STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N018010	A. BUILDING: _____ B. WING _____	02/06/2019

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ALDERBROOK VILLAGE LLC	402 WINDSOR ROAD ARKANSAS CITY, KS 67005

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S 000	INITIAL COMMENTS The following citations represent the findings of abbreviated/complaint survey with complaints #137688 and #137691 at the above named facility on 1/31/19, 2/4/19, 2/5/19, and 2/6/19.	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 identified a census of 32 residents. The sample included 3 residents. Based on record review, interviews, and observations for 1 (#2) of 3 residents sampled, the administrator failed to ensure no resident was subjected to neglect when he/she failed to provide and coordinate necessary services to address resident #2's elopement risk for a resident exhibited episodes of wandering. Resident #2 was found in courtyard, wedged under outside air conditioner unit in bush next to unit, yelling for help at approximately 6:45 a.m. Resident was last seen at 5:30 a.m. in room. The administrator also failed to ensure a licensed nurse assessed resident after being found outside in 32 degrees Fahrenheit (F), on the ground with jeans down to	S3026		

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

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ankles, no shirt, socks, shoes, complained of freezing and found to have a body temperature of 95.8 degrees Fahrenheit . These failures placed resident #2 in immediate jeopardy for harm, injury, or death.

Findings included:

- Record review for resident #2 revealed and admit date of 3/17/18 with diagnoses of psychotic with delusions, parkinson's disease, and depression.

The functional capacity screens dated 10/23/18 and 1/29/19 recorded resident required supervision with toileting, transfer, walking/mobility, eating, physical assistance with bathing, dressing, bladder incontinence, experienced impaired decision making, impaired vision, and fall/unsteadiness.

The functional capacity screens identified resident did not experience wandering or socially disruptive inappropriate behaviors.

The negotiated service agreement/health care served plan dated 10-23-18 and 1/29/19 recorded resident required physical assist with dressing, and staff to monitor and assist with toileting. Staff to monitor and ensure resident using walker properly during ambulation and is a fall risk. Behavioral/Mental status: Resident is mildly confused/disoriented, experienced hallucinations and becomes disoriented. Staff to monitor/reorientation of behaviors, providing safety to resident and surroundings. Resident has aggressive tendencies and becomes aggressive during redirection.

The resident log notes recorded the following:

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S3026	Continued From page 2 10/26/18 at 4:00 p.m. Resident was on the floor in the dining room, walker tipped over into wall. No injuries noted and assisted to stand. Signed licensed nurse A. 10/28/18 at 10:30 a.m. Received notification of resident sitting at dining room table refusing staff attempts of assisting with toileting and changing clothing, becoming agitated with staff during attempts. Signed licensed nurse A. Review of resident log notes on 1/31/19 lacked documentation of elopement on 12/22/18. 1/31/19 at 2:15 p.m. observed certified staff C transfer resident #2 from toilet to chair. Interview on 1/31/19 at 2:50 p.m. with resident #2 stated he/she liked to "whittle" and make things from wood. Resident #2 stated he/she loved fishing and anything about history. Asked resident if he/she ever fell outside in courtyard. Resident stated he/she did not recall falling. Surveyor asked if he/she fell and got stuck under air conditioner unit and could not get up? Resident stated did not recall. 1/31/19 at 3:20 p.m. observed resident ambulating with walker to front of licensed nurse A's office and stated he/she needed a bathroom. Certified staff C came and assisted resident to restroom. 2/4/19 at 11:15 a.m. observed resident #2 get up out of chair and start ambulating without walker. Resident unsteady on feet. Certified staff D came and assisted resident back to chair and placed walker in front of him/her.	S3026		

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S3026	Continued From page 3 Interview on 1/31/19 at 3:05 p.m. with resident #4 stated he/she would be glad when roofers are done putting roof on facility as they interfere with his/her nap and laughed. Asked resident #4 if he/she ever heard a resident knocking on outside window. Resident was hesitant and stated yes, it was (Resident #2). It was very cold that night and it was 12/22/18. I called and certified staff C came to my room. I told him/her that someone was knocking and banging on my window. Certified staff C stated no one was outside. I don't remember the time except it was very early in the morning and it was still dark out. I called again, and certified staff C came back to room and stated no one was at the door. Resident #4 stated he/she knew resident #2 and he/she wandered around the facility all the time, but he/she would not hurt anyone, and I am not afraid of him/her as he/she wandered in and out of resident rooms. Resident stated heard earlier that morning it was resident #2 stuck outside his/her air conditioner/bush and it was so cold outside. Interview on 1/31/19 at 3:35 p.m. with licensed nurse A asked if had any resident who was at risk for elopement or had eloped from facility in last few months. Licensed nurse A then stated "no unless going out to court yard and falling in a bush then I guess it would be yes. Yes, we did." Stated resident #2 eloped. Licensed nurse A stated certified staff E called and stated certified staff F could not find resident #2. They looked through out facility and outside of facility. At 7:10 a.m., Licensed nurse A asked who was the last person to see resident? (licensed nurse A checked the text on his/her phone). Certified staff called night shift certified staff C and he/she stated observed resident around 5:15 a.m. Resident #4 called and informed certified staff C	S3026		

