

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/01/2024  
FORM APPROVED  
OMB NO. 0938-0391

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>175242</b> |  | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                            |                                                                                                                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><b>12/19/2023</b> |                            |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>LAKEVIEW VILLAGE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                            |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>13840 W 91ST TERRACE</b><br><b>LENEXA, KS 66215</b> |                                                                                                                          |                                                                    |                            |
| (X4) ID<br>PREFIX<br>TAG                                    | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                            |  | ID<br>PREFIX<br>TAG                                                                             | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |                                                                    | (X5)<br>COMPLETION<br>DATE |
| F 000                                                       | <p><b>INITIAL COMMENTS</b></p> <p>The following citations represent the findings of complaint investigations #KS00184313, KS00184085, and KS00183530.</p> <p>On 12/19/23 at 04:07 PM the facility received a copy of the "Immediate Jeopardy [IJ] Template" and was informed of the IJ for Resident (R)1.</p> <p>On 11/26/23 at 01:23 PM, R1 pushed on a door leading to the stairwell for 15 seconds and was able to open the door. The door alarm sounded but the roam alert system (system which alerts when a linked roam alert bracelet is near) did not alert even though R1 wore a roam alert bracelet. Staff reset the door alarm but did not check the stairwell. R1 then went down a flight of stairs and exited through an outside door in the stairwell. R1 walked along the sidewalk around the building, to the front of the building where he entered the front door at 01:39 PM and was intercepted by Dietary BB then escorted back to long term care. The facility failed to provide adequate supervision and appropriate response to door alarms to prevent an elopement. These failures placed R1 in immediate jeopardy.</p> <p>The facility put the following corrective actions into place by 12/05/23:<br/>All elopement risk residents were placed on 15-minute checks until the roam alert system was fixed beginning 11/26/23.<br/>R1's "Care Plan" was updated on 11/27/23.<br/>The security system company replaced the circuit board and changed door alarm to sound when doors were pushed on 11/27/23.<br/>An elopement drill was completed 11/28/23 and two more were completed on 11/30/23.</p> |                                                                            |  | F 000                                                                                           |                                                                                                                          |                                                                    |                            |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| F 000                                                       | Continued From page 1<br>Staff were educated on responding to door<br>alarms from 11/27/23 to 12/05/23.<br>CNA M received a final written warning for<br>responding to door alarms on 12/01/23.<br><br>Due to the corrective measures implemented and<br>completed prior to the onsite survey, this deficient<br>practice was cited as past noncompliance. The<br>scope and severity remain a "J."                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | F 000                                                                      |                                                                                                                          |                            |                                                                    |
| F 689<br>SS=J                                               | The 2567 was sent electronically on 01/02/24.<br>Free of Accident Hazards/Supervision/Devices<br>CFR(s): 483.25(d)(1)(2)<br><br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment remains<br>as free of accident hazards as is possible; and<br><br>§483.25(d)(2) Each resident receives adequate<br>supervision and assistance devices to prevent<br>accidents.<br>This REQUIREMENT is not met as evidenced<br>by:<br>The facility identified a census of 113 residents.<br>The sample included three residents reviewed for<br>accidents. Based on observation, record review,<br>and interviews, the facility failed to provide<br>adequate supervision to prevent Resident (R) 1,<br>who was cognitively impaired and at risk for<br>elopement (when a cognitively impaired resident<br>leaves the facility without the knowledge or<br>supervision of staff), from exiting the facility<br>without staff knowledge or supervision on<br>11/26/23 at 01:23 PM. R1 pushed on a door<br>leading to the stairwell for 15 seconds and was<br>able to open the door. The door alarm sounded<br>but the roam alert system (system which alerts | F 689                                                                      | Past noncompliance: no plan of<br>correction required.                                                                   |                            |                                                                    |

