Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	101200	A. BUILDING: _____ B. WING _____	R-C 05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LANTERN AT MORNING POINTE ALZ & MI	225 RUCCIO WAY LEXINGTON, KY 40503

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{P 000}	Initial Comments An on site revisit was conducted on 05/10/2024 and based on the acceptable Plan of Correction (POC) received on 05/01/24, the facility was deemed to be in compliance on 05/09/24 as alleged.	{P 000}		

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

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P 000	Initial Comments A Re-licensure/Complaint Survey investigating Complaint KY00035343, KY00037284, KY00038679, KY00039649, KY00042085, and KY00042135 was initiated on 03/22/2024 and concluded on 03/28/2024. Deficient practice was identified for Complaint KY00042085. Imminent Danger was identified. The facility was notified of the Imminent Danger on 03/28/2024. No deficient practice was identified for Complaint KY00035343, KY00037284, KY00038679, KY00039649, and KY00042135. The facility admitted Resident (R)6 to its secure Alzheimer's specialty facility on 08/31/2023 with diagnoses to include vascular dementia unspecified severity with mood disturbance and schizophrenia unspecified. R6 was assessed by the facility to be at risk for elopement on admission, and the resident's care plan, dated 01/01/2024, reflected this. On 03/16/2024 at 11:30 AM, R6 was determined to have exited the facility without staff knowledge. An aide entered the resident's room and found the screws that prevented the window from opening had been removed, and the resident's screen had been neatly cut along the sides and bottom edge. The resident was found by rescuers approximately a mile away from the facility at 2:12 PM and was sent to a local emergency department for evaluation before being returned to the facility the following morning. In an interview with the resident's son he stated he had purchased a nail kit for the resident but was not aware the resident intended to use it to elope. Interview with the Executive Director revealed staff had no knowledge of R6 having a nail kit and would not have anticipated R6 using her nail kit to elope. Interview with the Advanced Practice Registered Nurse (APRN) revealed R6 had a higher level of	P 000	• **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident was moved to another room with an internal window. Completed on 03/16/2024. Sitters were started upon return to community 24-7 on 03/17/2024. Hourly Checks: Hourly checks were done by our Lantern staff for 1 week. • **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All residents are at risk for elopement. All rooms were searched for items that could be used to remove screws from windows, no items were identified. Window Security: All windows including resident room windows and common area windows are now secured with; 4 Star Drive 3-1/2" inch screws and the T25 Screw Bit to every window. Completed on 03/16/2024. Letter to Families: Letter was sent to all resident family members asking them not to bring any scissors, metal nail files or clippers, screw drivers, tweezers, etc. on 3/20/2024. A second letter to families/POA was sent out requesting signature was sent out on 04/24/2024 and was completed as of 5/1/24. All staff were educated to look for scissors, metal nail files, nail clippers, screw drivers, tweezers, in the environment that could be used to facilitate an elopement on 03/16/2024 and was completed on May 1, 2024. • **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;** Window Security: All windows including resident room windows and common area windows are now secured with; 4 Star Drive 3-1/2" inch screws and the T25 Screw Bit to every window. Window checks were started and completed on 03/16/2024 by maintenance director.	

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P 000	Continued From page 1 cognition than other facility residents; however, the resident did exhibit delusional thoughts and an altered sense of reality. The APRN stated if R6 were to elope, he did not believe the resident was capable of making well-informed decisions, which could put the resident at risk for harm to herself or others. It was determined the facility's failure to provide supervision placed the residents at risk for imminent danger or substantial risk of death or serious physical harm. A Type A Citation was issued to the facility on 03/28/2024.	P 000	• **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** Room Checks: All resident and common area rooms/windows will be checked by the Maintenance Director, Jason Westbrook or designee 3 times per week times 1 month, 1 time per week times 1 month, 1 time every two weeks times 1 month then once monthly times 3 months. The Executive Director, Chase Williams will receive the window check results and will oversee that any needed actions for window security are done. The window checks started the afternoon of March 16th and completed. • **By what date the systemic changes will be completed.** 5/1/2024	
P 185	902 KAR 20:036 4(1)(a)1-4 Section 4. Provision of Services (1) Basic health and health related services. (a) A PCH or SPCH shall provide basic health and health related services, including: 1. Supervision and monitoring of the resident to assure that the resident's health care needs are met; 2. Supervision of self-administration of medications; 3. Storage and control of medications; and 4. Arranging for therapeutic services ordered by the resident's health care practitioner, if the services are not available in the facility.	P 185		

