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	175448	A. BUILDING _____ B. WING _____	C 10/22/2024

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ABERDEEN VILLAGE	17500 W 119TH STREET OLATHE, KS 66061

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F 000	INITIAL COMMENTS The following citations represent the findings of partial extended survey and complaint investigation KS00191278. On 10/22/24 at 04:46 PM, the facility received the "Immediate Jeopardy [IJ] Template" and was informed of the IJ for Resident (R) 1. On 10/17/24 between 04:00 AM and 04:30 AM, Certified Nurse Aide (CNA) M heard R1's toilet flush, entered R1's bathroom, and asked R1 if she needed anything. R1 responded "No" and CNA M left to assist another resident without assisting R1 back to bed as CNA M assumed the resident would go back to bed. At approximately 04:40 AM, per camera footage, R1 ambulated to the elevator, took the elevator to the first floor, walked to a set of double doors, passed through them into the main lobby area, and proceeded to exit the main entrance doors on the south side of the facility without staff knowledge or supervision. At approximately 05:30 AM, Licensed Nurse (LN) G received a call informing her that Law Enforcement (LE) was with R1 at a nearby gas station. LN G confirmed R1 was a resident of the facility and at 05:22 AM LE returned R1 to the facility. Staff assessed R1 and noted her temperature to be 97.5 degrees Fahrenheit and her oxygen saturation was 94 percent (%) on room air (normal range is 97-100 %). She wore pajamas, shoes, and a jacket. The temperature outside on 10/17/24 was 36 degrees Fahrenheit at 04:53 AM and 34 degrees Fahrenheit at 05:53 AM. The lack of supervision allowed R1 to exit the facility without staff knowledge or supervision placing R1 in immediate jeopardy.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 10/30/2024

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 The facility submitted an acceptable plan of corrective actions for removal on 10/22/24. The plan included the following actions: A WanderGuard was placed on R1 with orders to monitor and document function each shift. R1's care plan was updated to include an intervention and monitoring for R1's WanderGuard. Staff completed an updated Elopement screening on R1 to reflect R1's new risk and behavior. The facility contacted maintenance and the facility door contractor to inspect the unit door's locking systems to ensure there was no other point of failure. The facility ordered parts to have a set of double doors R1 went through on 10/17/24 coded with a keypad lock to prevent future elopements through those doors. Administrative Nurse D was in the process of providing education for all staff related to elopement, wandering, and missing residents. Implementation of the corrective actions and removal of the immediacy was verified during the onsite survey on 10/22/24 at 04:17 PM. The deficient practice remained at a scope and severity of "D". The 2567 was sent electronically on 10/30/24.	F 000		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent	F 689		

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accidents.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 55 residents. The sample included three residents. Based on observation, record review, and interview, the facility failed to provide adequate supervision to prevent an elopement for cognitively impaired Resident (R)1, who required staff assistance for activities of daily living (ADL) including safe ambulation with her walker and was at risk for falls. On 10/17/24 between 04:00 AM and 04:30 AM, Certified Nurse Aide (CNA) M heard R1's toilet flush, entered R1's bathroom, and asked R1 if she needed anything. R1 responded "No" and CNA M left to assist another resident without assisting R1 back to bed as CNA M assumed the resident would go back to bed. At approximately 04:40 AM, per camera footage, R1 ambulated to the elevator, took the elevator to the first floor, walked to a set of double doors, passed through them into the main lobby area, and proceeded to exit the main entrance doors on the south side of the facility without staff knowledge or supervision. At approximately 05:30 AM, Licensed Nurse (LN) G received a call informing her that Law Enforcement (LE) was with R1 at a nearby gas station. LN G confirmed R1 was a resident of the facility and at 05:22 AM LE returned R1 to the facility. Staff assessed R1 and noted her temperature to be 97.5 degrees Fahrenheit and her oxygen saturation was 94 percent (%) on room air (normal range is 97-100 %). She wore pajamas, shoes, and a jacket. The temperature outside on 10/17/24 was 36 degrees Fahrenheit at 04:53 AM and 34 degrees Fahrenheit at 05:53 AM. The lack of supervision allowed R1 to exit the facility without staff knowledge or supervision placing R1 in immediate jeopardy.

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Findings Included:

- R1's Electronic Medical Record (EMR) documented diagnosis of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), unspecified dementia (progressive mental disorder characterized by failing memory, confusion), age-related osteoporosis (abnormal loss of bone density and deterioration of bone tissue with an increased fracture risk), syncope and collapse (fainting or passing out), and history of falling.

The "Quarterly Minimum Data Set" (MDS) dated 08/06/24 documented a Brief Interview for Mental Status (BIMS) score of nine which indicated moderate cognitive impairment. The MDS documented R1 used a walker and required supervision or touching assistance during ambulation. The MDS further documented R1 required partial, or moderate assistance with dressing and personal hygiene. The MDS documented R1 had no wandering behaviors.

