STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087267	A. BUILDING: _____ B. WING _____	C 08/15/2023

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LOIS HOUSE LLC	2758 N WELLESLEY AVE WICHITA, KS 67220

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S 000	INITIAL COMMENTS The following represent the findings of an abbreviated survey with review of facility report #182129 and #181339 at the above named home plus conducted on 08/14/23 and 08/15/23.	S 000		
S5026 SS=J	26-42-101 (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 26-42-101(f)(1)(B) The facility reported a census of 5 residents with one resident included in the sample. Based on observation, interview, and record review the operator failed to protect one resident from neglect by the failure to implement a method of identifying residents at high-risk for elopement, failure to follow facility's elopement policy, failure to describe services provided to keep him safe from wandering, and failure to ensure a functioning alarm was on all exit doors. Cognitively impaired Resident (R) 1 exited the facility through an unlocked and non-alarmed door to the outside without staff knowledge. He	S5026		

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was found the next day (18.25 hours after elopement) approximately 3 miles from the facility in a truck, in a parking lot of a local business, by workers of the business. This placed the resident in immediate jeopardy.

Findings included:

- Record review for R1 revealed an admission date of 08/10/23 with the following diagnoses: major neurocognitive disorder with behavioral disturbance, Alzheimer's disease, and dementia.

The 08/10/23 "Functional Capacity Screen" (FCS) identified R1 required supervision for bathing and dressing; was independent with walking/mobility; had short-term and long-term memory, memory/recall, and decision-making cognitive impairments; was sometimes understandable and sometimes understood others during communication; and was marked for impaired decision-making and wandering.

The 08/10/23 "Negotiated Service Agreement" (NSA) identified facility staff would provide supervision with bathing and dressing. The "NSA" failed to describe the services provided for cognition, communication, impaired decision-making, and wandering.

R1's record lacked evidence of documentation of an elopement risk assessment.

The 08/10/23 at 02:00 PM "Progress Note Observation" by Administrative Nurse B documented R1 admitted to the facility with the ability to ambulate independently and was alert and oriented to self only. He admitted from a

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behavioral unit with a history of aggression towards staff.

The 08/12/23 at 05:50 PM "Progress Note Observation" by Administrative Nurse B documented facility staff reported they were unable to find R1 after assisting another resident in his room. R1 left the facility and staff were unable to find him after looking outside around the home and in the neighborhood.

The 08/13/23 at 12:15 PM "Progress Note Observation" by Administrative Nurse B documented police called the facility to report R1 was found. He was transported back to the facility. He had abrasions to his forehead and nose and "a bump" on the corner of his left eye.

The 08/12/23 "Fall/Incident Report" by Certified Nurse Aide (CNA) C documented R1 had gone into the bathroom. She assisted another staff member with another resident. When the two staff finished, they could not find R1.

The facility's 08/14/23 incident report to the department documented R1 had eloped on 08/12/23 at 05:50 PM and returned to the facility with police on 08/13/23 at 12:15 PM. He was found three miles away from the facility.

Observation on 08/14/23 at 05:04 PM revealed R1 paced hallways and common areas. Staff redirected him to sit down, and he sat for three to five minutes. He got up and paced again. Administrative Staff A advised staff to call the nurse to administer medication to help him relax.

On 08/14/23 at 02:49 PM Administrative Staff A

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stated R1 usually paced the hallways and common areas of the facility but had not tried to exit the facility.

On 08/14/23 at 03:05 PM Administrative Staff A stated she was not present when R1 exited the facility. There were two staff in the facility who were assisting another resident in his room. They noticed R1 was missing when they returned to the common area. They believed he went out the front door because it was found open.

On 08/14/23 at 03:56 PM Administrative Staff A stated she had not read the elopement policy "in a while."

On 08/14/23 at 04:31 PM Administrative Staff A stated she had an alarm on the front door but had turned the volume down because she heard too many complaints it was too loud.

On 08/15/23 at approximately 09:50 AM Administrative Nurse B confirmed R1's "NSA" lacked descriptions of the services provided for cognition, communication, decision-making, and wandering. She stated someone reported that R1 had been sighted at a fast-food restaurant at an intersection with a busy four-lane street.

Observation on 08/15/23 at approximately 09:00 AM revealed the facility was in a residential neighborhood two blocks away from a busy four-lane street with a speed limit of 40 miles per hour (MPH). Google Maps satellite view of the three-mile area between the facility and where R1 was found revealed, in addition to the four-lane street, two ponds, a small creek, a wooded area, and an agriculture field.