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| F 689                                                       | <p>Continued From page 2</p> <p>when a linked roam alert bracelet is near) did not alert even though R1 wore a roam alert bracelet. Staff reset the door alarm but did not check the stairwell. R1 then went down a flight of stairs and exited through an outside door in the stairwell. R1 walked along the sidewalk around the building, to the front of the building where he entered the front door at 01:39 PM and was intercepted by Dietary BB then escorted back to long term care. The facility failed to provide adequate supervision and appropriate response to door alarms to prevent an elopement. These failures placed R1 in immediate jeopardy.</p> <p>Findings included:</p> <ul style="list-style-type: none"> <li>- R1's Electronic Medical Record (EMR) documented diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure) and dementia (progressive mental disorder characterized by failing memory, confusion) without behavioral disturbance.</li> </ul> <p>The "Admission Minimum Data Set (MDS)" dated 10/20/23, documented R1 had a Brief Interview for Mental Status (BIMS) score of five which indicated severe cognitive impairment. R1 had physical behaviors directed towards others and wandering behavior one to three days in the assessment period. R1 required substantial/maximal assistance with walking 10 feet. He had one noninjury and one injury fall since admission.</p> <p>The "Cognitive Loss/Dementia Care Area Assessment (CAA)" dated 10/26/23, documented R1 had a BIMS score of five, physical behaviors directed towards others, and wandering behavior.</p> | F 689                                                                      |                                                                                                                          |                            |                                                                    |

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| F 689                                                       | <p>Continued From page 3</p> <p>R1's factors that placed him at risk for a problem included modified independence, moderate impairment or severe impairment in decision making which may result in unsafe behavior and potential for injury, and difficulty with performance of activities of daily living (ADLs).</p> <p>The "ADL Functional/Rehabilitation Potential CAA" dated 10/26/23, documented R1 needed help with ADLs and mobility.</p> <p>The "Falls CAA" dated 10/26/23, documented R1 had a history of falls and he received staff support for transfer and safety needs.</p> <p>The "Behavioral Symptoms CAA" dated 10/26/23, documented R1 had rejection of care and wandering behavior. R1 became physically aggressive with staff while toileting and was observed wandering on the unit.</p> <p>R1's "Care Plan," dated 11/01/23, documented R1 had problems with remaining safe in his environment due to history of wandering and a diagnosis of dementia. The care plan directed he wore a wandering bracelet on his right ankle and staff redirected him when exit seeking or took him for a walk.</p> <p>R1's "Care Plan," dated 11/01/23, documented R1 was at risk for falling related to history of falls and muscle weakness. The care plan directed R1 may attempt to self-transfer and staff offered assistance.</p> <p>R1's "Care Plan," dated 11/01/23, documented R1 had an impaired ability to take care of himself and needed help with performing ADL. The care plan directed staff to provide assistance with one</p> | F 689                                                                      |                                                                                                                          |                            |                                                                    |

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| F 689                                                       | <p>Continued From page 4</p> <p>staff for bathing, dressing/grooming, and transfers.</p> <p>R1's EMR revealed an "Elopement Risk Assessment," dated 10/13/23, that documented R1 had an elopement risk score of six, which indicated he was not at risk for elopement.</p> <p>R1's EMR revealed a "Behavioral Documentation" note on 11/12/23 at 09:21 AM that documented R1 had been up wandering about both neighborhoods that morning and was easily redirected.</p> <p>R1's EMR revealed a "Behavioral Documentation" note on 11/26/23 at 01:07 PM that documented after lunch, R1 walked around carrying his house shoes without his walker. Staff attempted to remind him he needed to use his walker and he needed to leave his shoes in his room. R1 stated he was leaving town for two to three weeks and where he was going, he would not be able to use the walker. R1 walked away carrying his shoes and refused to take his walker.</p> <p>R1's EMR revealed a "Nursing Notes" note on 11/26/23 at 03:07 PM that documented staff reported R1 almost got out and the Wanderguard (bracelet that sets off an alarm when residents wearing one attempt to exit the building without an escort) needed to be checked for function. The nurse went to R1 in the living room and checked his Wanderguard, which was working. The staff notified the weekend supervisor and removed R1's Wanderguard to check it for function. The Wanderguard did not alarm when going out of the care center but did when staff brought the alarm back into the care center. Staff changed R1's Wanderguard tag and placed it on</p> | F 689                                                                      |                                                                                                                          |                            |                                                                        |

