STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087083	A. BUILDING: _____ B. WING _____	C 08/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOUNDER'S CREST LLC	6887 E ROCKHILL STREET WICHITA, KS 67206

(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 represent the findings of complaint investigations #182141, #179677, and #166829 at the above named residential healthcare facility conducted on 08/16/23.	S 000		
S3026 SS=D	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 24 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 ensure all exit doors were secured with an alarm loud enough to be heard in all locations of the building and the failure to ensure the gate from a courtyard was secured. Cognitively impaired Resident (R) 1 exited the facility through an unlocked, alarmed door through an unsecure outside gate without staff knowledge. He was found by a staff member sitting in her car in the parking lot.	S3026		

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

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Findings included:

- Record review for R1 revealed an admission date of 01/11/23 with the following diagnoses: Alzheimer's dementia.

The 01/11/23 "Functional Capacity Screen" (FCS) identified R1 required physical assistance with transfers; supervision with walking/mobility; had short-term and long-term memory, memory/recall, and decision-making cognitive difficulties; and was marked for impaired decision-making, wandering, and inappropriate behavior.

The 01/11/23 "Negotiated Service Agreement" (NSA) identified facility staff would provide instructions, supervision, and assistance of one to two persons the majority of the time for transfers; instructions, supervision, and assistance as needed with walking/mobility; and reassurance and redirection in times of need for cognitive difficulties, impaired decision-making, wandering, and inappropriate behavior.

The facility's incident report documented the following:

At 05:40 PM R1 was last seen in the dining room.
At 05:45 PM a hallway video surveillance camera recorded R1 entered another resident's room that had an exit door leading to a fenced courtyard. He was not recorded coming back out of the room.
At 06:00 PM Certified Medication Aide (CMA) C was unable to locate R1. All staff were alerted and began looking for him.

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At an undocumented time CMA found R1 sitting in her car.
At 06:15 PM the front entrance video surveillance camera recorded R1 entered the facility with facility staff.

Review of the "Safety Check" log for R1 from first shift on 08/11/23 to end of night shift on 08/13/23 revealed Certified Nurse Aide (CNA) D documented all doors and gates were checked at 01:33 PM, 4.25 hours before R1 entered the room with an exit door and went out the gate.

Observation on 08/16/23 at 09:40 AM revealed R1's room door was open. R1 laid in bed sleeping. It was approximately 82 steps from his room to the resident's room that had a door exiting to an outside fenced courtyard. An alarm was on the door and activated when the door was opened. It was six steps to the gate. The gate was locked and had a keypad to enter a code to unlock the gate to exit. A key fob was required to unlock the gate from the other side. It was approximately 58 steps from the gate to the parked car where R1 was found sitting.

Observation on 08/16/23 at approximately 01:04 PM revealed R1 ambulated in a secured courtyard area outside accompanied by a staff member. He ambulated back inside, through a common area, and down a hallway, stopping to chat with staff. He sat down at a table in a common area. Upon interview, R1 was oriented to self only.

On 08/16/23 at 10:14 AM Administrative Nurse B stated all facility staff were in the dining room assisting with the evening meal and did not hear

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the door alarm when R1 exited the building.

On 08/16/23 at 11:15 AM CMA C stated she worked at the time R1 exited the building without staff knowledge. He was independent with walking and wandered a lot. The door alarm could not be heard from the dining area.

On 08/16/23 at 01:10 PM during a phone interview, CNA D stated she worked the day R1 exited the building and checked all the doors and gates to ensure they were secure.

On 08/16/23 at 01:13 PM Administrative Nurse B stated the door alarms were installed so staff could hear in case someone went out of the building.

On 08/16/23 at approximately 01:32 PM Administrative Staff A stated only nurses, maintenance, and the Vice President of Operations had access to unlock the courtyard gate R1 exited to get to the parking lot. Family members always used the front entrance.

The facility's 08/11/23 "Elopement Prevention" policy documented: Staff were to do walking rounds at the beginning and end of their shift to ensure all residents were safe and accounted for and all doors and gates were locked and functioning properly. Staff were to observe all residents at a minimum of every 30 minutes by direct line of sight or walking around to ensure residents were safe and accounted for.

The operator failed to protect R1 from neglect by the failure to ensure all exit doors were secured with an alarm loud enough to be heard in all

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S3026	Continued From page 4 locations of the building and the failure to ensure the gate from a courtyard was secured. Cognitively impaired R1 exited the facility through an unlocked, alarmed door through an unsecure outside gate without staff knowledge. He was found by a staff member sitting in her car in the parking lot.	S3026		