STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N080004	A. BUILDING: _____ B. WING _____	07/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY LIVING OF LYONS	502 S MILES STREET LYONS, KS 67554

(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 the licensure resurvey for the above named assisted living facility conducted on 7/30/19 and 7/31/19.	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 17 residents. The sample included 3 residents. Based on observation, interview and record review the administrator/operator failed to ensure staff provided the required and planned supervision of resident #1 who was identified as an elopement (absent from the facility without staff's knowledge) risk and exited the facility without staff's knowledge on 7/24/19 at approximately 6:40 PM. The resident ambulated without an assistive device on a presumed route which included an uneven gravel road for 0.3 miles from the unknown exit location of the facility. Facility staff located the resident in a parking lot of a local business which was 0.3 miles away from the facility. The facility further failed to ensure all exit	S3026		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N080004	A. BUILDING: _____ B. WING _____	07/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY LIVING OF LYONS	502 S MILES STREET LYONS, KS 67554

(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
S3026	Continued From page 1	S3026		

doors were locked or alarmed as per facility's policy to ensure the resident's safety following the elopement on 7/24/19 which placed resident #1 in immediate jeopardy for harm, injury or death.

Findings included:

- Record review on 7/30/19 at 3:10 PM for resident #1 revealed an admission date of 1/09/17 with diagnosis of dementia diabetes mellitus type 2 and hypertension. The record identified the resident as 84 years old.

The annual functional capacity screening (FCS) dated 7/01/19 identified the resident with short and long-term memory impairment, impaired memory recall and impaired decision making. He/she could transfer independently from surface to surface and was independent with walking/mobility without the use of an assistive device. He/she experienced wandering behavior (movement with no identified rational purpose; resident appears oblivious to needs or safety).

An elopement risk assessment dated 3/25/18 and 7/01/18 identified the resident with a score of 21 (score of 10 or greater indicated at risk). The assessment indicated the resident had attempted to or had left the building, he/she was fully ambulatory and disoriented daily.

The negotiated service agreement/health care plan (NSA/HCP) dated 7/01/19 indicated the resident had difficulty with both long and short-term memory, required daily reminders by certified staff of meal times and activities, needed supervision and was at risk for wandering. The resident wore a WanderGuard (signals the controller when an at-risk resident approached and can lock a monitored door) bracelet to allow

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N080004	A. BUILDING: _____ B. WING _____	07/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY LIVING OF LYONS	502 S MILES STREET LYONS, KS 67554

(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
S3026	Continued From page 2	S3026		

24 hours daily monitoring of his/her location by certified staff for his/her safety. A door alarm placed on the emergency exit door closest to the resident's room which would sound whenever anyone attempted to exit the building through the door.

Review of a faxed communication to the resident's medical provider dated 7/25/19 revealed on 7/24/19 at 6:40 PM certified staff noted the resident no longer seated in the common area as per his/her usual routine. Certified staff last saw the resident at 6:20 PM before assisting another resident. Dietary staff had heard the door alarm sounding briefly earlier but then the alarm stopped, and he/she assumed another staff member had entered the code to stop the alarm. Staff left the facility in a car and searched the surrounding area with locating the resident at a local business (named) parking lot with no apparent injury and voiced, "I need to come back home". Staff brought the resident back and noted the WanderGuard on the door sounded. The medical care provider signed-off on the notification.

On 7/30/19 at 3:10 PM Review of the resident progress notes between 12/20/18 at 11:00 AM and 7/29/19 at 10:00 AM revealed an entry dated 6/26/19 at 11:00 AM about a medical care provider visit. The next entry dated 7/24/19 at 6:40 PM by licensed nurse A indicated certified staff C and D came out of resident #4's room after providing care the certified staff noted resident #1 was no longer seated in the day room. Certified staff spoke with dietary staff E who stated he/she had heard the resident's WanderGuard type door alarm while he/she was in the bathroom and then the alarm stopped so dietary staff E assumed certified staff C or D had

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N080004	A. BUILDING: _____ B. WING _____	07/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY LIVING OF LYONS	502 S MILES STREET LYONS, KS 67554

(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
S3026	Continued From page 3	S3026		

put the code into the door to stop the sound. The resident was last observed at 6:20 PM seated in the day room. Staff C, D and E search inside and outside the facility for the resident and then 2 staff searched by vehicle and located the resident in the parking lot of local restaurant ... staff assisted the resident back to the facility and noted the WanderGuard alarm sounded as the resident entered the facility. Staff tested the WanderGuard at both the front and back doors which functioned. The resident's vital signs were taken and within normal limits, provided fluids, assisted into his/her night clothes and the resident voiced no complaints.

