STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N023021	A. BUILDING: _____ B. WING _____	09/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEUVANT HOUSE OF LAWRENCE	1216 BILTMORE DRIVE LAWRENCE, KS 66049

(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 a complaint investigation 182728 at the above named Assisted Living, conducted on 09/18/23 and 09/19/23.	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 13 residents. The facility identified one resident at risk for elopement. Based on observation, interview, and record review the operator failed to ensure resident (R)101 was not subjected to neglect by the failure to ensure implementation of interventions for resident safety. This resulted in immediate jeopardy when cognitively impaired R101 exited the facility through an unalarmed exit door and patio gate without staff knowledge and was unaccounted for by staff for approximately 90 minutes. Findings included:	S3026		

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

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- R101's medical record revealed the resident moved into the facility on 01/11/22 with a diagnosis of dementia.

R101's "Functional Capacity Screen" (FCS) dated 09/01/22 revealed she was independent with transfers and mobility without the use of an assistive device, had a cognitive score of three indicating she was cognitively impaired with short-term memory, memory/recall and decision-making impairments.

R101's "Negotiated Service Agreement/Healthcare Service Plan" (NSA/HCSP) did not include information concerning wandering, elopement risk or other behavioral symptoms.

Resident record lacked an annual FCS/NSA/HCSP which was due on 09/01/23.

Review of R101's medical record revealed the following:

10/01/22 "Incident Note" by Administrative Nurse B documented, "Elopement incident that occurred at approximately 11:45[AM]. Resident went out the back door and made her way out of the gate and rang the doorbell to the front door wanting back into the facility."

03/02/23 "Behavior Note" by Administrative Nurse B documented, "Resident presents with continued confusion and packing her room. DPOA (Durable Power of Attorney) is requesting another UA (urinalysis.)"

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S3026	Continued From page 2 03/02/23 "Health Status Note" by Licensed Nurse (LN) C documented, " ...Resident has had change to mental status recently and has had increased confusion. Obtained urine specimen to send to lab for UA and increased her donepezil (cognition enhancing medication) to 10 mg (milligrams) per PCP (Primary Care Physician) orders." 06/19/23 "Behavior Note" by Administrative Nurse B documented, "Resident presents with confusion, she was in another resident room last night and started to pack her belongings to go home ..." 07/31/23 "Behavior Note" by Administrative Nurse B documented, "Resident was trying to get out of the front door. A staff member let her out so they could go on a walk, in hopes of redirecting her. She wound up more agitated on the walk ...was becoming increasingly aggressive ...She was confused and had no concept of reality at that point ... Upon returning to the building R101's ...Her behaviors ramped up once back into her house and she went to staff and resident asking questions and pacing the hallways ..." 09/09/23 "Incident Note" by LN D documented she was notified by phone at 08:09 PM that R101 was missing from her room in the East building. Staff reported R101 returned from a day trip with her daughter and was confused, agitated, and wanted to leave. Staff reported they last saw R101 when walking her back to her room after supper at approximately 06:30 PM. LN D instructed staff of both buildings to physically	S3026		

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check every room for R101. LN D also instructed two staff to walk the perimeter of the buildings. LN D called Administrative Staff A at 08:30 PM who was able to see on camera footage that R101 left the premises at 06:38 PM out the back gate of the East house. LN D arrived at the facility at 08:30 PM and first drove around the immediate surrounding neighborhood and walked the perimeter of the East house. LN D called 911 at 08:40 PM to report R101 was missing. A call was received from law enforcement at 08:45 PM to notify that an individual meeting the description of R101 was found and transported to a local emergency room approximately 45 minutes prior to this call. The emergency room nurse verified they did have R101 in their care and were in the process of completing a workup due to R101's confusion.

R101 was found in a residential neighborhood approximately 0.5 miles to the Southwest of the facility by some neighbors who saw her walking. They called law enforcement as they were concerned about R101's confusion. R101 was then transported to a local emergency room.

