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	N089041	A. BUILDING: _____ B. WING _____	08/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEXINGTON PARK ASSISTED LIVING	1021 SW FLEMING COURT TOPEKA, KS 66604

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S 000	INITIAL COMMENTS The following citations represent the findings of an abbreviated survey with complaint investigation 0558 at the above named assisted living facility conducted on 8-17-15, 8-18-15, 8-19-15 and 8-20-15. Revised 2567 mailed to facility 8-28-15.	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 58 residents. The sample included 3 residents and 1 focus review resident. Based on observation, record review and interviews for 1 (#1) of 3 sampled residents, the operator failed to ensure that no resident was subjected to neglect when the licensed nurse failed to provide or coordinate the provision of health care services necessary to address the cognitively impaired resident's risk for elopement, and the facility failed to enforce their policy for sign in and sign out when residents were leaving the building. These failures place this resident in immediate jeopardy for harm, injury or death. Resident #1 left the facility without staff ' s knowledge on 8-13-15 at	S3026		

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

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approximately 12:30 pm and was not noted to be missing until approximately 5:20 pm. The resident was found deceased 8-20-15 in a wooded area adjacent to the facility.

Findings included:

- Record review for resident #1 revealed admission on 6-18-15 with diagnoses Schizoaffective Disorder, Lumbago, Glaucoma, Schizophrenia, Tachycardia, Secondary Parkinsonism, Orthostatic Hypotension, Delirium, Pulmonary Mycobacteria, Constipation, Vitamin D Deficiency, Chronic Kidney Disease, and Urinary Tract Infection.

The Functional Capacity Screen (FCS) dated 6-19-15 recorded resident required physical assistance with dressing and management of medications/treatments, supervision of bathing; and independent with toileting, transfers, walking/mobility, eating and was continent of bladder (per catheter). Cognition: problems with short term memory, long term memory, memory/recall and decision-making. Communication: usually understands and usually understandable. Current problems/risks identified: falls/unsteadiness, impaired vision, impaired decision-making.

The Negotiated Service Agreement/Heath Care Service Plan (NSA/HCSP) dated 6-19-15 recorded the following services:
Bathing: staff will provide standby assist due to syncope issues and use of foley catheter.
Dressing: staff will assist with dressing in the morning and as requested.
Toileting: resident uses a foley catheter for voiding and does not use dignity products. Staff will assist with catheter care and bag drainage

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per shift. Physician will perform monthly catheter changes.
Transfers: independent
Walking/Mobility: independent
Eating: independent. Staff will prep plate and serve three meals daily. Resident prefers carbohydrate controlled diet or low concentrated sweets diet due to diagnoses of diabetes mellitus.
Medication and Medical Treatment Management: Physical assistance needed. Staff administers medications and treatments.
Cognitive Services: has diagnosis of schizo affective disorder ...has trouble recalling long/short term events. Has appointed a guardian to help assist with financial/medical concerns that arise. Has no at risk behaviors at this time.

The NSA/HCSP lacked documentation of use of sitters/companions and interventions to address elopement risk.

Elopement Risk assessment performed on 6-30-15 recorded resident scored 14 points which indicated resident to be " At Risk " for elopement (10-14 points = At Risk; 15 points or greater = High Risk) and stated " resident does wander throughout facility but he/she poses no risk of elopement at this time. " Electronically signed by administrative nurse A. The assessment lacked documentation to indicate resident #1 " experienced periods of restlessness " which would have made the total score 17 and placed the resident at high risk of elopement.

Hospital progress notes from hospitalization prior to admission stated the following:
Admission on 5-1-15 with " paranoia and confusion. "
Medical Diagnoses (included these among

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others): Schizoaffective disorder (4-11-2000); Schizophrenia (10-13-04); Delirium 2-25-15); Dementia (3-30-15).
5-1-15 at 9:43 am: Admit with schizoaffective disorder and recurrent Urinary tract infection leading to delirium and decompensation of mental illness presented to urgent care yesterday where diagnoses with a UTI ...has begun to present with confusion, speech has become more garbled and increase in behaviors such as pacing and pulling catheter. (Resident ' s) thoughts are disorganized ...paranoid. Oriented to self and place only, reports it is March 20, 2014 and after giving (resident) the current date, he/she perseverated on the word May and then when asked the date again, about 10 minutes later, he/she did not know (again, said March 29th, 2014).
5-31-15 6:15 am: alert oriented to self, Confused. Behavior: Cooperative, Wanders, Elopement Risk. Mobility devices/Other equipment used: low-boy bed, call light within reach of resident, body alarm (Wander-Guard alert bracelet).
6-17-15 "Condition at discharge: At the time of discharge, delirium resolved and resident is no longer confused and pacing; he has been cooperatorive and looking forward to discharge.. . ."

