STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N061009	A. BUILDING: _____ B. WING _____	C 01/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VINTAGE PARK AT OSAWATOMIE LLC	1520 PARKER AVE OSAWATOMIE, KS 66064

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S 000	INITIAL COMMENTS The following represent the findings of an abbreviated survey at the above named assisted living facility for complaints #162848, #166092, #168516 conducted on 1/11,12/2022.	S 000		
S3026 SS=D	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 31 residents. The sample included 1 Resident, (R) 3. Based on observation, interview, and record review for R3 the operator failed to ensure the resident was not subjected to neglect when staff failed to identify R3 as an elopement risk even though she had gone out facility doors multiple times without telling staff and had increased behaviors of wandering and saying that she needed to go home. According to the resident's "Progress Notes", on 10/01/21 at 07:05 PM staff called the facility nurse and told her they could not find the resident in her room. The resident was last seen at approximately 06:56 PM in her apartment and then at 07:02 PM she was not in her apartment. The resident was unaccounted for by staff from	S3026		

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

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S3026	Continued From page 1	S3026		

07:02 PM to approximately 07:26 PM when the police notified Administrative Staff A the resident was at the police department.

Findings included:

Review of the R3's medical record revealed the resident moved into the facility on 05/01/21 with diagnoses of dementia, Parkinson's, and major depressive disorder.

Review of the resident's only "Functional Capacity Screen" (FCS) dated 05/03/21 revealed the resident needed supervision with bathing, dressing, management of medications, and medical treatments. The resident had bladder incontinence and cognitive impairment. It identified the resident had impaired decision making, no wandering, and no inappropriate behaviors. The FCS failed to identify the resident wandered, which was identified on the admission elopement screening tool.

Review of the resident's only "Negotiated Service Agreement" dated 04/30/21 revealed staff assisted the resident with bathing, provided set up assistance with dressing, and provided reminders for toileting. The staff also administer the resident her medications and assisted the resident out of the facility in the event of an emergency. It identified the resident as independent with mobility with no assistive devise and had no services identified related to behavioral symptoms.

Review of the resident's "Elopement Risk Assessment" dated 04/30/21 revealed a score of 8, indicating a minimal risk of elopement. The indicators included: the resident wandered in the community but did not try to leave. The resident

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had a diagnosis of dementia, was ambulatory, and received antipsychotic medications. The next "Elopement Risk Assessment" was not completed until 10/04/21, even though the resident showed multiple signs of increased risk for elopement. The resident's score on 10/04/21 was 45, indicating high risk of elopement.

Review of the facility "Door Alarm Report" from 10/01/21 revealed multiple door openings. One alarm for the east door was noted at 06:25 PM, one alarm for the back-courtyard door was noted at 06:50 PM, and one alarm for the employee parking side door was noted at 06:54 PM. Staff assumed the 06:54 PM door alarm indicated the resident went out of the facility. The report further included door alarms at 06:58 PM and 06:59 PM, which according to Administrative Staff A were triggered by staff leaving the building to look for the resident.

Review of the resident's "Progress Notes" revealed the following:
05/04/21 at 08:45 PM revealed the resident wandered in the facility.
05/20/21 at 09:38 PM revealed the resident confused and asking about parents and husband. R3 went in and out of her room to the front door.
05/31/21 at 02:33 AM revealed the resident up and down several times tonight looking for her husband and children often. She had shoes and jacket on and prepared to leave to go home.
06/09/21 at 11:09 AM revealed at approximately 10:30 PM today, an unidentified nurse was in the back-employee parking lot when the facility radio went off and stated the back-employee parking lot door was open. The nurse looked at the door and observed the R3 walking out of the door. The resident was not sure what she was doing and walked around to the front door and back into the

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facility. Since medication changes were made, she sleeps better, but still has high anxiety from 02:00 PM to 10:00 PM.
07/04/21 at 03:00 PM another resident's family member came in the facility and alerted the nurse R3 was outside the front door and saying she had to go home. R3 came back into the building and the door was secured.
08/03/21 at 07:11 PM the resident was very confused, asked if she needed to drive home multiple times, and stated she needed to walk to Paola.
08/23/21 at 11:49 AM the resident attempted to leave the facility to go home three times today and tried to exit the back door by her room. The resident said she needed to go back to her mom and dad. The resident continued to ty to exit the building and could not be reoriented.
08/23/21 at 07:18 PM the resident continued to attempt to exit community
08/24/21 at 06:25 PM the resident attempted to wander towards doors every 5-10 minutes.
08/25/21 at 01:36 PM the resident wandered the community more and attempted to walk outside.
08/29/21 at 03:21PM revealed at approximately 02:30 PM the facility radio alerted staff the front west door was open, and they noted the resident exited out that door and around the building to the patio.
08/30/21 at 9:26 AM unidentified facility activity staff notified the medication aide that the resident was in the outside patio area and medication aide brought the resident back in.
09/05/21 at 09:28 PM the resident required close monitoring and frequent redirection and kept saying she was leaving "right now".
09/12/21 at 9:41 PM the resident went out the patio door two times and staff assisted her back into the building, she also went out the back-west door.