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| F 689                                                       | <p>Continued From page 5</p> <p>his right ankle. Administrative Staff A came to facility and reviewed the camera and saw that R1 had opened the door and exited. R1 refused to allow the nurse to complete vital signs, he was cool to the touch, but did not have any shivering or jaw shaking to alert staff to him being cold. R1 was dressed in a long-sleeved shirt with an undershirt, casual pants, tennis shoes, and socks.</p> <p>In a notarized witness statement on 11/26/23, CNA M stated she heard the door alarm and went to check the area. As she approached, she saw R2 turn from the door and walk back down the hall. CNA M stated she checked to ensure the door was closed/latched, which it was, and reset the door alarm with the impression it was R2 who triggered it as she had several times that day. She stated the alarm never sounded so she assumed no one had passed through the exit door. CNA M stated she had seen R1 wandering all over the halls off and on all day, including that afternoon but did not recall the last time she saw him.</p> <p>In a notarized witness statement on 11/28/23, Dietary BB stated R1 was walking toward the front doors when she saw him on 11/26/23 at about 01:30 PM. She stated R1 was one of her residents and had just moved to the second floor. She knew he was not to be out alone, so she asked him where he was headed. Dietary BB stated R1 said he was going to see his friend and needed to get to the elevators. She stated she showed him the elevators and took him to the second floor. Dietary BB stated he did not want to go back to his room. She notified staff about what happened.</p> | F 689                                                                      |                                                                                                                          |                            |                                                                    |

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| F 689                                                       | Continued From page 6<br>The facility's investigative report, dated 12/05/23, documented on 11/26/23 at approximately 01:23 PM, R1 was seen in the lobby by Dietary BB who escorted R1 back to the second floor of LTC and notified the charge nurse. The charge nurse reported the incident to the supervisor who informed Administrative Nurse D and Administrative Staff A. Administrative Staff A arrived at the facility to investigate the incident. Initially, staff reported they thought R1 possibly followed a family member off of the floor. The facility reviewed camera footage and identified that was not the case. R1 ambulated to the exit door, pushed the door for 15 seconds until the door/magnetic lock released, and walked down the stairs. The releasing of the door magnetic lock activated the door alarm. R1 ambulated to the lobby where Dietary BB recognized him and assisted him back to the second floor of LTC. The egress exit alarm activated when the door opened; however, the roam alert did not activate/alarm. Certified Nurse Aide (CNA) M immediately responded to the egress door alarm and reset the door alarm. Since the roam alert was not activated and another resident was standing by the door, CNA M indicated she believed that resident activated the door alarm. She reset the door alarm and directed the resident away from the door. Video footage showed the following: at approximately 01:23 PM, R1 pushed on the door until the door releases. CNA M walked to the door, as she was already headed towards the door prior to the door sounding because she saw R2 by the door, immediately when the alarm sounded. She was observed resetting the door alarm at 01:24 PM. CNA M redirected R2 away from the door. At approximately 01:29 PM, R1 ambulated independently in through the front doors from | F 689                                                                      |                                                                                                                          |                            |                                                                    |

