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 _____	10/04/2023

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
S 000	INITIAL COMMENTS The following citations represent the findings of an abbreviated survey for complaints #183163 of the above named facility conducted on 10/03/23 and 10/04/23.	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: K.A.R. 26-41-101(f)(1)(B) The facility reported a census of 24 residents. The sample included three "Residents'" (R)'s 1, 2, 3, and 4. Based on observation, interview and record review the operator failed to ensure R1 was not the subject of neglect when the facility staff failed to recognize exit seeking behaviors, implement interventions, and protect the resident from leaving the facility without facility staff knowledge. On 09/16/23 R1 left the facility without staff knowledge and was out of the facility for an undetermined length of time. Upon R1's return to the facility, the operator further failed to put interventions into place to monitor R1 for exit seeking behaviors, this placed R1 in	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
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S3026	Continued From page 1 immediate jeopardy. Findings included: - Record review for R1 revealed an admission date of 07/27/23 with diagnoses of Alzheimer's Dementia, coronary artery disease, essential (primary) hypertension, complete loss of teeth due to caries. R1 "Functional Capacity Screen" (FCS) dated 07/27/23 revealed he required physical assistance with bathing, transferring, walking/mobility and eating. He required supervision with dressing and toileting. He lacked the ability to manage his own medications and was occasionally incontinent of his bladder. He was marked with being able to repeat a sentence for short term memory, could repeat previous items for long term memory, could repeat one of three items for memory recall, and was unable to make decisions due to Alzheimer's diagnoses. He was usually able to make himself understood and he usually understood others. He was marked with impaired decision making and used no mobility device. The FCS was not marked with "Wandering" under section "III Current or Recent Problems and Risks" The "Negotiated Service Agreement" (NSA) dated 08/04/23 identified the following health services to be provided: assist with bathing, orientation reminders, medication management, and "Exit seeking behaviors upon admission. Staff to redirect as needed and ensure he does not exit the building".	S3026		

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S3026	Continued From page 2	S3026		

The "Health Service Plan" (HSP) revealed the following instructions to staff:
"Exit seeking behaviors upon admission. Staff to redirect as needed and ensure he does not exit the building".

The HSP lacked any other interventions for wandering/exit seeking behaviors.

In the electronic medical record under "Progress Notes" revealed only four total entries in the record:

07/31/23 At 12:51PM: "New admit on 07/28/23 first shift blood pressure 164/79 temperature 97.6 degrees Fahrenheit (F), oxygen saturation 96%, respirations 20, pulse 68. Second shift blood pressure 160/72, temperature 97.6 degrees F, oxygen saturation 96%, respirations 20, pulse 72, no abnormal findings. Third shift blood pressure 127/62, temperature 97.5 degrees F, oxygen saturation 95%, respirations 20, pulse 71, no abnormal findings. First shift blood pressure 120/74, pulse 52, temperature 97.4 degrees F, oxygen saturation 97%, respirations 20, no abnormal findings. Second shift blood pressure 134/80, pulse 68, temperature 97.1degrees F, oxygen saturation 98%, respirations 20, no abnormal findings. Third shift blood pressure 117/90, pulse 64, temperature 97.7 degrees F, oxygen saturation 95%, respirations 18, no abnormal findings.

The record contained only his vital signs when he admitted to the facility.

07/31/23 At 04:27 PM "Staff report resident is

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 _____	10/04/2023

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S3026	Continued From page 3	S3026		

very high risk for elopement. He has dementia but is capable of reading the "15 second" door notice for emergency exiting, in which he has gotten outside to the parking lot but was easily redirected by staff. He is attempting to return to his home. Family brought a bottle of Mirtazapine (anti-depressant medication)15 milligrams, in, but there was no order and the prescribing medical doctor refused to provide a signed order because the prescription was from June and the resident was no longer under that provider's service. The medication was filled by pharmacy, and they denied providing a copy of the prescription as well. Requires clarification with new primary provider. Staff will complete safety checks while on frequent rounds and will continue to redirect as indicated.

08/04/23 At 10:01 AM "Per staff report R1 has not presented with any exit seeking behaviors in the past five days. He is pleasantly confused and easily redirected".

08/09/23 at 04:19 PM "Spoke with the resident's durable power of attorney via phone. Informed her of the need to have service agreement signed as well as the pharmacy agreement. These documents were all emailed to her with instructions to send back to the community when completed."