09/09/23 "Incident and Accident Report" completed by "Certified Medication Aide" (CMA) E documented she went to R101's room at about 08:00 PM to give R101 her evening medications but could not find her. CMA E searched the different rooms in R101's apartment but was not able to find her. CMA E asked, "Certified Nurse Aide" (CNA) F if she had seen R101 but CNA F stated she had not. Both CMA E and CNA F then went out the back patio door and checked to see if R101 had gone outside. They were not able to locate R101 in the backyard, so CMA E called LN

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D around 08:09 PM to notify her that R101 was missing.

An observation on 09/18/23 at 02:05 PM revealed the front entrance to the East house required a keypad code to exit the door. There was a sign posted on the door stating, "Push Until Alarm Sounds. Door Can Be Opened in 15 Seconds." The North "Patio" door also required a keypad code to exit the door. There were two signs posted on this door. One stated, "Push Until Alarm Sounds. Door Can Be Opened in 15 Seconds." The second sign stated, "Please press call button for assistance to open door." Security cameras were located at all exit/entrance doors. The back patio and yard were fenced in with a metal fence and there was a sidewalk that led to the Southwest corner of the East building where there was a gate that was latched but not locked.

On 09/19/23 at 04:45 PM review of the facility camera footage from 09/09/23 revealed that at 06:38 PM, R101 was seen walking to the front door. R101 attempted but was not able to open the door. Soon after this R101 was seen on the camera at the rear "Patio" door and exited without any difficulty. About a minute after exiting through the rear "Patio" door R101 was seen exiting the backyard gate and then walked across the lawn in front of the West building and headed West out of the parking area.

An observation on 09/19/23 at 09:20 AM revealed the facility was in a mixed residential/commercial neighborhood with offices and businesses located around the assisted living facility and residential housing located nearby. The streets were paved with concrete

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sidewalks located on both sides of the streets. The speed limit was 25 miles per hour in the residential area and surrounding major roads had speed limits up to 45 miles per hour. The facility is approximately 0.1 miles west of a busy four-lane road, 0.5 miles south of a busy four-lane divided road, 0.5 miles north of a busy four-lane road and 0.5 miles east of a wooded greenway. Weather conditions at the time of the elopement as verified on https://www.wunderground.com/ revealed it was still light outside, the temperature was approximately 83 degrees Fahrenheit, and there was no noted precipitation at that time.

On 09/18/23 at 02:30 PM CMA G stated R101 had tried to leave the facility twice and R101 would pace around at times and would not respond to redirection from staff due to her intense focus on leaving. CMA G stated R101 was not considered an elopement risk prior to these elopements. CMA G stated on the day R101 eloped, R101 had been out of the building with a family member most of the day and was brought back to the facility around supper time. During the supper meal R101 thought she was at a restaurant and stated she needed to go home. Some other residents present during the supper meal voiced their concerns to staff that R101 wanted to leave the facility. Another resident stated R101 asked for the door code to get out. Upon hearing this, CMA G took R101 out to the back patio to talk with her and try to redirect her by reassuring R101 that this was her home and then proceeded to take R101 to her apartment and showed R101 her cat which she recognized. CMA G then went back to the dining room area to assist other residents. CMA G stated R101 was

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S3026	Continued From page 6 being treated for a urinary tract infection at the time. CMA G stated that about 20 minutes after she last saw R101 she gave a report to oncoming nightshift CMA E but failed to complete walking rounds with CMA E and did not make visual contact with each resident. On 09/18/23 at 03:38 PM LN C stated that prior to the elopement incident R101 did not exhibit exit-seeking behaviors. LN C stated R101 had been confused and her dementia seemed to be increasing and had been experiencing sundowning behaviors. LN C stated a family member stated R101 had been calling her multiple times daily because R101 forgot times when the family member was to come and visit her and take her out. LN C stated the back door was currently always locked but learned before the elopement incident the door was on a timer and automatically locked around 09:00 PM. On 09/19/23 at 09:40 AM Administrative Nurse B stated the resident was fiercely independent and would get agitated if staff constantly came to her room to check on her. Administrative Nurse B stated she shared concerns with R101's family member about taking R101 out for all day trips due to her increased confusion where R101 thought she needed to be with her family after being brought back to the facility. Administrative Nurse B stated that prior to the elopement incident there was no indication from R101 that she was an elopement risk and that R101 had never tried to exit seek with the intent of "going home." Administrative Nurse B stated she expected staff to round and visualize all residents at approximately 01:00 AM and 05:00 AM.	S3026		

