STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087054	A. BUILDING: _____ B. WING _____	08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE EAST WICHITA	9191 E 21ST STREET NORTH WICHITA, KS 67206

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S 000	INITIAL COMMENTS The following citations represent the findings of a resurvey with a complaint #189653 at the above named Assisted Living conducted on 08/06/24 and 08/07/24.	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: 3026 KAR 26-41-101(f)(1)(B) The facility reported a census of 35 residents. The sample included three residents. The facility identified seven residents who wandered. Based on observation, interview and record review the operator failed to ensure resident (R)101 was not subjected to neglect by the failure to ensure the front entrance/exit door was adequately monitored when individuals exited the facility so that residents of the memory care facility did not exit the building unaccompanied by staff. This resulted in cognitively impaired R101 exiting the facility and being unaccounted for by staff for approximately 90 minutes until local law enforcement notified facility staff that R101 was found across town approximately 21 miles from	S3026		

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S3026	Continued From page 1	S3026		

the facility.

Findings included:

- R101's medical record revealed she moved into the facility on 02/23/24 with a diagnosis of dementia.

R101's "Functional Capacity Screen" (FCS) dated 02/23/24 identified R101 was cognitively impaired with deficits of short-term memory, memory/recall and decision-making. R101 was independent with transfers and mobility without the use of an assistive device and triggered for wandering.

R101's "Negotiated Service Agreement/Healthcare Service Plan" (NSA/HCSP) dated 03/28/24 included an intervention for staff to check on the whereabouts of R101 every two to three hours.

Review of R101's medical record revealed the following:
The 03/27/24 "General Progress Note" documented staff added more interventions for when R101 was packing to leave or going to the doors. Staff to complete frequent checks on her whereabouts.

The 07/30/24 "Alert Charting Note" documented that at approximately 05:05 PM staff went to R101's apartment to remind her that it was time for the evening meal but R101 was not in her apartment. Staff then proceeded to search the facility and the grounds outside but were unable to locate R101. Staff last saw R101 taking part in an activity with her peers at around 04:45 PM. Staff notified the police and continued with their search for R101 off the facility grounds. At 06:15

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S3026	Continued From page 2 PM the police notified facility staff that R101 had been located and transported her back to the facility. Review of the 08/06/24 facility "investigation" submitted by Administrative Staff A to the department revealed that police reported R101 was initially found near K96 and Webb Rd. approximately two miles from the facility when a passerby picked her up and drove R101, as requested, to an address located on the west side of town. The individual noticed something was not right when no one answered the door and R101 started discussing the community she lived at. The passerby contacted the police and the police escorted R101 back to the facility arriving at approximately 07:00 PM. When facility staff questioned R101 she insisted that she left with a group of people out the front door of the community. Staff believed this occurred when a mobile x-ray technician exited the building. "Certified Medication Aide" (CMA) C opened the door for the x-ray technician and was speaking with another individual at the time. Staff believed R101 was able to slip through the front door at that time. Observation on 08/06/24 at 09:05 AM revealed the facility was located at a junction of two busy four-lane roads, with a posted speed limit of 40 miles per hour each. There are sidewalks on both sides of the street with mixed residential and commercial properties in the vicinity. Weather conditions at the time of the elopement as verified on https://www.wunderground.com revealed partly cloudy conditions, a temperature of approximately 103 degrees Fahrenheit, with winds out of the south at 17 miles per hour.	S3026		

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S3026	Continued From page 3 Observation on 08/06/24 at 09:48 AM revealed the front entry/exit door was locked and required a code to be put in by facility staff in order to unlock it. The door was alarmed and would sound loudly when the bar was pushed without first entering a code. On 08/06/24 at 02:29 PM CMA C stated she last saw R101 on the day of the elopement incident around 04:30 PM in the sunroom area located on the west side of the facility. CMA C stated she had never witnessed R101 exit-seeking prior to this incident but in times past R101 would "pack" some belongings, but she never took them out of her room. CMA C stated she had gone to the front door at approximately 04:45 PM to unlock the door and let a family member into the facility. Soon after this a mobile x-ray technician requested to be let out of the facility, so CNA C entered the code to the front door and proceeded to talk with the visitor while standing nearby. CMA C stated she did not notice R101 in the area by the front door when she let the x-ray technician out. CMA C stated she was facing east with the front door to her left while she talked with the visitor. CMA C verified that if R101 exited the front door at the same time as the x-ray technician she would have approached unnoticed from behind her while she was talking with the visitor with the door being in her peripheral view. The operator failed to ensure R101 was not subjected to neglect when staff failed to ensure the front door was adequately monitored when visitors exited the facility. This resulted in cognitively impaired R101 exiting the facility without staff knowledge and being unaccounted for approximately 90 minutes. On 08/06/24 at 04:40 PM Administrative Staff A	S3026		