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that he/she heard someone outside banging on his/her window about 4:30 a.m. At 5:30 a.m. certified staff G was with resident #4 and stated nothing was said about hearing someone outside window. Certified staff C observed resident in chair in room at approximately 5:15 a.m. At 7:15 a.m. certified staff C went out to courtyard and found resident #2 stuck in a bush and under air conditioner unit outside of resident #4's room. Resident had brief on, no pants, shoes, or socks. Licensed nurse A told certified staff E to get warmed-up blanket and clothes from the dryer, warm resident up, and give some hot coffee. Resident's temperature was reported to be 95.0. Licensed nurse A stated did not come to facility to assess resident until approximately 2:00 p.m. on 12/22/18, did not document anything in the record, notify the physician, or the Department of the elopement. Licensed nurse A did reach into a file folder and pull out 2 incident reports fill out from certified staff E and F and provided surveyor a copy and stated that was the only documentation he/she had. Licensed nurse A stated resident #2 wandered around facility and required redirection.

Incident occurrence report dated 12/22/19 completed by certified staff E and provided on 1/31/19 at 3:40 p.m. from licensed nurse A, "recorded on 12/22/18 at 6:45 a.m. asked certified staff F if he/she had seen resident #2. I told him/her no and we both immediately split up to look for resident. I went outside to search courtyard and found resident on left side of courtyard laying in bush stuck halfway under the air conditioner unit. Certified staff F and I got resident up and in a wheelchair. Resident was freezing cold and had been there for a while. We brought resident in, dressed him/her and put a warm blanket around him/her and gave warm

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coffee. Resident laid in recliner and relaxed. Resident's temperature was 95.8. Resident #4 called to tell us that he/she told certified staff C at 4:30 a.m. someone was outside his/her window and night shift told him/her now one was at the window."

Incident occurrence report dated 12/22/19 completed by certified staff F and provided on 1/31/19 at 3:40 p.m. from licensed nurse A, "recorded on 12/22/18 at 6:45 a.m. resident #2 was missing and was found out in courtyard by a bush and was hooked on a near window in the cold. Resident looked like he/she had been there a while. Took resident back to his/her room and warmed him/her up. Resident had an indention from the air conditioner unit on right hip and scratches on hand."

Interview on 1/31/19 at 4:05 p.m. with administrator B when asked if had any residents elope, he/she stated resident #2 and had received a call from licensed nurse A that resident #2 was found outside, they got him/her up and inside, then warmed him/her up. Administrator stated he/she did make a sign and place on the courtyard doors that recorded doors to be kept locked at all times due to cold weather. Doors secured and sign placed on both doors at 8:00 a.m. on 12/22/18. Administrator stated was not aware resident was not assessed by licensed nurse. A
Weather underground recorded temperature at 5:00 a.m. was 32-degree F on 12/22/18.

Written statement from administrator B on 1/31/19 at 5:00 p.m. recorded, "On the night of 12/22/18 Resident #2 was found in the court yard in his/her brief and no clothes on. Staff found

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him/her and brought him/her inside, took to room, dressed him/her, then warmed up. Licensed nurse A told me about it when I got to the facility that morning and the temperature was chilly and I took immediate action by locking both doors to the courtyard and putting signs up saying the doors are to be locked at all times. The staff was instructed to check door and check on residents who go outside at all times."

Written statement provided from licensed nurse A on 1/31/19 at 5:06 p.m. recorded, "I licensed nurse A received a call from certified staff E at 7:10 stating 'have an issue'. At approximately 6:45 a.m. certified staff F and me went to help resident #2 get up and ready for the day and noticed he/she was not in his/her apartment. We both began looking for him/her around the facility when notified by another resident that someone was outside in a bush/under the air conditioner. We went outside and assisted resident #2 into a wheelchair and at this time was dressed only in a brief and t-shirt. Took resident to his/her room. I, licensed nurse A instructed certified staff E to put clothes (sweat pants, sweat shirt) in dryer to warm them and put them on him/her, also put socks on and cover with a blanket. I also instructed to give him/her warm coffee. At that time his/her temperature was 95.8. Resident #4 reported to certified staff E and F that he/she called at 4:30 a.m. stating someone was outside his/her window and was told no one was there. At 7:25 a.m. I contacted certified staff C via text to find out who and when someone had last seen resident #2. Certified staff C responded checked on him/her about 5:15 a.m. I asked certified staff G about resident #4 hearing someone outside window at 4:30 a.m. and if it was checked out. Certified staff G was in another resident room but went in resident #4's room with certified staff C at