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S3026	Continued From page 7 On 09/19/23 at 11:37 AM Administrative Staff A stated the paging transmitter, that included the gate that would alert staff that the gate was opened, was not working and has since been replaced. It was discovered on the 09/09/23 at 09:10 PM when a resident asked staff why they were not answering call pendants. Staff stated they were not getting any pages from anyone and that is when they found the paging transmitter was not working. The facility failed to ensure R101 was not subjected to neglect by the failure to ensure implementation of interventions for resident safety. On 09/19/23 at 02:15 PM Administrative Staff A and Administrative Nurse B were informed of the findings, which resulted in immediate jeopardy regarding a cognitively impaired resident exiting the facility, failure of staff to ensure they identified R101 was at risk for elopement and ensure interventions were put into place to keep R101 safe from exiting the building without staff being aware. Administrative Staff A submitted an abatement plan which included the following: 09/09/23 at 09:50 PM- Administrator immediately notified staff on duty to lock back door and remove timer. The door was originally set to open at 07:00 AM and alarm at 09:00 PM. Sign placed on door to remind resident to push pendants to assist with opening door. 09/09/23 at 11:15 PM- Staff on duty notified	S3026		

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Administrator that the paging system was not functioning properly, and pagers were not responding. The facility Administrator directed staff to give individual handheld bells to all residents to be able to call staff.

09/09/23- 15 Minute Rounding for 24-hour period- Immediate upon resident return.

09/10/23 at 02:50 PM- Facility administrator completed state report for incident and sent via email to the state complaint hotline.

09/10/23 at 05:00 PM- East staff notified that the 24-hour mark to keep resident on 30-minute checks until further notice.

09/11/23 at 08:00 AM- The facility administrator notified the paging vendor that the system was not functioning. A new paging transmitter was overnighted to the facility.

09/11/23 at 08:00 AM- The facility DON completed an Elopement Assessment Form. The resident scored 9 (High for Elopement). This triggered a change in care plan. Changes added to new care plan are the following: Adding Elopement Risk for staff to be alerted of this risk. Initiating 30-minute Rounding 24/7. Interventions for behavior: Staff to assist resident outdoors minimum of one time a day for minimum of 15 minutes. This change is weather permitting.

Care Plan Completed 09/11/23 at 11:00 AM. All facility staff notified to review new plan of care.

09/11/23 at 09:00 AM. Teachable Moment for all staff. This included teaching the importance of

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S3026	Continued From page 9 hourly rounding and laying eyes on residents every time. 09/11/23 at 07:00 PM- Corrective coaching for staff who were on duty at the time of elopement for failure to completed hourly rounding and physically laying eyes on the patient. This corrective coaching reset expectations for safety guidelines and proper rounding. 09/11/23 at 10:00 AM- Care Plan Meeting with resident's power of attorney to discuss the implementation of changes that will trigger a new care plan. We reviewed the new Elopement Assessment Form. Discussion was had about the need for a transition from assisted living to memory care when there is a room available. The Director of Nursing (DON) toured the memory unit with the resident's durable power of attorney (DPOA). 09/11/23- FCS/HSP (Health Service Plan) changes 11:00 AM reflected the following changes. 30-minute rounding/Added Elopement Risk. Interventions added to the HSP to take resident outside daily with staffing supervision. 09/12/23 at 08:00 AM- New paging transmitter was installed by facility Administrator. The facility Administrator noticed the new system was not functioning and the vendor was notified. The vendor scheduled a time to troubleshoot the system in person. 09/13/23 at 08:00 AM- Vendor arrived at facility and worked on paging transmitter. The vendor discovered the new transmitter was not working and reordered another transmitter.	S3026		

