

Kansas Department on Aging

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N023025 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____ | (X3) DATE SURVEY COMPLETED C 03/20/2025 |
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| NAME OF PROVIDER OR SUPPLIER CEDARHURST OF LAWRENCE | STREET ADDRESS, CITY, STATE, ZIP CODE 4450 BAUER FARM DRIVE LAWRENCE, KS 66049 |
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| S 000 | INITIAL COMMENTS The following citations represent the findings of an abbreviated survey for complaints # 193130, 192978, 192903, 192698, 192303, 191652, and 190952 of the above named assisted living facility conducted 03/18/25-03/20/25. | S 000 | | |
| S3026 SS=J | 26-41-101 (f) (1) Staff Treatment of Residents ANE (f)The administrator or operator shall ensure that all of the following requirements are met: (1) No resident shall be subjected to any of the following: (A) Verbal, mental, sexual, or physical abuse, including corporal punishment and involuntary seclusion; (B) neglect; or (C) exploitation. This REQUIREMENT is not met as evidenced by: KAR 26-41-101(f)(1)(B) The facility reported a census of 60 residents with five focused record reviews and five closed record reviews. Based on observation, interview, and record review the administrator failed to protect cognitively impaired Resident (R)4 from neglect when he exited the building unnoticed through an inactivated alarmed door. A staff member found him approximately 17 minutes later in the facility parking lot. This placed R4 in Immediate Jeopardy. Findings included: | S3026 | | |

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

TITLE

(X6) DATE

Kansas Department on Aging

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| S3026 | <p>Continued From page 1</p> <p>- Record review for R4 revealed an admission date of 11/25/24 with a diagnosis of mild cognitive impairment.</p> <p>The 12/30/24 "Functional Screen" (FCS) identified R4 required supervision with transfers, walking/mobility, and used a walker; he had short-term and long-term memory, memory/recall, and decision-making difficulties; and he had socially inappropriate disruptive behavior and impaired decision-making.</p> <p>The 12/30/24 "Individualized Service Plan/LOC" which is the facility's Negotiated Service Agreement and Healthcare Service Plan documented R4 needed to be watched closely with transfers and escorting with the "resident" listed as being responsible. The NSA/HSP directed community staff to keep R4 occupied in activities to keep safe from sundowning and mood swings. Staff were to check on R4 every hour. The NSA/HSP documented R4 had a history of elopement and staff should monitor for changes in behavior and report to nurse.</p> <p>The 12/30/24 "Move into MC" (memory care) assessment included an "Elopement Risk" assessment which documented R4 a high risk with 49 points. 16 points or more is high-risk category. The assessment selected no for past history of elopement and no for wanders.</p> <p>The 01/11/25 at 05:15 PM "Observation" note by Certified Medication Aide (CMA) E documented R4 was exit seeking through the memory care door.</p> <p>The "Observations" for R4 included a 01/13/25 at</p> | S3026 | | |

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| S3026 | <p>Continued From page 2</p> <p>08:59 PM "Incident Report (Elopement)" alert by Administrative Nurse B which lacked documentation of incident, date, time, actions taken, and results of action.</p> <p>R4's record lacked documentation of incident involving his elopement on 01/13/25.</p> <p>The facility's "Investigation" signed 01/17/25 by Administrative Staff A reported R4 was not in his room at 08:00 PM. Staff examined memory care rooms, assisted living, and then outside when they found him around 08:12 PM among cars in the parking lot. R4 was wearing a coat, sweatpants, and tennis shoes. The temperature was about 20 degrees Fahrenheit (F). R4 was last seen at 07:30 PM. R4 stated he was looking for a car with keys to drive away.</p> <p>The statement by CMA K and included in the facility's "Investigation" reported staff observed the "squack box" was not set which allowed R4 to easily elope.</p> <p>The 01/13/25 statement by CMA E and included in the facility's "Investigation" reported at 08:02 PM she went to R4's room to give R4 his medications. She searched other rooms before calling out a "Silver Alert."</p> <p>The 01/13/25 statement by CNA J and included in the facility's "Investigation" reported when R4's location was not known around bedtime, they searched for about 10 minutes before "Silver Alert" was sent out.</p> <p>Review of the facility's "Resident Roster" provided during the survey revealed ten</p> | S3026 | | |