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S3026	Continued From page 7 5:30 a.m. and nothing was said about someone being outside window. At 5:15 a.m. certified staff C stated would complete bed checks. At approximately 3:00 p.m. on 12/22/18 certified staff called and stated resident #2 was in room at 5:15 a.m. " Written statement provided from certified staff C on 2/5/19 at 10:00 a.m. recorded, "I was working the day shift as the medication aide. I counted medications and certified staff F went over shift change with certified staff C, the night aide. Certified staff F then went to start helping get residents ready for the day when he/she noticed (resident #2) was not in his/her room. He/she came by medication room and asked if (resident #2) had come by there as he/she likes to wander. I stated I had not seen him/her and at that point we split up down the halls checking rooms for him/her. When we couldn't find him/her I called the night shift staff to ask if where (resident #2) was and when was the last time they seen him/her. I didn't get a response from certified staff C, but certified staff G texted me right back and said certified staff C did the bed checks at 5:00 a.m. At that point I had certified staff F double checking rooms and our cook went outside around the building and I went outside to the courtyard with my phone as a flashlight and heard resident #2 saying please help me. I ran back inside and pulled the call light and told certified staff F to meet me in the courtyard now! Resident #2 was lying in a bush stuck between the bush and the air conditioning unit with his/her pants down around his/her ankles and no shoes, socks, or shirt on. We got him/her up and brought him/her inside the building to his/her room. I call licensed nurse A immediately and	S3026		

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asked what to do. Licensed nurse A stated give him/her some warm clothes and warm up blankets in dryer and wrap him/her up. Resident had no wounds just scratches on back and bottom and his/her skin was freezing to touch. I ask should I send resident to hospital and licensed nurse A stated no because he/she more than likely would refuse treatment anyway. Licensed nurse A stated would come in and check (resident #2) over. License nurse A did not come in on day shift that day. We continued to check his/her temperature and kept a close eye on him/her. Resident slept in and ate breakfast. Resident #4 told us he/she call at 3:00 a.m. to tell the staff someone was knocking on my window, staff told him/her no one was there. Resident #4 stated he/she called again at 3:30 a.m. to say someone was still at the window and was told to stop call no one was there. The bush that resident #2 was stuck in was under resident #4's window."

Policy and procedure provided on 1/31/19 at 5:23 p.m. recorded, "Fall/Incident Documentation." Policy to provide a mechanism for assessment of falls/incidents with a focus on prompt investigation and immediate intervention to minimize reoccurrence. When a resident experience a fall/incident, the associate caring for the resident will record the incident in the medical record and evaluate for at least 72 hours or until resident's condition is stabilized. Examples of incidents include, but not limited to: falls with or without injury, skin tears, injury of unknown origin, elopement. The nurse is required to document the facts about the event in the resident's clinical record and should include: The date, time, effect of the incident including results of a physical examination, vital signs and emotional status,

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notification of the physician, current vital signs and assessment including any known injuries, ROM difficulties or pain, and notification of responsible party. Upon completion of report, an investigation will begin to determine the cause and an appropriate intervention will be put in place. The resident's Negotiated Service Agreement (NSA) will be updated to include the new interventions. The nurse will complete the investigation by reviewing incident reports, nursing documentation, witness statements, fall risk assessment, and the NSA plan. The charge nurse will initiate neuro checks for any unwitnessed fall. Follow up observations of the resident's condition will be recorded every shift for 72 hours unless condition stabilizes. Executive Director or designate staff will notify the appropriate State Agency according to state regulations as warranted."

On 1/31/19 at 5:30 p.m. Executive Director H in-serviced licensed nurse A on 1/31/19 on policy of fall management completing both visual/physical as well as written assessments following falls/accidents/injuries. An assessment is to be completed on admission, readmission, after every fall and annually. Policy and procedure provided with licensed nurse signature.

For resident #2, the administrator failed to ensure no resident was subjected to neglect when Resident #2 was found in courtyard, wedged under outside air conditioner unit in bush next to unit, yelling for help at approximately 6:45 a.m. on 12/22/18. Resident was last seen at 5:30 a.m. in room. The administrator also failed to ensure a licensed nurse assessed resident after being found outside in 32 degrees Fahrenheit (F), on

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S3026	Continued From page 10 the ground with jeans down to ankles, no shirt, socks, shoes, complained of freezing and found to have a body temperature of 95.8 degrees Fahrenheit. These failures placed resident #2 in immediate jeopardy for harm, injury, or death. The jeopardy was removed when the Administrator placed a sign on the door at 8 a.m. on 12/22/18 and locked the doors to the courtyard and provided education on 1/31/19 to the licensed nurse regarding the responsibility for assessment of residents following falls, accidents or injuries.	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 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	S3028		

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S3028	Continued From page 11 investigation of reported abuse, neglect, or exploitation. This REQUIREMENT is not met as evidenced by: KAR 26-41-101(f)(3)(A)(C)(D)(E)(F) The facility identifed a census of 32 residents. The sample included 3 residents. Based on record review, interviews, and observations for 1(#2) of 3 residents sampled, the administrator failed to report allegation of neglect to the department within 24 hours, start an investigation of alleged violation, thoroughly investigate within five working days of the report, appropriate corrective action taken if violation verified, complete and submit the Department's complaint investigation report within five working days of the initial report, and a written record shall be maintained of each investigation of reported neglect. Findings included: - Record review for resident #2 revealed and admit date of 3/17/18 with diagnoses of psychotic with delusions, parkinson's disease, and depression. The functional capacity screens dated 10/23/18 and 1/29/19 recorded resident required supervision with toileting, transfer, walking/mobility, eating, physical assistance with bathing, dressing, bladder incontinence, experienced impaired decision making, impaired vision, and fall/unsteadiness.	S3028		