Interview on 8-17-15 at 3:37 pm with hospital staff member confirmed resident has been on their unit multiple times. Confirmed they used a Wander-Guard and staff escort at all times. Stated resident was allowed to go out on passes with friend and companion for outings and appointments. Stated resident was " confused ...missed details, was paranoid and delusional from time to time ...had a lot of trouble with

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his/her catheter, would try to empty it and end up tearing it to shreds and " the leg bag was impossible to do on his/her own. " Confirmed resident had a couple of falls while in the hospital, " would lose balance and fall backward, but would get up on his/her own. " Stated the resident had frequent UTI ' s which would cause him/her to experience increased confusion and agitation. Had been admitted with delirium at different times and the Body Alarm/Wander-Guard bracelet was place on him/her due to confusion. Stated resident would get lost on the hospital unit when first admitted, but later would be able to help other residents find their way. Stated resident never made any attempts to leave their unit, " but then we never gave him/her any opportunity to get off the unit. "

Facility Clinical Notes:
Written on 6-19-15 at 3:00 pm: " Resident admitted to facility escorted with personal sitter. Observed ambulating with slow strong gait no assistive devices. Appears alert to self and situation and confused regarding date and time ... " Signed by licensed staff B.

Written on 8-17-15 at 11:30 am: " On (8)-13-15 this writer was notified that resident was not observed at his/her dining room table for dinner. All staff was asked if he/she had mentioned he/she was going out anywhere and staff declined. Staff was then questioned as to the last time he/she was seen. Staff stated lunch time. Resident has a history of going on afternoon walks but always returns. He/She often goes out with his/her caregivers as well. As the evening proceeded, his/her guardians and caregivers were notified and questioned to see if they know where he/she might go. They declined knowing. Topeka Police were then notified with a report

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made. " Signed by administrative nurse A.

Facility clinical notes lacked any additional documentation of adjustment to the facility or assessment of behaviors.

Interviews/written statements with the operator on 8-17-15 and 8-19-15 stated resident had a dental appointment on the morning of 8-13-15. He/she returned to the facility (per facility transportation) in time for lunch which he/she ate in the dining room. After lunch resident " went outside for a walk. " Approximately at 5:31 pm, administrative staff B phoned operator to ask if resident had left with friends for dinner. Operator called two of resident ' s sitters who had no knowledge of resident ' s whereabouts. Administrative staff B then began to search inside and outside of facility. Resident sign in/out book was checked and a resident head count was performed. Operator arrived at facility around 6:00 pm and performed another search of facility inside and outside. All doors were checked at this time to ensure full function and found to be in good working order. All resident with impaired decision-making were accounted for. At approximately 6:30 pm administrative staff B notified resident ' s legal representatives and called to check the local hospitals. At 6:30 pm, housekeeping staff C searched Gage Park while operator and administrative staff B searched nearby shopping center and stores. At 7:00 pm, administrative staff B reviewed surveillance camera footage of common area " to locate a time resident was last seen. That time was found to be 12:25 pm. " Between 7:00 pm and 8:00 pm, operator with two other staff searched by cars in different directions. Corporate staff notified around 8:00 pm and the decision was made to call the police and make a missing

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person report. Staff continued to search until 2:30 am. On 8-14-15, another search of the facility and surrounding areas was done and operator checked with the police department. Remainder of the day, operator responded to calls of sightings. Resident was not found. Over next few days, operator and administrative staff B continued to respond to calls of sightings and checking the hospitals. Administrative nurse A reviewed care plans of all residents with Wander-Guards and another resident with a mental illness diagnosis. Beginning 8-14-15 through 8-16-15, operator stated extra staff was provided to support direct care staff.

Interview with Topeka Police Department on 8-17-15 at 4:07 pm stated facility filed police report on 8-13-15 at 9:08 pm.

Interview on 8-17-15 at 11:59 am with administrative nurse A stated the first week at the facility, resident wandered throughout the facility trying to find his/her room, would go out for afternoon walks and return. Licensed nurse A confirmed he/she did not read the hospital reports which stated resident was confused and had been considered an elopement risk and used a Wander-Guard alert bracelet while hospitalized prior to admission. Licensed nurse A could not remember if he/she went to the hospital to perform an assessment prior to admission at the facility. Confirmed resident was being treated for psychiatric issues and was taking several psychotropic medications.

Review of Sign Out/In register at the front door revealed resident signed out one time on 6-25-15. Interview on 8-17-15 at 2:41 pm with administrative nurse A confirmed the resident did not sign out when he/she left the building, had

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only signed out the one time. Stated he/she did not know who monitored the sign out register and confirmed he/she did not monitor the book to make sure residents were signing out appropriately.

Policy for " Signing Residents In and Out" stated: " It is the policy for all residents to sign out when leaving the facility premises. General Guidelines: 1. Each resident leaving the facility premises (excluding transfers/discharges) must be signed out. 2. A resident Sign In/Sign Out/Visitor Record is located at the entrance of each facility. (3 and 4 refer to medications taken with the resident) 5. A resident must sign or be signed in upon return ... "

Interview on 8-1-7-15 at 3:15 pm with operator regarding who monitored the sign in/out book stated he/she did along with administrative staff B because their office was adjacent to the front entryway and they could see whoever came and went while there were in their offices. Common areas were also monitored by video surveillance. Stated, " families are lax about doing it and if residents go with our transportation aide, we don ' t sign them out. " Confirmed the facility lacked formal monitoring of the sign out register.