Kansas Department on Aging

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| S3026 | <p>Continued From page 3</p> <p>residents in the memory care unit and one resident in the assisted living were marked for wandering.</p> <p>Observation on 03/18/25 at approximately 05:00 PM revealed a possible route R4 took from his room approximately 30 steps to exit door. The most direct route from exit door to cars in parking lot was approximately 500 feet. The area around the facility included shopping centers, restaurants, and several other businesses.</p> <p>The weather on 01/13/25 at 07:53 PM according to Wunderground.com was 19 degrees Fahrenheit with a wind speed of 6 mph.</p> <p>On 03/18/25 at 01:56 PM Administrative Staff A stated according to cameras R4 left facility at 07:55 PM on 01/13/25.</p> <p>On 03/18/25 at approximately 04:19 PM CNA F stated the door alarm was not set so it did not ring when R4 exited building.</p> <p>On 03/18/25 at approximately 02:47 PM R4's family member stated she was under the impression that the door had malfunctioned but the next morning it was working properly. She stated R4 was not able to recall events of that night in the days following.</p> <p>On 03/19/25 at 04:53 PM Administrative Staff A responded via email R4 was returned to the facility at 08:14 PM on 01/13/25.</p> <p>On 03/20/25 at approximately 11:40 AM CMA C stated R4 walked and wandered a lot from admission, and it increased when he was moved</p> | S3026 | | |

Kansas Department on Aging

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| S3026 | <p>Continued From page 4</p> <p>into memory care, likely due to wife not being there to direct him.</p> <p>The 06/13/23 facility's "Elopement Risk" policy documented personalized approaches to prevent elopement were in the "Individualized Service Plan."</p> <p>The administrator failed to protect cognitively impaired Resident (R)4 from neglect when he exited the building unnoticed through an inactivated alarmed door and was found 17 minutes later.</p> <p>On 03/20/25 the facility's "Abatement Plan" was accepted by the department at 02:43 PM which included:</p> <ol style="list-style-type: none"> 1. Facility staff completed every 15-minute safety checks until 01/14/25 when he was admitted to hospital. 3. R4's elopement risk assessment was updated. 4. R4's Elopement Root Cause Analysis was completed on 01/14/25. 5. Referral sent to behavioral health facility on 01/15/25 due to increased need, agitation, and elopement. 6. Environmental Services Director completed door checks three times per week to ensure proper functionality. 7. Missing Resident Drills completed 01/14/25 at 10:58 AM involving seven staff, 01/14/25 at 02:34 PM involving an additional seven staff, and 01/15/25 at 01:12 PM involving staff who had already completed a drill. 8. Missing Resident In-Service completed on 01/16/25 involving all staff. 9. Missing Resident In-Service and elopement | S3026 | | |
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| S3026 | Continued From page 5 drill completed on 02/20/25 involving all staff. 10. Daily walking rounds completed by Director of Nursing or designee to ensure exit door was properly functioning since 02/15/25. 11. Alzheimer's and Dementia Training completed on 02/05/25 for all staff. 12. Elopement Risk assessments completed on all residents in memory care unit. 13. Redirection training completed 02/04/25-02/06/25 for memory care staff. 14. Director of Nursing or designee will complete elopement drills each shift for one week, once per week for four weeks and then monthly ongoing. 15. Monthly in-service trainings conducted including missing resident and elopement training. 16. Director of Nursing or designee will ensure door checks completed and signed off each shift for next four weeks. | S3026 | | |
| S3082 SS=E | 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 ' s is accurately reflected on that resident ' s screening form. This REQUIREMENT is not met as evidenced by: KAR 26-41-201(d) The facility reported a census of 60 residents with five focused record reviews and five closed record reviews. Based on interview and record review the administrator failed to ensure | S3082 | | |

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| S3082 | <p>Continued From page 6</p> <p>designated facility staff documented the "Functional Capacity Screen" (FCS) accurately on the functional capacity screening form for Resident (R) 3, R4, and R5.</p> <p>Findings included:</p> <ul style="list-style-type: none"> - Record review for R3 revealed an admission date of 10/21/24 with diagnoses of dementia, pseudobulbar affect, and Pick's disease. <p>The 11/04/24 Functional Capacity Screen (FCS) identified R3 required supervision with transfers and walking/mobility and used no assistive devices; he had short-term and long-term memory, memory/recall, and decision-making difficulties; and he had inappropriate disruptive behavior and impaired decision-making. The FCS failed to document R3's problem of wandering.</p> <p>The 11/04/24 "Individualized Service Plan/LOC" which is the facility's Negotiated Service Agreement and Healthcare Service Plan (NSA/HSP) documented R3 had no behaviors, was a high elopement risk, and had a history of wandering. Staff were to redirect if seen at an exit door.</p> <p>Review of R3's record revealed an "Elopement Risk" assessment completed 11/04/24 which documented "yes" for wanders.</p> <p>Review of "Observations" for R3 revealed daily exit seeking from 10/25/24 to 10/28/24.</p> <p>On 03/20/25 at approximately 11:40 AM Certified Medication Aide C stated R3 wandered</p> | S3082 | | |

