training information not received. For all Residents of MC unit, the Administrator failed to ensure written policies and procedures were developed and implemented for the operation of the MC, failed to ensure admission and discharge criteria were in effect, failed to ensure a written order from a medical care provider was obtained for admission of #5, failed to ensure documentation of staff training for specialty unit completed and maintained, and failed to inform in writing #5 or #5's representative of the available services and programs specific to the needs of the #5.	S3130		
S3155 SS=J	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	S3155		

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	N046086	A. BUILDING: _____ B. WING _____	02/02/2017

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S3155	Continued From page 15 agreement. This REQUIREMENT is not met as evidenced by: KAR 26-41-204(a) The census included 43 assisted living (AL) residents, 27 memory care (MC) residents and 1 adult day care (ADC) resident. Facility staff identified 7 MC residents with history of exit seeking or wandering. The sample included 1 sampled MC resident and 6 focus review MC residents. Based on observation, interview, and record review for one sampled (#3) and for five focus reviewed (#2, #5, #6, #7 and #8) residents, the Administrator failed to ensure a licensed nurse provided or coordinated the provision of health care services to address wandering and risk for elopement of cognitively impaired residents. On 11/28/16 at approximately 6:30am, cognitively impaired Resident #3 left the facility unattended by staff, walked nearly one mile, crossed general public streets and one major four lane street, was discovered by law enforcement at a fast-food restaurant, and was returned to facility. Facility identified Resident #3 with cognitive issues, wandering, and at risk for elopement 3/2016, 4/2016, 7/2016, and 8/2016 . The Negotiated Service Agreements (NSA) and HSP (individual service plans/health service plans) lacked individualized services to address wandering and exit seeking. The failure to provide and coordinate services to address potential elopement placed this Resident in Immediate Jeopardy.	S3155		

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S3155	Continued From page 16 Findings included: - Review of record revealed #3 admitted to facility 3/11/16 with a diagnosis of Alzheimer's. The admission Functional Capacity Screen (FCS) dated 3/11/16 recorded #3: Required physical assistance with toileting; required supervision with transfers, and mobility; with frequent bladder incontinence; with impaired short term memory, long term memory, memory recall, and decision making; with impaired communication; Current or recent problems identified as falls/unsteadiness, wandering, and impaired decision making. Fall Risk Evaluation Tool of 3/11/16 (score of 8) identified #3 at risk for falls (tool score of 6 or more indicated " Additional Shared Risk Agreement regarding fall risk. ") The record lacked Shared Risk agreement of March 2016. The record contained additional fall risk evaluations on 8/23/16 and 12/23/16 that continued to identify resident #3 at risk for falls Elopement Risk Tools of 3/14/16, 4/01/16, 8/23/16, and 12/23/16 each identified #3 at higher risk of elopement attempts. These scored at "8" and "10" and the tool documented scores of 6-15 required additional Negotiated Risk Agreements. The NSA/HSP dated 3/11/16 lacked interventions or services to address risk for falls or elopement risk. A revised FCS dated 4/01/16 recorded #3 now independent with toileting, transfer, mobility. The revised NSA/HSP dated 4/1/16 continued to	S3155		

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S3155	Continued From page 17	S3155		

lack interventions to address the risk for falls or elopement risk.

The NSA/HSP of 4/01/16 (signed 4/27/16) lacked interventions or services to address falls or elopement risk.

A physician's Medical Evaluation for Assisted Living dated 7/19/16 documented the above diagnoses, and added: "forgetfulness" and "may wander... needs to be returned to bed several times."

The medical record Nurse's Notes documented:

8/01/16 - 12 p.m. - admitted to memory care . . .... alert with some confusion...

8/04/16 - 9:30 a.m. - Resident exit seeking... staff redirecting resident away from exit doors...

10/16/16 - 2:40 p.m. - Receptionist reported alarm was going off so he/she went to shut if off... happened to look at the side door that goes outside to AL... saw Resident opening door and heading out... receptionist took Resident's hand and redirected back to Memory Care

11/17/16 - (no time) - Resident agitated... wouldn't sit down... trying to get out, going from door to door... gave Seroquel 25mg (milligrams)... 30 minutes was sound asleep... had to be carried in chair to bed...

11/18/16 - 5:30 p.m. - Resident very agitated... trying to get out... gave Seroquel 25 mg... 30 minutes was asleep..

11/28/16 - 7:40 a.m. - writer arrived around 7 a.m... CNA (certified nurse aide) notified writer

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	N046086	A. BUILDING: _____ B. WING _____	02/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S3155	Continued From page 18	S3155		

Resident #3 missing... last seen 6:30am... search in progress... notified Executive Director... notified family and law enforcement... approximately 7:20am law enforcement reported Resident who matched description at fast food Restaurant... identified by this writer as #3... law enforcement returned Resident #3 to facility... appears to be in pleasant mood... no complaints of pain... no apparent injury... fully dressed with shoes on, no jacket... temperature outside 56 degrees... notified family Resident found... placed on 15 minute checks for 72 hours...