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| F 689                                                       | <p>Continued From page 7</p> <p>outside. He wore pants, shoes, and a long-sleeved shirt at that time. Investigation of the incident indicated the roam alert at that door did not alarm. R1's roam alert tag was functioning appropriately. It was identified that the door alarm did not activate until the magnetic lock released after 15 seconds. R1 ambulated independently. The temperature outside at the time of the incident was approximately 36 degrees and the sidewalks were shoveled and salted. When questioned about the incident, R1 stated he was headed to his villa/home, which was on campus. In closing, the investigation indicated the incident was related to failure of equipment. The equipment did not activate at the time of the incident. The circuit board had not and did not display a warning signal to alert staff and/or maintenance. R1 was away from the neighborhood for a total of six minutes.</p> <p>According to the "Kansas State University Historical Weather" website, the temperature on 11/26/23 at 01:00 PM was 32.2 degrees Fahrenheit (F).</p> <p>On 12/19/23 at 12:50 PM, the outside door R1 left out of exited onto a sidewalk. The sidewalk was in good repair and continued around the building to the front entrance. There was parking lots located to the side and in front of the facility with a street that ran in front of the facility with a posted speed limit of 25 miles per hour.</p> <p>On 12/19/23 at 02:25 PM, the second-floor door R1 exited led to a stairwell. The stairs were made of cement/concrete and R1 had to walk down one flight of stairs to leave through the outside exit door.</p> | F 689                                                                      |                                                                                                                          |                            |                                                                    |

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| F 689                                                       | <p>Continued From page 8</p> <p>On 12/19/23 at 12:45 PM, Administrative Staff A stated R1 was identified as a wanderer and he had a roam alert bracelet staff checked every shift for placement and checked weekly for functioning. He stated on 11/26/23, R1 pushed on the door and set the alarm off but the roam alert alarm did not go off. R2 was also there, and she wore a roam alert which triggered in the alarm window but did not sound. Administrative Staff A stated Dietary BB saw R1 in the front entrance and escorted him back inside. He stated R1 exited out a stairwell door then walked around the sidewalk to the main entrance where he was able to enter the front door. Administrative Staff A stated the circuit board for the roam alert was failing and intermittently sending signals.</p> <p>On 12/19/23 at 02:24 PM, Administrative Staff A stated the door alarm did sound after the magnetic lock released when pushed for 15 seconds and if it had alarmed immediately when the door was pushed then staff would have answered right away. He stated R1 did go down a flight of stairs to exit.</p> <p>On 12/19/23 at 02:32 PM, Administrative Nurse D stated on 11/26/23, she was notified around 01:30 PM that R1 was brought back in through the front doors. She stated it was not reported to her that he had any wandering behaviors that day. Administrative Nurse D stated when a door alarm sounded, staff were expected to go to the door alarm, open the door to check and find the person, verify the roam alert number that popped up in the alarm window with the number in Kardex (CNA care plan) before resetting the alarm.</p> <p>On 12/19/23 at 04:05 PM, Administrative Staff A</p> | F 689                                                                      |                                                                                                                          |                            |                                                                    |

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| F 689                                                       | <p>Continued From page 9</p> <p>stated he expected staff to always respond to door alarms immediately, open the door and check the area, then account for all the residents. He stated he expected this every single time the alarm went off.</p> <p>On 12/20/23 at 10:43 AM, CNA M stated she was not aware that R1 was a wanderer or exit seeker. She stated on 11/26/23, she was documenting at the computer when she saw R2 going towards the exit door at the end of that hallway. She stated she jumped up from charting but did not take her Kardex with her as she wanted to get to R2 before she got to the end of the hall. CNA M stated by time she got to the end of the hall, R2 had made a U-turn and she passed her. While she was at the end of the hall, CNA M checked the door and saw it was closed and latched. She stated she did not see anybody and the only resident she saw in that direction was R2. CNA M stated since the door was latched and R2 was safely inside, she checked the roam alert window to see what number was on the code display but because she did not have her Kardex on her, she memorized the last three digits to check against the papers at the desk. CNA M stated the last three numbers were the same as R2's roam alert. She stated the roam alert alarm did not go off and staff relied on the roam alert alarm to go off. CNA M stated besides checking the roam alert number, there was no roam alert alarm going off to indicate a reside had went through that exit. She stated the door alarms went off frequently throughout the day if someone pushed on a door or left it open too long. CNA M stated the roam alert alarm sounded through the computer as well and indicated a resident passed over a threshold. She stated if a roam alert alarm went off, everybody, no matter who it was, went to assist.</p> | F 689                                                                      |                                                                                                                          |                            |                                                                    |