Kansas Department on Aging

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| S3082 | <p>Continued From page 7</p> <p>frequently from admission to discharge.</p> <p>On 03/20/25 at approximately 12:42 PM Administrative Nurse B confirmed R3's FCS failed to identify his wandering problem.</p> <p>- Record review for R4 revealed an admission date of 11/25/24 with a diagnosis of mild cognitive impairment.</p> <p>The 02/11/25 "Functional Screen" (FCS) identified R4 required supervision with transfers, walking/mobility, and used a walker; he had short-term and long-term memory, memory/recall, and decision-making difficulties; and he had socially inappropriate disruptive behavior and impaired decision-making. The FCS failed to document R3's problem of wandering.</p> <p>The 02/11/25 NSA/HSP documented R4 needed to be watched closely with transfers and escorting with the "resident/self" being responsible for this service. The NSA/HSP directed community staff to keep occupied in activities to keep safe from sundowning and mood swings. The NSA/HSP documented R4 had a history of elopement and staff should monitor for changes in behavior and report to nurse.</p> <p>Review of R4's record revealed Administrative Nurse B created incident report for elopement on 01/13/25.</p> <p>On 03/20/25 at approximately 11:40 AM CMA C stated R4 walked and wandered a lot from admission, and it increased when he moved into</p> | S3082 | | |

Kansas Department on Aging

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| S3082 | <p>Continued From page 8</p> <p>memory care.</p> <p>On 03/20/25 at approximately 12:42 PM Administrative Nurse B confirmed R4's FCS failed to identify his wandering problem.</p> <p>- Record review for R5 revealed an admission date of 11/22/24 with a diagnosis of Alzheimer's disease.</p> <p>The 12/27/24 FCS failed to document R5's impaired vision.</p> <p>The 12/27/24 NSA/HSP documented R5 had visual deficits and required assistance from staff with walker for prevention of falls and direction of eating utensils.</p> <p>Review of 12/27/24 "Fall Risk" assessment revealed Administrative Nurse B documented R5 had visual deficit.</p> <p>On 03/20/25 at approximately 12:42 PM Administrative Nurse B confirmed R5's FCS failed to identify her impaired vision.</p> <p>The facility's undated "Assessment (KS)" policy stated the facility assessed it residents according to state regulations or procedures in the policy whichever is more stringent. Each resident was assessed prior to admission with the appropriate state-specific assessment tool.</p> <p>The administrator failed to ensure designated facility staff documented the FCS accurately on the functional capacity screening form for Resident (R) 3, R4, and R5.</p> | S3082 | | |

Kansas Department on Aging

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| S3085 | Continued From page 9 | S3085 | | |
| S3085 SS=E | <p>26-41-202 (a) Negotiated Service Agreement</p> <p>(a) The administrator or operator of each assisted living facility or residential health care facility shall ensure the development of a written negotiated service agreement for each resident, based on the resident ' s functional capacity screening, service needs, and preferences, in collaboration with the resident or the resident ' s legal representative, the case manager, and, if agreed to by the resident or the resident ' s legal representative, the resident ' s family. The negotiated service agreement shall provide the following information:</p> <p>(1) A description of the services the resident will receive;</p> <p>(2) identification of the provider of each service; and</p> <p>(3) identification of each party responsible for payment if outside resources provide a service.</p> <p>This REQUIREMENT is not met as evidenced by: KAR 26-41-202(a)(1)(2)</p> <p>The facility reported a census of 60 residents with five focused record reviews and five closed record reviews. Based on interview and record review the administrator failed to ensure the Negotiated Service Agreement was fully developed based on the resident's Functional Capacity Screen (FCS), service needs, and preferences for resident (R)2, R3, R4 and R10 including a description of the services the resident received and the provider of each service.</p> | S3085 | | |