Review of the "Elopement Risk Assessment" dated 07/27/23 revealed the following: R1 had been diagnosed with dementia, he had Alzheimer's disease and required occasional redirection, the resident did not have history of elopement. The assessment lacked a scoring system to indicate level of elopement risk.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S3026	Continued From page 4 The record lacked a new "Elopement Risk Assessment" after the resident successfully exited the building on 07/31/23 by holding the door for 15 seconds and it released, and it was noted he was trying to "return home". Review of complaint from the department dated 09/29/23 revealed R1 had eloped from the facility and went to a restaurant across the "highway" and was 0.2 miles away from the facility. The complaint stated the restaurant staff called the local police department. Review of the "Call Detail Report" dated 09/16/23 from the Police Department revealed the following: At 08:13:42 "Elderly male walked into the local restaurant and seems confused wearing green shorts, white shoes, and grey hat" At 08:14:02 "Now at local farm store" At 08:14:22 "The manager at the local restaurant called" At 08:22:42 "On the east side of the building wandering around At 08:23:38 A tag number was run through the police department At 08:23:06 "They're back in route to facility" At 08:24:05 "R1 left facility, is back in route to that facility". Operator A "Executive Director of the facility called to advise this male is a resident	S3026		

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 _____	10/04/2023

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ALDERBROOK VILLAGE LLC	402 WINDSOR ROAD ARKANSAS CITY, KS 67005

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S3026	Continued From page 5	S3026		

and they have picked him up and brought him back to the facility".

Interview on 10/04/23 at 04:30 PM with Police Lieutenant CC, he confirmed that the responding officers ran the license plate tag of the vehicle R1 was sitting in. He continued to state that the police department did not transport R1 to the facility.

Review of "Electronic Mail" (E-Mail) dated 10/07/23 from Patrol Sergeant DD, he wrote: Officers were called regarding a male subject that had left the facility. Upon arrival to the are R1 was, the officer saw R1. He was walking by himself on the sidewalk at the street in front of the department store. When the officer passed R1 to turn his patrol car around, he noticed a white in color minivan stop in the roadway and R1 got in on the front passenger side of the vehicle. The officer stopped the vehicle, and the driver was an employee of the facility who stated she was going to take him back to the facility. The officer asked R1 if he was OK and if he needed medical attention. The resident stated "yes, he was ok, and "no" he did not need medical attention.

Interview on 10/03/23 at 02:30 PM Operator A stated she was unaware of an elopement. She stated that there was an incident that she returned a call to the local police department related to an employee who followed a resident when he exited the building. She continued to state the employee never lost sight of the resident and that is why she did not report it to the department as an elopement.

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	N018010	A. BUILDING: _____ B. WING _____	10/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S3026	Continued From page 6 On 10/04/23 Review of Operator A signed, and notarized "Witness Statement" revealed the following: On 09/16/23 she was notified by "Certified Medication Aide" (CMA) D, that R1 had set off the alarm and she was getting in her car to get him. He had walked across to a local restaurant and then gone into a local farm store parking lot. She stated the local restaurant had called police before she got there, but she had picked him up and was headed back to the building with him". Operator A included the following: Operator A had notified R1 daughter, and the daughter stated, "He has a tile in his shoe so if you ever can't find him just call me". On page two of the signed and notarized witness statement Operator A wrote "Staff knew his location at all times. I called police to notify them that we had him with us and he said, "Thank you for letting me know". Operator A continued to write "Investigation was not opened and was not reported due to staff knowing his location at all times". Interview on 10/04/23 at approximately 04:00 PM CMA D stated she thought the event happened in July and she stated she could not really remember the instance/details. She could not recall the last time she had seen the resident nor the time of day that the incident took place. She just knew 2 people she did not know had opened the front door of the facility, and the alarm going off. She stated she did not see R1 exit the building and that she remembered someone told her (she could not remember who) that R1 had gone out the front door. She stated she did not have her phone or keys and she went out the front door to look for R1. She stated she did not	S3026		

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 _____	10/04/2023

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

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S3026	Continued From page 7	S3026		

see R1 and the people outside of the apartment to the southeast across the street in front of the facility pointed to the west as to the R1 location. She stated the people in the smoking area of the apartment complex to the southwest across the street to the front of the facility told her they did not see anyone. She stated she looked down the street and across the field to the west of the apartment complex and she did not see the R1. She stated that she went to the facility and got her phone and her keys and called Operator A. She stated that the operator was on the phone with her the whole time she was looking for R1 and telling her the location of the resident. She went and got her car to go and find him. She continued he was not at the local restaurant when she arrived, and he was not in the local farm store parking lot. She stated the operator told her to drive towards the department store where she found him on the sidewalk past the "3way". She stated she asked him if he needed a ride, she got him in her car and buckled his seat belt. She stated that the police arrived and that she confirmed that he did belong at the facility, and that she was taking him back to the facility. CMA D stated she did not see the resident until she picked him up.