By review of Wunderground.com data for 11/28/16:
Sun rise at 7:16am
Overcast sky
Wind at 11.5 miles per hour
Temperature at 6:53am was 55 degrees Fahrenheit.

The record lacked documentation of review or revision of NSA/HSP on 11/28/16. Interview on 01/24/17 at 10:30am with Executive Director #F confirmed no review or revision of NSA/HSP completed 11/28/16.

New Elopement Risk Assessment completed 12/12/16 defined #3 as "high" elopement risk. The tool " Conclusion " section offered " Low " " Medium " or " High " as the risk options to choose from to summarize the Elopement Risk Assessment.

The record contained a revised NSA/HSP dated 12/23/16 that lacked signatures of the facility staff and responsible party. The 12/23/16 NSA/HSP documented: Remains in the secured neighborhood due to wandering and exit seeking... must be frequently redirected away

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046086	A. BUILDING: _____ B. WING _____	02/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S3155	Continued From page 19	S3155		

from the exit doors... staff will encourage to participate in multiple activities throughout the day... encourage activities of liking when exit seeking... continue 30 minute visual checks...

By interview on 01/24/16 at 11:20am Executive Director #F and Memory Care Coordinator #G confirmed this intervention on NSA/HSP was an error... #3 has never been on 30 minute checks, only 15 minute checks for 72 hours beginning 11/28/16 and then hourly checks thereafter.

By interview on 01/24/17 11:14am, Executive Director #F stated we did a new NSA/HSP on 12/23/16... but when we sat down with spouse to review, form printed blank... had another meeting "about a week later" with spouse to review the NSA/HSP... he/she attended... took forms home... has not returned a signed copy in spite of contacts and attempts to get these signed and in the chart ... all verbal ... have no documentation of attempts to get NSA/HSP signed.

Behavior Monitoring Notes of Memory Care unit documented:

01/11/17 - third shift... #3 tried to get out a few times... and grabbed my arm for blocking the door...

01/16/17 - wandering... did set off alarm two times...

01/18/17 and 01/19/17 - #3 was trying to get out twice...

By observation on 01/23/17 at 2:24pm, an ambulatory Resident (later identified as #3) walked up to Surveyor, pointed at locked exit door of Memory Care unit and asked "can I get out that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046086	A. BUILDING: _____ B. WING _____	02/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S3155	Continued From page 20	S3155		

door?"

By interview on 01/23/17 at 1:35pm, Executive Director #F stated I believe the elopement occurred because alarms not loud enough... "screamer alarms" put on until permanent louder alarms can be installed... have received permission to change egress time on fire code doors from 15 seconds to 30 seconds... #3 was able to figure out if egress bar pressed for 15 seconds would allow him/her to go out... he/she goes to doors all the time... is so fast... talked with spouse about health care provider evaluation or personal sitter... said "no".

By observation on 01/23/17 during tour of facility beginning at 2:00pm, "screamer alarms" absent from one door in memory care unit, and turned off and not functioning on other door of memory care unit.

By observation on 01/24/17 at 6:08pm, "screamer alarms" again turned off and not functioning.

On 01/23/17 at 4:55pm and on 01/25/17 at 2:25pm, requested copy of Door alarm policy and procedure. Executive Director #F confirmed no policy and procedure available on 01/25/17.

This log indicated if Resident left as suspected (between 6:30 and 6:40am) the next door activation did not occur for 18 minutes.

Written staff statement by CNA #N: #3 up at 4:30am ... I encouraged to get some rest ... #3 woke up around 5:50am and I encouraged to get dressed ... #3 was assisted to the dining room ...sat down ... was given yogurt at the dining area and was calm and ok ... I continued my morning duties ... at approximately 6:40am I heard the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046086	A. BUILDING: _____ B. WING _____	02/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S3155	Continued From page 21	S3155		

main door alarm sounding. I went to the door and opened it and check outside the unit and no one was there ... I check on Residents to make sure everyone was still there ... I discovered #3 missing ...

Written staff statement by CMA (certified medication aide) #M: " Around 6:40 CNA (certified nurse aide) #N came and found me in a Resident ' s room to tell me he/she couldn ' t find #3 ... I started looking for #3 and eventually called my Director of Nursing who told me call the police and family ... I did and kept looking ... until police found someone who matched description at [fast food restaurant] ... police brought #3 back

Review of door alarm log for Memory Care Door on 11/28/16 revealed activations at:
6:02am
6:03am
6:10am
6:36am
6:54am
6:58am
6:58am
6:59am

The facility records lacked an investigation to determine cause of activation for times listed above, except for statement from CNA #N who indicated he/she opened the door at approximately 6:40 a.m. (6:36 a.m. on log), indicating that the resident likely left the facility 26 minutes earlier at 6:10 a.m..

By observation, fast food restaurant where the resident was found by police is approximately 1 mile from the facility. The road directly in from of the facility was a neighborhood street with sidewalks, street lights and moderate traffic. The

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	N046086	A. BUILDING: _____ B. WING _____	02/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S3155	Continued From page 22	S3155		

restaurant was located across a 4 lane main thoroughfare with a posted speed limit of 35 mile per hour and traffic signals at the intersection.