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| S3085 | <p>Continued From page 10</p> <p>Findings included:</p> <ul style="list-style-type: none"> - Record review for R2 revealed an admission date of 09/30/24 with diagnoses of vascular dementia, depression, anxiety, Alzheimer's disease, neurocognitive disorder with Lewy bodies, and impulse disorder. <p>The 09/30/24 Functional Capacity Screen (FCS) identified R2 required physical assistance with bathing, dressing, toileting; was unable to perform management of medications and treatments; was usually continent of bladder; was independent with transfers and walking/mobility and used no assistive devices; he had short-term and long-term memory, memory/recall, and decision-making difficulties; usually understood and was able to understand; and he was at risk for falls, wandering and had impaired decision-making.</p> <p>The 02/04/25 "Individualized Service Plan/LOC" which is the facility's Negotiated Service Agreement and Healthcare Service Plan (NSA/HSP) failed to document interventions for impaired decision making.</p> <p>Review of nurse note dated 02/08/25 at 04:30 PM revealed the resident was resistant to taking medications but when given option to take medications on spoon and drink water with straw, R2 completed task.</p> <p>On 03/20/25 at approximately 11:42 AM Certified Medication Aide (CMA) C stated staff gave R2 options, for example, holding out two pairs of pants or if not eating, would bring a different food options.</p> | S3085 | | |

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| S3085 | <p>Continued From page 11</p> <p>On 03/20/25 at approximately 12:47 PM Administrative Nurse B confirmed R2's NSA failed to describe the services provided for impaired decision making and toileting, bathing, and eating and lacked provider of service.</p> <p>The administrator failed to ensure R2's NSA described the services he received, and the provider of the services based on his FCS.</p> <p>- Record review for R3 revealed an admission date of 10/21/24 with diagnoses of dementia, pseudobulbar affect, and Pick's disease.</p> <p>The 12/17/24 FCS identified R3 required assistance with bathing, dressing, and management of medications and treatments; supervision with transfers and walking/mobility and used no assistive devices; was usually continent of bladder; had short-term and long-term memory, memory/recall, and decision-making difficulties; was rarely or never understood or understandable with communication; and he had inappropriate disruptive behavior and impaired decision-making. The FCS failed to document R3's problem of wandering.</p> <p>The 12/17/24 NSA/HSP documented R3 had no behaviors. The NSA/HSP lacked services and provider of service for communication, inappropriate behaviors, and impaired decision making.</p> <p>Review of nurse note dated 12/11/24 at 04:00 PM revealed R3 entered into other residents' rooms.</p> | S3085 | | |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
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| S3085 | <p>Continued From page 12</p> <p>On 03/20/25 at approximately 11:42 AM CMA C stated staff communicated with R3 using simple questions and simple directions. CMA C stated his inappropriate behaviors included wandering into other resident apartments and aggression toward other residents and staff.</p> <p>On 03/20/25 at approximately 12:47 PM Administrative Nurse B confirmed R3's NSA failed to describe the services provided and provider of service for communication, inappropriate behavior, and impaired decision making.</p> <p>The administrator failed to ensure R3's NSA described the services he received, and the provider of the service based on his FCS.</p> <p>- Record review for R4 revealed an admission date of 11/25/24 with a diagnosis of mild cognitive impairment.</p> <p>The 12/30/24 FCS identified R4 required supervision with transfers, walking/mobility, and used a walker; he had short-term and long-term memory, memory/recall, and decision-making difficulties; and he had socially inappropriate disruptive behavior and impaired decision-making.</p> <p>The 12/30/24 NSA/HSP failed to document service and provider of service for impaired decision making.</p> <p>On 03/20/25 at approximately 12:47 PM Administrative Nurse B confirmed R4's NSA failed to describe the services provided and</p> | S3085 | | |

Kansas Department on Aging

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N023025 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____ | (X3) DATE SURVEY COMPLETED C 03/20/2025 |
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| S3085 | <p>Continued From page 13</p> <p>provider of service for impaired decision making.</p> <p>The administrator failed to ensure R4's NSA described the services he received, and the provider of the service based on his FCS.</p> <p>- Record review for R10 revealed an admission date of 09/17/24 with diagnoses of dementia and mild cognitive impairment.</p> <p>The 01/18/25 FCS identified R10 required physical assistance with bathing, dressing, toileting, transferring, and management of medications and treatments; had short-term memory, long-term memory, memory/recall, and decision-making difficulties; was incontinent of bladder; and was at risk of falls and had impaired decision making.</p> <p>The 01/18/25 NSA/HSP documented R10 received frequent reassurance, redirection, and was reminded of importance of cares for cognition and impaired decision-making without listing the provider of the services.</p> <p>On 03/20/25 at approximately 12:47 PM Administrative Nurse B confirmed R10's NSA failed to explain the provider of service for cognition and impaired decision-making services.</p> <p>The administrator failed to ensure R10's NSA described the provider of services based on his FCS.</p> | S3085 | | |
| S3155 SS=J | <p>26-41-204 (a) Health Care Services</p> <p>. (a) The administrator or operator in each assisted living facility or residential health care</p> | S3155 | | |

