Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087090	A. BUILDING: _____ B. WING _____	C 04/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARHURST OF WICHITA	11820 W 29TH N WICHITA, KS 67205

(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 complaint investigations 192526, 192963, 193587 and 193762 at the above named Assisted Living conducted on 04/28/25, 04/29/25 and 04/30/25.	S 000		
S 190 SS=D	26-39-102 (e) Admission, Transfer, Discharge (e) Before a resident is transferred or discharged involuntarily, the administrator or operator, or the designee, shall perform the following: (1) Notify the resident, the resident ' s legal representative, and if known, a designated family member of the transfer or discharge and the reasons; and (2) record the reason for the transfer or discharge under any of the circumstances specified in paragraphs (d) (1) through (4) in the resident ' s clinical record, which shall be substantiated as follows: (A) The resident's physician shall document the rationale for transfer or discharge in the resident ' s clinical record if the transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met by the adult care home; (B) the resident's physician shall document the rationale for transfer or discharge in the resident ' s clinical record if the transfer or discharge is appropriate because the resident's health has improved sufficiently so that the resident no longer needs the services provided by the adult care home; and (C) a physician shall document the rationale for transfer or discharge in the resident ' s clinical record if the transfer or discharge is necessary because the health or safety of other individuals in the adult care home is	S 190		

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

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S 190	Continued From page 1 endangered. This REQUIREMENT is not met as evidenced by: KAR 26-39-102 (e)(2)(C) The facility reported a census of 59 residents. The sample included five focused record reviews. Based on interview and record review the administrator failed to have the resident's physician document the rationale for transfer or discharge in the resident's medical record prior to discharge from the facility for resident (R)101. Findings included: - Review of R101's medical record revealed she moved into the facility on 12/09/24 Alzheimer's disease. Review of R101's "Functional Capacity Screen" (FSC) dated 11/26/24 identified a cognition score of four indicating severely impaired cognition with impairments to short-term memory, long-term memory, memory/recall and decision making. The FCS also identified R101 wandered and exhibited inappropriate behaviors. Review of R101's "Negotiated Service Agreement" (NSA) did not identify any services provided by staff related R101 wandering into other resident's rooms or to inappropriate behaviors and how staff were to help R101 if she became angry or aggressive with staff.	S 190		

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S 190	Continued From page 2 Review of the letter provided by corporate staff on 01/10/25, addressed to the resident's "Durable Power of Attorney" (DPOA) identified R101 was to be discharged due to the fact she exhibited behavior that endangered the safety of other individuals in the adult care home. Review of R101's records failed to find any documentation of the physician's rationale for discharge necessary because the health or safety of other individuals in the adult care home were endangered. Review of the undated discharge guidelines concerning "Termination of Agreement by Community" documented, "Residents shall only be moved or transferred for the following reasons: (b) The Resident exhibits behavior or actions that repeatedly and substantially interfere with the rights or well-being of other residents and the Community has tried prudent and reasonable interventions. There will be documentation of the interventions attempted..." On 04/30/25 at 04:31 PM Administrative Staff A stated there should have been a physician's rationale included in R101's medical record concerning her involuntary discharge, but Administrative Staff A stated she was unable to find one. The operator failed to ensure prior to R101 being discharged, the resident's physician documented the rationale for transfer or discharge in the resident's medical record specifically related to the facility not being able to meet the residents needs and for the safety of other individuals in the facility.	S 190		

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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 59 residents with 35 residents in Assisted Living and 24 residents in the Memory Care Unit. The facility identified no current residents at risk for elopement in the Assisted Living. Based on observation, interview, and record review the operator failed to ensure Resident (R)105 was not subjected to neglect by the failure to ensure implementation of interventions for resident safety when facility staff did not complete safety checks as care planned. This resulted in immediate jeopardy when cognitively impaired R105 exited the facility through an unalarmed exit door without staff knowledge and was unaccounted for by staff for approximately 10 minutes with temperatures at or below freezing. Findings included: - R105's medical record revealed R105 moved	S3026		

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into assisted living on 11/05/24 with a diagnosis of Alzheimer's Disease.

R105's "Functional Capacity Screen" (FCS) dated 02/12/25 revealed he required physical assistance with transfers and mobility with the use of a walker. R105 had a cognitive score of three indicating he was cognitively impaired with short-term memory, memory/recall and decision-making impairments. The FCS did not identify R105 as at risk for wandering.

R105's "Negotiated Service Agreement" (NSA) identified R105 was not an elopement risk. Staff were to check on R105 every two hours throughout the shift to ensure he was safe.

Review of R105's medical record revealed the following:

An elopement risk assessment was completed on 02/12/24 was at moderate risk for elopement. He had no prior history or elopements and did not wander.

The 02/09/25 at 02:45 AM "Observation Note" documented the resident roamed the hallways and ate food from the bistro area. R105 was very confused and did not remember why he was out of his room.

The 02/15/25 at 03:45 AM "Observation Note" documented staff found R105 in the main lobby of the facility sitting in a chair. R105 had his wallet and a remote tucked into his socks. He was fully clothed but did not have his shoes on. He was confused about where he was and stated he had been waiting for someone to come by to

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ask about where he was.

The 02/18/25 at 12:45 AM "Observation Note" documented R105 came out to the lobby and insisted that the front doors are opened. Staff showed and told him the doors were not open, had to redirect him back to his apartment. R105 was observed to be very confused.

