STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N078016	A. BUILDING: _____ B. WING _____	12/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WALDRON PLACE	1700 E 23RD HUTCHINSON, KS 67502

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S 000	INITIAL COMMENTS The following represents the findings of a resurvey with attached complaints #184364, #181705, #181511, and #181527 at the above named assisted living facility conducted on 12/04/23 and 12/05/23.	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 54 residents with 18 residents residing in the secured memory care unit. There were 3 residents included in the sample and two closed records reviewed. Based on observation, interview, and record review the operator failed to protect Resident (R) 1 when staff failed to respond appropriately when the exit door and elopement bracelet system activated. This failure placed R1 in immediate jeopardy on 11/28/23 when the cognitively impaired resident exited the facility through the front door without staff knowledge. He walked outside, unsupervised, for approximately three blocks and	S3026		

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

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S3026	Continued From page 1	S3026		

was eventually found near an intersection by a family member. R1 returned to the facility with a family member approximately 45 minutes after he left.

Findings included:

- Record review for R1 revealed an admission date of 10/24/23 with a diagnosis of Alzheimer's disease, restlessness and agitation.

The 11/30/23 "Functional Capacity Screen" (FCS) identified R1 required supervision for transfers and walking/mobility with no assistive devices; he had short-term and long-term memory, memory/recall, and decision-making cognitive impairments; and was marked for wandering.

The 11/30/23 combined "Negotiated Service Agreement/Healthcare Service Plan" (NSA/HSP) identified R1 was independent with transfers; staff would provide frequent visual checks and assist with ambulation when sick or weak; and staff would offer toileting assistance or redirect by offering an activity for wandering. Services provided for cognitive difficulties was not addressed on R1's "NSA/HSP."

R1's record lacked evidence of documentation of an "Elopement Risk Assessment" completed before the elopement.

The 10/24/23 "Wanderguard Information" form documented R1 was provided an elopement bracelet to his left ankle upon admission on 10/24/23.

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S3026	Continued From page 2	S3026		

The 11/28/23 late entry "Incident Note" documented the following: At approximately 03:30 PM, the housekeeper informed the unidentified Certified Medication Aide (CMA) on duty the door alarm had activated, and the housekeeper was unable to shut it off. Meanwhile, R1's unidentified family member arrived and was looking for R1. The CMA and an unidentified Certified Nurse Aide (CNA) began looking for the resident inside the building. At 04:15 PM staff were notified R1 had been located and was on his way back to the facility.

The 11/28/23 at 07:12 PM late entry "Nurses Note" documented she had been informed at 04:09 PM that R1 was missing. Staff checked all rooms inside the facility and then started searching outside. Approximately 15 minutes later, R1 was found on the north side (opposite the facility) of an intersection three blocks away. R1's daughters were present and his elopement at a previous facility was discussed. Staff were informed to provide 15-minute checks until further notice to ensure R1's safety.

The "Procedural Steps for Missing Resident" form documented R1 was last seen in the common area at 03:00 PM wearing a blue and brown plaid long-sleeved button-down shirt with jeans, shoes, and a red hat. His daughter arrived at the facility at 03:55 PM and R1 was discovered missing at 04:00 PM.

The 11/30/23 "Facility Reported Incident" report sent to the state agency revealed R1 was able to exit the facility because the exit door unlocks after 15 seconds of being pushed. Staff provided 15-minute checks for R1, and all elopement

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S3026	Continued From page 3	S3026		

bracelets were checked to ensure they functioned, Administrative Staff A provided immediate education on the elopement policy with the staff involved, online elopement training was assigned and to be completed by all staff within the next two weeks; and staff elopement live training would be scheduled.

Review of the door alarm check log from 11/01/23 to 12/04/23 revealed the alarms were checked at each door in the facility once a week for proper functioning.

Review of the facility's "Emergency Management Plan" quarterly reviews revealed training for the missing resident policy and procedures was provided quarterly to all staff and residents on 02/28/23, 04/26/23, 07/13/23, and 11/16/23.