10/04/23 review of CMA D signed and notarized "Witness Statement" revealed the following: "R1 had eloped through the doors while visitors were coming in, so I went to physically return him while the other worker called the Executive Director". "Not seeing him, I returned to building and got keys to go and search for him. Executive Director called and said R1's tracker had him at the local restaurant". She wrote she did not see R1 in the parking lot, so she turned out of the

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	N018010	A. BUILDING: _____ B. WING _____	10/04/2023

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

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S3026	Continued From page 8	S3026		

local farm store parking lot and saw R1 "past the three-way traffic stop". CMA D seat belted him and pulled over to speak to the "cops", She wrote she was on the phone with the Executive Director / Operator A" telling" CMA D where the tracker was locating R1.

Interview on 10/04/23 At 05:00 PM with Operator A and Licensed Nurse Consultant B, Operator A confirmed that she did call the daughter after she was notified that R1 was missing. Operator A stated the daughter was telling her where R1 was because she was tracking him on her phone. Operator A confirmed she did not report to the state the elopement and the FCS, NSA, and HSP were not updated when the facility staff identified the exit seeking behavior. Operator A and Licensed Nurse Consultant B further confirmed there were no interventions put into place after R1 was returned to the facility on 09/16/23 at approximately 08:24 PM, wearing shorts, white shoes, and a grey hat, after crossing 77 highway/Summit street, a busy four lane with no stop lights or crossing signal with a speed limit of 45 miles per hours. The weather temperature at 08:00 PM was approximately 69.8 degrees F according to "localconditions.com/weather-arkansas-city-kansas/67005/past.php".

The operator failed to ensure R1 was not the subject of neglect when the facility staff failed to recognize exit seeking behaviors, implement interventions, and protect the resident from leaving the facility without facility staff knowledge.

On 10/04/23 At 05:30 PM Operator A and

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 _____	10/04/2023

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

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S3026	Continued From page 9 Licensed Nurse Consultant B were informed of Immediate Jeopardy for failure to put interventions in place for R1 when staff identified R1 having exit seeking behaviors on 07/31/23 and was found in the facility parking lot, and after he returned to the facility on 09/16/23. Abatement plan was accepted 0n 10/04/23 at 06:15 PM and included the following interventions for R1 exit seeking and wandering behavior and signed by Operator A: 10/04/23 the area in which R1 does puzzles daily will be moved to the center of the building away from the exit doors. Safety checks every one hour for two weeks will be conducted and reduce to safety checks every two hours for two weeks to ensure R1 is in the building. The safety checks will be for one month, when a reassessment will be performed to show if the need is required. Doors are alarmed at exits continuously. Anytime visualization is not obtained the facility will contact R1 daughter to. She stated she had a tracker in his only pair of shoes.	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	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 _____	10/04/2023

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
S3028	Continued From page 10 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: K.A.R 26-41-101 (f)(3)(A)(B)(C)(D)(E) The facility reported a census of 24 residents. The sample included three "Residents" ((R)'s 1, 2, 3, and 4). Based on interview and record review, the operator failed to report to the department within twenty-four hours an incident of elopement for R1 on 09/16/23, she failed to open an investigation when she was notified that R1 had left the facility and facility staff could not locate him, she failed to thoroughly investigate	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 _____	10/04/2023

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
S3028	Continued From page 11	S3028		

the elopement and how R1 was able to leave the facility, and she further failed to report to the department within five working days the initial report ruling out neglect, and maintain a written record of the investigation of neglect.

Findings included:

- Record review for R1 revealed an admission date of 07/27/23 with diagnoses of Alzheimer's Dementia, coronary artery disease, essential (primary) hypertension, complete loss of teeth due to caries.

R1 "Functional Capacity Screen" (FCS) dated 07/27/23 revealed he required physical assistance with bathing, transferring, walking/mobility and eating. He required supervision with dressing and toileting. He lacked the ability to manage his own medications and was occasionally incontinent of his bladder. He was marked with being able to repeat a sentence for short term memory, could repeat previous items for long term memory, could repeat one of three items for memory recall, and was unable to make decisions due to Alzheimer's diagnoses. He was usually able to make himself understood and he usually understood others. He was marked with impaired decision making and used no mobility device.

The "Negotiated Service Agreement" (NSA) dated 08/04/23 identified the following health services to be provided: assist with bathing, orientation reminders, medication management, and "Exit seeking behaviors upon admission. Staff to redirect as needed and ensure he does not exit the building".