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This requirement is not met as evidenced by:
Based on observation, interview, record review, review of the facility's investigation, review of a Kentucky Crisis Intervention Report, review of the website localconditions.com, review of the website googlemaps.com, and review of the facility's policy, it was determined the facility failed to have an effective system to ensure safety of residents by providing supervision and monitoring to prevent elopement for one (1) of nine (9) sampled residents, Resident (R)6.

On 03/16/2024, R6 exited the facility without staff's knowledge. R6 was last seen by Resident Assistant (RA)1 at 8:31 AM heading back to her room following the breakfast meal service. RA1 went to R6's room to remind the resident of the lunch meal service at 11:30 AM and noted the resident was not in her room. RA1 alerted Licensed Practical Nurse (LPN) Lead1, who initiated elopement protocol at that time, notifying the responsible party, the Executive Director (ED), the Director of Nursing (DON), and the Medical Director. Staff members were unable to locate R6 within the facility and determined the resident had egressed through her bedroom window unassisted. Staff continued using the elopement protocol, searching outside of the facility for R6. Police were notified and arrived at the facility at 12:28 PM. Police located R6 at 2:03 PM, approximately one mile from the facility across a busy highway. R6 had a purse, a reusable shopping bag, a water bottle, and was carrying a jacket. R6 was not injured and was transported to the local hospital for assessment.

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P 185	Continued From page 3 Based on these findings, it was determined the facility failed to ensure each resident received adequate supervision and monitoring to prevent elopement. This failure presents an imminent danger and creates substantial risk that death or serious physical harm to residents could occur. The findings include: Review of the facility's policy titled, "Elopement," dated 11/13/2015, revealed residents would be assessed quarterly and at the time of any significant change in behavior for appropriateness for facility placement. The policy revealed residents would be placed in a secure environment if available, and if not, one-on-one supervision would be required at the resident's expense. Review of R6's "Face Sheet" revealed the facility admitted R6 to its secure Alzheimer's specialty facility on 08/31/2023 with diagnoses to include vascular dementia unspecified severity with mood disturbance and schizophrenia unspecified. Review of R6's "Care Plan," dated 01/01/2024, revealed the resident was independent with most activities of daily living (ADL), requiring staff reminders or staff assist with activities to include housekeeping and laundry. Review of R6's "Progress Note," dated 02/16/2024, revealed the resident was seen by Medical Doctor #1 for a chronic care visit with no noted distress or changes in behavior. Review of R6's "Progress Notes," from time of admission to 03/16/2024, revealed no mention of exit seeking behaviors or statements indicative of elopement. The resident was previously noted as	P 185		

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P 185	Continued From page 4 refusing medications in October 2023, with increased paranoia, requiring hospitalization for medication management. Review of R6's "Progress Note," dated 03/16/2024 at 11:38 AM, revealed RA1 alerted nursing staff the resident was not in her room, and a search was initiated. Staff determined R6 had egressed through the bedroom window. Staff initiated elopement protocol and notified the ED, DON, Medical Director, and responsible party. Further review revealed the resident was located, assessed with no obvious injuries, and transported to the hospital for evaluation with the responsible party at the bedside. Review of the facility's "Investigation Report," dated 03/16/2024, revealed R6 was last seen by facility staff following the breakfast meal service at 8:30 AM. Per the investigation, at 11:30 AM staff members were unable to locate R6 to remind her about the lunch meal service. The report stated staff determined R6 had removed the secure screws from her window which had prevented it from fully opening, had removed one of the window latches that secured the window in place, and had cut along the edges of her screen at the bottom and sides, before pulling the curtains and closing the window from the outside. Observation on 03/22/2024 at 12:26 PM outside of R6's window revealed a wooden fence approximately 10 feet from the facility and railroad tracks beyond that. Review of a "Kentucky Crisis Intervention Report," dated 03/16/2024, revealed R6 was last seen at the facility on 03/16/2024 at 8:30 AM. A local police officer arrived at the facility at 12:28 PM and met with the DON. The report stated the	P 185		