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S3028	Continued From page 12 The functional capacity screens identified resident did not experience wandering or socially disruptive inappropriate behaviors. The negotiated service agreement/health care served plan dated 10-23-18 and 1/29/19 recorded resident required physical assist with dressing, and staff to monitor and assist with toileting. Staff to monitor and ensure resident using walker properly during ambulation and is a fall risk. Behavioral/Mental status: Resident is mildly confused/disoriented, experienced hallucinations and becomes disoriented. Staff to monitor/reorientation of behaviors, providing safety to resident and surroundings. Resident has aggressive tendencies and becomes aggressive during redirection. The resident log notes recorded the following: 10/26/18 at 4:00 p.m. Resident was on the floor in the dining room, walker tipped over into wall. No injuries noted and assisted to stand. Signed licensed nurse A. 10/28/18 at 10:30 a.m. Received notification of resident sitting at dining room table refusing staff attempts of assisting with toileting and changing clothing, becoming agitated with staff during attempts. Signed licensed nurse A. Review of resident log notes on 1/31/19 lacked documentation of elopement on 12/22/18. 1/31/19 at 2:15 p.m. observed certified staff C transfer resident #2 from toilet to chair. Interview on 1/31/19 at 2:50 p.m. with resident #2 stated he/she liked to "whittle" and make things from wood. Resident #2 stated he/she loved	S3028		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N018010	A. BUILDING: _____ B. WING _____	02/06/2019

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S3028	Continued From page 13	S3028		

fishing and anything about history. Asked resident if he/she ever fell outside in courtyard. Resident stated he/she did not recall falling. Surveyor asked if he/she fell and got stuck under air conditioner unit and could not get up? Resident stated did not recall.

1/31/19 at 3:20 p.m. observed resident ambulating with walker to front of licensed nurse A's office and stated he/she needed a bathroom. Certified staff C came and assisted resident to restroom.

2/4/19 at 11:15 a.m. observed resident #2 get up out of chair and start ambulating without walker. Resident unsteady on feet. Certified staff D came and assisted resident back to chair and placed walker in front of him/her.

Interview on 1/31/19 at 3:05 p.m. with resident #4 stated he/she would be glad when roofers are done putting roof on facility as they interfere with his/her nap and laughed. Asked resident #4 if he/she ever heard a resident knocking on outside window. Resident was hesitant and stated yes, it was (Resident #2). It was very cold that night and it was 12/22/18. I called and certified staff C came to my room. I told him/her that someone was knocking and banging on my window. Certified staff C stated no one was outside. I don't remember the time except it was very early in the morning and it was still dark out. I called again, and certified staff C came back to room and stated no one was at the door. Resident #4 stated he/she knew resident #2 and he/she wandered around the facility all the time, but he/she would not hurt anyone, and I am not afraid of him/her as he/she wandered in and out of resident rooms. Resident stated heard earlier that morning it was resident #2 stuck outside his/her

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S3028	Continued From page 14 air conditioner/bush and it was so cold outside. Interview on 1/31/19 at 3:35 p.m. with licensed nurse A asked if had any resident who was at risk for elopement or had eloped from facility in last few months. Licensed nurse A then stated "no unless going out to court yard and falling in a bush then I guess it would be yes. Yes, we did." Stated resident #2 eloped. Licensed nurse A stated certified staff E called and stated certified staff F could not find resident #2. They looked through out facility and outside of facility. At 7:10 a.m., Licensed nurse A asked who was the last person to see resident? (licensed nurse A checked the text on his/her phone). Certified staff called night shift certified staff C and he/she stated observed resident around 5:15 a.m. Resident #4 called and informed certified staff C that he/she heard someone outside banging on his/her window about 4:30 a.m. At 5:30 a.m. certified staff G was with resident #4 and stated nothing was said about hearing someone outside window. Certified staff C observed resident in chair in room at approximately 5:15 a.m. At 7:15 a.m. certified staff C went out to courtyard and found resident #2 stuck in a bush and under air conditioner unit outside of resident #4's room. Resident had brief on, no pants, shoes, or socks. Licensed nurse A told certified staff E to get warmed-up blanket and clothes from the dryer, warm resident up, and give some hot coffee. Resident's temperature was reported to be 95.0. Licensed nurse A stated did not come to facility to assess resident until approximately 2:00 p.m. on 12/22/18, did not document anything in the record, notify the physician, or the Department of the elopement. Licensed nurse A did reach into a file folder and pull out 2 incident reports fill out from certified staff E and F and provided surveyor	S3028		