Kansas Department on Aging

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| S3155 | <p>Continued From page 14</p> <p>facility shall ensure that a licensed nurse provides or coordinates the provision of necessary health care services that meet the needs of each resident and are in accordance with the functional capacity screening and the negotiated service agreement.</p> <p>This REQUIREMENT is not met as evidenced by: KAR 26-41-204(a)</p> <p>The facility reported a census of 60 residents with five focused record reviews and five closed record reviews. The facility identified nine residents at risk for elopement and resided on a locked memory care unit. Based on observation, interview, and record review the administrator failed to ensure a licensed nurse provided the necessary health care services that met the needs of Resident (R) 3 by the failure to include interventions for safety when they failed to secure a window R3 could manipulate, in his "Negotiated Service Agreement" (NSA). R3 exited the building through his room window without staff knowledge and was unaccounted for by staff for approximately 14 minutes. An off-duty staff member found R3 at least 0.6 miles away from the facility in a busy parking lot. This placed R3 in Immediate Jeopardy.</p> <p>Findings included:</p> <ul style="list-style-type: none"> - Record review for R3 revealed an admission date of 10/21/24 with diagnoses of dementia, | S3155 | | |
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Kansas Department on Aging

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| S3155 | <p>Continued From page 15</p> <p>pseudobulbar affect, and Pick's disease.</p> <p>The 09/26/24 Functional Capacity Screen (FCS) identified R3 was independent with transfers and walking/mobility and used no assistive devices; he had short-term and long-term memory, memory/recall, and decision-making difficulties; and he had inappropriate disruptive behavior and impaired decision-making.</p> <p>The 10/23/24 "Individualized Service Plan/LOC" which is the facility's Negotiated Service Agreement and Healthcare Service Plan documented R3 had no behaviors, was a high elopement risk, and had a history of wandering. Staff were to redirect if seen at an exit door.</p> <p>The 10/23/24 "Initial Assessment" included an "Elopement Risk" assessment which documented R3 a high risk with 26 points. 16 points or more is high-risk category. The assessment selected no for past history of elopement, yes for wanders, no for sundowning, and no for inappropriate behavior.</p> <p>The 10/25/24 at 06:30 PM "Observation" note by Certified Nurse Aide (CNA) G documented R3 was exit seeking through the kitchen.</p> <p>The 10/26/24 at 05:30 PM "Observation" note by Certified Medication Aide (CMA) E documented R3 exited the unit and then the facility's front door before staff redirected.</p> <p>The 10/27/24 at 04:45 PM "Observation" note by CMA C documented R3 left the unit at 02:20 PM through the "side door" and made it across the street before redirected by staff back to the unit.</p> | S3155 | | |

Kansas Department on Aging

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| S3155 | <p>Continued From page 16</p> <p>The 10/28/24 at 05:15 PM "Observation" note by CNA H documented R3 was exit seeking and agitated.</p> <p>The 11/04/24 at 02:15 PM "Observation" note by CMA C documented R3 was trying to enter the kitchen at 12:50 PM.</p> <p>The 11/04/24 at 02:15 PM "Observation" note by CNA D documented R3 was pacing around the community at 12:50 PM.</p> <p>The 11/04/24 at 02:15 PM "Observation" note by CMA E documented she last saw R3 around 01:30 PM pacing around the building and looking out the windows in the living room area.</p> <p>R3's record lacked documentation of incident involving his elopement on 11/04/24.</p> <p>The undated facility's "Investigation" signed 11/06/24 by Administrative Staff A reported R3 resided in the facility's memory care unit. He was found approximately 0.5 miles from the community. He had removed the window, casing, and screen in his room allowing exit from his apartment. At the time of the elopement, it was 61 degrees, overcast, and rainy.</p> <p>The 11/04/24 "Witness Statement" by CMA I and included in the facility's "Investigation" reported she was leaving a local store parking lot at 01:44 PM when she saw R3. She called Administrative Staff A and stayed with R3 until other staff and R3's wife arrived to get him back to facility.</p> <p>Review of the facility's "Resident Roster"</p> | S3155 | | |

