STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N073002	A. BUILDING: _____ B. WING _____	08/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY LIVING OF LARNED	714 W 9TH STREET LARNED, KS 67550

(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 citations represent the findings of an abbreviated survey for complaint #190144 at the above named facility conducted on 08/27/24.	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 18 residents. The sample included 1 resident. Based on record review and interview for cognitively impaired Resident (R)1, Operator/Licensed Nurse (LN) A failed to ensure no resident was subjected to neglect when Operator/LN A failed to provide or coordinate services reasonably necessary to ensure the resident's safety and well-being and to avoid harm when R1 was confused, eloped from the facility on 08/16/24 and walked unsupervised approximately 0.3 miles from the facility and facility staff were unaware of elopement. R1 walked out of the facility unsupervised a second time on 08/23/24 without staff knowledge and was found by facility staff trying to get into parked vehicles outside the facility. This failure placed the resident in immediate jeopardy for harm,	S3026		

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

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S3026	Continued From page 1	S3026		

injury, or death.

Findings included:

- The resident roster obtained on 08/27/24 identified R1 had impaired cognition "at times" and was at risk for wandering

R1's medical record revealed she admitted to the facility on 09/14/23 with diagnoses of dementia/ Alzheimer's Disease and depression.

The "Functional Capacity Screen" (FCS) dated 09/14/23 recorded the resident was independent with dressing, toileting, transfer, walk/ mobility and eating; required supervision with bathing; required physical assistance with management of medications and was unable to perform management of treatments. The FCS recorded R1 had short term memory impairment and impaired decision making.

R1's record lacked an updated FCS completed upon significant change in status after elopement on 08/16/24.

The "Negotiated Service Agreement/ Health Care Plan" (NSA/ HCP) dated 09/14/23 recorded facility staff provided supervision with cognition due to mild impairment and short-term memory loss. The NSA/HCP further recorded R1 had challenges with remembering appointments, day of the week and calendar dates as well as generalized confusion of location and family.

R1's record lacked an updated NSA/HCP completed after the 08/16/24 elopement to reflect interventions to prevent incident reoccurring.

An "Amended Negotiated Service Agreement"

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dated 08/23/24 recorded certified staff were to complete hourly safety checks on R1 during the day and thirty-minute safety checks during the night to ensure R1 was in the facility. The addendum was signed by Operator/ LN A and LN B but lacked signatures of R1 and any legal representative or family members.

R1's medical record lacked documentation of hourly and thirty-minute safety checks completed from 08/23/24 through 08/27/24.

R1's medical record lacked an elopement risk assessment completed.

The resident's record lacked physician notification of the resident's 08/16/24 elopement until 08/23/24.

R1's medical record revealed no assessment was completed by a licensed nurse after returning to the facility after elopement from the facility on 08/16/24.

Review of R1's electronic medical record revealed the following "Progress Notes":

On 03/30/24, LN B recorded R1 had intermittent confusion and misplaced items.
On 04/30/24, LN B recorded some confusion and inability to track had begun, R1 called out bingo when her card did not have any winning columns and further recorded R1 enjoyed sitting outside.
On 05/30/24, LN B recorded R1 required guidance of daily routines and reminders for mealtimes.
On 06/30/24, LN B recorded R1 required extra guidance of daily routines and reminders of mealtimes and family visits made her anxious, resulting in R1 packing her room.

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On 07/15/24, LN B recorded R1 continued to pack her room when family visited and increase in anxiety was noted after visits.
On 08/15/24, LN B recorded R1 continued to pack her room, lose items at times and behaviors increased when family visited.
On 08/27/24, Operator/LN A recorded R1 was observed trying to get into a parked car in the car lot on 08/23/24.

"Progress Notes" lacked documentation related to the 08/16/24 elopement.

Review of R1's August 2024 "Medication Administration Record" (MAR) revealed R1 last received medication on 08/16/24 at 08:24 AM by Certified Medication Aide (CMA) C.

Facility's "Resident sign-in/ sign out sheet" recorded R1 signed herself out on 08/16/24 with a time out of 05:30 and a time in of 10:00. (AM and PM were not specified). Destination listed by R1 was café.

Facility records lacked documentation of education given to staff members to prevent elopement of R1 from reoccurring.