On 7/25/19 at 10:00 AM licensed nurse A made an entry of follow-up on the resident's condition regarding a restful night and sitting in the day room relaxing, drinking coffee and no complaints.

On 7/25/19 at 8:00 PM licensed nurse A wrote certified staff reported the resident had been increasingly anxious since around the evening meal, going into other resident's rooms, verbal outburst and shaking his/her hands at the staff. Certified staff provided assistance by placing him/herself close by the resident. The resident denied pain/discomfort, currently seated in the day room with certified staff. The WanderGuard was working on both side doors.

Entries on 7/26/19 indicated the resident went to the medical care provider's office for follow-up with lab testing which revealed no evidence of urinary tract infection and no new orders.

Note - on 7/30/19 at 3:15 PM upon request to review the facility's investigation of the incident licensed nurse A provided a single page front and back side document titled incident report. When

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N080004	A. BUILDING: _____ B. WING _____	07/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY LIVING OF LYONS	502 S MILES STREET LYONS, KS 67554

(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
S3026	Continued From page 4	S3026		

asked for statements from staff about the incident he/she reported the back side included the narrative event written and signed by all 3 staff present in the facility at the time of the incident. The incident report identified on 7/24/19 at 6:40 PM the resident had left the facility without any witnesses or staff's knowledge. The resident's condition before the incident was confused and disoriented. The incident report/investigation did not indicate when staff had last seen the resident, provided the resident with care or evaluated the WanderGuard system for placement and function.

The narrative portion indicated dietary staff E was in the restroom and certified staff C and D were in helping another resident. Dietary staff E heard the alarm go off for a minute or two and then shut off. Certified staff C and D did not hear the alarm. Certified staff C and D then went resident #5's room to provide assistance. When certified staff C and D left resident #5's room he/she noted resident #1 was not anywhere in the living area. Certified staff C and D searched the whole facility and could not find resident #1. Then certified staff D and dietary staff E left the facility in a personal vehicle and found resident #1 in the parking lot at the (named) local business. The resident was a little confused when found and was talking to people who knew him/her in the parking lot. The resident stated, "(he/she) needed to come back home, (he/she) should not do that again". When the resident got home, staff tested his/her alarm which worked at the front and back door, notified the nurse and took the resident's vital signs.

On 7/30/19 at 2:30 PM during the onsite tour of the facility, observation revealed resident #1 sat in a lounging chair of the common area next to the dining room area. The resident's room was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N080004	A. BUILDING: _____ B. WING _____	07/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY LIVING OF LYONS	502 S MILES STREET LYONS, KS 67554

(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
S3026	Continued From page 5	S3026		

located to the left of the dining area and back side of the facility. To the right of the resident's room was another resident's room and the next door was an interior exit door that opened freely and without any audible alarm. This interior hallway included a staff use area with the time clock and an exit to the outside. The lockable exit door was not locked and opened onto the fenced in back patio. Moving along the paved area to the left without any obstacles was a gated exit out of the patio area and the gate opened freely and exited onto a sidewalk area which continued around the facility. At the side of the facility and front of the facility sidewalk junction the paved portion of the traffic area became an uneven gravel road which lead to the area where staff had located the resident on 7/24/19.The patio gate also had a chain (loop type) which was wrapped and secured around the door portion only and did not secure the gate in any fashion. Across the patio the other gate also opened freely and had a chain on the door portion only.