The "ADL Functional/Rehabilitation Potential" CAA, dated 05/07/24, documented R1 was admitted from home due to the need for 24-hour care and supervision related to Alzheimer's disease. The CAA documented staff provided supervision and limited assistance with daily care tasks. The CAA further documented R1 used a walker, due to an unsteady gait, and R1 forgot to use the walker at times and needed to be reminded by staff. The CAA documented R1 had orders for physical therapy (PT) and occupational therapy (OT) for strengthening, ambulation, and ADL training to reach the highest level of function and safety possible.

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R1's "Falls CAA," dated 05/07/24, documented R1 had Alzheimer's disease and was not a reliable historian about recent falls; however, R1 reported they had a fall within the last 30 days where R1 had a loss of balance. The CAA documented staff noted R1 had an unsteady gait and R1 was provided with a walker which helped when walking, but R1 often did not remember to use it and needed reminders. The CAA documented R1 worked on balance and ambulation using the walker as well as strengthening and safety with ADLs reducing R1's risk for falls with PT and OT. The CAA further documented staff offered toileting throughout the day and night to reduce incontinence and attempts to take herself to the bathroom without assistance.

R1's "Care Plan" with a start date of 05/14/24, documented R1 had an alteration in thought processes, memory problems, and impaired decision-making that impacted R1's communication related to Alzheimer's disease. The care plan, with a start date of 05/14/24, documented R1 had a self-care deficit. An approach with a start date of 05/14/24, documented R1 used a walker with ambulation and an assist of one. An approach with a start date of 05/14/24 documented R1 required supervision for bed mobility, transfers, and ambulation and limited assistance of one with dressing, grooming, and toileting. The approach further documented R1's ability may fluctuate due to cognition and episodes of elevated blood pressure. R1's "Care Plan" with a start date of 05/14/24 documented R1 was at risk for falls, due to a history of falls and syncope. R1 had Alzheimer's disease, impaired safety awareness,

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increased risk for fractures from falls due to osteoporosis, and R1's blood pressure ran high at times which could have caused R1 to fall. R1's plan of care did not address elopement potential prior to R1's elopement.

An "Elopement Risk Screen" dated 04/29/24, documented R1 had a score of eight which indicated R1 was not at risk for elopement. The "Elopement Risk Screen" documented R1 had no elopement attempts in the previous 90 days.

A "Fall Risk Assessment Tool" completed on 04/29/24 documented R1 had a total fall risk score of seven and was a moderate fall risk.

An "Elopement Risk Screen" dated 10/17/24, after the incident, documented R1 had a score of 16 which indicated R1 was a risk for elopement.

A "Registered Nurse (RN) Note" dated 10/17/24 at 05:54 AM, documented at approximately 05:30 AM, the nurse received a telephone call from the assisted living (AL) nurse reporting that LE called and were asking if staff knew R1, and said R1 was at a gas station. The note documented the nurse called dispatch back and confirmed that the staff knew R1 and R1 resided at the facility. LE brought the resident back to the main entrance door and staff assisted R1 back to her room. The note documented R1 was noted with her walker, wearing top and bottom pajamas, a black jacket, and shoes. Staff assessed R1 for injuries, with no injury or skin issues noted on the assessment. The note further documented R1 stated she was just walking around the neighborhood and was going to the gas station. R1 also stated she did not know how she got out the door. The note further documented the facility initiated a

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WanderGuard (a bracelet that sets off an alarm when residents wearing one attempt to exit the building without an escort) and placed it on R1's left arm for elopement risk. The note documented R1's representative was notified, and they stated R1 had that problem at home and that was one of the reasons the representative brought R1 to the facility. The note documented vital signs were obtained as follows: 127 millimeters of mercury (mmHg) over 59 mmHg, pulse 80 beats per minute, temperature 97.5 degrees Fahrenheit, respirations 18 breaths per minute, and oxygen saturation was 94 percent on room air.

Undated investigation documents provided by the facility recorded that on the morning of 10/17/24 at approximately 05:30 AM, the facility received a phone call from LE that reported R1 was at a gas station in front of the property. LE returned R1 to the facility. Upon return to the building, R1 was asked by the RN what she was doing and R1 told the RN she was going for a walk and went to the gas station. R1 was wearing pajamas, shoes, and a jacket and had her walker with her. RN performed a physical and skin assessment on R1 and did not identify any physical concerns, R1's representative and her durable power of attorney (DPOA- a legal document that named a person to make healthcare decisions when the resident was no longer able to), physician and administration were notified. The investigation documents recorded that a WanderGuard was applied to R1's left wrist. The investigation documents further recorded that R1 scored an eight on the BIMS indicating moderately impaired cognition. The investigation documents recorded staff interviews revealed that R1 was last seen by staff between 04:00 AM to 04:30 AM. CNA M had been assisting a resident directly across the hall