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	N018010	A. BUILDING: _____ B. WING _____	10/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S3028	Continued From page 12 The "Health Service Plan" (HSP) revealed the following instructions to staff: "Exit seeking behaviors upon admission. Staff to redirect as needed and ensure he does not exit the building". In the electronic medical record under "Progress Notes" revealed only four entries in the record: 07/31/23 At 12:51PM: "New admit on 07/28/23 first shift blood pressure 164/79 temperature 97.6 degrees Fahrenheit (F), oxygen saturation 96%, respirations 20, pulse 68. Second shift blood pressure 160/72, temperature 97.6 degrees F, oxygen saturation 96%, respirations 20, pulse 72, no abnormal findings. Third shift blood pressure 127/62, temperature 97.5 degrees F, oxygen saturation 95%, respirations 20, pulse 71, no abnormal findings. First shift blood pressure 120/74, pulse 52, temperature 97.4 degrees F, oxygen saturation 97%, respirations 20, no abnormal findings. Second shift blood pressure 134/80, pulse 68, temperature 97.1degrees F, oxygen saturation 98%, respirations 20, no abnormal findings. Third shift blood pressure 117/90, pulse 64, temperature 97.7 degrees F, oxygen saturation 95%, respirations 18, no abnormal findings. 07/31/23 At 04:27 PM "Staff report resident is very high risk for elopement. He has dementia but is capable of reading the "15 second" door notice for emergency exiting, in which he has gotten outside to the parking lot but was easily redirected by staff. He is attempting to return to his home. Family brought a bottle of Mirtazapine (anti-depressant medication)15 milligrams in, but	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 _____	10/04/2023

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

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S3028	Continued From page 13 there was no order and the prescribing medical doctor refused to provide a signed order because the prescription was from June and the resident was no longer under that providers service. The medication was filled by pharmacy, and they denied providing a copy of the prescription as well. Requires clarification with new primary provider. Staff will complete safety checks while on frequent rounds and will continue to redirect as indicated. 08/04/23 At 10:01 AM "Per staff report R1 has not presented with any exit seeking behaviors in the past five days. He is pleasantly confused and easily redirected". 08/09/23 at 04:19 PM "Spoke with the resident's durable power of attorney via phone. Informed her of the need to have service agreement signed as well as the pharmacy agreement. These documents were all emailed to her with instructions to send back to the community when completed." Review of the "Elopement Risk Assessment" dated 07/27/23 revealed the following: R1 had been diagnosed with dementia, he had Alzheimer's disease and required occasional redirection, the resident did not have history of elopement. The assessment lacked a scoring system to indicate level of elopement risk. Review of complaint from the department dated 09/29/23 revealed R1 had eloped from the facility and went to a restaurant across the "highway" and was 0.2 miles away from the facility. The complaint stated the restaurant staff called the loc local police department.	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 _____	10/04/2023

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

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S3028	Continued From page 14 Review of "Electronic Mail" (E-Mail) dated 10/07/23 from Patrol Sergeant DD, he wrote: "Officers were dispatched to the area of the local restaurant regarding a male subject that had left the facility. I arrived in the area and noticed a male subject fitting the description given to be walking on the sidewalk southbound in front of the department store. As I passed the male subject and turned my Patrol vehicle around, I noticed a white in color minivan stop in the roadway and the male subject got in on the front passenger side of the vehicle. I conducted a Traffic Stop on the vehicle in another local restaurant parking lot and made contact with a facility employee, who advised she located him and was going to return him back to the facility. I made contact with R1 in the front passenger seat and asked him if he was OK and he stated "yes" and asked if he was in need of any medical treatment and he stated "no" he was fine. The employee then returned R1 back to the facility." Interview on 10/03/23 at 02:30 PM Operator A stated she was unaware of an elopement. She stated that there was an incident that she returned a call to the local police department related to an employee who followed a resident when he exited the building. She continued to state the employee never lost sight of the resident and that is why she did not report it to the department as an elopement. On 10/04/23 Review of Operator A signed, and notarized "Witness Statement" revealed the following:	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 _____	10/04/2023

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

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S3028	Continued From page 15 On 09/16/23 she was notified by "Certified Medication Aide" (CMA) D, that R1 had set off the alarm and she was getting in her car to get him. He had walked across to a local restaurant and then gone into local farm store parking lot. She stated the local restaurant had called police before she got there, but she had picked him up and was headed back to the building with him". Operator A included the following: Operator A had notified R1 daughter, and the daughter stated, "He has a tile in his shoe so if you ever can't find him just call me". On page two of the signed and notarized witness statement Operator A wrote "Staff knew his location at all times. I called police to notify them that we had him with us and he said, "Thank you for letting me know". Operator A continued to write "Investigation was not opened and was not reported due to staff knowing his location at all times". Interview on 10/04/23 at approximately 04:00 PM CMA D stated she thought the event happened in July and she stated she could not really remember the instance/details. She could not recall the last time she had seen the resident nor the time of day that the incident took place. She just knew 2 people she did not know had opened the front door of the facility, and the alarm going off. She stated she did not see R1 exit the building and that she remembered someone told her (she could not remember who) that R1 had gone out the front door. She stated she did not have her phone or keys and she went out the front door to look for R1. She stated she did not see R1 and the people outside of the apartment to the southeast across the street in front of the facility pointed to the west as to the R1 location. She stated the people in the smoking area of the	S3028		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDERBROOK VILLAGE LLC	402 WINDSOR ROAD ARKANSAS CITY, KS 67005

