STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N023009A	A. BUILDING: _____ B. WING _____	C 02/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRANDON WOODS AT ALVAMAR	1501 INVERNESS DR LAWRENCE, KS 66047

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS The following represent the findings of an abbreviated survey with review of facility report #193599 at the above assisted living conducted on 02/24/25.	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 27 residents with one resident included in the sample. Based on observation, interview, and record review the operator failed to protect one resident from neglect by the failure to ensure staff were aware of what to do when exit alarms are activated. This failure placed Resident (R)1 in Immediate Jeopardy when he exited the facility. R1 walked outside, without proper outerwear, in 34-degree weather, crossed a four-lane road, and was found by law enforcement approximately 95 minutes later 0.3 miles from the facility. Findings included:	S3026		

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

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S3026	Continued From page 1 - Record review for R1 revealed an admission date of 06/17/23 with the following diagnoses: other symptoms and signs involving cognitive functions and awareness, sleep apnea, hypotension, and Parkinson's disease. The 12/30/24 Functional Capacity Screen (FCS) identified R1 required physical assistance with bathing, dressing, and toileting; required supervision with transfers and mobility; was unable to perform management of medications and treatments; was independent with eating; had short term memory, memory/recall, and decision-making cognitive impairments; and was marked for impaired hearing, risk of falls, wandering, socially inappropriate behavior, and impaired decision making. The 12/30/24 "Service Plan Report" which is the facility's combined Negotiated Service Agreement and Healthcare Service Plan (NSA/HSP) identified facility staff would provide assistance with bathing four times a week; assistance with dressing; would administer medications; supervision for safety and decision-making; escort with walking a safe distance; offer to walk with R1 when exit seeking; and staff ensured wander guard in place every shift. The NSA/HSP documented R1 had intermittent confusion, exit seeking behaviors, elopement risk, and had some unpredictable behaviors. R1 wandered continuously, was not to leave the community unescorted, and needed reminded to wear appropriate clothing for being outside. The 02/15/25 "Event Note" at 01:51 PM	S3026		

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S3026	Continued From page 2	S3026		

documented R1 was agitated and showed signs of exit seeking at 08:25 AM. At 08:41 AM the elevator alarm was activated and cleared at 08:44 AM. The CMA at approximately 08:44 AM checked the resident's room and started the elopement protocol. The receptionist on duty at the time reported that she had cleared the alarm but did not see the resident. Police arrived at 09:15 AM and reviewed camera footage showing R1 leaving facility at 08:44 AM with shoes, pants, shirt, and a light jacket. R1 called his daughter at 10:15 AM, she notified the police, who located the resident. R1 returned to the facility at 10:40 AM.

Review of R1's record revealed an elopement risk assessment on 12/29/24 with score of 32 points including points for voicing desire to leave and previous elopement attempts. The assessment documented a score of 10 or greater was considered at risk of elopement.

Review of Certified Medication Aide C's "Statement" revealed R1 was resistant to her suggestions on the morning of 02/15/25. While she was assisting another resident, the elevator alarm was activated, and she knew R1 had stepped on the elevator. When she began investigating, the receptionist said she had not seen R1, and she did not turn off the alarm. Later, the receptionist admitted that she had reset the alarm, but she did not know what the alarm was for.

Review of Unlicensed Staff D's "Statement" revealed she had turned off the alarm but was unaware of the alarm's purpose.

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S3026	Continued From page 3	S3026		

Review of the facility's investigation report submitted to the department stated the plan was to provide elopement training for front desk staff.

Review of "Staff In-Service" for 02/17/25 revealed five front desk staff were trained on what to do during an elopement and more specifically when the wander guard alarm is activated.

Observation on 02/24/25 at 12:23 PM revealed the most probably route R1 took to exit the facility was approximately 180 feet from last seen location to elevator, down two floors which takes approximately 20 seconds, and then 180 feet from elevator door to unlocked door leading to outside. The location R1 was found was 0.3 miles from the facility. R1 would have crossed a 40 miles per hour, 4 lane road to get to location found.

The weather on 02/15/25 according to Wunderground.com was 34 degrees Fahrenheit with a wind speed of 20 miles per hour at 08:53 AM and gusts of up to 30 miles per hour at 09:53 AM.

On 02/24/25 at 12:02 PM Administrative Nurse B stated when she assessed R1 upon his return to the facility, he was very clear with his attempt to find the bus stop and that he had been outside walking around until he called his daughter. Administrative Nurse B stated the receptionist should have waited for the elevator doors to open to see R1 before going to reset the alarm.

On 02/24/25 at 12:09 PM Certified Medication Aide (CMA) C stated she knew R1 was exhibiting

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a different behavior on 02/15/25 because he was fully dressed and had not received assistance with dressing. CMA C stated the receptionist knew she had done something wrong when first questioned about the alarm.

On 02/24/25 at 12:44 PM Administrative Staff A stated her expectation was for staff to visualize the resident who activated alarm and not disarm the alarm until the resident is located.

The facility's "Wandering and Elopement" policy dated 03/19/24 failed to instruct staff for what to do when a wandering alarm was activated.

The operator failed to protect R1 from neglect by the failure to ensure staff were aware of what to do when exit alarms are activated and placed R1 in Immediate Jeopardy when he exited the facility, walked outside, without proper outerwear, in 34-degree weather, crossed a four-lane road, and was found by law enforcement approximately 95 minutes later 0.3 miles from the facility.

The following actions were taken by the facility on or before 02/17/25 to protect the residents:
1. "Reception Staff Training" comprising of steps to complete with resident safety equipment was activated including not disarming the alarm until authorized.
2. "Reception Staff Involvement" will be communicating to other departments and reporting to search leader when a search for missing resident has started.
3. R1 completed planned discharged with his son 02/20/25.