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S3026	Continued From page 4 and Administrative Nurse B were informed of the findings which resulted in immediate jeopardy when staff failed to ensure the front door was sufficiently monitored while unlocked allowing a cognitively impaired resident to exit the facility unaccompanied by staff. On 08/07/24 at 11:20 AM Administrative Staff A submitted an abatement plan which included the following: 1. Change door codes immediately changed July 31, 2024, and again August 5, 2024. 2. (R101) one-on-one with staff until discharge from community. 3. HWD (Health and Wellness Director) will audit resident charts to identify any other residents at risk and will discuss him or her at Collaborative Care Meeting to develop a plan to reduce elopement risk. 4. All staff will attend the Managing the Risk of Elopement in the Resident with Dementia: Policy, Procedure, and Preparedness Training. 5. Maintenance Technician to check all exit doors a minimum of twice a week to verify proper operation. 6. Community will conduct Elopement Drills on each shift quarterly. All associates will be retrained on elopement risks and procedures by August 8, 2024. All associates will also complete the Relias online training course, Understanding Wandering and Elopement, by August 8, 2024. If an associate has not been trained by August 8, 2024, they will be in-serviced before assuming a shift. The Executive Director is responsible for follow up monitoring and will verify the Quality Assurance Committee monitors elopement risks monthly for three months.	S3026		

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S3026	Continued From page 5 The immediate jeopardy was abated on 08/07/24 at 11:20 AM based on the facility's plan of correction and approved by the department.	S3026		
S3213 SS=E	26-41-205 (g) (2) Medication Labeling (g) (2) Each prescription medication container shall have a label that was provided by a dispensing pharmacist or affixed to the container by a dispensing pharmacist in accordance with K.A.R. 68-7-14. This REQUIREMENT is not met as evidenced by: 3213 KAR 26-41-205 (g)(2) The facility reported a census of 35 residents. Based on observation and interview the operator failed to ensure each prescription medication container had a label provided by a dispensing pharmacist affixed to the container. Findings included: - Observation on 08/06/23 at 11:12 AM revealed the facility's medication cart designated Hall C and D contained the following prescription medication containers which were not labeled with a resident's full name: Resident (R)104: One tube of Diclofenac Sodium Topical Gel	S3213		

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S3213	Continued From page 6 R105: One bottle of Trazadone 50 milligrams Observation of the facilities medication cart designated Hall A and B contained the following prescription medication containers which were not labeled with a resident's full name: R106: One bottle of Latanoprost Ophthalmic Solution 0.005% One bottle of Dorzolamide HCL Ophthalmic Solution 2% One tube of Hydrocortisone Cream 2.5% R107: One Breo Ellipta 100/25 microgram inhaler Observation of the overflow cabinet contained the following prescription medication containers which were not labeled with a resident's full name: R105: One bottle of Lotemax Gel 0.5% eyedrops One bottle of Combigan 0.2/0.5% eyedrops On 08/06/24 at 11:35 AM Administrative Nurse B stated it was her expectation that prescription medication containers be labeled with the full name of the resident. The operator failed to ensure each prescription medication container had a label provided by a dispensing pharmacist affixed to the container.	S3213		
S3320 SS=F	28-39-254 CONSTRUCTION (a) The assisted living facility or residential health care facility shall be designed, constructed, equipped and maintained to protect the health	S3320		

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S3320	Continued From page 7 and safety of residents, personnel and the public. (b) All new construction, renovation, remodeling and changes in building use in existing buildings shall comply with building and fire codes, ordinances and regulations enforced by city, county, and state jurisdictions, including the state fire marshal. (c) New construction, modifications and equipment shall conform to the following codes and standards: (1) Title III of the Americans with disabilities act, 42 U.S.C. 12181, effective as of January 26, 1992; and (2) "Food Service Sanitation Manual," health, education, and welfare (HEW) publication no. FDA 78-2081, as in effect on July 1, 1981. This REQUIREMENT is not met as evidenced by: 3320 KAR 28-39-254 (a) The facility reported a census of 35 residents. Based on observation, and interview the operator failed to ensure staff secured all chemicals to maintain the safety of all residents. Findings included: - Observations during initial tour on 08/06/24 at 10:05 AM it was found that the door handle to the "D Hall Spa" was locked but the door was not latched and could be opened by pushing against the door. Inspection of the spa revealed there	S3320		

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S3320	Continued From page 8 was a door that led to an adjoining laundry room which contained the following unlocked chemicals: The lower lefthand cabinet located under the work counter contained the following chemicals in a carrying tote which had "Keep out of reach of children" warning labels: Two 22 fluid ounce (fl. oz.)bottles of Ecolab StainBlaster Enzyme Boost laundry pre-spotter One 32 fl. oz. bottle of Ecolab Lemon-Eze bathroom crème cleanser Four 22 fl. oz. bottles of Ecolab Revitalize Miracle Spotter Carpet and Upholstery Spotter One 32 fl. oz. bottle of Ecolab Peroxide Multi Surface Cleaner and Disinfectant One 20 fl. oz. spray bottle of Ecolab Lemon Lift Heavy Duty Kitchen and Bathroom Cleaner with Bleach On 08/07/24 at approximately 01:50 PM Administrative Nurse B acknowledged the door latch to the "D Hall Spa" did not lock without someone pulling it till it engaged. The operator failed to ensure staff kept chemicals locked for resident safety.	S3320		