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S3028	Continued From page 16	S3028		

apartment complex to the southwest across the street to the front of the facility told her they did not see anyone. She stated she looked down the street and across the field to the west of the apartment complex and she did not see the R1. She stated that she went to the facility and got her phone and her keys and called Operator A. She stated that the operator was on the phone with her the whole time she was looking for R1 and telling her the location of the resident. She went and got her car to go and find him. She continued he was not at the local restaurant when she arrived, and he was not in the local farm store parking lot. She stated the operator told her to drive towards department store where she found him on the sidewalk past the "3way". She stated she asked him if he needed a ride, she got him in her car and buckled his seat belt. She stated that the police arrived and that she confirmed that he did belong at the facility, and that she was taking him back to the facility. CMA D stated she did not see the resident until she picked him up.

10/04/23 review of CMA D signed and notarized "Witness Statement" revealed the following: "R1 had eloped through the doors while visitors were coming in, so I went to physically return him while the other worker called the Executive Director". "Not seeing him, I returned to building and got keys to go and search for him. Executive Director called and said R1's tracker had him at the local restaurant". She wrote she did not see R1 in the parking lot, so she turned out of the local farm store parking lot and saw R1 "past the three-way traffic stop". CMA D seat belted him and pulled over to speak to the "cops", She wrote she was on the phone with the Executive

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDERBROOK VILLAGE LLC	402 WINDSOR ROAD ARKANSAS CITY, KS 67005

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S3028	Continued From page 17 Director / Operator A" telling" CMA D where the tracker was locating R1. 10/04/23 At 05:00 PM with Operator A and Licensed Nurse Consultant B, Operator A confirmed that she did call the daughter after she was notified that R1 was missing. Operator A stated the daughter was telling her where R1 was because she was tracking him on her phone. Operator A confirmed she did not report to the state the elopement The operator failed to report to the department within twenty-four hours an incident of elopement for R1 on 09/16/23, she failed to open an investigation when she was notified that R1 had left the facility and facility staff could not locate him, she failed to thoroughly investigate the elopement and how R1 was able to leave the facility, and she further failed to report to the department within five working days the initial report ruling out neglect, and maintain a written record of the investigation of neglect.	S3028		
S3080 SS=E	26-41-201 (a) (b) Functional Capacity Screen on Admission a) On or before each individual ' s admission to an assisted living facility or residential health care facility, a licensed nurse, a licensed social worker, or the administrator or operator shall conduct a screening to determine the individual ' s functional capacity and shall record all findings on a screening form specified by the department. The administrator or operator may integrate the department ' s screening form into a form developed by the facility, which shall include each element and definition specified by the	S3080		

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 _____	10/04/2023

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

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S3080	Continued From page 18	S3080		

department.
(b) A licensed nurse shall assess any resident whose functional capacity screening indicates the need for health care services.

This REQUIREMENT is not met as evidenced by:
K.A.R. 26-41-201 (a)

The facility reported a census of 24 residents. The sample included "Residents'" (R)'s 1, 2, 3, and 4. Based on record review and interview the operator failed to ensure screening findings were recorded on the form specified by the department and included each element and definition specified by the department, prior to or at the time of admission for R3 that determined her functional capacity.

Findings included:

- Record review for R3 revealed an admission date of 10/02/23 with no diagnosis list documented.

R3 Admission Agreement was signed on 10/02/23, which defined care fees and the summary of monthly fees.

R3 electronic medical record "Progress Notes" contained only one note dated 10/02/23 at 03:10 PM Resident came to facility with her nephew. R3 was alert times three but needed constant reminders of new surroundings. R3 cam with medications from home in bottles.

Review of facility document titled "Level of Care

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 _____	10/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S3080	Continued From page 19 Appraisal" revealed the following: R3 required reminders for the following: grooming, bathing, mealtimes, administration of her medications twice daily, she was independent with dressing, toileting, transferring, was not a fall risk, had no identified at-risk behaviors, and had elopement history and concerns. Interview on 10/04/23: Operator A and regional nurse consultant B confirmed the "Level of Care Appraisal" findings were not recorded on the form specified by the department. The operator failed to ensure screening findings were recorded on the form specified by the department and included each element and definition specified by the department, prior to or at the time of admission for R3 that determined her functional capacity.	S3080		
S3101 SS=D	26-41-202 (h) NSA Signatures (h) Each individual involved in the development of the negotiated service agreement shall sign the agreement. The administrator or operator shall ensure that a copy of the initial agreement and any subsequent revisions are provided to the resident or the resident's legal representative. This REQUIREMENT is not met as evidenced by: K.A.R. 26-41-202 (h) The facility reported a census of 24 residents. The sample included four "Residents'" (R)'s 1, 2,	S3101		