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S3026	Continued From page 4 10/02/21 at 03:16 PM "follow up note" revealed on 10/01/21 the resident walked with the Certified Medication Aide (CMA) and medication cart on the middle hall and then went into her room around 06:56 PM. The medication aide continued to get medications ready for another resident and then activated the alarm on R3's door around 06:58 PM. Then the medication aide went into another resident's room to give medications. At around 07:02 PM the other staff member asked if the writer had seen the resident as she was no longer in her room and no one heard the door alarm or exit door alarms go off. Staff searched the facility, contacted the nurse and Executive Director and then called the police at 07:13 PM. They arrived at the facility at 07:15 and upon arrival he got a call from the station confirming the resident was sat the police station. On 01/11/21 at 10:12 AM Operator A reported there were alarms on all the facility doors, but they were not checked daily for functionality. Operator A stated there was a lot of traffic in and out during day shift and the alarms all come across the pagers. She stated the facility could now run a report on the door alarms to see if any of the batteries were running low and they would try to run those reports weekly. On 01/11/22 at 1:30 PM Certified Nurse Aide (CNA) C reported the resident had been with her in the wheelchair as she and the other aide were picking up trash. She did not normally use a wheelchair, but this helped the staff to keep a better eye on her. She got up out of the chair and headed toward the hall where her room was, and we had to gather trash for that hall next. When we got to her room, she was not in it and so we started to look for her. CNA B stated the resident had an alarm on her bedroom door, but it did not	S3026		

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go off and she did not hear any of the exit door alarms go off.

On 01/11/22 at 01:37 PM CMA D reported the resident was very confused all the time and looked for her parents or her husband. Staff tried to redirect her, but it would not last long. She would go to the back door to go out, because she would see one of our outbuildings and when we got to her and asked where she was going she would say to church. CMA D stated staff tried to involve her in activities such as shoestring weaving, folding towels, and other things and just kept a close eye on her. The facility also placed a door alarm on her room door and the exit doors all had an alarm that came over the radio. CMA C stated the resident did not like to be alone, so they tried to keep her with them when possible.

On 01/11/21 at 01:43 PM CNA C reported the resident tried to leave a lot and they could get her to come back in the facility or get her to do an activity. During the day there were more people in the facility to help keep an eye on her.

On 01/11/21 at 01:51 PM Licensed Nurse (LN) B reported when she first screened the resident, she was very pleasant and knew her surroundings. When the resident came to the facility, she showed increased confusion and did not realize where she was, so they thought it was part of her adjusting to the facility.

On 01/11/22 at 02:07 PM CMA E reported the resident paced through the facility, would wander into other residents' rooms and always asked where her family was. Staff tried to get her to sit and work with beads and buttons, but that would only last about 10 minutes and then she was up again. The resident would talk about going home

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S3026	Continued From page 6 so staff tried to keep her with them in the wheelchair as they did rounds. Review of the "Elopement Policy" revised on 09/14/20 revealed the facility failed to complete the following according to policy guidance: 1. "An elopement/Missing Resident Risk Assessment and Intervention Form will be completed ... whenever a resident's risk for elopement increases, such as with an increase in exit-seeking behavior ..." 2. "The residents individual service plan will be developed and implemented based on the Elopement/Missing Resident Risk Assessment and Interventions results." 3. "Communities will conduct a daily check of alarmed doors ..." Based on record review and interview Operator A failed to check all exit doors functionality daily. She failed to ensure designated staff completed an "Elopement/Missing Resident Risk Assessment" and "Intervention Form" when R3 began to have multiple exit-seeking behaviors and exited the facility multiple times with staff responding properly to the door alarms. This failure resulted in a failure to complete a "Functional Capacity Screen" to identify the resident wandered, had inappropriate behaviors, and impaired decision making and further failed to revise the resident's "Negotiated Service Agreement" to include interventions to help reduce risk of the resident eloping from the facility.	S3026		
S3081 SS=D	26-41-201 (c) Functional Capacity Screen Reassessment (c) Designated facility staff shall conduct a	S3081		