Interview on 08/27/24 at 10:20 AM with Operator/ LN A confirmed there were three exit doors in the facility and further confirmed there were no alarms on the doors, even when doors were locked at night. Operator/LN A further confirmed she was not aware of R1's 08/16/24 elopement until 08/23/24, when R1's son informed her of the incident.

Interview on 08/27/24 at 12:21 PM with CMA C stated she last saw R1 at approximately 04:30 PM on 08/16/24. CMA C stated R1's family

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member then informed her R1 was outside on the corner. CMA C further stated R1 was brought back the facility by a community member before 05:00 PM on 08/16/24. CMA confirmed times were approximate based on her recollection of events.

Interview on 08/27/24 at 12:38 PM with LN B confirmed facility doors are unlocked during the day and locked at approximately 09:00 PM every night and then unlocked at between approximately 06:00 AM and 07:00 AM.

Phone interview on 08/27/24 at 12:46 PM with Community Member E stated she observed R1 walking in the middle of the street at approximately 03:50 PM on 08/16/24. R1 then sat at a residence . She was wearing pants, a shirt, hat and had a large purse and a brown paper bag with her. Community Member E notified Community Member F, who took R1 back to the facility. Community Member E stated R1 left with Community Member F between approximately 05:10 PM and 05:15 PM on 08/16/24 to go back to the facility.

Phone interview on 08/27/24 at 01:01 PM with Community Member F stated she was contacted on 08/16/24 to pick R1 up from a residence and take her back to the facility she resided at. Community Member F stated she arrived to pick R1 up between approximately 04:15 PM and 04:20 PM and returned R1 to the facility at approximately 04:35 PM. Community Member F stated when she returned R1 to the facility, she informed the aide on duty of R1 being gone from the facility and further stated the aide was not aware R1 had left the facility.

Interview on 08/27/24 at 03:04 PM with CMA C

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stated she assumed R1 was in the driveway of the facility when R1's family member told her R1 was outside on the corner and further confirmed she did not see R1 outside or go check on her.

Record review and interview on 08/16/24 with Operator/LN A confirmed at the time of the 08/16/24 elopement around 04:30 PM, there was 1 CMA (CMA C) and 1 dietary staff member on duty.

"Weather Underground History" reported the following temperatures, events, and conditions for 08/16/24 at 04:30 PM; the temperature was 89 degrees F (Fahrenheit), no precipitation, 76% humidity, UV index was 5, mostly sunny.

R1 eloped and was found 0.3 miles away from the facility at a residence. The distance was a minimum of a 7-minute walk. R1 would have likely crossed four intersections. R1 would have crossed a heavily traveled street, which leads to the town's state hospital.

Facility's "Missing Resident Procedure" policy dated 2014 recorded, "Each staff member is responsible for the whereabouts of all residents. No reasonable period should pass when the staff on duty does not know where all the residents are ... If the resident is not discovered within 10 minutes, an organized search effort is to be instigated and the director will contact the police department and request search assistance ... Time is a major factor in finding missing residents. Immediate danger is present when elderly residents, particularly those who are confused, are exposed to street traffic, hazardous terrain, or physical exposure to sun, heat or inclement weather. Health department officials tell us that residents have been killed by

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automobiles, by exposure to sun and heat, and have even been murdered. Therefore, it is important that missing resident be discovered soon and that efforts be organized and thorough."

Facility's "Elopement Prevention" policy dated 2014 recorded, "elopement of a resident is defined as "the leaving of a building without the knowledge of the staff, of a resident who has impaired decision ability, is oblivious to his or her own safety needs and those at risk for injury outside the confines of the building" ... Procedure 1. Each applicant for residency is assessed prior to and at admission for health care, social and personnel preference needs. This assessment includes identification of potential elopement risk. 6. The building has defined what would constitute risk for injury of a resident based on the physical environment in the building location. Such risks include roadways, heavy traffic, uneven pavement, absence of sidewalks."

Facility's "Elopement Protocol" policy dated 2014 recorded, "1. Any staff member observing a resident attempting to leave the premises shall, with proper courtesy and conduct, attempt to prevent such departure ... 6. Upon return of the resident to the facility, the following steps shall be carried out: ... b. the resident shall be checked thoroughly by the staff for any signs of injury. c. Complete documentation in the resident's record. d. Check on resident frequently and monitor throughout the next 24 hours."