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 _____	10/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S3101	Continued From page 20 3, and 4. Based on interview and record review the operator failed to ensure each individual involved in the development of the "Negotiated Service Agreement" shall sign the agreement for R2. Findings included: - Record review for R2 revealed an admission date of 06/27/20 with diagnoses of glaucoma, congestive heart failure, atrial fibrillation, supraventricular tachycardia, and osteoarthritis. R2 "Functional Capacity Screen" (FCS) for significant change dated 09/13/23, revealed R2 required physical assistance with bathing, dressing, toileting, and transferring. She lacked the ability to manager her own medications, was frequently incontinent of her bladder, and had impaired short-term memory, impaired memory recall, and impaired decision making. She was able to make herself understood and she understood others. Under the ordered therapies and treatments, hospice is listed. R2 NSA updated on 09/13/23 identified the following health services to be provided: hospice, pureed diet with nectar thickened liquids "only, due to choking". The signature page lacked all signatures. The operator failed to ensure each individual involved in the development of the "Negotiated Service Agreement" shall sign the agreement for R2.	S3101		

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 _____	10/04/2023

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

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S3155	Continued From page 21	S3155		
S3155 SS=E	26-41-204 (a) Health Care Services . (a) The administrator or operator in each assisted living facility or residential health care facility shall ensure that a licensed nurse provides or coordinates the provision of necessary health care services that meet the needs of each resident and are in accordance with the functional capacity screening and the negotiated service agreement. This REQUIREMENT is not met as evidenced by: K.A.R. 26-41-204 (a) The facility reported a census of 24 residents. The sample included "Residents'" (R)'s 1, 2, 3, and 4. Based on record review and interview the operator failed to ensure that a licensed nurse provided or coordinated the provision of necessary health care services that met the needs for R1 and R3 for wandering / exit seeking behaviors. Findings included: - Record review for R1 revealed an admission date of 07/27/23 with diagnoses of Alzheimer's Dementia, coronary artery disease, essential (primary) hypertension, complete loss of teeth due to caries. R1 "Functional Capacity Screen" (FCS) dated 07/27/23 revealed he required physical	S3155		

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	N018010	A. BUILDING: _____ B. WING _____	10/04/2023

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

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S3155	Continued From page 22	S3155		

assistance with bathing, transferring, walking/mobility and eating. He required supervision with dressing and toileting. He lacked the ability to manage his own medications and was occasionally incontinent of his bladder. He was marked with being able to repeat a sentence for short term memory, could repeat previous items for long term memory, could repeat one of three items for memory recall, and was unable to make decisions due to Alzheimer's diagnoses. He was usually able to make himself understood and he usually understood others. He was marked with impaired decision making and used no mobility device.

The "Negotiated Service Agreement" (NSA) dated 08/04/23 identified the following health services to be provided: assist with bathing, orientation reminders, medication management, and "Exit seeking behaviors upon admission. Staff to redirect as needed and ensure he does not exit the building".

The "Health Service Plan" (HSP) revealed the following instructions to staff:
"Exit seeking behaviors upon admission. Staff to redirect as needed and ensure he does not exit the building".

R1 had a successful elopement on 09/16/23.

- Record review for R3 revealed an admission date of 10/02/23 with no diagnosis list documented.

R3 Admission Agreement was signed on 10/02/23, which defined care fees and the

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 _____	10/04/2023

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

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S3155	Continued From page 23 summary of monthly fees. R3 electronic medical record "Progress Notes" contained only one note dated 10/02/23 at 03:10 PM Resident came to facility with her nephew. R3 was alert times three but needed constant reminders of new surroundings. R3 came with medications from home in bottles. Review of facility document titled "Level of Care Appraisal" revealed the following: R3 required reminders for the following: grooming, bathing, mealtimes, administration of her medications twice daily, she was independent with dressing, toileting, transferring, was not a fall risk, had no identified at-risk behaviors, and had elopement history and concerns. Interview on 10/04/23: Operator A and regional nurse consultant B confirmed the R1 HSP lacked identification of services that addressed wandering / exit seeking behaviors, and they further confirmed that R3 record lacked an HSP upon admission to the facility. The operator failed to ensure that a licensed nurse provided or coordinated the provision of necessary health care services that met the needs for R1 and R3 for wandering / exit seeking behaviors.	S3155		
S3215 SS=E	26-41-205 (h) Medication Storage (h) Storage. Licensed nurses and medication aides shall ensure that all medications and biologicals are securely and properly stored in accordance with each manufacturer ' s recommendations or those of the pharmacy	S3215		