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S3028	Continued From page 15 a copy and stated that was the only documentation he/she had. Licensed nurse A stated resident #2 wandered around facility and required redirection. Incident occurrence report dated 12/22/19 completed by certified staff E and provided on 1/31/19 at 3:40 p.m. from licensed nurse A, "recorded on 12/22/18 at 6:45 a.m. asked certified staff F if he/she had seen resident #2. I told him/her no and we both immediately split up to look for resident. I went outside to search courtyard and found resident on left side of courtyard laying in bush stuck halfway under the air conditioner unit. Certified staff F and I got resident up and in a wheelchair. Resident was freezing cold and had been there for a while. We brought resident in, dressed him/her and put a warm blanket around him/her and gave warm coffee. Resident laid in recliner and relaxed. Resident's temperature was 95.8. Resident #4 called to tell us that he/she told certified staff C at 4:30 a.m. someone was outside his/her window and night shift told him/her now one was at the window." Incident occurrence report dated 12/22/19 completed by certified staff F and provided on 1/31/19 at 3:40 p.m. from licensed nurse A, "recorded on 12/22/18 at 6:45 a.m. resident #2 was missing and was found out in courtyard by a bush and was hooked on a near window in the cold. Resident looked like he/she had been there a while. Took resident back to his/her room and warmed him/her up. Resident had an indention from the air conditioner unit on right hip and scratches on hand." Interview on 1/31/19 at 4:05 p.m. with	S3028		

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S3028	Continued From page 16 administrator B when asked if had any residents elope, he/she stated resident #2 and had received a call from licensed nurse A that resident #2 was found outside, they got him/her up and inside, then warmed him/her up. Administrator stated he/she did make a sign and place on the courtyard doors that recorded doors to be kept locked at all times due to cold weather. Doors secured and sign placed on both doors at 8:00 a.m. on 12/22/18. Administrator stated was not aware resident was not assessed by licensed nurse. A Weather underground recorded temperature at 5:00 a.m. was 32-degree F on 12/22/18. Administrator failed to start an investigation within 24 hours when reported to him/her and failed to report to department within 24 hours. Written statement from administrator B on 1/31/19 at 5:00 p.m. recorded, "On the night of 12/22/18 Resident #2 was found in the court yard in his/her brief and no clothes on. Staff found him/her and brought him/her inside, took to room, dressed him/her, then warmed up. Licensed nurse A told me about it when I got to the facility that morning and the temperature was chilly and I took immediate action by locking both doors to the courtyard and putting signs up saying the doors are to be locked at all times. The staff was instructed to check door and check on residents who go outside at all times." Administrator failed to thoroughly investigate within five working days of the initial report, complete the department's complaint investigation, and submit with five working days. Written statement provided from licensed nurse A on 1/31/19 at 5:06 p.m. recorded, "I licensed	S3028		

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S3028	Continued From page 17 nurse A received a call from certified staff E at 7:10 stating 'have an issue'. At approximately 6:45 a.m. certified staff F and me went to help resident #2 get up and ready for the day and noticed he/she was not in his/her apartment. We both began looking for him/her around the facility when notified by another resident that someone was outside in a bush/under the air conditioner. We went outside and assisted resident #2 into a wheelchair and at this time was dressed only in a brief and t-shirt. Took resident to his/her room. I, licensed nurse A instructed certified staff E to put clothes (sweat pants, sweat shirt) in dryer to warm them and put them on him/her, also put socks on and cover with a blanket. I also instructed to give him/her warm coffee. At that time his/her temperature was 95.8. Resident #4 reported to certified staff E and F that he/she called at 4:30 a.m. stating someone was outside his/her window and was told no one was there. At 7:25 a.m. I contacted certified staff C via text to find out who and when someone had last seen resident #2. Certified staff C responded checked on him/her about 5:15 a.m. I asked certified staff G about resident #4 hearing someone outside window at 4:30 a.m. and if it was checked out. Certified staff G was in another resident room but went in resident #4's room with certified staff C at 5:30 a.m. and nothing was said about someone being outside window. At 5:15 a.m. certified staff C stated would complete bed checks. At approximately 3:00 p.m. on 12/22/18 certified staff called and stated resident #2 was in room at 5:15 a.m. " Written statement provided from certified staff C on 2/5/19 at 10:00 a.m. recorded, "I was working the day shift as the medication aide. I counted	S3028		

