

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046059	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 07/29/2020
NAME OF PROVIDER OR SUPPLIER CEDAR LAKE VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 15325 S LONE ELM RD OLATHE, KS 66061		
(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 citation represents the findings of an abbreviated survey with complaint investigation #154517, 154539 along with the special infection control survey for COVID-19 # EJ9N11 for the above named facility conducted on 7/27/20, 7/28/20, 7/29/20.	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: K.A.R. 26-41-101(f)(1)(B) The facility reported a census of 56 residents (23 memory care residents, 33 assisted living residents). The sample included 1 resident. Based on observation, record review and interview for resident #1, the administrator failed to ensure that no resident was subjected to neglect when a resident with a history of wandering and poor decision making, left the fenced outdoor area of memory care through an unlocked gate, was unaccounted for by staff for at least 2 hours and 15 minutes and returned to the facility by police. The resident continued to be at risk for elopement when she continued to reside	S3026		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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S3026	Continued From page 1 in the memory care unit each night without documented staff observation checks. Findings included: - Record review for resident #1 recorded admission date of 10/1/18 with diagnoses of: dementia, chronic kidney disease, hypertension, polymyalgia rheumatica, coronary artery disease and cardiomyopathy. Functional Capacity Screen (FCS) dated 3/30/2020 recorded resident independent with transfer and walk/mobility, has problems with long term memory, short term memory, memory recall and decision making. Resident has a history of falls, impaired vision, impaired decision making and wandering. Negotiated service agreement/ health care service plan (NSA/HCSP) dated 3/30/2020 lacked interventions for fall risk, impaired vision, impaired decision making and wandering. Interview on 7/28/20 at 11:12am with licensed nurse #B confirmed NSA/HCSP lacked interventions for fall risk, wandering and exit seeking. She confirmed NSA/HCSP has not been updated since 3/30/2020. She confirmed record lacked risk assessments for elopement. Facility policy titled Elopement From Assisted Living Communities, recorded: residents will be assessed for history and/or risk of elopement by the assisted living community (ALC) registered nurse using the functional living assessment tool. Ongoing assessments and adjustments to the	S3026		

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S3026	Continued From page 2 service plan will be made as warranted by a change in the medical condition of the resident per state regulations. Physician's admission orders dated 10/1/18 recorded: is the resident at risk for elopement? "Yes", "Has been wandering at [another facility]". Interdisciplinary progress notes [nurses notes] dated 7/24/20 at 2:50 pm recorded: "On 7/23/20 at approximately 10 pm, this writer received a call from staff that police were at the community and brought this resident back. Police reported to this writer that the resident was found approximately two hours earlier by a community member who stayed with her and called the police" Signed by Administrator #A. Observation of facility on 7/27/20 at 1:25pm revealed resident resided in a room on the locked memory care unit. The unit is one of two units with keypad locked entries, both units connect to one enclosed outdoor courtyard area. Courtyard is accessed thru an unlocked door from the unit, door is not alarmed. Courtyard has a large stone wall on the backside approximately 12-foot high, with approximately 12-foot heavy iron gates at each end. Gate #1 is bordered by a short 3-foot unlocked fence with a sidewalk leading to an alarmed keypad iron gate, gate #2 is poorly accessible by walking on a small grass path, between tall grasses and lavender plants. Gate #2 is mostly obscured by the plants. Observation of Gate #2 from the outside: Gate had a single key lock and drop latch only accessible from the outside and was zip-tied shut with a sign on the outside of the gate that read "Attention keep gate closed and locked". Observation of facility video of Gate #2 for	S3026			