Kansas Department on Aging

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| S3155 | <p>Continued From page 17</p> <p>provided during the survey revealed ten residents in the memory care unit and one resident in the assisted living were marked for wandering.</p> <p>Observation on 03/18/25 at approximately 05:00 PM revealed a possible route R3 took from his room window to location found. The most direct route was around front of facility, along 25 mile per hour (mph), two lane road, around a round-about, and between businesses including their parking lots. Other possible routes include a 40 mph four-lane road or 30 mph two-lane road. All routes include crossing a 45 mph four lane road with turning lanes. These routes range from 0.6 to 0.7 miles in distance. All routes include stop signs but no crosswalks. The area between the facility and the parking lot where R3 was found included a wide grassy area lined with trees, shopping centers, restaurants, and several other businesses.</p> <p>The weather on 11/04/25 at 01:30 PM according to Wunderground.com was 61 degrees Fahrenheit with a wind speed of 6 mph.</p> <p>On 03/18/25 at 11:31 AM CMA C stated all residents that wandered, or sought exits were "redirected away from door."</p> <p>On 03/18/25 at 04:14 PM CNA F stated she was unaware R3 was out of the facility until CMA I called to say she was with R3 outside the facility. CNA F stated she saw the screen out of his window in his room after the incident. CNA F stated R3 would put his coat on and that was his sign he wanted to leave.</p> | S3155 | | |

Kansas Department on Aging

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| S3155 | <p>Continued From page 18</p> <p>On 03/19/25 at 09:18 AM R3's family member stated she had told staff repeatedly to watch the resident and his window. She stated the facility staff were well aware that he had been "messaging with the window and he knew how to remove the child locks and get the screen off."</p> <p>On 03/19/25 at 04:53 PM Administrative Staff A responded via email R3 was returned to the facility at 02:25 PM on 11/04/24.</p> <p>On 03/20/25 at 03:18 PM CNA J stated R3's family stated R3 had taken apart windows at his home and that was the reason he was moved to facility.</p> <p>The 06/13/23 facility's "Elopement Risk" policy documented personalized approaches to prevent elopement were in the "Individualized Service Plan."</p> <p>The administrator failed to ensure a licensed nurse provided the necessary health care services that met the needs of Resident (R) 3 by the failure to include interventions for safety when they failed to secure a window R3 could manipulate in his "Negotiated Service Agreement" (NSA).</p> <p>On 03/20/25 the facility's "Abatement Plan" was accepted by the department at 02:43 PM which included:</p> <ol style="list-style-type: none"> 1. Facility staff moved R3 to interior facing apartment. 2. Facility staff completed every 15-minute safety checks during waking hours until 12/11/24 [sic]. 3. R3's elopement risk assessment was | S3155 | | |
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Kansas Department on Aging

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| S3155 | Continued From page 19 updated. 4. R3's Elopement Root Cause Analysis was completed on 11/04/24 [sic]. 5. Staffing was increased, and one-to-one attention given to R3 starting on 12/11/24 [sic]. 6. Environmental Services Director monitored all windows in Memory Care to ensure proper stopping, weekly for four weeks, then monthly for six months, then quarterly ongoing. 7. Monthly in-service trainings conducted including missing resident and elopement training. | S3155 | | |
| S3200 SS=E | 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 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: | S3200 | | |

Kansas Department on Aging

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| S3200 | <p>Continued From page 20</p> <p>KAR 26-41-205(d)</p> <p>The facility reported a census of 60 residents with five focused record reviews and five closed record reviews. Based on interview and record review the administrator failed to ensure facility staff administered all medications to Resident (R) 1, R3, and R4 in accordance with their medical care provider's orders, professional standards of practice, or the manufacturer's recommendations.</p> <p>Findings included:</p> <ul style="list-style-type: none"> - Record review for R1 revealed an admission date of 08/17/24 with diagnoses of dementia, hypothyroidism, constipation, and gastroesophageal reflux disease. <p>The 10/09/24 "Functional Capacity Screen" (FCS) identified R1 required physical assistance with management of medications.</p> <p>The 10/09/24 "Negotiated Service Agreement" identified facility staff would provide R1 assistance with management of medications.</p> <p>The 10/09/24 medical provider's order for gabapentin 100 milligram (mg) was to take one tablet by mouth three times a day.</p> <p>The 10/19/24 medical provider's order for quetiapine 50 mg was to take one tablet by mouth three times a day for 30 days.</p> <p>Review of the November 2024 "Medication Administration Record" (MAR) revealed R1 was not administered gabapentin or quetiapine at</p> | S3200 | | |