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S3028	Continued From page 18	S3028		

medications and certified staff F went over shift change with certified staff C, the night aide. Certified staff F then went to start helping get residents ready for the day when he/she noticed (resident #2) was not in his/her room. He/she came by medication room and asked if (resident #2) had come by there as he/she likes to wander. I stated I had not seen him/her and at that point we split up down the halls checking rooms for him/her. When we couldn't find him/her I called the night shift staff to ask if where (resident #2) was and when was the last time they seen him/her. I didn't get a response from certified staff C, but certified staff G texted me right back and said certified staff C did the bed checks at 5:00 a.m. At that point I had certified staff F double checking rooms and our cook went outside around the building and I went outside to the courtyard with my phone as a flashlight and heard resident #2 saying please help me. I ran back inside and pulled the call light and told certified staff F to meet me in the courtyard now! Resident #2 was lying in a bush stuck between the bush and the air conditioning unit with his/her pants down around his/her ankles and no shoes, socks, or shirt on. We got him/her up and brought him/her inside the building to his/her room. I call licensed nurse A immediately and asked what to do. Licensed nurse A stated give him/her some warm clothes and warm up blankets in dryer and wrap him/her up. Resident had no wounds just scratches on back and bottom and his/her skin was freezing to touch. I ask should I send resident to hospital and licensed nurse A stated no because he/she more than likely would refuse treatment anyway. Licensed nurse A stated would come in and check (resident #2) over. License nurse A did not come in on day shift that day. We continued to check his/her temperature and kept a close eye

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S3028	Continued From page 19 on him/her. Resident slept in and ate breakfast. Resident #4 told us he/she call at 3:00 a.m. to tell the staff someone was knocking on my window, staff told him/her no one was there. Resident #4 stated he/she called again at 3:30 a.m. to say someone was still at the window and was told to stop call no one was there. The bush that resident #2 was stuck in was under resident #4's window." For resident #2, the administrator failed to report allegation of neglect to the department within 24 hours, start an investigation of alleged violation, thoroughly investigate within five working days of the report, appropriate corrective action taken if violation verified, complete and submit the Department's complaint investigation report within five working days of the initial report, and a written record shall be maintained of each investigation of reported neglect.	S3028		
S3261 SS=D	26-41-105 (f) (11) Resident Record Documentation of Incidents (f) (11) documentation of all incidents, symptoms, and other indications of illness or injury including the date, time of occurrence, action taken, and results of the action This REQUIREMENT is not met as evidenced by: KAR 26-41-105(f)(11) The facility identified a census of 32 residents. The sample included 3 residents. Based on record review, interviews, and observations for 1	S3261		

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S3261	Continued From page 20 (#2) of 3 residents sampled, the administrator failed to ensure documentation of all incidents, symptoms, and other indications of illness or injury including the date, time of occurrence, actions taken, and results of actions taken. Findings included: - Record review for resident #2 revealed and admit date of 3/17/18 with diagnoses of psychotic with delusions, parkinson's disease, and depression. The functional capacity screens dated 10/23/18 and 1/29/19 recorded resident required supervision with toileting, transfer, walking/mobility, eating, physical assistance with bathing, dressing, bladder incontinence, experienced impaired decision making, impaired vision, and fall/unsteadiness. The functional capacity screens identified resident did not experience wandering or socially disruptive inappropriate behaviors. The negotiated service agreement/health care served plan dated 10-23-18 and 1/29/19 recorded resident required physical assist with dressing, and staff to monitor and assist with toileting. Staff to monitor and ensure resident using walker properly during ambulation and is a fall risk. Behavioral/Mental status: Resident is mildly confused/disoriented, experienced hallucinations and becomes disoriented. Staff to monitor/reorientation of behaviors, providing safety to resident and surroundings. Resident has aggressive tendencies and becomes aggressive during redirection. The resident log notes recorded the following:	S3261		

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S3261	Continued From page 21 10/26/18 at 4:00 p.m. Resident was on the floor in the dining room, walker tipped over into wall. No injuries noted and assisted to stand. Signed licensed nurse A. 10/28/18 at 10:30 a.m. Received notification of resident sitting at dining room table refusing staff attempts of assisting with toileting and changing clothing, becoming agitated with staff during attempts. Signed licensed nurse A. Review of resident log notes on 1/31/19 lacked documentation of elopement on 12/22/18. 1/31/19 at 2:15 p.m. observed certified staff C transfer resident #2 from toilet to chair. Interview on 1/31/19 at 2:50 p.m. with resident #2 stated he/she liked to "whittle" and make things from wood. Resident #2 stated he/she loved fishing and anything about history. Asked resident if he/she ever fell outside in courtyard. Resident stated he/she did not recall falling. Surveyor asked if he/she fell and got stuck under air conditioner unit and could not get up? Resident stated did not recall. 1/31/19 at 3:20 p.m. observed resident ambulating with walker to front of licensed nurse A's office and stated he/she needed a bathroom. Certified staff C came and assisted resident to restroom. 2/4/19 at 11:15 a.m. observed resident #2 get up out of chair and start ambulating without walker. Resident unsteady on feet. Certified staff D came and assisted resident back to chair and placed walker in front of him/her. Interview on 1/31/19 at 3:05 p.m. with resident #4	S3261		

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S3261	Continued From page 22	S3261		

stated he/she would be glad when roofers are done putting roof on facility as they interfere with his/her nap and laughed. Asked resident #4 if he/she ever heard a resident knocking on outside window. Resident was hesitant and stated yes, it was (Resident #2). It was very cold that night and it was 12/22/18. I called and certified staff C came to my room. I told him/her that someone was knocking and banging on my window. Certified staff C stated no one was outside. I don't remember the time except it was very early in the morning and it was still dark out. I called again, and certified staff C came back to room and stated no one was at the door. Resident #4 stated he/she knew resident #2 and he/she wandered around the facility all the time, but he/she would not hurt anyone, and I am not afraid of him/her as he/she wandered in and out of resident rooms. Resident stated heard earlier that morning it was resident #2 stuck outside his/her air conditioner/bush and it was so cold outside.