On 7/30/19 at 2:35 PM with licensed nurse A observation of the exit door close to the resident's room opened freely and no alarm sounded. He/she said the door was supposed to alarm when opened to alert staff someone went in or out the door. He/she verified the alarm was not working. Administrator B arrived at the area about a minute later and also confirmed the door was to alarm but the alarm did not function, and he/she was going to find out why.

Interviews on 7/30/19 at 2:40 PM with both administrator B and licensed nurse A revealed that prior to the incident nor after the incident did the facility have evidence of checking the alarm for functioning at the exit near the resident's room. Licensed nurse A reported the checking of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N080004	A. BUILDING: _____ B. WING _____	07/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY LIVING OF LYONS	502 S MILES STREET LYONS, KS 67554

(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
S3026	Continued From page 6	S3026		

the function for the resident's WanderGuard occurred most days when the resident wandered and would set the alarm off but had no evidence of a routine checking for placement of the alarm, the battery function or the alarm functioning.

Observation on 7/30/19 at 3:20 PM with administrator B revealed the exit door close to the resident's room remained unlocked and no alarm sounded when the door was opened. He/she reported the alarm was in the off mode and the key fob which turned the alarm on/off was lost during the search for the resident on 7/24/19 and not reported to him/her of the loss or non-functioning alarm.

Observation on 7/30/19 at 3:25 PM revealed the resident independently stood from the chair in the common area next to the dining room, walked independently towards his/her room and the area with the exit door. He/she opened his/her apartment door and entered the room. The exit door (just 1 door over from his/her room) remained unlocked and no alarm sounded when opened. The exit door to the outside was locked at this time. Exiting from the back-patio door revealed both patio gates remained unlocked or secured with the chain and opened freely.

On 7/30/19 at 3:33 PM a discussion with administrator B occurred regarding the incident and the immediate jeopardy to the resident based on non-functioning alarms, unlocked exits, unlocked patio gates and no system in place for routine checking for placement of the WanderGuard alarm, the battery function of the WanderGuard neck pendant used or the WanderGuard alarm functioning at the 2 exit doors equipped with the WanderGuard.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N080004	A. BUILDING: _____ B. WING _____	07/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY LIVING OF LYONS	502 S MILES STREET LYONS, KS 67554

(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
S3026	Continued From page 7 Interview on 7/30/19 at 2:47 PM certified staff G reported he/she arrived to work around 2:00 PM on 7/30/19, parked in the side lot and entered through the patio gate, entered the side door from the patio into the time clock area and then through the kitchen. He/she reported going back out at about 2:30 PM to fix the chain and lock the gate. He/she reported a usual practice of the staff to enter and exit through the patio gate into the side door into the time clock area. Interview on 7/30/19 at 5:09 PM with certified staff C revealed the resident had been getting more confused after supper, resistant to care, stayed up later and wandered looking for his/her room or something. On 7/24/19 after supper at approximately 6 or 6:15 PM certified staff C went out on the back patio for a break and the resident walked out the back-patio door setting off the WanderGuard alarm. Certified staff C deactivated the code and had the resident sit with him/her for the rest of the break about 5 minutes. Certified staff C then assisted the resident back into the facility and to sit in the recliner chair in the day room (TV area-which is the other side of the facility from his/her room). Certified staff C and D entered the room of resident #4 to provide cares at about 6:20 PM. He/she reported the cares took about 10 minutes. When certified staff C and D left the room of resident #4, they went to provide care for resident #5 whose room was next to resident #1 room. After providing toileting assistance and dressing for bed to resident #5 certified staff C and D returned to the common area and noted the resident no longer seated in the recliner and began searching for the resident. Certified staff C reported an no time other the break on the patio was an alarmed heard. He/she reported checking the function of all door alarms and locks of the exits. The WanderGuard	S3026		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N080004	A. BUILDING: _____ B. WING _____	07/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY LIVING OF LYONS	502 S MILES STREET LYONS, KS 67554

(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
S3026	Continued From page 8	S3026		

functioned on the front and back door but the door by the resident's room/kitchen did not alarm and when talking with the on-coming certified staff F decided to lock the door which exited to the outside. He/she reported prior to the incident staff routinely used the door close to the resident's room to enter and exit after clocking in/out for the shift but since the incident he/she has not used that door.