Observation of front door on 8-17-15 at 11:11 am revealed it to be unlocked. Noted keypads on outside and inside. Also noted back door to be unlocked (opening to unsecured back yard area with patio, flower garden and access to two ponds) and keypadded. Both doors were alarmed with an alarm that sounded loudly at the door as was audible throughout the facility. Side doors were locked and required a code to open the doors from the inside and outside.

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S3026	Continued From page 8 Interview on 8-17-15 at 4:07 pm with operator stated the front and back doors are locked by a timer at 10:00 or 10:30 pm at night and unlocks on a timer around 5:00 or 5:30 am and there is video monitoring of the common areas which includes the doors. "Missing Resident " and " Elopement " components of the facility ' s " Disaster and Emergency Preparedness Manual " stated the following: " Elopements: It is the policy of (the company) to ensure that each resident receives adequate supervision and assistive devices to prevent elopements and that all personnel will report and investigate all reports of missing residents. 1. It is the policy of all personnel to report any resident attempting to leave the premises or suspected of being missing to the Executive Director as soon as practical. 2. Should an employee observe a resident leaving the premises, he/she should · Attempt to prevent the departure. · Obtain assistance from other staff members in the immediate vicinity, if necessary · Instruct another staff member to inform the Executive Director and the Resident Care Coordinator (RCC) that a resident has left the premises. · Be courteous in preventing the departure and in returning the resident to the facility. 3. Upon return of the resident to the facility, the RCC should · Examine the resident for injuries · Contact the attending physician and report what happened · Contact the resident ' s legal representative and inform them of the incident · Complete and file and incident report · Make appropriate notations in the resident ' s	S3026		

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medical record.
4. If an employee discovers that a resident is missing from the facility they should:
· Determine if the resident is out on an authorized pass. If NOT:
· Make a thorough search of the building(s) and premises. If NOT located:
· Notify the Executive Director and RCC
· Notify the resident ' s legal representative
· Notify the attending physician
· Notify law enforcement officials
· Notify the Regional Manager and In-house Counsel
· If necessary, notify volunteer agencies
· Provide search teams with resident identification information
· Make an extensive search of the surrounding area.
5. Upon return of the resident to the facility, the RCC should
· Examine the resident for injuries
· Contact the attending physician and report findings and condition of the resident. Follow orders given by the physician
· Notify the resident ' s legal representative
· Notify search teams that the resident has been located
· Complete and file an incident report
· Make appropriate entries into the resident ' s medical record. "

Documentation recorded last staff in-service which reviewed the missing resident policy dated 2-25-15 and performed quarterly.

Interview on 8-18-15 at 3:12 pm with sitter #1 stated he/she had worked for resident over 5 years and knew him/her well. Confirmed resident required someone to be with him/her whenever out of facility due to short term memory problems

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stating, " I wouldn ' t let him/her go anywhere by him/herself. I would follow him/her even in Wal-Mart. " Stated resident required sitters to socialize with him/her, resident liked talking to someone and would talk to him/herself if no one else was around. Sitters would provide transportation to appointments, take resident to go shopping for personal items and take resident out to eat. Stated resident didn ' t go out for walks when the sitter was there, would take naps. Stated resident knew about his/her family, where they lived and the work they did, but could not remember something he/she did 2 hours ago. Sitter #1 stated on 8-13-15 someone called up to resident ' s apartment and told him/her of a dental appointment. The resident abruptly left the room to go downstairs. Facility staff took resident to the appointment and the sitter stated he/she left the facility.

Resident #1 was admitted to the facility with a history of confusion, short-term memory impairment and identified risk of elopement. The facility failed to accurately assess the resident ' s elopement risk, ensure the resident followed the policy for signing in and out when leaving the facility. The resident left the facility without staff knowledge and without signing out on 8-13-15 at approximately 12:30 p.m., was not discovered missing until approximately 5:20 p.m. The resident was found deceased on 8-20-2015 in a wooded area adjacent to the facility.

For resident #1, the operator failed to ensure that no resident was subjected to neglect when the licensed nurse failed to provide or coordinate the provision of health care services necessary to address the cognitively impaired residents risk for elopement, and the facility failed to enforce their policy for sign in and sign out when residents

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S3026	Continued From page 11 were leaving the building. These failures place this resident in immediate jeopardy for harm, injury or death. The jeopardy was removed on 8-13-15 when the facility completed checks of all doors to ensure alarms were functioning properly, checked all wanderguards to ensure they were functioning properly, reviewed and updated care plans of other residents with impaired cognition, impaired decision making or mental health diagnoses and implemented new policies and procedures to enforce sign in and sign out policy.	S3026		