Interview on 1/31/19 at 3:35 p.m. with licensed nurse A asked if had any resident who was at risk for elopement or had eloped from facility in last few months. Licensed nurse A then stated "no unless going out to court yard and falling in a bush then I guess it would be yes. Yes, we did." Stated resident #2 eloped. Licensed nurse A stated certified staff E called and stated certified staff F could not find resident #2. They looked through out facility and outside of facility. At 7:10 a.m., Licensed nurse A asked who was the last person to see resident? (licensed nurse A checked the text on his/her phone). Certified staff called night shift certified staff C and he/she stated observed resident around 5:15 a.m. Resident #4 called and informed certified staff C that he/she heard someone outside banging on

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S3261	Continued From page 23	S3261		

his/her window about 4:30 a.m. At 5:30 a.m. certified staff G was with resident #4 and stated nothing was said about hearing someone outside window. Certified staff C observed resident in chair in room at approximately 5:15 a.m. At 7:15 a.m. certified staff C went out to courtyard and found resident #2 stuck in a bush and under air conditioner unit outside of resident #4's room. Resident had brief on, no pants, shoes, or socks. Licensed nurse A told certified staff E to get warmed-up blanket and clothes from the dryer, warm resident up, and give some hot coffee. Resident's temperature was reported to be 95.0. Licensed nurse A stated did not come to facility to assess resident until approximately 2:00 p.m. on 12/22/18, did not document anything in the record, notify the physician, or the Department of the elopement. Licensed nurse A did reach into a file folder and pull out 2 incident reports fill out from certified staff E and F and provided surveyor a copy and stated that was the only documentation he/she had. Licensed nurse A stated resident #2 wandered around facility and required redirection.

Incident occurrence report dated 12/22/19 completed by certified staff E and provided on 1/31/19 at 3:40 p.m. from licensed nurse A, "recorded on 12/22/18 at 6:45 a.m. asked certified staff F if he/she had seen resident #2. I told him/her no and we both immediately split up to look for resident. I went outside to search courtyard and found resident on left side of courtyard laying in bush stuck halfway under the air conditioner unit. Certified staff F and I got resident up and in a wheelchair. Resident was freezing cold and had been there for a while. We brought resident in, dressed him/her and put a warm blanket around him/her and gave warm coffee. Resident laid in recliner and relaxed.

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S3261	Continued From page 24	S3261		

Resident's temperature was 95.8. Resident #4 called to tell us that he/she told certified staff C at 4:30 a.m. someone was outside his/her window and night shift told him/her now one was at the window."

Incident occurrence report dated 12/22/19 completed by certified staff F and provided on 1/31/19 at 3:40 p.m. from licensed nurse A, "recorded on 12/22/18 at 6:45 a.m. resident #2 was missing and was found out in courtyard by a bush and was hooked on a near window in the cold. Resident looked like he/she had been there a while. Took resident back to his/her room and warmed him/her up. Resident had an indention from the air conditioner unit on right hip and scratches on hand."

Interview on 1/31/19 at 4:05 p.m. with administrator B when asked if had any residents elope, he/she stated resident #2 and had received a call from licensed nurse A that resident #2 was found outside, they got him/her up and inside, then warmed him/her up. Administrator stated he/she did make a sign and place on the courtyard doors that recorded doors to be kept locked at all times due to cold weather. Doors secured and sign placed on both doors at 8:00 a.m. on 12/22/18. Administrator stated was not aware resident was not assessed by licensed nurse. A
Weather underground recorded temperature at 5:00 a.m. was 32-degree F on 12/22/18.

Written statement from administrator B on 1/31/19 at 5:00 p.m. recorded, "On the night of 12/22/18 Resident #2 was found in the court yard in his/her brief and no clothes on. Staff found him/her and brought him/her inside, took to room,

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	N018010	A. BUILDING: _____ B. WING _____	02/06/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDERBROOK VILLAGE LLC	402 WINDSOR ROAD ARKANSAS CITY, KS 67005

(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
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dressed him/her, then warmed up. Licensed nurse A told me about it when I got to the facility that morning and the temperature was chilly and I took immediate action by locking both doors to the courtyard and putting signs up saying the doors are to be locked at all times. The staff was instructed to check door and check on residents who go outside at all times."