Interview on 7/30/19 at 5:32 PM with certified staff D revealed on 7/24/19 at about 6:20 PM he/she and certified staff C were in resident #4's room providing care and when they came out of resident #4's room he/she noted resident #1 seated in a chair in the TV area. He/she and certified staff D went to the room of resident #5 to provide cares. After getting the resident into the bathroom certified staff D left the room to go to another resident and prep for showering then returned to resident #5's room to help certified staff C complete the cares for bedtime prep. When completed certified staff C and D exited resident #5's room, entered the common area and noted resident #1 was no longer seated in the TV area. Staff C and D separated to search both sides of the facility at the same time and check every room. Then he/she went outside and walked all around the facility looking for the resident. He/she reported searching about a block each direction from the facility then he/she and dietary staff E went by personal vehicle and found the resident in the parking lot of the local restraunt about 3 blocks away. He/she reported at about 3:30 PM-4:00 PM several residents were out on the patio when resident #1 walked out the patio door and the alarm sounded, had to ask him/her to walk away from the door and reset the alarm. He/she reported not hearing any alarms sounding after supper. He/she had worked at the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N080004	A. BUILDING: _____ B. WING _____	07/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY LIVING OF LYONS	502 S MILES STREET LYONS, KS 67554

(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
S3026	Continued From page 9	S3026		

facility for about 3 weeks and used the exit door close to resident #1's room to enter/exit the facility after clocking in. He/she was not aware of an alarm on the door and had never heard the door alarm.

Interview on 7/30/19 at 5:45 PM with dietary staff E revealed he/she on 7/24/19 at about 6:00 PM following supper had been on the phone talking with his/her supervisor and had loaded the dish machine then went to the bathroom. He/she indicated being in the bathroom a minute or so when he/she heard the WanderGuard alarm sound, but he/she could not respond. The alarm sounded for 2-3 minutes he/she guessed and stopped. Once he/she was done using the bathroom and exited the bathroom he/she saw both certified staff C and D come from the direction of resident #4's room. He/she then unloaded and reloaded the dish machine when certified staff C and D came and told him/her they were looking for resident #1 and he/she told them about hearing the alarm, but it stopped so he/she assumed one of certified staff had deactivated it. He/she assisted with the search for the resident.

Note - interview with certified staff C indicated the resident exited the back-patio and the alarm sounded at about 6:15 PM when he/she was outside on break and may have been the timeframe that dietary staff E heard the alarm.

Review of the facility's policy dated 2016 and titled, Monitoring Entry Ways directed staff the front and rear doors of the building will remain unlocked during the hours of 7:00 AM and 7:00 PM. The service door opening to the patio will remain locked at all times.

The facility's policy dated 2016 titled, reporting

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N080004	A. BUILDING: _____ B. WING _____	07/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY LIVING OF LYONS	502 S MILES STREET LYONS, KS 67554

(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
S3026	Continued From page 10 requirement in case of abuse, neglect and exploitation included a definition for neglect as - the failure or omission by one's self, caretaker, or another person to provide goods or services which are reasonably necessary to ensure the safety and well-being and to avoid physical or mental harm or illness. The administrator/operator failed to ensure staff provided the required and planned supervision of resident #1 who was identified as an elopement risk and exited the facility without staff's knowledge on 7/24/19 at approximately 6:40 PM. The resident ambulated without an assistive device on a presumed route which included an uneven gravel road for 0.3 miles from the unknown exit location of the facility. Facility staff located the resident in a parking lot of a local business which was 0.3 miles away from the facility. This failure placed resident #1 in immediate jeopardy for harm, injury or death. The jeopardy was removed on 7/30/19 at 4:20 PM when administrator B placed a new magnetic type alarm on the interior door which exited to an area with an outside exit door, secured the door from manually being opened and locked the outside exit door. He/she also secured the patio exit gates and provided education to the staff regarding the alarms, locks and gates along with a system of monitoring the alarms, locks and gates with documentation of such.	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	S3028		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N080004	A. BUILDING: _____ B. WING _____	07/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY LIVING OF LYONS	502 S MILES STREET LYONS, KS 67554