For one of seven Residents reviewed (#3), the Administrator failed to ensure a licensed nurse provided or coordinated the provision of health care services to address wandering and risk for elopement of cognitively impaired #3 from the facility. Resident #3 made repeated exit seeking attempts and eloped from facility on 11/28/16 45 minutes to one hour before sunrise, walked nearly one mile, crossed city streets and one four lane busy street, and was discovered by law enforcement at a fast food Restaurant. This failure placed #3 in immediate jeopardy.

The Executive Director (ED) submitted a Corrective Plan of Action on 01/24/17 at 7:29pm:

Facility will ensure no Resident leaves the memory care unit without knowledge of staff by: ensuring exit door alerts sends a message to all employee's pagers.

All staff will immediately be trained/educated by the ED or designee, that immediate response to the alert is mandatory.

Upon arrival employees will make a mental note of the time. If no one is visible, a head count of the appropriate memory care unit will begin.

To ensure immediate response is achieved, a minimum of two responding employees will document the time of initial alarm alert and the time an employee arrived at the alarming door.

Screamers are to be in the on, screamer position Not chime from 7pm to 7am.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046086	A. BUILDING: _____ B. WING _____	02/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADDINGTON PLACE OF PRAIRIE VILLAGE	2700 SOMERSET DRIVE PRAIRIE VILLAGE, KS 66206

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S3155	Continued From page 23 Louder alarms have been approved and awaiting installation for all exit doors on memory care units. Additional alternatives will be considered and decided upon within the next 3 days. By observation and interviews of direct care staff #H on 01/25/17 at 10:40am, #G at 10:55am, #J at 11:26am, and #K at 11:39am, reported the understanding of new training on alarms from night before is that each time door activates they are to write down on a paper the time and who came or went. All confirmed this was not taking place when they were out of visual sight of door, such as when in a Resident room providing care, or in the bathroom. The Executive Director submitted a revised Corrective Plan of Action on 01/25/17 at 4:19pm that added: Facility will ensure no Resident leaves the memory care unit without knowledge of staff by: Ensuring exit door egress alerts (which is someone trying to exit the memory care unit by holding in the push bar until it releases in 30 seconds, allowing someone to exit) will send a message to all employee's pagers. All staff, means every staff member on duty in the building at the time of the egress alarm, must report to the alarming door immediately. Response to the egress alert is mandatory. This means if someone tries to leave the memory care unit by holding in the push bar for 30 seconds and it release, letting the door open for the person to exit.	S3155		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046086	A. BUILDING: _____ B. WING _____	02/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S3155	Continued From page 24 To ensure immediate response is achieved, a minimum of two responding employees will document the time of initial alarm alert and the time an employee arrived at the alarming door. This information will be utilized in our Quality Assurance program to make sure we are getting to the alarming door quickly, the quicker we are, the lessor chance of a Resident eloping from the unit. Maintenance Director is checking the alarms daily for proper operation. RN or LPN or Med aide/designee will check the alarms for proper operation and perform a head count of each unit every shift and document on the MAR. Louder alarms . . .to be installed 01/30/17. Additional alternatives will be considered and decided upon within the next 3 days. We are open to investigate all person's suggestions. - Review of record revealed #5 admitted 3/22/16 with diagnoses of Dementia with behaviors, Hip fracture, Cerebrovascular accident, Atrial fibrillation, Muscle weakness, Depression, and Hypertension. The current functional capacity screen of 3/16/16 assessed #5 in need of supervision with bathing, dressing, toileting, transfers, and mobility; unable to perform medication and treatment management; with bladder incontinence; with short term memory, long term memory, memory recall, and decision making impairments; with communication impairment; used a walker and	S3155		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046086	A. BUILDING: _____ B. WING _____	02/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S3155	Continued From page 25	S3155		

with falls/unsteadiness.
The current NSA (negotiated service agreement)/HSP of 3/16/16 documented physical assistance with bathing, physical assistance with dressing, stand by assistance with transfers and ambulation, reminders and redirection for orientation, staff management of medications, and some physical assistance with toileting.
The medical record contained an Elopement Risk Evaluation Tool - score of "6" (6-15 score required "Additional Negotiated Risk Agreement regarding elopement risk"). Elopement not addressed on the 3/16/16 NSA/HSP. The "Negotiated Risk Agreement (elopement risk)" of 3/22/16, Exhibit B, identified "Potential Risks" as: Unknown whereabouts, Physical injury, Loss of life. The section for alternatives considered or attempted, and the section for agreement regarding actions to be taken, persons participating, and signature lines all left blank.
The medical record contained a Fall Risk Evaluation Tool - score of "19" (6 or more score required" Additional Shared Risk Agreement regarding fall risk"). Falls not addressed on the 3/16/16 NSA/HSP. The "Negotiated Risk Agreement (fall risk)" of 3/22/16 Exhibit B, identified "Potential Risks" as Physical Injury, Loss of Life. The section for alternatives considered or attempted, and the section for agreement regarding actions to be taken, persons participating, and signature lines all left blank.
The medical record contained hospital admission/evaluation notes dated 12/10/16 and 12/11/16: Patient was found by Police Department walking outside several blocks from his/her assisted living facility ... family feels patient is more confused than baseline ... presents to the Emergency Department after being found wandering outside of Nursing Home