Written statement provided from licensed nurse A on 1/31/19 at 5:06 p.m. recorded, "I licensed nurse A received a call from certified staff E at 7:10 stating 'have an issue'. At approximately 6:45 a.m. certified staff F and me went to help resident #2 get up and ready for the day and noticed he/she was not in his/her apartment. We both began looking for him/her around the facility when notified by another resident that someone was outside in a bush/under the air conditioner. We went outside and assisted resident #2 into a wheelchair and at this time was dressed only in a brief and t-shirt. Took resident to his/her room. I, licensed nurse A instructed certified staff E to put clothes (sweat pants, sweat shirt) in dryer to warm them and put them on him/her, also put socks on and cover with a blanket. I also instructed to give him/her warm coffee. At that time his/her temperature was 95.8. Resident #4 reported to certified staff E and F that he/she called at 4:30 a.m. stating someone was outside his/her window and was told no one was there. At 7:25 a.m. I contacted certified staff C via text to find out who and when someone had last seen resident #2. Certified staff C responded checked on him/her about 5:15 a.m. I asked certified staff G about resident #4 hearing someone outside window at 4:30 a.m. and if it was checked out. Certified staff G was in another resident room but went in resident #4's room with certified staff C at 5:30 a.m. and nothing was said about someone

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S3261	Continued From page 26 being outside window. At 5:15 a.m. certified staff C stated would complete bed checks. At approximately 3:00 p.m. on 12/22/18 certified staff called and stated resident #2 was in room at 5:15 a.m. " Written statement provided from certified staff C on 2/5/19 at 10:00 a.m. recorded, "I was working the day shift as the medication aide. I counted medications and certified staff F went over shift change with certified staff C, the night aide. Certified staff F then went to start helping get residents ready for the day when he/she noticed (resident #2) was not in his/her room. He/she came by medication room and asked if (resident #2) had come by there as he/she likes to wander. I stated I had not seen him/her and at that point we split up down the halls checking rooms for him/her. When we couldn't find him/her I called the night shift staff to ask if where (resident #2) was and when was the last time they seen him/her. I didn't get a response from certified staff C, but certified staff G texted me right back and said certified staff C did the bed checks at 5:00 a.m. At that point I had certified staff F double checking rooms and our cook went outside around the building and I went outside to the courtyard with my phone as a flashlight and heard resident #2 saying please help me. I ran back inside and pulled the call light and told certified staff F to meet me in the courtyard now! Resident #2 was lying in a bush stuck between the bush and the air conditioning unit with his/her pants down around his/her ankles and no shoes, socks, or shirt on. We got him/her up and brought him/her inside the building to his/her room. I call licensed nurse A immediately and asked what to do. Licensed nurse A stated give	S3261		

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him/her some warm clothes and warm up blankets in dryer and wrap him/her up. Resident had no wounds just scratches on back and bottom and his/her skin was freezing to touch. I ask should I send resident to hospital and licensed nurse A stated no because he/she more than likely would refuse treatment anyway. Licensed nurse A stated would come in and check (resident #2) over. License nurse A did not come in on day shift that day. We continued to check his/her temperature and kept a close eye on him/her. Resident slept in and ate breakfast. Resident #4 told us he/she call at 3:00 a.m. to tell the staff someone was knocking on my window, staff told him/her no one was there. Resident #4 stated he/she called again at 3:30 a.m. to say someone was still at the window and was told to stop call no one was there. The bush that resident #2 was stuck in was under resident #4's window."

Policy and procedure provided on 1/31/19 at 5:23 p.m. recorded, "Fall/Incident Documentation." Policy to provide a mechanism for assessment of falls/incidents with a focus on prompt investigation and immediate intervention to minimize reoccurrence. When a resident experience a fall/incident, the associate caring for the resident will record the incident in the medical record and evaluate for at least 72 hours or until resident's condition is stabilized. Examples of incidents include, but not limited to: falls with or without injury, skin tears, injury of unknown origin, elopement. The nurse is required to document the facts about the event in the resident's clinical record and should include: The date, time, effect of the incident including results of a physical examination, vital signs and emotional status, notification of the physician, current vital signs

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S3261	Continued From page 28 and assessment including any known injuries, ROM difficulties or pain, and notification of responsible party. Upon completion of report, an investigation will begin to determine the cause and an appropriate intervention will be put in place. The resident's Negotiated Service Agreement (NSA) will be updated to include the new interventions. The nurse will complete the investigation by reviewing incident reports, nursing documentation, witness statements, fall risk assessment, and the NSA plan. The charge nurse will initiate neuro checks for any unwitnessed fall. Follow up observations of the resident's condition will be recorded every shift for 72 hours unless condition stabilizes. Executive Director or designate staff will notify the appropriate State Agency according to state regulations as warranted." On 1/31/19 at 5:30 p.m. Executive Director H in-serviced licensed nurse A on 1/31/19 on policy of fall management completing both visual/physical as well as written assessments following falls/accidents/injuries. An assessment is to be completed on admission, readmission, after every fall and annually. Policy and procedure provided with licensed nurse signature. For resident #2, the administrator failed to ensure documentation of all incidents, symptoms, and other indications of illness or injury including the date, time of occurrence, actions taken, and results of actions taken.	S3261		