(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 11 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 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 (f)(3)(A)(B)(C) The facility reported a census of 17 residents. The sample included 3 residents. Based on interview and record review the administrator/operator failed to ensure an allegation of neglect was reported timely to the state agency, thoroughly investigated and appropriate immediate measures taken to prevent further neglect for 1 of 3 sampled residents (#1) who left the building without staff's	S3028		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N080004	A. BUILDING: _____ B. WING _____	07/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY LIVING OF LYONS	502 S MILES STREET LYONS, KS 67554

(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 12	S3028		

knowledge on 7/24/19.

Findings included:

- On 7/29/19 at 4:26 PM administrator/operator B made a report to the state agency of resident #1's elopement on 7/24/19 at 6:40 PM.

Record review on 7/30/19 at 3:10 PM for resident #1 revealed an admission date of 1/09/17 with diagnosis of dementia diabetes mellitus type 2 and hypertension. The record identified the resident as 84 years old.

The annual functional capacity screening (FCS) dated 7/01/19 identified the resident with short and long-term memory impairment, impaired memory recall and impaired decision making. He/she could transfer independently from surface to surface and was independent with walking/mobility without the use of an assistive device. He/she experienced wandering behavior (movement with no identified rational purpose; resident appears oblivious to needs or safety).

An elopement risk assessment dated 3/25/18 and 7/01/18 identified the resident with a score of 21 (score of 10 or greater indicated at risk). The assessment indicated the resident had attempted to or had left the building, he/she was fully ambulatory and disoriented daily.

The negotiated service agreement/health care plan (NSA/HCP) dated 7/01/19 indicated the resident had difficulty with both long and short-term memory, required daily reminders by certified staff of meal times and activities, needed supervision and was at risk for wandering. The resident wore a WanderGuard (signals the controller when an at-risk resident approached

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N080004	A. BUILDING: _____ B. WING _____	07/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY LIVING OF LYONS	502 S MILES STREET LYONS, KS 67554

(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	S3028		

and can lock a monitored door) bracelet to allow 24 hours daily monitoring of his/her location by certified staff for his/her safety. A door alarm placed on the emergency exit door closest to the resident's room which would sound whenever anyone attempted to exit the building through the door.

Review of the resident progress notes revealed an entry dated 7/24/19 at 6:40 PM by licensed nurse A indicated certified staff C and D came out of resident #4's room after providing care the certified staff noted resident #1 was no longer seated in the day room. Certified staff spoke with dietary staff E who stated he/she had heard the resident's WanderGuard type door alarm while he/she was in the bathroom and then the alarm stopped so dietary staff E assumed certified staff C or D had put the code into the door to stop the sound. The resident was last observed at 6:20 PM seated in the day room. Staff C, D and E search inside and outside the facility for the resident and then 2 staff searched by vehicle and located the resident in the parking lot of local restaurant ... staff assisted the resident back to the facility and noted the WanderGuard alarm sounded as the resident entered the facility. Staff tested the WanderGuard at both the front and back doors which functioned. The resident's vital signs were taken and within normal limits, provided fluids, assisted into his/her night clothes and the resident voiced no complaints.

Note - on 7/30/19 at 3:15 PM upon request to review the facility's investigation of the incident licensed nurse A provided a single page front and back side document titled incident report. When asked for statements from staff about the incident he/she reported the back side included the narrative event written and signed by all 3 staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N080004	A. BUILDING: _____ B. WING _____	07/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY LIVING OF LYONS	502 S MILES STREET LYONS, KS 67554

(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 14	S3028		

present in the facility at the time of the incident. The incident report identified on 7/24/19 at 6:40 PM the resident had left the facility without any witnesses or staff's knowledge. The resident's condition before the incident was confused and disoriented. The incident report/investigation did not indicate when staff had last seen the resident, provided the resident with care or evaluated the WanderGuard system for placement and function.