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 _____	10/04/2023

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

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S3215	Continued From page 24 provider and with federal and state laws and regulations. (1) Licensed nurses or medication aides shall store non-controlled medications and biologicals managed by the facility in a locked medication room, cabinet, or medication cart. Licensed nurses and medication aides shall store controlled medications managed by the facility in separately locked compartments within a locked medication room, cabinet, or medication cart. Only licensed nurses and medication aides shall have access to the stored medications and biologicals. (2) Each resident managing and self-administering medication shall store medications in a place that is accessible only to the resident, licensed nurses, and medication aides. (3) Any resident who self-administers medication and is unable to provide proper storage as recommended by the manufacturer or pharmacy provider may request that the medication be stored by the facility. (4) A licensed nurse or medication aide shall not administer medication beyond the manufacturer ' s or pharmacy provider ' s recommended date of expiration. This REQUIREMENT is not met as evidenced by: K.A.R. 26-41-205 (h) (4) The facility reported a census of 24 residents. Based on observation and interview the operator failed to ensure the" Licensed Nurse" medication beyond the manufacturers or pharmacy providers	S3215		

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 _____	10/04/2023

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

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S3215	Continued From page 25 recommended date of expiration for insulin pens. Findings included: - Observation on 10/03/23 at 03:56 PM of the medication cart located in the locked medication room, revealed the following undated insulin pens: 1 pen of Insulin Glargine labeled with R4 name. 1 pen of Novolog labeled with R4 name. 1 pen of Insulin Lispro labeled with R5 name 1 pen of Levemir labeled with R6 name. Interview on 10/03/23 at 03:56 with LN C, she confirmed the insulin pens lacked the beyond use date and lacked the date the pens were opened for use. Manufacturers recommendations for Insulin Glargine state once you take the pen out of cool storage you can use if for up to 28 days and then discard. Manufacturers recommendations for Novolog Flex pen state to discard after 28 days even if there is insulin left. Manufacturers recommendations for Insulin Lispro pen after 28 days even if there is inulin left. Manufacturers recommendations for Levemir Flex Touch pen state: "Open or in use pens should be kept at room temperature for a maximum of 42 days, after 42 days flex pens should be thrown away even if there is insulin left.	S3215		

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 _____	10/04/2023

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

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S3215	Continued From page 26 Interview the operator failed to ensure the" Licensed Nurse" medication beyond the manufacturers or pharmacy providers recommended date of expiration for insulin pens.	S3215		
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: K.A.R. 26-41-105 (f)(11) The facility reported a census of 24 residents. The sample included "Residents'" (R)'s 1, 2, 3, and 4. Based on record review and interview the operator failed to ensure the resident records contained documentation of all incidents, symptoms, and other indications of illness or injury including the date and time of the occurrence, action taken and results of the action taken for R1 when he left the facility without facility staff knowledge. Findings included: - Record review for R1 revealed an admission date of 07/27/23 with diagnoses of Alzheimer's Dementia, coronary artery disease, essential (primary) hypertension, complete loss of teeth	S3261		

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 _____	10/04/2023

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
S3261	Continued From page 27	S3261		

due to caries.

R1 "Functional Capacity Screen" (FCS) dated 07/27/23 revealed he required physical assistance with bathing, transferring, walking/mobility and eating. He required supervision with dressing and toileting. He lacked the ability to manage his own medications and was occasionally incontinent of his bladder. He was marked with being able to repeat a sentence for short term memory, could repeat previous items for long term memory, could repeat one of three items for memory recall, and was unable to make decisions due to Alzheimer's diagnoses. He was usually able to make himself understood and he usually understood others. He was marked with impaired decision making and used no mobility device.

The "Negotiated Service Agreement" (NSA) dated 08/04/23 identified the following health services to be provided: assist with bathing, orientation reminders, medication management, and "Exit seeking behaviors upon admission. Staff to redirect as needed and ensure he does not exit the building".

The "Health Service Plan" (HSP) revealed the following instructions to staff:
"Exit seeking behaviors upon admission. Staff to redirect as needed and ensure he does not exit the building".