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S3026	Continued From page 10 09/16/23 at 12:00 PM- New transmitter arrived at facility and was installed by facility Administrator. The paging transmitter and system functioned properly once completed. The immediate jeopardy was abated on 09/19/23 at 04:11 PM based on the facility's plan of correction and approved by the department.	S3026		
S3081 SS=D	26-41-201 (c) Functional Capacity Screen Reassessment (c) Designated facility staff shall conduct a screening to determine each resident ' s functional capacity according to the following requirements: (1) At least once every 365 days; (2) following any significant change in condition as defined in K.A.R. 26-39-100; and (3) at least quarterly if the resident receives assistance with eating from a paid nutrition assistant. This REQUIREMENT is not met as evidenced by: KAR 26-41-201(c)(1) The facility reported a census of 13 residents. The sample included one abbreviated record review. Based on interview, and record review the operator failed to ensure designated staff completed a "Functional Capacity Screen" (FCS) for resident (R)101 at least once every 365 days. Findings included:	S3081		

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S3081	Continued From page 11 - R101's medical record revealed the resident moved into the facility on 01/11/22 with a diagnosis of dementia. The most current FCS available in R101's medical records was dated 09/11/23 which was completed 10 days after the due date. On 09/19/23 at 04:12 PM Administrative Nurse B stated she completed an FCS and Negotiated Service Agreement (NSA) on 09/01/23 in a word document but R101's durable power of attorney had not yet signed it before R101 eloped on 09/09/23. Administrative Nurse B stated she updated the FCS and NSA to include information concerning the elopement but did not save the previous FCS/NSA she had prepared on 09/01/23 therefore could not show documentation an FCS was completed in the required time. The operator failed to ensure designated staff completed a FCS for R101 at least once every 365 days.	S3081		
S3092 SS=D	26-41-202 (d) Negotiated Service Agreement Revisions (d) Each administrator or operator shall ensure the review and, if necessary, revision of each negotiated service agreement according to the following requirements:(1) At least once every 365 days; (2) following any significant change in condition, as defined in K.A.R. 26-39-100; (3) at least quarterly, if the resident receives assistance with eating from a paid nutrition	S3092		

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assistant; and
(4) if requested by the resident or the resident ' s legal representative, facility staff, the case manager, or, if agreed to by the resident or the resident ' s legal representative, the resident ' s family.

This REQUIREMENT is not met as evidenced by:
KAR 26-41-202(d)(1)

The facility reported a census of 13 residents. The sample included one abbreviated record review. Based on interview, observation, and record review the operator failed to ensure designated staff revised a "Negotiated Service Agreement/Health Care Service Plan" (NSA/HCSP) for resident (R)101 at least once every 365 days.

Findings included:

- R101's medical record revealed the resident moved into the facility on 01/11/22 with a diagnosis of dementia.

The most current NSA/HCSP available in R101's medical records was dated 09/11/23 which was completed 10 days after the due date.

On 09/19/23 at 04:12 PM Administrative Nurse B stated she completed an Functional Capacity Screen (FCS) and NSA on 09/01/23 in a word document but R101's durable power of attorney had not yet signed it before R101 eloped on

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S3092	Continued From page 13 09/09/23. Administrative Nurse B stated she updated the FCS and NSA to include information concerning the elopement but did not save the previous FCS/NSA she had prepared on 09/01/23 therefore could not show documentation an NSA was completed within the required time. The operator failed to ensure designated staff completed an NSA for R101 at least once every 365 days.	S3092		