Facility last reviewed "Elopement Prevention and Procedures" with staff on 09/05/23.

Facility's "Abuse & Neglect & Exploitation Policy" dated 2014 recorded, "Neglect: Means the failure or omission by one's self, caretaker, or another

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person to provide gods or services which are reasonably necessary to ensure safety and well-being and to avoid physical or mental harm or illness."

Operator/LN A failed to ensure no resident was subjected to neglect when Operator/LN A failed to provide or coordinate services reasonably necessary to ensure the resident's safety and well-being and to avoid harm when R1 eloped from the facility on 08/16/24 and left the facility a second time on 08/23/24. This failure placed the resident in immediate jeopardy for harm, injury, or death.

The immediate jeopardy was removed on 08/27/24 when R1 was placed on one-to-one care and then discharged from the facility to a secured memory care unit.

Abatement plan obtained on 08/28/24, recorded, "Regarding [R1's] Elopement 08/16/24, I [Operator/LN A] witnessed the above resident being returned to the facility by employee [Business Office Staff D] on Friday 08/23/24 around 1pm. At the time I tried to contact her son, at approximately 03:30pm I was able to reach the son to inform him that his mother was found in the parking area trying to get into vehicles. We discussed moving his mother into the Licensed Home Plus (HP) within the week, which is a locked building for her safety. At that time, he said there was another incident the Friday prior (08/16/24) that he was contacted to pick up his mother by a resident in town, she was walking towards a school that she used to teach at down on [name of street]. When I asked for more details, he became frustrated and stated he thought it was a good idea to move her to the locked setting. I was not aware of the 08/16/24

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S3026	Continued From page 8 incident prior to this conversation with [R1's family]. We implemented 1 hour checks OTC. The same staff work all weekend. I texted night shift to make sure they continued those checks without fail. [LN B] sent admission orders to her provider on 08/23/24. On Monday 8/26/24 [provider's] office was contacted per [LN B], she was told he would not be in until Tuesday 08/27/24. On 08/27/24 we received admission orders to move [R1] from Senior Living. [R1] is a one to one with staff currently. The staff is assisting son in moving her items to the new room he picked out yesterday. She will remain a one on one until she is fully admitted into the HP building which is a locked building. We will start remediation training immediately 08/27/24 with staff that are on and each shift regarding the procedures for Elopement. On hire and every September, we have Elopement procedure training. We will be adding an elopement drill to our staff meeting next week 9/3/24, 0900 and 9/5/24, 1700 along with our annual Elopement training. Regarding [R2], [LN B] is completing a Wandering Risk Assessment. At this time, we will implement 15 minutes checks. I will talk with the owners to get alarms for the doors in Senior Living." Printed, signed, dated and timed by Operator/LN A.	S3026		
S3028 SS=D	26-41-101 (f) (3) Staff Treatment of Residents Reporting (f) (3) Each allegation of abuse, neglect, or exploitation shall be reported to the administrator or operator of the facility as soon as staff is aware of the allegation and to the department within 24 hours. The administrator or operator shall ensure that all of the following requirements are met: (A) An investigation shall be started when the	S3028		

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S3028	Continued From page 9 administrator or operator, or the designee, receives notification of an alleged violation. (B) Immediate measures shall be taken to prevent further potential abuse, neglect, or exploitation while the investigation is in progress. (C) Each alleged violation shall be thoroughly investigated within five working days of the initial report. Results of the investigation shall be reported to the administrator or operator. (D) Appropriate corrective action shall be taken if the alleged violation is verified. (E) The department ' s complaint investigation report shall be completed and submitted to the department within five working days of the initial report. (F) A written record shall be maintained of each investigation of reported abuse, neglect, or exploitation. This REQUIREMENT is not met as evidenced by: KAR 26-41-101 (f) (3) The facility reported a census of 18 residents. The sample included 1 resident. Based on record review and interview for 1 Resident (R)1, Operator/ Licensed Nurse (LN) A failed to ensure each allegation of neglect was reported to the Department within 24 hours when R1 was confused, eloped from the facility on 08/16/24 and walked unsupervised approximately 0.3 miles from the facility and facility staff were unaware of elopement. R1 walked out of the facility unsupervised a second time on 08/23/24 without staff knowledge and was found by facility staff trying to get into parked vehicles outside the	S3028		

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facility.