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from R1's room. CNA M heard a noise in R1's room and went over to investigate. R1 was in the bathroom and was pulling her pajama pants up after toileting. CNA M asked R1 if she needed assistance with anything else, and R1 replied "No." CNA M went back across the hall to finish with the resident in the other room. The investigation documents recorded that neither CNA M nor the charge nurse had noticed R1 behaving any differently than usual prior to this and R1 had no recent illness or medication changes. When the administrator arrived at the facility, R1's actions were confirmed by video as having left the facility via the main front entrance. R1 has had no previous attempts to leave the facility. The investigation documents recorded staff reported that in conversation with R1's representative, her representative informed the staff that R1 had episodes like that when she lived in the community. The investigation documents record it was the first time that information related to elopement behaviors was shared with the facility. The investigation documents further recorded R1 was seen on video leaving the front entrance at 04:40 AM and re-entering the facility at 05:22 AM accompanied by LE. It was estimated that R1 ambulated approximately 1,018 feet, the weather conditions were clear, parking lot lights were on, the wind was Southerly at nine miles per hour, and the temperature was 36 degrees Fahrenheit.

CNA M's "Witness Statement" with a signed date of 10/21/24, documented CNA M was working on R1's neighborhood the night shift of 10/17/24. Sometime between 04:00 AM and 04:30 AM CNA M was in the room across the hall from R1's room when CNA M heard some noise and a toilet flush. CNA M documented they left the room and

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entered R1's room and found R1 in the bathroom pulling her pants up and it appeared R1 had finished toileting. CNA M documented they asked R1 if she needed some help with anything else and R1 stated "No." CNA M documented they thought R1 was going back to bed as R1 usually did and CNA M went back across the hallway to finish assisting the resident in that room. CNA M documented they did not see or hear anything from R1's room while assisting the other resident.

Licensed Nurse (LN) G's "Witness Statement" with a signed date of 10/21/24, documented LN G was scheduled for night shift on 10/17/24. LN G first saw R1 at 11:00 PM when LN G did their first rounds and R1 was asleep in her bed. LN G documented they next checked on R1 again around 01:00 AM and R1 was in bed asleep. LN G documented that at approximately 04:30 AM CNA M called LN G to a room via walkie-talkie to help her with a bed that wasn't working. LN G documented staff worked on the bed for a while and when they couldn't fix it, they decided to move a bed from an empty room to accommodate the resident until maintenance could fix the bed. LN G documented that at approximately 05:15 AM to 05:30 AM LN G received a call from an assisted living nurse informing LN G that LE had called and asked about R1. LN G returned the call to LE and confirmed R1 was our resident. LE escorted R1 back to the building and LN G performed a physical assessment and did not observe anything unusual for R1. LN G documented they asked R1 where she had been. R1 stated she was just taking a walk through the neighborhood and went to the gas station. LN G documented they asked R1 how she got out and R1 stated she didn't know. R1 was then assisted back to

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her room, and she went to sleep. LN G documented they notified R1's family, the doctor, and the nurse manager.

On 10/22/24 at 10:41 AM, an observation was made inside the facility along the route R1 took to exit the facility with Administrative Staff A. Administrative Staff A stated the route inside the facility was verified by a review of camera footage. Administrative Staff A walked from R1's room down to the unit elevator and took it down to the first floor. Administrative Staff A stated the elevator was the only way off the unit without an access code. All exit doors on the unit were noted to have access keypads. The elevator had a WanderGuard alarm and Administrative Staff A stated if a resident had a WanderGuard the elevator would not function or allow the resident to access the other floor. Administrative Staff A then walked to a set of double doors on the first floor. Administrative Staff A stated the double doors had a WanderGuard alarm as well and would stop access to residents that had a WanderGuard on; however, if a resident did not have a WanderGuard they could walk through the door by pressing it or pressing an access button on the wall. Administrative Staff A stated this was the door R1 accessed to get out into the main lobby area and out the main entrance doors of the facility. The double doors did not have a keypad lock and opened when an access button was pressed on the wall. All other doors en route to the main entrance had locks or keypad access on them. Observation of the facility's South (front) parking lot, and surrounding area, revealed the main entrance door opened to a sidewalk that ran South along the edge of the facility driveway. To the West of the sidewalk, there were several bushes and a steep hill that went down to another

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section of the facility. A curb ran the length of the East side of the sidewalk. The facility's main driveway continued South and connected to a smaller facility drive that ran East and West. The south end of the facility drive connected to a busy road with two lanes of traffic that ran East and two lanes that ran West. The two-lane roads had a posted speed of 45 mph. The smaller facility driveway that ran East and West sat between the South side (front) of the facility and the North (rear) side of the gas station R1 was found at by LE. The facility drive that traveled East and West had a posted speed of 25 mph and had to be crossed to get to the gas station parking lot. The East and West facility drive are attached to other access roads near the gas station and these other access roads are connected to apartment complexes, other local businesses, and the two-lane road on the South side of the facility with a posted speed of 45 mph.