The narrative portion indicated dietary staff E was in the restroom and certified staff C and D were in helping another resident. Dietary staff E heard the alarm go off for a minute or two and then shut off. Certified staff C and D did not hear the alarm. Certified staff C and D then went to resident #5's room to provide assistance. When certified staff C and D left resident #5's room he/she noted resident #1 was not anywhere in the living area. Certified staff C and D searched the whole facility and could not find resident #1. Then certified staff D and dietary staff E left the facility in a personal vehicle and found resident #1 in the parking lot at the (named) local business. The resident was a little confused when found and was talking to people who knew him/her in the parking lot. The resident stated, "(he/she) needed to come back home, (he/she) should not do that again". When the resident got home, staff tested his/her alarm which worked at the front and back door, notified the nurse and took the resident's vital signs.

On 7/30/19 at 2:30 PM during the onsite tour of the facility, observation revealed resident #1 sat in a lounging chair of the common area next to the dining room area. The resident's room was located to the left of the dining area and back side of the facility. To the right of the resident's room

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N080004	A. BUILDING: _____ B. WING _____	07/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY LIVING OF LYONS	502 S MILES STREET LYONS, KS 67554

(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 15	S3028		

was another resident's room and the next door was an interior exit door that opened freely and without any audible alarm. This interior hallway included a staff use area with the time clock and an exit to the outside. The lockable exit door was not locked and opened onto the fenced in back patio. Moving along the paved area to the left without any obstacles was a gated exit out of the patio area and the gate opened freely and exited onto a sidewalk area which continued around the facility. At the side of the facility and front of the facility sidewalk junction the paved portion of the traffic area became an uneven gravel road which lead to the area where staff had located the resident on 7/24/19. The patio gate also had a chain (loop type) which was wrapped and secured around the door portion only and did not secure the gate in any fashion. Across the patio the other gate also opened freely and had a chain on the door portion only.

Interview on 7/30/19 at 4:30 PM with administrator/operator B confirmed he/she was not in the state at the time of the incident and licensed nurse A was the responsible party for the facility. He/she confirmed the elopement met the requirements for a state reportable event and was not reported until 7/29/19. He/she reported the investigation was the incident report and there were no other statements or notes about the investigation most of the investigation was done through phone calls. He/she confirmed after the incident the WanderGuard the resident wore was changed out to ensure proper function, but no system was put into place for routine checking of placement of the WanderGuard and/or functioning with documentation to support the task. He/she was not aware the alarm on the exit door by the resident's room was not working and did not have a system in place for routine

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N080004	A. BUILDING: _____ B. WING _____	07/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY LIVING OF LYONS	502 S MILES STREET LYONS, KS 67554

(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 16 checking of the alarm function. Review of the facility's policy dated 2016 and titled, Monitoring Entry Ways revealed directions to staff that the front and rear doors of the building will remain unlocked during the hours of 7:00 AM and 7:00 PM. The service door opening to the patio will remain locked at all times. The facility's policy dated 2016 titled, reporting requirement in case of abuse, neglect and exploitation included a definition for neglect as - the failure or omission by one's self, caretaker, or another person to provide goods or services which are reasonably necessary to ensure the safety and well-being and to avoid physical or mental harm or illness. The policy directed all licensed administrators, administrative officers, social workers, nurses or other health care professionals are required by state law to report all suspected adult abuse, neglect and exploitation. The director (administrator/operator) will be notified immediately of any issues from which abuse, neglect or exploitation could be alleged. Each allegation of abuse, neglect or exploitation shall be reported to state agency within 24 hours. An investigation shall be started by the director immediately upon being notified. immediate measures shall be taken to prevent further potential abuse, neglect or exploitation while the investigation is in progress. All allegations are to be thoroughly investigated within five (5) working days of the initial report. The administrator/operator failed to ensure an allegation of neglect was reported timely to the state agency, thoroughly investigated and appropriate immediate measures taken to prevent further neglect for this resident who left the building without staff's knowledge on 7/24/19.	S3028		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N080004	A. BUILDING: _____ B. WING _____	07/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY LIVING OF LYONS	502 S MILES STREET LYONS, KS 67554

(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