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S3155	Continued From page 26	S3155		

with shirt on backwards and more disoriented than baseline ... in week leading up to this ... progressively more confused ...
Nurse ' s Notes of medical record documented:
12/10/16 - 12:20 - nurse received phone call from Police Department stating a patient was noticed on the corner and officers would return that patient ... #5 was escorted to facility with two officers ... wearing black coat ... stated went for a walk, no apparent injury noted ... alert and oriented x2 ... family was called and instructed to take to hospital for evaluation ... 12:45 left with family for hospital
12/21/16 - 2155 - aide called Resident fell out of bed hit head on wall ... got up put self to bed, frontal, hurt right ... emergency medical service came went to hospital ... Resident seemed very confused ... family, executive director, physician called...
12/30/16 - no time - Resident had unwitnessed fall this morning ... was found on the floor in room by aide ... family, director of nursing, executive director called ...
01/23/17 - no time - fell in bathroom? Has bruising on lower back. Just did remember what happened found out when he/she started having back pain
By interview on 01/24/17 at 2:35pm, Administrator #F stated police did bring #5 back ... was in the Assisted Living at the time not the Memory Care so this was not called in ... no one knew he/she was gone ... but was appropriately dressed and said was going for a walk ... Administrator #F confirmed the evaluation tools identified fall and elopement risks, but these not included on the FCS or the NSA/HSP ... confirmed no review or revision of the NSA/HSP after falls or after #5 returned to community by police.
The Administrator failed to ensure the licensed nurse provided or coordinated the provision of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046086	A. BUILDING: _____ B. WING _____	02/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADDINGTON PLACE OF PRAIRIE VILLAGE	2700 SOMERSET DRIVE PRAIRIE VILLAGE, KS 66206

(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
S3155	Continued From page 27 necessary health care services to #5 in regard to identified risks for falls and elopement. - Review of record revealed #6 admitted 10/29/14 with diagnoses of Cognitive decline, Hearing loss, Hyperlipidemia, Dementia with behaviors, and Hypertension. The current functional capacity screens of 4/01/16 and 8/08/16 assessed #6 in need of physical assistance with Bathing, Dressing, Toileting, Medications and Treatments; with Wandering, Falls/unsteadiness, Impaired short memory, long term memory, memory recall, and impaired decision making. The current NSA/HSP of 4/01/16 lacked any interventions or services related to risk of falls or elopement risk. Behavior Notes included: 01/19/17 and 01/20/17 - #6 tried to get out six times... Nurse's Notes included: 12/27/16 - 0730 - upon arrival to shift notified by 11-7 shift Resident was found on the floor at 0500... assessed... blue discoloration middle of forehead, raised, 3x2cm (centimeters)... denies pain...refused neuro checks... notified nurse practitioner, unit coordinator, durable power of attorney, director of nursing... 12/05/16 - 1110 - staff reported Resident laying on floor in apartment from a fall... bleeding to back of head... contacted family... sent by emergency services to hospital for evaluation... 11/14/16 - 0930 - staff reported Resident had a non-injury fall on 11/13/16 at 1045... no complaints of pain or discomfort...refusing all vital signs, etc... 10/16/16 - 0935 - had a new fall 10/15/16... continues on fall follow-up... no complaints of pain or discomfort... refusing vital signs...	S3155		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046086	A. BUILDING: _____ B. WING _____	02/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S3155	Continued From page 28 10/14/16 - 1925 - Resident had a new fall today at 1314... reported to physician as reported to nurse... no complaints of pain... refusing vitals... 8/02/16 - 0950 - wearing black slip on shoes when Resident fell in dining room and hit head on back of chair on 8/01/16 around 1820... Resident sent to hospital for evaluation, later returned... By interview on 01/24/17 at 2:57pm, Administrator #F stated I did elopement training after #3 got out in December... but have no idea when training completed by previous administration... #F confirmed the NSA/HSP for #6 lacked interventions to address falls and elopement or exit seeking behaviors. The Administrator failed to ensure the licensed nurse provided or coordinated the provision of necessary health care services to #6 in regard to identified risks for falls and elopement. - Review of record revealed #2 admitted 3/09/13 with diagnoses of Alzheimer's and Diverticulitis. The current functional capacity screen of 4/01/16 assessed #2 with a need for physical assistance with bathing, dressing, toileting, transfers, mobility; unable to perform medication and treatment management; with frequent bladder incontinence; with impaired communication; with Falls/unsteadiness, Impaired short memory, long term memory, memory recall, and impaired decision making. The current NSA (negotiated service agreement)/HSP of 4/01/16 documented physical assistance with bathing, supervision with dressing, stand by assistance with transfers and mobility, reminders and redirection for orientation, staff management of medications, and some physical assistance with toileting. The medical record contained a 4/01/16 Elopement Risk Evaluation Tool - score of " 8 " (6-15 score required " Additional Negotiated Risk	S3155		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046086	A. BUILDING: _____ B. WING _____	02/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADDINGTON PLACE OF PRAIRIE VILLAGE	2700 SOMERSET DRIVE PRAIRIE VILLAGE, KS 66206