The 02/23/25 at 01:45 AM "Observation Note" documented R105 was outside of the building by the kitchen with bare feet and no coat on. Dining Services Director E had come to work early to complete some work and saw R105 at the back door and let him back into the building. It was noted there were several notes documented in R105's medical record indicating he wandered the halls, was very confused and could not remember how he got where he was. The note also documented there was no indication on staff pagers that R105 had gotten outside through the doors.

The 02/22/25 - 02/23/25 "Care History" report concerning safety checks revealed documentation of safety checks were not completed every two hours as care planned for R105. The last safety check completed on 02/22/25 was at 09:57 PM and the first safety check for 02/23/25 was completed at 12:11 PM.

An incident report submitted to the state agency documented the following events according to video footage:
At 01:41 AM, R105 exited the community on the east side of the building near apartments 52 and 53. Neither R105's wife nor staff were aware the resident exited the building. The resident was

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wearing a gray sweatshirt, navy blue pants, gray slippers, and black socks.

At 01:42 AM Dining Services Director E entered the building on the east side.

At 01:43 AM R105 was seen turning the corner from the door he exited.

At 01:45 AM R105 began to walk across the east lawn. As he was walking, he lost his balance and fell to the ground. R105 attempted to stand up, was unable to regain strength to stand, and he crawled across the snow until he reached the sidewalk. At that point, R105 stood up and tried to open the outside door to the Maintenance Director's office, but it was locked. R105 then walked across the flower beds which contained snow and rocks. As he made his way to the next door, he had his hands on the HVAC units to help maintain his balance. R105 then tried to open the Employee Exit and again was unable to enter the building, as the door was locked and required a code for entry. R105 turned to try another door, and it was at that time the Dining Services Director E who was at the copy machine located in the administrative area of the building, recognized R105, then helped him into the building.

Observation on 04/28/25 at 02:30 PM Administrative Staff A accompanied the surveyor on a tour around the facility, which revealed four exits in the assisted living area beside the main front entrance. The exit door located near apartments 52 and 53 where R105 exited the facility according to the report submitted to the state agency, was not alarmed and did not

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require a code in order to open the door. This door was located at the northeast corner of the building. Looking east from this door was a grass lawn and a sidewalk leading to a staff/ resident parking area. To the south there was a grass lawn that extended to the service area located just outside of the memory care unit, the facility kitchen and administrative offices. There was a locked glass door located by the administrative offices with a copy machine located near this door.

Observation on 04/28/25 at 03:35 PM revealed the facility was located in a mixed residential/ rural neighborhood just off a four-lane undivided road with a turning lane in the center. The street was paved with concrete sidewalks located on both sides of the street. The posted speed limit was 40 miles per hour. The terrain was pretty much flat with some nearby fields. There was a large pond to the north with residential areas to the north and east. There were grass fields to the south and west of the facility. Weather conditions at the time of the elopement as verified on https://www.wunderground.com/ revealed it was dark outside, the temperature was approximately 31 degrees Fahrenheit, winds were out of the south at eight miles per hour and there was no noted precipitation at that time although facility documentation revealed snow on the ground.

On 04/30/25 at 11:42 AM "Certified Medication Aide" (CMA) C stated she was told in report by other staff that they found R105 in the dining room area and in the movie theater and he would be confused and looked for his wife, but staff never reported R105 attempted to exit the facility. CMA C stated she never witnessed R105

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verbalize that he wanted to go home or needed to get out of the facility. CMA C stated staff were to document safety checks in the electronic medical records program as ordered.

On 04/29/25 at 04:37 PM Administrative Staff A stated at the time of the elopement, the assisted living doors were unsecured, and staff would be alerted on their pagers only if a resident pressed their pendant if they had gone out the door and wanted back in. Administrative Staff A acknowledged staff did not complete safety checks as care planned for R105 the night of the elopement.
The facility failed to ensure R105 was not subjected to neglect by the failure to ensure implementation of interventions for resident safety.

On 04/30/25 at 02:30 PM Administrative Staff A and Administrative Staff B were informed of the findings, which resulted in immediate jeopardy regarding a cognitively impaired resident exiting the facility unsupervised, and failure to ensure staff followed care planned interventions put into place to monitor the safety and whereabouts of R105.

Administrative Staff A submitted an abatement plan on 04/30/25 which included the following:

On 02/23/25 at 01:51 am Dining Services Director E let R105 back into the building and escorted him to his shared apartment where his spouse was sleeping.

R105 was assessed for injury, and none was noted at this time. Family declined to send him to

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S3026	Continued From page 9 the emergency room for evaluation however resident was subsequently sent to the hospital for evaluation at the suggestion of the executive director. R105 was not left alone while waiting for EMS (emergency services). Spouse verified she and the executive director stayed with the resident and EMS arrived quickly. On 02/24/25, Staff in-service was held related to elopement and missing person policy. On 02/24/25, R105 was admitted to a Memory Care Respite apartment at 08:44 AM and then a permanent apartment, where he remained as a resident. On 02/25/25, R105's health service plan was updated to reflect his residency status in memory care. On 03/03/25 all assisted living entry/exit points from the corridors and main entry were added on the plan for door transmitters to ensure safety for all residents. The immediate jeopardy was abated on 05/01/25 at 11:45 PM based on the facility's plan of correction and approved by the department.	S3026		