Observation on 12/04/23 at 02:34 PM revealed the front door to the facility was keypad locked. The door alarmed and would not open because a resident wearing an elopement bracelet was near the door. All other exit doors were keypad locked and had green lights indicating the elopement bracelet system was functioning.

Observation on 12/04/23 at approximately 05:15 PM revealed the possible route R1 walked after he exited the building. The route was up a sidewalk next to a two-lane street with a center turning lane and had a speed limit of 35 miles per hour (MPH). The location where R1 was found by a family member, on the opposite side of the intersection controlled by traffic lights, was three blocks from the facility. The four-lane cross street had a speed limit of 45 MPH.

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S3026	Continued From page 4 Observation on 12/05/23 at 10:29 AM revealed R1 sat in the common area with other residents and participated in an activity. From 10:29 AM until 11:48 AM (approximately 1 hour and 20 minutes) R1 did not appear to be restless, agitated, anxious, wandering, or exit-seeking. The weather on 11/28/23 according to www.Wunderground.com revealed a temperature of 40 degrees Fahrenheit (F) with 10 MPH wind speed. On 12/04/23 at 01:58 PM Administrative Staff B stated all exit doors in the facility were secured with an elopement bracelet system. If the door handle was held down for 15 seconds, the door could be opened per state fire marshal's regulations. On 12/04/23 at 02:26 PM Administrative Staff B stated the code to unlock all exit doors in the facility was never given out. Staff had to let visitors out of the facility. On 12/04/23 at approximately 04:42 PM during a phone interview, Administrative Staff A confirmed staff did not respond to the door alarm appropriately. Staff did not go out the door and look or perform a head count to ensure all residents were accounted for. Staff on duty during the elopement were re-educated the same evening about how they should have responded to the door and elopement bracelet system alarms, aAn online elopement training was assigned and had been completed by all staff except two and a live elopement training was	S3026		

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S3026	Continued From page 5 scheduled for 12/12/23. On 12/04/23 at 02:06 PM Administrative Nurse B stated the "NSA" and "HSP" were combined in one document. The facility's undated "Elopement Drill and Procedural Steps" policy documented staff should know what to do in the event a person left the facility without staff knowledge. The operator failed to protect Resident (R) 1 from elopement by the failure to ensure all staff responded appropriately when the exit door and elopement bracelet system was activated. This failure placed R1 in immediate jeopardy for neglect on 11/28/23 when the cognitively impaired resident exited the facility through the front door without staff knowledge. He walked outside, unsupervised, for approximately three blocks and was eventually found near a controlled intersection by a family member. R1 was returned to the facility approximately 45 minutes after he left. The Immediate Jeopardy was removed on 11/28/23 at 05:00 PM when the 15-minute visual checks were initiated for R1 and on-duty staff were provided re-education on the elopement policy and procedures. The following actions were documented in the "Abatement Plan" and accepted by the department on 12/05/23 at 10:18 AM. 1. Administrative Staff A educated floor staff on duty during the elopement including the importance of performing a head count following	S3026		

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S3026	Continued From page 6	S3026		

door alarms activating.
2. Administrative Staff A informed all facility staff via a messaging app to review the missing resident policy and procedures and to know where the binder was located.
Administrative Staff A informed all facility staff an online elopement course was assigned to be completed by 12/12/23.
3. Administrative Staff A ensured all elopement bracelets on all residents were checked for proper functioning the evening of the elopement.
4. Administrative Staff A ensured all door alarms were checked for proper functioning the evening of the elopement.
5. Administrative Staff A ensured first shift on 11/29/23 checked elopement bracelets and door alarms for proper functioning.
6. Placement of elopement bracelets to be checked every shift and for functionality every week and to be documented on each resident's MAR.
7. Staff to complete visual checks of doors to ensure functionality of alarms daily.
8. Webinar scheduled for 12/07/23 on elopement policy for staff involved in the elopement on 11/28/23.
9. Facility-wide elopement in-service scheduled for 12/14/23.
10. Elopement bracelets and interventions for wandering documented on "NSA's" for all memory care admissions.
11. Starting immediately Administrative Staff A and Administrative Nurse D will review the elopement policy and procedures with new employees on the first day of orientation.
12. The elopement policy and procedures will be reviewed with an emphasis on performing head counts immediately following alarms every other