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S3155	Continued From page 29	S3155		

Agreement regarding elopement risk ").
Elopement not addressed on the 4/01/16 NSA/HSP. The NSA/HSP did not include a " Negotiated Risk Agreement (elopement risk) " form.
The medical record contained a 4/01/16 Fall Risk Evaluation Tool - score of " 13 " (6 or more score required " Additional Shared Risk Agreement regarding fall risk "). Falls not addressed on the 4/01/16 NSA/HSP. The NSA/HSP did not include a " Negotiated Risk Agreement (fall risk) " form.
Nurse's Notes included:
02/22/16 - 0930 - had a fall on 2/19/16... per staff Resident appeared to be leaning over in wheelchair to pick something up off the floor... unwitnessed and with no apparent injuries...
02/19/16 - 1845 - Resident had new fall at 1820 in living room... stated he/she wanted to get to floor because it was easy... no apparent injuries at this time...
02/16/16 - 1030 - Resident was on floor in the living room... may have been trying to transfer self onto couch... wheelchair not locked... no apparent injuries...
By interview on 01/24/17 at 11:23am, Administrator #F stated last evening (01/23/17) at about 7:00 or 7:15pm... a family member of a Resident came running up the hallway of Assisted Living said somebody (#2) had gotten out of Memory Care Unit... #2 observed outside of Memory Care Unit at turn in the hallway... investigating to determine the facts of #2 being outside Memory Care...
By interview on 01/25/17 a 2:05pm Administrator #F and Resident Care Director #D confirmed the NSA/HSP for #2 lacked interventions to address the identified care needs of falls and elopement.
The Administrator failed to ensure the licensed nurse provided or coordinated the provision of necessary health care services to #2 in regard to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046086	A. BUILDING: _____ B. WING _____	02/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S3155	Continued From page 30	S3155		

identified risks for falls and elopement.

- Review of record revealed #7 admitted 8/26/13 with diagnoses of Mild Alzheimer's, Moderate dementia, and Osteoarthritis of right knee.
The current 8/01/16 functional capacity screen assessed #7 in need of physical assistance with bathing and toileting; in need of supervision with dressing; unable to perform medication and treatment management; occasionally incontinent and with impaired communication; with impaired short term memory, memory recall, and decision making.
The medical record contained a 7/28/16 Elopement Risk Evaluation Tool - score of "9" (6-15 score required "Additional Negotiated Risk Agreement regarding elopement risk").
Elopement not addressed on the 7/28/16 NSA/HSP. The "Negotiated Risk Agreement (elopement risk)" of 8/23/16, Exhibit B, identified "Potential Risks" as: Unknown whereabouts, Physical injury, Loss of life. The section for alternatives considered or attempted, and the section for agreement regarding actions to be taken, and persons participating all left blank.
The medical record contained a 7/28/16 Fall Risk Evaluation Tool - score of "7" (6 or more score required "Additional Shared Risk Agreement regarding fall risk"). Falls not addressed on the 7/28/16 NSA/HSP. The record contained only page one of a "Negotiated Risk Agreement (fall risk)" form, no signatures of Resident or family members, signed by facility nurse on 8/23/16.
The Administrator failed to ensure the licensed nurse provided or coordinated the provision of necessary health care services to #7 in regard to identified risks for falls and elopement.

- Review of record revealed #8 admitted with diagnoses of Dementia, Gastroesophageal reflux

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046086	A. BUILDING: _____ B. WING _____	02/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADDINGTON PLACE OF PRAIRIE VILLAGE	2700 SOMERSET DRIVE PRAIRIE VILLAGE, KS 66206

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S3155	Continued From page 31 disease, Insomnia, and Artificial mitral valve. The current 01/01/16 functional capacity screen assessed #8 in need of physical assistance with bathing, dressing, eating; supervision with toileting; unable to perform medication and treatment management; occasional incontinence; with falls/unsteadiness; with impaired short term memory, memory recall, and decision making. The current NSA (negotiated service agreement)/HSP of 2/02/16 documented physical assistance by family with bathing and dressing; reminders and redirection for orientation, staff management of medications, and some physical assistance with toileting. The medical record contained a 2/02/16 Elopement Risk Evaluation Tool - score of "8" (6-15 score required "Additional Negotiated Risk Agreement regarding elopement risk"). Elopement not addressed on the 2/02/16 NSA/HSP. The NSA/HSP did not include a "Negotiated Risk Agreement (elopement risk)" form. The medical record contained a 2/02/16 Fall Risk Evaluation Tool - score of "8" (6 or more score required "Additional Shared Risk Agreement regarding fall risk"). Falls not addressed on the 2/02/16 NSA/HSP. The NSA/HSP did not include a "Negotiated Risk Agreement (fall risk)" form. The Administrator failed to ensure the licensed nurse provided or coordinated the provision of necessary health care services to #8 in regard to identified risks for falls and elopement.	S3155		
S3200 SS=D	26-41-205 (d) (1-2) Facility Administration of Medications (d) Facility administration of resident ' s medications. If a facility is responsible for the administration of a resident ' s medications, the	S3200		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046086	A. BUILDING: _____ B. WING _____	02/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADDINGTON PLACE OF PRAIRIE VILLAGE	2700 SOMERSET DRIVE PRAIRIE VILLAGE, KS 66206