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S3026	Continued From page 3 7/23/20 revealed maintenance staff #E entered the courtyard thru Gate #2 at 9:15am. He is seen later entering the facility via one of the locked units and does not go back out thru gate #2. At 7:42pm resident #1 is seen exiting the courtyard thru gate #2, she walked along the building, past the assisted living building, past the employee parking lot and past the garages headed towards 153rd Place Road. It is approximately a 500-foot walk to 153rd Place Road. The facility sits on the corner of 153rd Place and Lone Elm Road, it faces west towards Lone Elm Road. The memory care unit and courtyard are on the backside of the complex. A fountain pond sits at the front of the facility and Cedar Lake (57 acres of water) is directly West of the facility across Lone Elm Road. Confidential citizen #Z reported to the department, the resident was seen walking alone near a church, on the sidewalk bordering Lone Elm Road, a divided 4 lane paved road, at approximately 8:06pm and again 30 minutes later near the industrial park talking to a bicyclist. Resident was wearing a button-down pajama top with another shirt over it, tan pants and shoes. Resident was returned to the facility at approximately 10pm by the Olathe police officers. Interview on 7/28/20 at with Citizen #Z stated the resident was seen on the same side the facility is located on (East side), first near the church at 8:06pm then at 8:40pm near the industrial park (located south of the church). The church and industrial park are located on the east side of Lone Elm Road, approximately 1.75 miles from the facility. The east side sidewalk crosses a 4 lane on/off ramp to I35, goes over an overpass of I35, crosses 159th Road (2 lanes) before	S3026		

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S3026	Continued From page 4 reaching the church and industrial park. By calculations resident #1 walked to the church area in approximately 24 minutes. Wunderground.com recorded the weather in Olathe at 7:53pm on 7/23/20 to be 86F (degrees Fahrenheit) sunny with 15 mph (mile per hour) winds from the east-southeast. Review of staff schedule for 7/23/20; 2-10pm evening shift for the unit, revealed certified staff #C worked 2-10pm, certified medication aide (CMA) #F worked 2-6pm and certified medication aide #G worked 6-10pm (listed on other unit's schedule sheet). Interview on 7/28/20 at 11:30am with licensed nurse #B, stated there are usually 2 staff: 1 CMA and 1 CNA (certified nurse aide) on both units, but on 7/23/20 they were short-staffed and the CMA's split the shift and floated between the 2 units from 2-10pm. Resident roster recorded a census of 23 residents for the 2 memory care units, all residents had impaired cognitive status and have access to the courtyard area. Observation of resident #1 on 7/27/20 at 4:25pm, on the unit, revealed resident dressed in 2 layered shirts, pants and tennis shoes, she ambulated quickly and independently about the unit, and unsuccessfully attempted to open the exit door to the unit three times in 10 minutes. Interview with the resident revealed resident was confused, she thought she was in another city and did not know what year it was. Notarized statement dated 7/28/20 for certified staff #D recorded: "[resident #1] ate around 4:30	S3026			

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S3026	Continued From page 5 to 4:45pm when dinner is usually passed. From there she was exit seeking and asking how to get home I redirected her and told her that our doors were locked for the night ... I talked to her around 7pm and a few minutes later she went out into the courtyard which residents are allowed, to sit, walk, explore etcetera in, with free range of. About 9:30-10pm I noticed that she was missing and the medication aide who was in [the other unit] had notified me about what was going on. The Olathe police had brought her back" Interview on 7/27/20 at 3:58pm with administrator #A stated after resident was returned to the facility, they had staff do a check on everybody every 2 hours. She confirmed they had no documentation of resident checks following the elopement. Logbook documentation for doors and gates recorded staff checked the gates monthly with a check completed on 6/30/20 and after the elopement on 7/24/20. On 7/27/20 at 4:52pm administrator #A was notified of immediate jeopardy regarding the elopement of resident #1. For resident #1, the administrator failed to ensure that no resident was subjected to neglect when a resident with a history of wandering and poor decision making, left the fenced outdoor area of memory care through an unlocked gate, was unaccounted for by staff for at least 2 hours and 15 minutes and returned to the facility by police. The resident continued to be at risk for elopement when he/she continued to reside in the memory care unit each night without documented staff observations. These failures placed the resident	S3026		

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S3026	Continued From page 6 in immediate jeopardy for harm, injury or death. The jeopardy was removed on 7/27/20 at 5:50pm. when administrator #A provided a written plan to that included: 15 minute staff checks on resident #1; twice daily checks of all memory care doors including courtyards; courtyard key will be kept in the maintenance office; education of maintenance staff regarding the lock on the gate; staff education to check on residents every 20 minutes when outside, courtyard doors to be locked at 8pm and checked by night shift that they are properly locked; resident count after 8pm door lock; doctor evaluation of resident; care plan update for exit seeking behavior and interventions.	S3026		