Kansas Department on Aging

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| S3200 | <p>Continued From page 21</p> <p>02:00 PM on 11/14/24, 11/19/24, or 11/21/24.</p> <p>Review of R1's medication administration revealed staff failed to administer medications per medical care provider's orders.</p> <p>- Record review for R3 revealed an admission date of 10/21/24 with diagnoses of dementia, pseudobulbar affect, and Pick's disease.</p> <p>The 12/17/24 FCS identified R3 was unable to perform management of medications.</p> <p>The 12/17/24 NSA identified facility staff would manage R3's medications.</p> <p>The December 2024 MAR instructed staff to administer morning medications including magnesium, sertraline, stool softener, vitamin D3, vitamin B12, buspirone, and divalproex at 08:00 AM.</p> <p>Review of 11/01/24 to 12/31/24 "Med Pass History" for R3 revealed his 08:00 AM scheduled medications were administered as follows: 14 of 61 days medications were given between 09:00 AM and 10:00 AM 14 of 61 days medications were given between 10:00 AM and 11:00 AM 12 of 61 days medications were given between 11:00 AM and 12:00 PM 5 of 61 days medications were given between 12:00 PM and 01:00 PM 1 of 61 days medications were given between 02:00 PM and 03:00 PM</p> <p>Review of R3's medication administration times revealed staff failed to administer 08:00 AM</p> | S3200 | | |

Kansas Department on Aging

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| S3200 | <p>Continued From page 22</p> <p>medications when scheduled.</p> <p>- Record review for R4 revealed an admission date of 11/25/24 with a diagnosis of mild cognitive impairment.</p> <p>The 02/11/25 FCS identified R4 required physical assistance with management of medications.</p> <p>The 02/11/25 NSA identified facility staff would assist R4 with all aspects of medications.</p> <p>The February 2025 MAR instructed staff to administer morning medications to R4 including omeprazole, aspirin, divalproex, escitalopram, gabapentin, and risperidone at 08:00 AM.</p> <p>Review of 02/01/25 through 03/01/25 "Med Pass History" for R4 revealed his 08:00 AM scheduled medications were administered as follows: 6 of 29 days medications were given between 09:00 AM and 10:00 AM 6 of 29 days medications were given between 10:00 AM and 11:00 AM 1 of 29 days medications were given between 11:00 AM and 12:00 PM 2 of 29 days medications were given between 12:00 PM and 01:00 PM</p> <p>On 02/23/25 the 08:00 AM scheduled medications were not charted. The 02:00 PM divalproex and gabapentin were documented as not given due to "morning medications just given." 16 of 29 days (55% of days) medications were administered outside the expected time frame.</p> | S3200 | | |

Kansas Department on Aging

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| S3200 | <p>Continued From page 23</p> <p>Review of R4's medication administration times revealed staff failed to administer 08:00 AM medications when scheduled.</p> <p>On 03/20/25 at 02:15 PM Administrative Staff A confirmed R4's medication administration times were consistently outside the expected time frame.</p> <p>- Record review for R10 revealed an admission date of /24 with diagnoses of dementia and mild cognitive impairment.</p> <p>The 01/18/25 FCS identified R10 required physical assistance with management of medications.</p> <p>The 01/18/25 NSA identified facility staff would assist R10 with all aspects of medications.</p> <p>Review of the February 2025 MAR for R10 revealed brimonidine eye solution, donepezil, lansoprazole, timolol eye solution, and latanoprost eye solution were ordered to be given at 07:00 PM and were not administered on 02/05/25, 02/17/25, and 02/20/25.</p> <p>On 03/18/25 at 04:20 PM Administrative Nurse B confirmed the medications with blanks on the MARs for R1 and R10. She stated her understanding was the medications were not given.</p> <p>On 03/20/25 at 03:18 PM Certified Medication Aide C confirmed that R4's medications were consistently outside the administration timeframe and that the expectation was for medications to be administered in a two-hour time from one hour</p> | S3200 | | |

Kansas Department on Aging

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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 |
|--------------------|--|---------------|---|--------------------|
| S3200 | Continued From page 24 before to one hour after time listed on MAR. On 03/20/25 at 03:54 PM Administrative Staff A stated that the expectation was for medications to be administered within a one hour before or one hour after time on MAR. The facility's 09/27/24 "Medication Administration" policy failed to instruct staff on expected administration time frame. The administrator failed to ensure facility staff administered all medications to R1, R3, R4, and R10 in accordance with their medical care provider's orders, professional standards of practice, or the manufacturer's recommendations. | 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)(11) The facility reported a census of 60 residents with five residents included in the sample and five closed record reviews. Based on interview and record review the administrator failed to ensure licensed staff documented all incidents, | S3261 | | |