(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
S3200	Continued From page 32 administrator or operator shall ensure that all medications and biologicals are administered to that resident in accordance with a medical care provider ' s written order, professional standards of practice, and each manufacturer ' s recommendations. The administrator or operator shall ensure that all of the following are met: (1) Only licensed nurses and medication aides shall administer and manage medications for which the facility has responsibility. (2) Medication aides shall not administer medication through the parenteral route. This REQUIREMENT is not met as evidenced by: KAR 26-41-205(d)(1-2) The census included 43 Assisted Living (AL) Residents, 27 Memory Care (MC) Residents and one Adult Day Care (ADC) Resident, as identified on the Resident Roster. The facility identified all Residents of Memory Care as receiving medication management. One MC Resident sampled and six MC Residents focus reviewed. Based on interview and review of record, for one of one sampled (#3), the Administrator failed to ensure all medications administered in accordance with a medical provider's written orders and in accordance with professional standards. Findings included: - Review of record revealed #3 admitted to facility 3/11/16 with a diagnosis of Alzheimer's.	S3200		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046086	A. BUILDING: _____ B. WING _____	02/02/2017

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S3200	Continued From page 33 The previous (3/11/16) and the current (4/01/16) FCS's (functional capacity screen) assessed #3 in need of medication and treatment management (3) unable to perform. The current 4/01/16 NSA (negotiated service agreement) documented #3 to receive medication management by facility. A newer NSA completed 12/23/16, not yet signed by participating parties, also described the staff management of #3's medications. According to Medical Record Nurse's Notes: 11/19/16 - 1730 - Resident very agitated - called spouse to see if he/she would come, didn ' t want to give Seraquel (sic) - puts Resident to sleep. Gave him/her ½ Seraquel - calmed down. Spouse to busy to come, told Resident he/she would be here tomorrow and he/she was fine (signed by licensed nurse #P. Review of the written Physician Fax Communication order revealed: "Date": 11/19/16 "Concerns": Seroquel 25mg (milligrams) is too strong puts #3 to sleep - would you mind writting (sic) and signing a order for 1/2 of a 25mg Seroquel. Thank You so much. Sorry to have to ask. "Dr. Orders": "Yes 1/2 tablet one a day prn (as needed) agitation... signed by physician 11/22/16" Medical record Nurse's Notes and Physician Fax Communication form lacked evidence of any contact with physician for medication order change prior to new dose being administered. The Administrator failed to ensure all medications administered to #3 in accordance with a medical	S3200		

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	N046086	A. BUILDING: _____ B. WING _____	02/02/2017

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S3200	Continued From page 34 provider's written order and in accordance with professional standards.	S3200		
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: KAR 26-41-105(f) The census included 43 Assisted Living (AL) Residents, 27 Memory Care (MC) Residents and one Adult Day Care (ADC) Resident who received services in the MC, as identified on the Resident Roster. One MC Resident sampled and six MC Residents focus reviewed. Based on interview and review of record, for one of one sampled (#3) and for 3 of 6 focused reviews (#5, #2, and #6), the Administrator failed to ensure each Resident record contained 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. Findings included: - Review of record revealed #5 admitted 3/22/16 with diagnoses of Dementia with behaviors, Hip fracture, Cerebrovascular accident, Atrial fibrillation, Muscle weakness, Depression, and Hypertension.	S3261		

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	N046086	A. BUILDING: _____ B. WING _____	02/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S3261	Continued From page 35 The current functional capacity screen of 3/16/16 assessed #5 in need of supervision with bathing, dressing, toileting, transfers, and mobility; unable to perform medication and treatment management; with bladder incontinence; with short term memory, long term memory, memory recall, and decision making impairments; with communication impairment; used a walker and with falls/unsteadiness. The medical record contained a 3/16/16 Elopement Risk Evaluation Tool - score of "6" (6-15 required Additional Negotiated Risk Agreement). The medical record contained a 3/16/16 Fall Risk Evaluation Tool - score of "19" (6 or more required Additional Shared Risk Agreement. Elopement and Falls not addressed on the 3/16/16 NSA (negotiated service agreement)/HSP. The NSA/HSP documented physical assistance with bathing, physical assistance with dressing, stand by assistance with transfers and ambulation, reminders and redirection for orientation, staff management of medications, and some physical assistance with toileting. Nurse ' s Notes of medical record documented: 12/10/16 - 12:20 - #5 was escorted to facility with two officers ... stated went for a walk, no apparent injury noted ... alert and oriented x2 ... family was called and instructed to take to hospital for evaluation ... 12:45 left with family for hospital The Nurse's Notes failed to document the date and time of #5's return to facility from the hospital, and an assessment of #5 at time of return. 12/12/16 - 1027 - Resident in his/her apartment this morning... assisted with dressing... reported Resident with increased confusion... will continue to monitor for confusion alert and oriented x1... 12/13/16 - 1010 - Resident remains in MC room...	S3261		