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| F 689                                                       | <p>Continued From page 10</p> <p>She stated staff always carried the Kardex and pulled it out to check the roam alert number with the screen. CNA M stated she did not take the Kardex with her to get R2 because she thought it was more important to go to R2. She stated if she knew there was another resident in that area, she would have gone through the doors and down the stairs asking if anyone had seen him. CNA M stated the Kardex was updated every day and new ones were printed every shift and listed which residents were wanderers with their roam alert numbers on the back. She stated she had assigned residents that she received report on and R1 was not one of her assigned residents, so she did not receive report on him.</p> <p>On 12/20/23 at 12:50 PM, Licensed Nurse (LN) G stated on 11/26/23, R1 was restless, was walking without his walker, and kept saying he was leaving. She stated staff kept telling him he needed to stay at the facility and wait for his wife to come get him. LN G stated she talked to R1 about 10 to 15 minutes before he had got out of the door, and he stated he was going to leave but she told him to wait for his wife. She stated another resident had asked for her to step into their room and that was when another nurse told her R1 had got out then was brought back in. LN G stated when a door alarm went off, staff were supposed to respond and if there was a code in the Wanderguard box, they looked at the Kardex to find the number and make sure the resident was still in the building. She stated everyone carried a Kardex which were reprinted at least every day and were supposed to be updated every day. LN G stated she had not observed R1 trying to push on any doors, but he would go look out of the front door to the care center then would turn around and sit down in the lobby area then</p> | F 689                                                                      |                                                                                                                          |                            |                                                                    |

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| F 689                                                       | <p>Continued From page 11</p> <p>back up to wandering again. She stated R1 wore a Wanderguard at the time. She stated R1 was not easily redirected that day because he was very agitated and had started cussing at staff for telling him to wait for his wife. LN G stated staff offered him food, offered him rest, and offered to call his wife but none of that seemed to work for him that day. She stated she did not feel like he needed to be one-on-one or closer observation because he had not tried to actually push on any doors to go out, he just walked up to them to look out then walked away.</p> <p>The facility's "Elopement Prevention" policy, last revised 06/18/12, directed specific interventions were developed and implemented for residents at risk for elopement such as increased frequency of checks to ensure safety, wander bracelet may be placed on resident, and resident may be moved to the 2nd floor care center. The policy directed it was the responsibility of all personnel to report any resident attempting to leave the care center to the charge nurse as soon as practical.</p> <p>The facility's "Wandering Resident" policy, dated 02/17/08, directed every effort was made to prevent wandering episodes while maintaining the least restrictive environment for residents who were at risk for elopement. The policy directed if a resident repeatedly attempted to wander off the neighborhood, a monitoring schedule was implemented to ensure resident safety.</p> <p>The facility failed to provide adequate supervision to prevent R1 from eloping out of the facility on 11/26/23 at 01:23 PM when the temperature was near freezing. This deficient practice placed R1 in immediate jeopardy.</p> | F 689                                                                      |                                                                                                                          |                            |                                                                    |

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| F 689                                                       | <p>Continued From page 12</p> <p>The facility put the following corrective actions into place by 12/05/23:</p> <p>All elopement risk residents were placed on 15-minute checks until the roam alert system was fixed beginning 11/26/23.</p> <p>R1's "Care Plan" was updated on 11/27/23.</p> <p>The security system company replaced the circuit board and changed door alarm to sound when doors were pushed on 11/27/23.</p> <p>An elopement drill was completed 11/28/23 and two more were completed on 11/30/23.</p> <p>Staff were educated on responding to door alarms from 11/27/23 to 12/05/23.</p> <p>CNA M received a final written warning for responding to door alarms on 12/01/23.</p> <p>Due to the corrective measures implemented and completed prior to the onsite survey, this deficient practice was cited as past noncompliance. The scope and severity remain a "J."</p> | F 689                                                                      |                                                                                                                          |                            |                                                                    |