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S3081	Continued From page 7 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)(2) The facility reported a census of 31 residents. The sample included 2 residents. Based on interview and record review the operator failed to ensure designated staff conducted a screening to determine the resident's functional capacity when 1 (Resident, R3) of 2 sampled residents had a significant change in condition as defined in KAR 26-39-100 related to increased wandering and exit-seeking behaviors. Findings included: - Review of R3's medical record revealed the resident moved into the facility on 5/1/21 with diagnoses of dementia, Parkinson's and major depressive disorder. Review of R3's Functional Capacity Screen (FCS) dated 5/3/21 revealed the resident needed supervision with bathing, dressing, and management of medications and medical treatments. The resident had bladder incontinence and cognitive impairment. It identified the resident had impaired decision making, no wandering and no inappropriate	S3081		

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S3081	Continued From page 8 behaviors. The FCS failed to identify the resident wandered which was identified on the admission elopement screening tool. The FCS dated 5/3/21 was the only FCS in the resident's record. Review of the residents progress notes revealed the following dates and time staff documented the resident had increased anxiety, wandering, and exit seeking behaviors: 05/04/21 at 08:45 PM; 05/20/21 at 09:38 PM; 05/26/21 at 09:53 PM; 05/31/21 at 02:33 AM; 06/01/21 at 07:31 PM; 06/02/21 at 04:46 PM; 06/09/21 at 11:09 AM; 07/04/21 at 03:00 PM; 07/19/21 at 07:47 PM; 08/03/21 at 07:11 PM; 08/23/21 11:49 AM; 08/23/21 at 07:18 PM; 08/25/21 at 01:36 PM; 08/26/21 at 03:38 PM; 08/30/21 at 09:26 AM; 09/4/21 at 09:51 PM; 09/05/21 at 09:28 PM; 09/11/21 at 09:51 PM; 09/12/21 at 09:41 PM; and on 10/2/21 at 03:16 PM after the resident eloped from the facility. On 1/11/21 at 12:30 PM Licensed nurse B confirmed she did not complete a new FCS when the resident started having increased anxiety, wandering throughout the facility, increased exit-seeking, or even when the resident went to /returned from the behavior unit related to the increased behaviors. The operator failed to ensure designated staff completed a new FCS when R3 had a significant change in status related to wandering, exit seeking, and increased confusion.	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	S3092		

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S3092	Continued From page 9 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 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)(2) The facility reported a census of 31 residents. The sample included 2 residents. Based on interview and record review the operator failed to ensure designated staff revised the Negotiated Service Agreement when 1 (R3) of 2 sampled residents had a significant change in condition as defined in KAR 26-39-100 related to increased wandering and exit-seeking behaviors. Findings included: - Review of the R3's medical record revealed the resident moved into the facility on 5/1/21 with diagnoses of dementia, Parkinson's and major depressive disorder. Review of the resident's only Functional Capacity Screen (FCS) dated 5/3/21 revealed the resident needed supervision with bathing, dressing, and management of medications and medical treatments. The resident had bladder	S3092		

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S3092	Continued From page 10	S3092		

incontinence and cognitive impairment. It identified the resident had impaired decision making, no wandering and no inappropriate behaviors. The FCS failed to identify the resident wandered which was identified on the admission elopement screening tool.

Review of the resident's only Negotiated Service Agreement (NSA) dated 4/30/21 revealed staff assisted the resident with bathing, provided set up assistance with dressing and provided reminders for toileting. The staff also administer the resident her medications and had to assist the resident out of the facility in case of an emergency. It identified the resident as independent with mobility with no assistive devise. The NSA failed to be revised to include any services staff needed to provide related to the residents wandering, increased confusion, and exit seeking behaviors.

Review of the residents progress notes revealed the following dates and time staff documented the resident had increased anxiety, wandering, and exit seeking behaviors:
05/04/21 at 08:45 PM; 05/20/21 at 09:38 PM; 05/26/21 at 09:53 PM; 05/31/21 at 02:33 AM; 06/01/21 at 07:31 PM; 06/02/21 at 04:46 PM; 06/09/21 at 11:09 AM; 07/04/21 at 03:00 PM; 07/19/21 at 07:47 PM; 08/03/21 at 07:11 PM; 08/23/21 11:49 AM; 08/23/21 at 07:18 PM; 08/25/21 at 01:36 PM; 08/26/21 at 03:38 PM; 08/30/21 at 09:26 AM; 09/4/21 at 09:51 PM; 09/05/21 at 09:28 PM; 09/11/21 at 09:51 PM; 09/12/21 at 09:41 PM; and on 10/2/21 at 03:16 PM after the resident eloped from the facility.

On 1/11/21 at 12:30 PM Licensed nurse B confirmed she did not revise the NSA when the resident started having increased anxiety,

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S3092	Continued From page 11 wandering throughout the facility, increased exit-seeking, or even when the resident went to /returned from the behavior unit related to the increased behaviors. LN B did not complete an amended NSA until 10/4/21, after the resident had eloped from the facility. The operator failed to ensure designated staff revised the Negotiated Service Agreement when R3 had a significant change in status related to wandering, exit seeking, and increased confusion.	S3092		