Kansas Department on Aging

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N023025 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____ | (X3) DATE SURVEY COMPLETED C 03/20/2025 |
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| S3261 | <p>Continued From page 25</p> <p>symptoms, and other indications of illness or injury including the date and time of occurrence, action taken, and results of the action when Resident (R) 2 had a resident-to-resident altercation, R3 eloped, and R4 eloped.</p> <p>Findings included:</p> <ul style="list-style-type: none"> - Record review for R2 revealed an admission date of 09/30/24 with diagnoses of vascular dementia, depression, anxiety, Alzheimer's disease, neurocognitive disorder with Lewy bodies, and impulse disorder. <p>The 09/30/24 Functional Capacity Screen (FCS) identified R2 required physical assistance with bathing, dressing, toileting; was unable to perform management of medications and treatments; was usually continent of bladder; was independent with transfers and walking/mobility and used no assistive devices; he had short-term and long-term memory, memory/recall, and decision-making difficulties; usually understood and was able to understand; and he was at risk for falls, wandering and had impaired decision-making.</p> <p>The 02/04/25 "Individualized Service Plan/LOC" which is the facility's Negotiated Service Agreement and Healthcare Service Plan (NSA/HSP) documented R2 received full assist from staff for dressing, was reminded to use bathroom for toileting without provider of service, reminded and provided standby assist with bathing without provider of service, reminder of meal times with no provider, and staff or hospice redirected to room, gave activity or snack for wandering. The NSA/HSP failed to document</p> | S3261 | | |
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Kansas Department on Aging

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| S3261 | <p>Continued From page 26</p> <p>interventions for impaired decision making.</p> <p>The 01/22/25 at 09:06 PM "Incident Report" alert documented resident-to-resident altercation without any further details.</p> <p>Review of R2's record revealed lack of documentation of actions taken or results of action for resident-to-resident incident on 01/22/25.</p> <p>On 03/19/25 at 04:53 PM Administrative Staff A confirmed via email the details of the incident were on an incident report which is not within R2's chart.</p> <p>- Record review for R3 revealed an admission date of 10/21/24 with diagnoses of dementia, pseudobulbar affect, and Pick's disease.</p> <p>The 09/26/24 Functional Capacity Screen (FCS) identified R3 was independent with transfers and walking/mobility and used no assistive devices; he had short-term and long-term memory, memory/recall, and decision-making difficulties; and he had inappropriate disruptive behavior and impaired decision-making.</p> <p>The 10/23/24 NSA/HSP documented R3 had no behaviors, was a high elopement risk, and had a history of wandering. Staff were to redirect if seen at an exit door.</p> <p>The 11/04/24 at 02:30 PM "Observation" note by CNA D documented she had seen R2 pacing around 12:50 PM.</p> <p>The next "Observation" note was 11/19/24 by Licensed Nurse L which documented R2 was exit</p> | S3261 | | |

Kansas Department on Aging

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| S3261 | <p>Continued From page 27</p> <p>seeking.</p> <p>Review of R3's record revealed lack of documentation of all incidents including the date and time of occurrence, action taken, and results of the action when R3 eloped from the facility on 11/04/24.</p> <p>On 03/20/25 at 12:33 PM Administrative Nurse B confirmed R3's record lacked documentation of elopement incident on 11/04/24, actions taken, and results of the action.</p> <p>- Record review for R4 revealed an admission date of 11/25/24 with a diagnosis of mild cognitive impairment.</p> <p>The 12/30/24 FCS identified R4 required supervision with transfers, walking/mobility, and used a walker; he had short-term and long-term memory, memory/recall, and decision-making difficulties; and he had socially inappropriate disruptive behavior and impaired decision-making.</p> <p>The 12/30/24 NSA/HSP documented R4 needed to be watched closely with transfers and escorting with the resident being responsible for this service. The NSA/HSP directed community staff to keep occupied in activities to keep safe from sundowning and mood swings. Staff were to check on R4 every hour. The NSA/HSP documented R4 had a history of elopement and staff should monitor for changes in behavior and report to nurse.</p> <p>The 01/13/25 at 08:59 PM "Incident Report" alert by Administrative Nurse B was an elopement</p> | S3261 | | |

Kansas Department on Aging

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| S3261 | <p>Continued From page 28</p> <p>alert with no further details.</p> <p>Review of R4's record revealed lack of documentation of incident involving his elopement on 01/13/25.</p> <p>On 03/20/25 at 12:33 PM Administrative Nurse B confirmed R4's record lacked documentation of elopement incident on 01/13/25, actions taken, and results of the action.</p> <p>The administrator failed to ensure licensed staff documented all incidents, symptoms, and other indications of illness or injury including the date and time of occurrence, action taken, and results of the action when Resident (R) 2 had a resident-to-resident altercation, R3 eloped, and R4 eloped.</p> | S3261 | | |