Findings included:

- The resident roster obtained on 08/27/24 identified R1 had impaired cognition "at times" and was at risk for wandering

R1's medical record revealed she admitted to the facility on 09/14/23 with diagnoses of dementia/ Alzheimer's Disease and depression.

The "Functional Capacity Screen" (FCS) dated 09/14/23 recorded the resident was independent with dressing, toileting, transfer, walk/ mobility and eating; required supervision with bathing; required physical assistance with management of medications and was unable to perform management of treatments. The FCS recorded R1 had short term memory impairment and impaired decision making.

R1's record lacked an updated FCS completed upon significant change in status after elopement on 08/16/24.

The "Negotiated Service Agreement/ Health Care Plan" (NSA/ HCP) dated 09/14/23 recorded facility staff provided supervision with cognition due to mild impairment and short-term memory loss. The NSA/HCP further recorded R1 had challenges with remembering appointments, day of the week and calendar dates as well as generalized confusion of location and family.

A "Amended Negotiated Service Agreement" dated 08/23/24 recorded certified staff to complete hourly safety checks on R1 during the day and thirty-minute safety checks during the night to ensure R1 was in the facility. The

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addendum was signed by Operator/ LN A and LN B but lacked signatures of R1 and any legal representative or family members.

By review of R1's electronic medical record revealed a "Progress Notes" dated 08/27/24 by Operator/LN A, which recorded R1 was observed trying to get into a parked car in the car lot on 08/23/24.

"Progress Notes" lacked documentation related to the 08/16/24 elopement.

Record lacked a completed investigation after 08/16/24 elopement and after being found outside the facility on 08/23/24 trying to get into parked vehicles.

Facility records lacked documentation of education given to staff members to prevent elopement of R1 from reoccurring.

Interview on 08/27/24 at 12:21 PM with Certified Medication Aide (CMA) C stated she last saw R1 at approximately 04:30 PM on 08/16/24. CMA C stated R1's family member then informed her R1 was outside. CMA C further stated R1 was brought back the facility by a community member before 05:00 PM on 08/16/24. CMA confirmed times were approximate based on her recollection of events.

Phone interview on 08/27/24 at 12:46 PM with Community Member E stated she observed R1 walking in the middle of the street at approximately 03:50 PM on 08/16/24. R1 then sat at a residence. She was wearing pants, a shirt, hat and had a large purse and a brown paper bag with her. Community Member E notified Community Member F, who took R1 back to the

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facility. Community Member E stated R1 left with Community Member F between approximately 05:10 PM and 05:15 PM on 08/16/24 to go back to the facility.

Phone interview on 08/27/24 at 01:01 PM with Community Member F stated she was contacted on 08/16/24 to pick R1 up from a residence and take her back to the facility she resided at. Community Member F stated she arrived to pick R1 up between approximately 04:15 PM and 04:20 PM and returned R1 to the facility at approximately 04:35 PM. Community Member F stated when she returned R1 to the facility, she informed the aide on duty, who was not aware R1 had left the facility.

Interview on 08/27/24 at 10:20 AM with Operator/ LN A confirmed she was not aware of R1's 08/16/24 elopement until 08/23/24, when R1's son informed her of the incident and further confirmed it was not reported to the department.

Facility's "Abuse & Neglect & Exploitation Policy" dated 2014 recorded, "All reported allegations concerning abuse, neglect, or exploitation of any resident shall be dealt with following [name of facility] policies and procedures for "Reporting Requirements in Case of Suspected Abuse, Neglect, and Exploitation" and shall be reported to the State Regulatory Department."

Operator/LN A failed to ensure each allegation of neglect was reported to the Department within 24 hours when R1 was confused, eloped from the facility on 08/16/24 and walked unsupervised approximately 0.3 miles from the facility and facility staff were unaware of elopement. R1 walked out of the facility unsupervised a second time on 08/23/24 without staff knowledge and

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	N073002	A. BUILDING: _____ B. WING _____	08/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY LIVING OF LARNED	714 W 9TH STREET LARNED, KS 67550

(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
S3028	Continued From page 13 was found by facility staff trying to get into parked vehicles outside the facility.	S3028		