On 10/22/24 at 03:28 PM, R1 sat out in a common area, with another resident, and watched TV. R1 had a walker within reach and a WanderGuard bracelet was on her right wrist.

On 10/22/24 at 10:22 AM a joint interview was conducted with Administrative Nurse D and Administrative Staff A. Administrative Nurse D stated no one saw the R1 leave the unit or facility. Administrative Nurse D stated R1 went down to the first floor and accessed a set of double doors that opened into the main lobby area and then left through the main entrance facility entrance. Administrative Nurse D stated the facility was in the process of installing a keypad for the double doors R1 went through so that the doors cannot be accessed without a code in the future. Administrative Nurse D stated R1 now has a

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WanderGuard in place and the elevator would not work if a resident with a WanderGuard attempted to access it. Administrative Nurse D stated the other doors on the unit all had keypads and required a code for access. Administrative Nurse D further stated once the door on the main level is coded, even if a resident made their way downstairs, the resident would not be able to gain access to the main entrance doors without a code. Administrative Nurse D stated there was no one at the main lobby desk after 01:00 AM and no one would have been down there to witness R1 leave the facility when she did. Administrative Nurse D stated they had staff that acted as security, but that staff left at 01:00 AM. Administrative Nurse D stated R1 had no history of elopement at the facility and R1 has never gone outside without staff or family.
Administrative Staff A stated R1 had never attempted to elope from the unit or facility since admission. Administrative Staff A stated he reviewed the camera footage and confirmed R1 had made it outside of the facility. Administrative Staff A stated he contacted the contractor the facility used for the facility doors, and the facility's maintenance staff, to inspect the locks on the other doors on the unit to ensure there were no other points of failure. Administrative Staff A stated now that R1 had a WanderGuard R1 would not be able to access the elevator to exit the unit. Administrative Staff A stated the double doors R1 accessed to get out into the main lobby area were inspected and the facility ordered parts to have that door coded with a keypad so it could not be accessed by residents in the future. Administrative Staff A stated he believed the contractor planned to install the new keypad locks for the double door on 10/29/24.

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On 10/22/24 at 04:17 PM Administrative Nurse D stated she had provided staff education related to elopement, wandering, and missing residents to staff after the event; however, she stated she had not met with all the facility staff. Administrative Nurse D stated she believed there were about 20 more staff that needed to complete that education. Administrative Nurse D stated the WanderGuard was placed on R1 when she was brought back to the facility, another elopement screening was completed and her elopement score was changed to reflect the new risk. Administrative Nurse D stated staff updated R1's care plan to reflect the use and monitoring of the WanderGuard.

The facility's "Hazardous Wandering and Elopement (Unwitnessed Exit)" policy with a revised date of 10/12/22, documented the community will define what constitutes a risk for injury of a resident based on the physical location and attributes of the manor and identification of residents at risk. The community will exercise reasonable care to prevent injuries and ensure a secure environment for residents. The unwitnessed exit policy procedure will be reviewed with each staff member during orientation and reviewed thereafter, at least annually.

On 10/22/24 at 04:46 PM, the facility received the "Immediate Jeopardy [IJ] Template" and was informed that the facility failed to provide adequate supervision to prevent R1, who was cognitively impaired, required staff assistance for ADLs including safe ambulation with her walker and was at risk for falls, from exiting the facility without staff supervision or knowledge and entering an unsafe location placed R1 in IJ.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175448	A. BUILDING _____ B. WING _____	C 10/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABERDEEN VILLAGE	17500 W 119TH STREET OLATHE, KS 66061

(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) COMPLETION DATE
F 689	Continued From page 13 The facility submitted an acceptable plan of corrective actions for removal on 10/22/24. The plan included the following actions: A WanderGuard was placed on R1 with orders to monitor and document function each shift. R1's care plan was updated to include an intervention and monitoring for R1's WanderGuard. Staff completed an updated Elopement screening on R1 to reflect R1's new risk and behavior. The facility contacted maintenance and the facility door contractor to inspect the unit door's locking systems to ensure there was no other point of failure. The facility ordered parts to have a set of double doors R1 went through on 10/17/24 coded with a keypad lock to prevent future elopements through those doors. Administrative Nurse D was in the process of providing education for all staff related to elopement, wandering, and missing residents. Implementation of the corrective actions and removal of the immediacy was verified during the onsite survey on 10/22/24 at 04:17 PM. The deficient practice remained at a scope and severity of "D".	F 689		