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S3026	Continued From page 7 month.	S3026		
S3085 SS=F	26-41-202 (a) Negotiated Service Agreement (a) The administrator or operator of each assisted living facility or residential health care facility shall ensure the development of a written negotiated service agreement for each resident, based on the resident ' s functional capacity screening, service needs, and preferences, in collaboration with the resident or the resident ' s legal representative, the case manager, and, if agreed to by the resident or the resident ' s legal representative, the resident ' s family. The negotiated service agreement shall provide the following information: (1) A description of the services the resident will receive; (2) identification of the provider of each service; and (3) identification of each party responsible for payment if outside resources provide a service. This REQUIREMENT is not met as evidenced by: KAR 26-41-202(a)(1) The facility reported a census of 54 residents with three residents included in the sample and two closed record reviews. Based on interview and record review the operator failed to ensure the "Negotiated Service Agreements" (NSA) for Residents (R) 1, R2, R3, and R4 described the services they received based on their "Functional Capacity Screens" (FCS).	S3085		

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S3085	Continued From page 8 Findings included: - Record review for R1 revealed an admission date of 10/24/23 with a diagnosis of Alzheimer's disease. The 11/30/23 "FCS" identified R1 had short-term and long-term memory, memory recall, and decision-making cognitive difficulties, and was marked for impaired hearing and impaired decision-making. The 11/30/23 "NSA" failed to identify the services provided R1 for cognitive difficulties, impaired hearing and impaired decision-making. - Record review for R2 revealed an admission date of 11/04/21 with diagnoses of polyp of colon and personal history of malignant neoplasm of breast. The 12/12/22 "FCS" identified R2 had short-term memory, memory/recall, and decision-making cognitive difficulties, and was marked for impaired vision, impaired hearing, and impaired decision-making. The 12/12/22 "NSA" failed to identify the services provided R2 for short-term memory, memory/recall, and decision-making cognitive difficulties, and was marked for impaired vision, impaired hearing, and impaired decision-making. - Record review for R3 revealed an admission date of 07/06/23 with diagnoses of acute embolism and thrombosis of unspecified deep veins of left-lower extremity and pararenal abdominal aortic aneurysm, without rupture.	S3085		

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S3085	Continued From page 9 The 07/06/23 "FCS" identified R3 had short-term memory, memory/recall, and decision-making cognitive difficulties, and was marked for falls, impaired vision, and impaired decision-making. The 07/06/23 "NSA" failed to identify the services provided R3 for short-term memory, memory/recall, and decision-making cognitive difficulties, impaired vision, impaired decision-making, and to prevent injury from falls. - Record review for R4 revealed an admission date of 05/27/22 with diagnoses of dementia, malignant neoplasm of right breast, and secondary malignant neoplasm of bone. The 05/22/23 "FCS" identified R4 had short-term and long-term memory, memory/recall, and decision-making cognitive difficulties, and was marked for falls, impaired vision, impaired hearing, and impaired decision-making. The 05/22/23 "NSA" failed to identify the services provided R4 for short-term and long-term memory, memory/recall, and decision-making cognitive difficulties, impaired vision, impaired hearing, impaired decision-making and to prevent injury from falls. On 12/05/23 at approximately 01:19 PM Administrative Nurses C and D confirmed R1, R2, R3 and R4's "NSA's" failed to describe the services provided based on their "FCS's" The operator failed to ensure the "NSA's" for R1, R2, R3 and R4 described the services provided based on their "FCS's".	S3085		

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