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	N046086	A. BUILDING: _____ B. WING _____	02/02/2017

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S3261	Continued From page 36	S3261		

alert and oriented... increased confusion... will see medical care provider today... will continue to monitor for change in condition...
12/14/16 - 0922 - Resident adjusting well to MC room...
12/15/16 - 1028 - Resident sitting in a chair of MC common area... will continue to monitor...
The medical record lacked documentation of the date and time #5 admitted to the MC unit.
12/21/16 - 2155 - aide called... Resident fell out of bed hit head on wall ... got up put self to bed, frontal, hurt right ... emergency medical service came... went to hospital ... Resident seemed very confused ... family, executive director, physician called...
12/30/16 - no time - Resident had unwitnessed fall this morning ... was found on the floor in room by aide ... family, director of nursing, executive director called ...
The medical record lacked documentation of the time and other details... who found #5, position found in, last time observed, assessment of condition, actions taken, results of the actions...
01/23/17 - no time - fell in bathroom? Has bruising on lower back. Just did remember what happened found out when he/she started having back pain
The medical record lacked documentation of the time and other details... date and time of fall, assessment of bruising, actions taken and results of the actions....
By interview on 01/25/17 at 4:05pm, Administrator #F and Resident Care Director #D confirmed medical record lacked required documentation details... deferred documentation question to LPN (licensed practical nurse) #P.
The Administrator failed to ensure #5's record contained documentation of all incidents, symptoms and other indications of illness or injury, including the date, time of occurrence,

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	N046086	A. BUILDING: _____ B. WING _____	02/02/2017

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S3261	Continued From page 37 action taken, and results of the action. - Review of record revealed #6 admitted 10/29/14 with diagnoses of Cognitive decline, Hearing loss, Hyperlipidemia, Dementia with behaviors, and Hypertension. The current functional capacity screens of 4/01/16 and 8/08/16 assessed #6 in need of physical assistance with Bathing, Dressing, Toileting, Medications and Treatments; with Wandering, Falls/unsteadiness, Impaired short memory, long term memory, memory recall, and impaired decision making. The 4/01/16 NSA (negotiated service agreement) documented services to be provided to meet these needs. The NSA lacked any interventions or services related to risk of falls or elopement risk. Behavior Notes maintained by direct care staff included: 12/26/16 - clothing visibly soiled... same outfit for weeks... refusals of bathing assistance... techniques attempted by staff... 01/19/17 and 01/20/17 - #6 tried to get out six times... Medical Record Nurse's Notes lacked these behavior observations; lacked date, times, actions taken at times of behaviors, assessment of #6 at the time, and response to actions taken. 12/27/16 - 0730 - upon arrival to shift notified by 11-7 shift Resident was found on the floor at 0500... assessed... blue discoloration middle of forehead, raised, 3x2cm (centimeters)... denies pain...refused neuro checks... notified nurse practitioner, unit coordinator, durable power of attorney, director of nursing... 11/14/16 - 0930 - staff reported Resident had a non-injury fall on 11/13/16 at 1045... no complaints of pain or discomfort...refusing all vital signs, etc...	S3261		

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	N046086	A. BUILDING: _____ B. WING _____	02/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADDINGTON PLACE OF PRAIRIE VILLAGE	2700 SOMERSET DRIVE PRAIRIE VILLAGE, KS 66206

(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
S3261	Continued From page 38 10/16/16 - 0935 - had a new fall 10/15/16... continues on fall follow-up... no complaints of pain or discomfort... refusing vital signs... 10/14/16 - 1925 - Resident had a new fall today at 1314... reported to physician as reported to nurse... no complaints of pain... refusing vitals... Medical Record lacked documentation of investigation completed, actions taken, and results to actions taken. By interview on 01/25/17 at 4:05pm, Administrator #F stated I did elopement training after #3 got out in December... but have no idea when training completed by previous administration... #F confirmed the NSA/HSP for #6 lacked interventions to address falls and elopement or exit seeking behaviors. By interview on 01/25/17 at 4:05pm, Administrator #F and Resident Care Director #D confirmed medical record lacked required documentation details... deferred documentation question to LPN (licensed practical nurse) #P. By interview on 01/25/17 at 4:05pm LPN #P stated if they (direct care staff) tell us (licensed nurses) of a behavior problem, then it gets into the chart... if they don't tell us what's going on it's not put into the chart... licensed nurses do not ask questions, ask for input or go to behavior logs and read... there isn't time... since Medical Record notes say "Nurse's Notes" only licensed nurses document... direct care staff makes notes on communication logs or behavior sheets but not in the Medical records... The Administrator failed to ensure #6's record contained 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. - Review of record revealed #2 admitted 3/09/13 with diagnoses of Alzheimer's and Diverticulitis.	S3261		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046086	A. BUILDING: _____ B. WING _____	02/02/2017