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S5026	Continued From page 4 The weather according to Wunderground.com on 08/12/23 at 05:50 PM was 83 degrees Fahrenheit (F) with a wind speed of 21 MPH. The lowest temperature was during early morning of 08/13/23 at 75 degrees F with a wind speed of 7 MPH. Attempts to reach weekend staff who were present when R1 exited the facility failed. The facility's undated "Elopement Policy" documented: "Elopement assessment prior to admission by a licensed nurse. . . If a risk then denial of admission to the facility. . . If a resident becomes at risk after placement, family notification and a 30-day notification of discharge notice will be served." The operator failed to protect R1 from neglect by the failure to implement a method of identifying residents at high-risk for elopement, failure to follow facility's elopement policy, failure to describe services provided to keep him safe from wandering, and failure to ensure a functioning alarm was on all exit doors. This failure resulted in immediate jeopardy when cognitively impaired R1 exited the facility through an unlocked and non-alarmed door to the outside without staff knowledge. He was found the next day (18.25 hours after elopement) approximately 3 miles from the facility in a truck, in a parking lot of a local business, by workers of the business. Jeopardy was removed on 08/14/23 when the following actions were documented by the facility in the "Abatement Plan for Elopement" and accepted by the department at 06:25 PM.	S5026		

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S5026	Continued From page 5 1) Resident checked by staff every 30 minutes for the next week and documented on the "30 Minute Daily Planner" sheet to observe his behavior patterns. Started 05:00 AM on 08/14/23. 2) Bed alarm on while resident in bed. 3) Bells and sensor alarm placed on resident's room door. 4) Privacy fence to be installed around backyard to allow resident to walk around outside in a secured area. 5) Sensor alarm to be installed on front door by end of day on 08/14/23. 6) Staff in-service on elopement policy will be completed each shift beginning with night shift 08/14/23 and day shift 08/15/23 morning. Weekend staff will be done Saturday 08/19/23. 7) All current residents will be assessed for elopement risk per facility policy by end of the day on 08/15/23.	S5026		
S5095	26-42-201 (d) Functional Capacity Screen Accurate (d) Designated staff shall ensure that each resident ' s functional capacity at the time of screening is accurately reflected on that resident ' s screening form. This REQUIREMENT is not met as evidenced by: KAR 26-42-201(d) The facility reported a census of five residents with one abbreviated review included in the	S5095		

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sample. Based on observation, interview, and record review the operator failed to ensure the "Functional Capacity Screen" (FCS) for Resident (R) 1 accurately reflected his functional capacity at the time of screening.

Findings included:

- Record review for R1 revealed an admission date of 08/10/23 with the following diagnoses: major neurocognitive disorder with behavioral disturbance, Alzheimer's disease, and dementia.

The 08/10/23 "Functional Capacity Screen" (FCS) identified R1 had short-term and long-term memory, memory/recall, and decision-making cognitive impairments scored at "3" for each with a total score of "39."

The 08/10/23 "Negotiated Service Agreement" (NSA) failed to describe the services provided for cognition.

Observation on 08/14/23 at 05:04 PM revealed R1 paced hallways and common areas. Staff redirected him to sit down, and he sat for three to five minutes. He got up and paced again. Administrative Staff A advised staff to call the nurse to administer an as needed medication to help him relax.

On 08/15/23 at approximately 09:50 AM Administrative Nurse B confirmed R1's "FCS" score for cognition was not correct.

The department's "Resident Functional Capacity Screen" form Section D. Cognition - Memory, Recall instructed "Record results from exam in

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S5095	Continued From page 7 manual." The department's updated 07/11/08 "Resident Functional Capacity Screen Manual" pages 12-14 included instructions to enter a "0" if there was no difficulty or a "1" if there was difficulty for each of four items in Section D. Cognition - Memory, Recall for a total no greater than four. The operator failed to ensure the "FCS" for R1 accurately reflected his functional capacity at the time of screening.	S5095		
S5105 SS=D	26-42-202 (a) Negotiated Service Agreement a) The administrator or operator of each home plus shall ensure the development of a written negotiated service agreement for each resident, based on the resident ' s functional capacity screening, service needs, and preferences, in collaboration with the resident or the resident ' s legal representative, the case manager, and, if agreed to by the resident or the resident ' s legal representative, the resident ' s family. The negotiated service agreement shall provide the following information: (1) A description of the services the resident will receive; (2) identification of the provider of each service; and (3) identification of each party responsible for payment if outside resources provide a service. This REQUIREMENT is not met as evidenced by: KAR 26-42-202(a)(1)	S5105		

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S5105	Continued From page 8 The facility reported a census of five residents with one abbreviated review included in the sample. Based on interview and record review the operator failed to ensure the "Negotiated Service Agreement" (NSA) for Resident (R) 1 described the services provided for cognition, communication, impaired decision-making, and wandering based on his "Functional Capacity Screen" (FCS). Findings included: - Record review for R1 revealed an admission date of 08/10/23 with the following diagnoses: major neurocognitive disorder with behavioral disturbance, Alzheimer's disease, and dementia. The 08/10/23 "Functional Capacity Screen" (FCS) identified R1 required supervision for bathing and dressing; was independent with walking/mobility; had short-term and long-term memory, memory/recall, and decision-making cognitive impairments; was sometimes understandable and sometimes understood others during communication; and was marked for impaired decision-making and wandering. The 08/10/23 "Negotiated Service Agreement" (NSA) identified facility staff would provide supervision with bathing and dressing. The "NSA" failed to describe the services provided for cognition, communication, impaired decision-making, and wandering. On 08/15/23 at approximately 09:50 AM Administrative Nurse B confirmed R1's "NSA" lacked descriptions of the services provided for cognition, communication, decision-making, and	S5105		

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S5105	Continued From page 9 wandering. The operator failed to ensure the "NSA" for R1 described the services provided for cognition, communication, impaired decision-making, and wandering based on his "FCS."	S5105		