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P 185	Continued From page 5 DON told the officer R6 had been making statements about wanting to go out-of-state for weeks and was upset with her family for putting her in the facility. The report revealed R6 was located by police at 2:03 PM, approximately one mile from the facility, and stated she had left the facility because she did not like it there. R6 was sent to the local hospital. Review of local weather conditions from the website localconditions.com revealed the temperature on 03/16/2024 at 8:30 AM was 37.4 degrees Fahrenheit (F); at 11:30 AM was 46.4 degrees F; and at 2:00 PM was 57.2 degrees F. Review of R6's "Emergency Department Encounter," dated 03/16/2024 and 03/17/2024, revealed the resident presented for evaluation following elopement from a nursing facility, with plans to hitchhike out-of-state where her sister was. Per the document, R6 reported to hospital staff that she was a beautician, who went to work for the federal government as an undercover agent and had top security clearance from the White House. Per the Emergency Department document, R6 was kept for observation admission overnight at the recommendation of hospital behavioral health and to provide the facility an opportunity to arrange for a one-on-one sitter. Per the document, R6 stated to hospital staff she had crawled out the window at the facility and followed the railroad tracks. Hospital documentation noted the resident had been missing from the facility for approximately five hours prior to being located. R6 was discharged to the facility the morning of 03/17/2024. Review of the website googlemaps.com revealed the railroad tracks behind the facility crossed over a busy highway and led to the grassy area near a	P 185		

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P 185	Continued From page 6 car dealership, approximately one mile away, where R6 was located by police. Review of R6's "Triage Notes," dated 03/18/2024 and signed by Advanced Practice Registered Nurse (APRN) #2, revealed R6 admitted to planning the elopement for months. The note stated R6 had a map, bus routes, phone numbers, hotel locations, and had made statements indicating she would elope again. Review of R6's "Progress Notes," dated 03/21/2024, revealed R6 was seen by APRN #1 following the elopement on 03/16/2024. Per the note, R6 denied any mental health issues and exhibited increasing delusions to APRN #1. In an interview with R6 on 03/22/2024 at 3:08 PM, she stated she had recently returned from the hospital following leaving the building. R6 alleged a fellow resident had been screaming all night and walking up and down the halls in just a brief, and another resident would make noise at night and keep her awake. The resident stated she had planned to go out-of-state after leaving the building recently. The resident discussed her job as an inspector for the government, traveling to meat processing plants all over the country. The resident stated many of her former co-workers had been shot in the head while on assignments to which she had almost been assigned. In an interview with R6's son and Power of Attorney (POA) on 03/25/2024 at 3:20 PM, he confirmed R6 worked as a meat processing plant inspector and had traveled through her job to different states across the country. He stated, due to the resident's dementia, he became her guardian. Regarding the resident's elopement, he stated the resident planned it meticulously, as he	P 185		

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P 185	Continued From page 7 found stacks of papers in the resident's purse with addresses, phone numbers, maps, and employee schedules. He described R6 as manipulative, telling people she was working undercover and telling stories based on things that happened 40 years ago. R6's son stated he did not believe the facility could have done anything differently and admitted in hindsight purchasing a nail kit for R6 was possibly a bad idea, although he would never have imagined it being used as a tool kit for the resident to elope. He stated the resident had always kept herself presentable, taking pride in her appearance. He stated, although R6 loved the staff at the facility, she did not want to lose her freedom and could not take care of herself. In an interview with the ED on 03/26/2024 at 3:04 PM, she stated all facility residents were considered at risk for elopement given the population the facility served. She stated, although there were no separate elopement assessments completed on residents, they were recognized as at risk and documented as at risk for elopement on all quarterly level of care assessments conducted. In an interview with RA1 on 03/22/2024 at 1:55 PM, she stated she had been working at the facility for under a month and remembered seeing R6 at breakfast. She described R6 as private and independent, as well as smart. She stated R6 needed very little assistance. She stated nothing seemed out of character that day. She stated she was getting residents ready for lunch in the dining room at 11:30 AM and noticed R6 was not at her table, so she went to the resident's room to remind her about lunch. She stated she could not locate the resident. She stated she alerted LPN Lead1, and everyone	P 185		

