STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175242	A. Building B. Wing	04/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakeview Village	13840 W 91st Terrace Lenexa, KS 66215

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 128 residents. The sample included three residents, with three residents reviewed for elopement (when a cognitively impaired resident leaves the facility without the knowledge or supervision of staff). Based on observations, record review, and interviews, the facility failed to ensure staff provided adequate supervision to prevent an elopement for Resident (R) 1 and further failed to provide a thorough search in response to a WanderGuard (sensors that monitor doors and a technology platform that sends safety alerts in real-time) alert. On 04/13/25 at 07:15 PM, R1 who was severely cognitively impaired and at high risk for elopement, set off the WanderGuard alert system. Staff responded to the alarm 36 seconds later but did not see R1. Staff started searching for R1 but did not immediately open the staircase door and search the staircase where the WanderGuard alert system sounded. By the time the staff searched the staircase, R1 had exited the building through the staircase and walked around the sidewalk in the back of the facility. The facility located R1 approximately five to six minutes later near the parking lot on the ground. She had visible injuries including an abrasion to her forehead and right ankle swelling. The facility called an ambulance and R1 was transported to the hospital for evaluation and treatment. She returned later that evening with no fractures. The facility's failure to provide adequate supervision and implement a thorough search in response to the WanderGuard alert placed R1 in immediate jeopardy. Findings included: - R1's Electronic Medical Record (EMR) documented diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), abnormalities of gait and mobility, dementia (a progressive mental disorder characterized by failing memory and confusion), need for assistance with personal care, and restlessness and agitation. R1's Significant Change Minimum Data Set (MDS) dated 09/18/24, documented a Brief Interview for Mental Status (BIMS) was not conducted due to R1 being rarely or never understood. R1 had no behaviors and used a wander alarm daily. R1 was independent with bed mobility, transfers, and walking and had no falls since the last assessment. R1's Quarterly MDS dated 02/26/25, documented R1's BIMS score was 99, which indicated severe cognitive impairment. R1 had rejection of care and wandering behaviors for one to three days in the assessment period. R1 was independent with bed mobility, transfers, and walking and had no falls since the last assessment. The Cognitive Loss/Dementia Care Area Assessment (CAA) dated 09/19/24, documented R1 had short-term and long-term memory deficits and moderately impaired cognitive skills for daily decision-making. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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NAME OF PROVIDER OR SUPPLIER Lakeview Village		STREET ADDRESS, CITY, STATE, ZIP CODE 13840 W 91st Terrace Lenexa, KS 66215	

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Activities of Daily Living (ADL) Functional/Rehabilitation Potential CAA dated 09/24/24, documented R1 required assistance with ADLs and mobility. R1 ambulated independently and used no devices for locomotion. The Falls CAA dated 09/24/24, documented R1's balance was sometimes slightly impaired, and she had wandering behaviors reported almost daily. R1 had two falls since her last MDS. R1's Care Plan dated 12/22/22, documented R1 had problems with remaining safe in her environment due to dementia and a history of wandering. R1's Care Plan documented R1 had a WanderGuard bracelet (a bracelet that helps monitor residents who are at risk of wandering) on her left ankle and staff redirected R1 when she was exit seeking or took a walk. R1's Care Plan dated 03/26/25, documented R1 had an impaired ability to take care of herself and needed help performing ADLs. The plan directed R1 was independent with transfers and ambulation with no devices. R1's Fall Risk assessment, dated 02/26/25 but created on 03/26/25, documented a high fall risk score of 17. R1's Elopement Risk Assessment dated 02/26/25 but created on 03/26/25, documented R1 was at risk for elopement with a score of 10 and wore a WanderGuard bracelet. The facility's Investigation dated 04/18/25, documented on 04/13/25 at 07:31 PM, Administrative Nurse E notified Administrative Staff A and Administrative Nurse D of an incident that occurred. Administrative Nurse E reported that R1 got out of the doors and staff found her in the parking lot; R1 had apparently fallen after losing her balance on the rocks next to the sidewalk. Administrative Nurse E initially reported R1 got out of the facility doors around 07:15 PM and staff responded to the door where her WanderGuard alert sounded. Staff started searching for R1 and when they were unable to find R1, they reported her missing. Staff notified Administrative Nurse E at 07:19 PM and she notified security at 07:20 PM to drive the campus while staff continued to search inside the facility. At approximately 07:21 PM, a staff member stated they saw R1 in the parking lot on the ground and staff headed to her. At about the same time, security noticed R1 and pulled up next to her. It appeared R1 walked around the backside of the building on the sidewalk towards the Independent Living entrance but lost her balance on the rocks near the sidewalk and fell. Upon nursing assessment, the staff called for an ambulance due to possible injuries to R1's ankle. R1 returned a few hours later with no fractures. R1's EMR revealed the following notes: A Nursing Notes dated 04/13/25 at 11:33 PM, documented around 07:10 PM, R1 eloped through the Heritage door. The WanderGuard alarm went off and staff started looking for her. Staff found R1 sitting on the ground, and it appeared R1 fell in the parking area. R1's ankle was swollen. Staff called an ambulance and kept R1 on the ground until the paramedics arrived. The facility notified R1's representative, provider, and hospice. A Nursing Notes dated 04/14/25 at 12:20 AM documented R1 returned to the facility at 11:45 PM, accompanied by R1's representative. R1's representative stated the hospital completed a computed tomography (CT scan - a test that uses X-ray technology to make multiple cross-sectional views of organs, bone, soft tissue, and blood vessels) scan with no abnormal findings. R1 had a forehead contusion (an (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	injury where blood and tissue damage occur beneath the skin without breaking the skin's surface), multiple bruises, and right ankle swelling. On 04/22/25 at 01:42 PM, R1 laid in bed with her eyes closed. Observation revealed an abrasion on her left forehead. Additionally, there was a high back wheelchair in R1's room. On 04/22/25 at 01:48 PM, Administrative Staff A walked the surveyor down the route that R1 took during her elopement on 04/13/25. Per Administrative Staff A, R1 exited through the Heritage stairwell doors that opened after 15 seconds of pushing on them. Observation revealed the Heritage stairwell double doors opened up into a hard-floor staircase with two flights of stairs descended to get to the first level with outside door access. The outside door opened up to the back of the building where generators and Independent Living parking were. The sidewalk from the door turned right towards an Independent Living entrance and there was a staircase to the right side of the sidewalk as one walked towards the entrance. Once past the Independent Living entrance, the sidewalk continued to the left. There were rocks on the right side of the sidewalk and sometimes on the left side as well. A dog park was located near the area R1 was found on the ground. The area where staff located R1 was all parking for the facility with no public streets per Administrative Staff A. On 04/22/25 at 01:58 PM, review of the camera footage provided from R1's elopement on 04/13/25 revealed at 07:14:05 PM, R1 was seen on camera wearing a long-sleeved shirt, pants, and shoes while she walked down the hallway. At 07:14:35 PM, R1 walked around the corner to the Heritage stairwell door and was out of camera view. Certified Nurse Aide (CNA) M exited the kitchen at 07:15:00 PM in response to a door alarm and she went to the elevator door. CNA M and CNA N realized it was the Heritage stairwell door and walked to that door at 07:15:36 PM. It was not seen whether or not the door was opened for staff to check the stairwell for R1. CNA M and CNA N started walking away from the Heritage stairwell door when the nurse walked down the hall asking where R1 was. On the camera, R1 was seen turning the corner of the stairwell at 07:16:17 PM while staff started searching for her. Staff went down the Heritage stairwell door to check for R1 who had already exited the stairwell and was off camera at 07:19:00 PM. There was no camera footage of the area where R1 was found. On 04/22/25 at 01:22 PM, CNA M stated on 04/13/25, she heard the door alarm go off and she called another aide to help assist her as she did not know how to reset the alarm. She stated CNA N typed in the code, but the alarm did not turn off. CNA M stated they looked out of the first door because it had a window but the second door they responded to did not have a window. She stated the door had an alarm code on it, but she did not know what it meant. CNA M stated she did not open the second door to check the stairwell and that was the door R1 exited from. She stated as soon as staff found out R1 was missing, staff immediately started looking. CNA M stated she saw R1 standing outside when she was upstairs and ran outside to find her but went out the wrong door. She stated she last saw R1 about two minutes prior to the alarm going off. CNA M stated R1 walked up and down the halls all the time but she had not seen R1 trying to go out of any doors. On 04/22/25 at 02:18 PM, Administrative Nurse D stated on 04/13/25, she received a call saying there was a fall and an elopement. She stated she arrived at the facility and started trying to figure out what happened while obtaining witness statements. She stated she believed the staff did everything correctly in response to the alarm but there was some confusion on where staff needed to look. She stated she expected staff to open the door and check the stairwell immediately. Administrative Nurse D stated she expected staff to check the back of the [NAME] (nursing tool that gives a brief overview of the care needs of each resident) with the alarm code to see which resident could set the alarm off and if they did not locate that resident, staff were not able to clear the alarm until the (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	resident was found. On 04/22/25 at 02:42 PM, Licensed Nurse (LN) G stated if a WanderGuard alarm went off, the code would show up on the screen with the location of the alarm and staff responded to that location. She stated once at the location, there was a number that staff identified the resident with, and they went through the doors to make sure a resident did not go through those doors. LN G stated once staff found the resident and knew they were safe, they cleared the WanderGuard alarm. She stated if a stairwell door alarm went off and the resident was not immediately seen, the staff were to go through the doors to search for the resident. On 04/22/25 at 04:15 PM, Administrative Staff A stated on 04/13/25, he received a call from Administrative Nurse E about R1 and drove to the facility. Administrative Staff A stated he was not sure what had happened when he arrived, but he started reviewing door codes and cameras. Administrative Staff A stated he expected staff to always check the immediate area and if staff had walked through the door, they could have seen her down the stairs. He stated he expected staff to open the door and search for the resident. The facility's Missing Resident policy, dated 05/18/18, directed the facility staff to act promptly and thoroughly to investigate and determine the whereabouts of any resident who was unable to be located. On 04/22/25 at 04:25 PM Administrative Staff A received a copy of the Immediate Jeopardy [IJ] Template and was informed that the failure to provide adequate supervision to prevent an elopement for R1 placed R1 in immediate jeopardy. The facility put the following interventions into place prior to the onsite visit: The facility sent R1 to the hospital for evaluation and treatment on 04/13/25. The facility completed a post-incident review with immediate education with staff working on 04/13/25. The facility sent out an email and an alert to all staff with education on the elopement on 04/14/25. The facility started ongoing elopement education with all staff on 04/14/25. The facility updated R1's Care Plan on 04/15/25. The facility reviewed the WanderGuard list on 04/15/25. Due to the facility having completed all corrective actions by 04/15/25, prior to the onsite survey event, this deficient practice was cited as past noncompliance at the scope and severity of a J.