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S3261	Continued From page 39 The current functional capacity screen of 4/01/16 assessed #2 with a need for physical assistance with bathing, dressing, toileting, transfers, mobility; unable to perform medication and treatment management; with frequent bladder incontinence; with impaired communication; with Falls/unsteadiness, Impaired short memory, long term memory, memory recall, and impaired decision making. The medical record contained a 4/01/16 Elopement Risk Evaluation Tool - score of "8" (6-15 required Additional Negotiated Risk Agreement). The medical record contained a 4/01/16 Fall Risk Evaluation Tool - score of "13" (6 or more required Additional Shared Risk Agreement. Elopement and falls not addressed in the current NSA (negotiated service agreement)/HSP of 4/01/16. The NSA/HSP documented physical assistance with bathing, supervision with dressing, stand by assistance with transfers and mobility, reminders and redirection for orientation, staff management of medications, and some physical assistance with toileting. By interview on 01/24/17 at 11:23am, Administrator #F stated last evening #3's family member came running up the hallway (of Assisted Living)... said somebody had gotten out of MC - #2... had made turn in hall when aide #Q (from MC) got to #2... aide #Q was in bathroom with #3... heard the alarm... never heard door hit wheelchair of #2 (as wheelchair getting through door way auto close door most likely would have hit or come to rest on wheelchair during process)... just heard the alarm... By review of written facility investigation on 01/31/17 noted: On 11/23/17 (actual date 01/23/17) at 7:15pm a MC Resident's family member came into Executive Director (ED) office... saying a	S3261		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046086	A. BUILDING: _____ B. WING _____	02/02/2017

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S3261	Continued From page 40	S3261		

Resident had escaped MC... ED observed #2 coming around corner... approximately one minute later aide #Q came into AL to get #2... per aide #Q statement the alarm did not sound...
The Medical Record Nurse's Notes lacked any information or reference to this event. The record lacked the date, time, signs or symptoms (assessment), actions taken, and results of the actions taken.
By interview on 01/25/17 at 4:05pm, Administrator #F and Resident Care Director #D confirmed medical record lacked required documentation details.
The Administrator failed to ensure #2's record contained 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.

- Review of record revealed #3 admitted to facility 3/11/16 with a diagnosis of Alzheimer's.

The Functional Capacity Screen (FCS) dated 3/11/16 assessed #3 in need of physical assistance with toileting; required supervision with transfers, and mobility; with frequent bladder incontinence; with impaired short term memory, long term memory, memory recall, and decision making; with impaired communication; Current or recent problems identified as falls/unsteadiness, wandering, and impaired decision making.
A revised FCS dated 4/01/16 recorded #3 now independent with toileting, transfer, mobility.

Fall Risk Evaluation Tools of 3/11/16, 8/23/16 and 12/23/16, and Elopement Risk Tools of 3/14/16, 4/01/16, 8/23/16, and 12/23/16 each identified #3 at higher risk of elopement attempts and falls.
The NSA/HSP dated 3/11/16 lacked interventions or services to address risk for falls or elopement

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S3261	Continued From page 41	S3261		

risk. The revised NSA/HSP dated 4/1/16 continued to lack interventions to address the risk for falls or elopement risk.
The NSA/HSP documented services to be provided to meet needs of bathing, dressing, toileting, re-orientation, and medication management.

Behavior Monitoring Notes of Memory Care unit documented:

01/11/17 - third shift... #3 tried to get out a few times... and grabbed my arm for blocking the door...

01/16/17 - wandering... did set off alarm two times...

01/18/17 and 01/19/17 - #3 was trying to get out twice...

MAR (medication administration record) of December 2016 documented:

12/25/16 - 1700 - Memantine 10mg (milligrams) po (by mouth) "out of building" - scheduled times of this medication on front of MAR at 0900 and 2000

Medical Record Nurse's Notes (NN) lacked any information regarding the above behaviors 01/11/17, 01/16/17, 01/18/17.

Medical Record NN lacked any documentation regarding the medication entry at 1700 on 12/25/16.

By review, Medical Record NN last page of documentation contained an entry 12/02/16 - 1500 - "Resident stable... no behaviors

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S3261	Continued From page 42 today... went with spouse to lunch." The next and final NN entry: 01/04/17 - 0800 - eyes with drainage... eye lids red... called spouse and fax to physician... By interview on 01/24/17 at 2:20pm, Unit Manager #G confirmed no NN documentation available from 12/02/16 to 01/04/17, and from 01/04/17 to 01/24/17... #G stated only the nurses chart in the record... we communicate to them what goes on and then they decide whether to chart... The Administrator failed to ensure #3's record contained 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.	S3261		