In the electronic medical record under "Progress Notes" revealed only four entries in the record:

07/31/23 At 12:51PM: "New admit on 07/28/23 first shift blood pressure 164/79 temperature

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 _____	10/04/2023

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
S3261	Continued From page 28 97.6 degrees Fahrenheit (F), oxygen saturation 96%, respirations 20, pulse 68. Second shift blood pressure 160/72, temperature 97.6 degrees F, oxygen saturation 96%, respirations 20, pulse 72, no abnormal findings. Third shift blood pressure 127/62, temperature 97.5 degrees F, oxygen saturation 95%, respirations 20, pulse 71, no abnormal findings. First shift blood pressure 120/74, pulse 52, temperature 97.4 degrees F, oxygen saturation 97%, respirations 20, no abnormal findings. Second shift blood pressure 134/80, pulse 68, temperature 97.1degrees F, oxygen saturation 98%, respirations 20, no abnormal findings. Third shift blood pressure 117/90, pulse 64, temperature 97.7 degrees F, oxygen saturation 95%, respirations 18, no abnormal findings. 07/31/23 At 04:27 PM "Staff report resident is very high risk for elopement. He has dementia but is capable of reading the "15 second" door notice for emergency exiting, in which he has gotten outside to the parking lot but was easily redirected by staff. He is attempting to return to his home. Family brought a bottle of Mirtazapine (anti-depressant medication)15 milligrams in, but there was no order and the prescribing medical doctor refused to provide a signed order because the prescription was from June and the resident was no longer under that providers service. The medication was filled by pharmacy, and they denied providing a copy of the prescription as well. Requires clarification with new primary provider. Staff will complete safety checks while on frequent rounds and will continue to redirect as indicated. The record lacked documentation of actions	S3261		

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S3261	Continued From page 29	S3261		

taken, and results of the actions taken when he walked out of the facility. The record lacked documentation of safety checks of R1.

08/04/23 At 10:01 AM "Per staff report R1 has not presented with any exit seeking behaviors in the past five days. He is pleasantly confused and easily redirected".

08/09/23 at 04:19 PM "Spoke with the resident's durable power of attorney via phone. Informed her of the need to have service agreement signed as well as the pharmacy agreement. These documents were all emailed to her with instructions to send back to the community when completed.

Interview on 10/04/23 at 07:33 PM with Operator A and regional nurse consultant B, they confirmed the resident record lacked the documentation of the incident when R1 left the facility without staff knowledge.

The record lacked the documentation of the successful elopement on 09/16/23, and further lacked documentation of actions taken and results of actions taken to keep him safe upon return the facility.

The operator failed to ensure the resident records contained documentation of all incidents, symptoms, and other indications of illness or injury including the date and time of the occurrence, action taken and results of the action taken for R1 when he left the facility without facility staff knowledge.

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S9999	Continued From page 30	S9999		
S9999	Final Observations K.S.A. 39-938 Adult care homes shall comply with all the lawfully established requirements and rules and regulations of the secretary of aging and the state fire marshal and any other agency of government so far as pertinent and applicable to adult care homes, their building, operators, staffs, facilities, maintenance, operation, conduct and the care and treatment of resident. This requirement is not met as evidenced by: The facility reported a census of 24 residents. The sample included 4 residents. Based on observation and interviews for all residents, the facility failed to post a conspicuous notice at the entrance to the adult care home and each resident's room stating that the rooms of some residents may be monitored electronically by or on behalf of the room's resident or residents. Scope and severity F. Findings included: - Record review for R1 revealed an admission date of 07/27/23 with diagnoses of Alzheimer's Dementia, coronary artery disease, essential (primary) hypertension, complete loss of teeth due to caries. R1 "Functional Capacity Screen" (FCS) dated 07/27/23 revealed he required physical assistance with bathing, transferring,	S9999		

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S9999	Continued From page 31	S9999		

walking/mobility and eating. He required supervision with dressing and toileting. He lacked the ability to manage his own medications and was occasionally incontinent of his bladder. He was marked with being able to repeat a sentence for short term memory, could repeat previous items for long term memory, could repeat one of three items for memory recall, and was unable to make decisions due to Alzheimer's diagnoses. He was usually able to make himself understood and he usually understood others. He was marked with impaired decision making and used no mobility device.

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The "Health Service Plan" (HSP) revealed the following instructions to staff:
"Exit seeking behaviors upon admission. Staff to redirect as needed and ensure he does not exit the building".

The admission packet contained a form titled "Request for Authorized Electronic Monitoring" and signed by R1 durable power of attorney.

10/04/23 at approximately 10:15 AM the door of R1 room is opened by operator A, on the third shelf down on the shelfs sitting in the northeast corner of the front room sits a small white square camera that looks directly at the entrance door of the apartment.

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S9999	Continued From page 32 For all residents, the facility failed to post a conspicuous notice at the entrance to the adult care home and each resident's room stating that the rooms of some residents may be monitored electronically by or on behalf of the room's resident or residents. For all residents, the facility failed to post a conspicuous notice at the entrance to the adult care home and each resident's room stating that the rooms of some residents may be monitored electronically by or on behalf of the room's resident or residents.	S9999		