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P 185	Continued From page 8 started searching for R6 at that time and did a head count of residents. RA1 stated R6 did not return to the facility that day. In an interview with State Registered Nurse Aide (SRNA)2 on 03/25/2024 at 12:55 PM, she stated R6 was in a good mood on the morning of 03/16/2024, with no unusual behaviors. She described R6 as being a person that needed little assistance and could take care of herself with little supervision. She stated the resident never talked about leaving, went on outings, and was a generally happy person that kept to herself a lot. In an interview with RA4 on 03/26/2024 at 10:17 AM, she stated she had worked at the facility since 03/06/2024 and had observed R6 at breakfast on 03/16/2024. She stated the resident did not seem different in any way that morning. She stated RA1 noticed the resident was missing around 11:30 AM when doing a room check, and staff checked rooms and did a head count at that time. RA4 stated she stayed inside with residents while other staff went to look for R6. In an interview with LPN Lead1 on 03/22/2024 at 1:28 PM, she stated she had worked on 03/16/2024 from 7:00 AM until 7:00 PM. She stated she last saw R6 leaving breakfast around 8:30 AM. She stated she had not noticed anything different about R6 that morning. She stated RA1 reported to her around 11:30 AM that R6 was missing. LPN Lead1 stated she initiated the elopement protocol and contacted management staff. She stated when R6 was located behind a nearby car dealership, she was wearing a short-sleeved black and white shirt and carrying around a jacket, purse, and reusable grocery bag. She stated although the wind was chilly, R6 did not appear to be cold. She stated R6 was upset	P 185		

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P 185	Continued From page 9 that she had been found and was transported to the hospital for evaluation before returning to the facility the following day. In another interview with the ED on 03/22/2024 at 9:45 AM, she stated 03/16/2024 was a typical day for R6, with no one suspecting anything. She stated the resident did not exhibit exit-seeking behaviors or verbalize leaving. Following R6's elopement, she stated it was determined the resident had used a nail kit, which the resident kept hidden in her purse. She stated the resident removed screws from her window and removed the lock with the nail kit, before cutting neatly along the edges of the window screen. The ED stated R6 told her, after the elopement, she liked everyone at the facility but just wanted to live on her own. In an interview with the DON on 03/25/2024 at 2:17 PM, she stated she was called on 03/16/2024 when R6 eloped and called 911 on her way to the facility. She stated she had worked the day prior, and R6 seemed fine and did not say she wanted to leave. The DON stated she did not feel there was a facility failure but did state facility staff would not allow residents to purchase a nail kit or anything sharp while on shopping trips. In an interview on 03/26/2024 at 3:39 PM with APRN #1, he stated he saw R6 on 03/21/2024 after being informed of an attempted elopement. He stated he was surprised when State Survey Agency (SSA) staff informed him of where R6 had been located. He stated anyone in a memory care unit that was locked was an elopement risk. He stated as R6 was more ambulatory she would be at an increased elopement risk. He stated, compared to other facility residents, R6 had a higher cognition, although she did exhibit some	P 185		

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P 185	Continued From page 10 delusional thoughts and an altered sense of reality. He stated he did not believe the resident could make well-informed decisions, which would place the resident at risk for harm to herself or others if she were to elope. In another interview with the ED on 03/25/2024 at 12:05 PM, she stated when R6 was located, both she and the Regional Vice President offered R6 their coats, but the resident stated she did not need them. The ED stated the resident was in good spirits and said she loved that kind of weather. The ED stated when they asked R6 about leaving, the resident stated she just wanted to be on her own and felt she could manage medications and finances without help. The ED stated, following the elopement, R6's room was relocated to look on a secure courtyard, and all windows were secured with specialty screws requiring a special tool to remove to prevent them from being opened.	P 185		