STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N030005	A. BUILDING: _____ B. WING _____	03/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCK CREEK OF OTTAWA	1100 W 15TH STREET OTTAWA, KS 66067

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S 000	INITIAL COMMENTS The following citations represent the findings of an abbreviated survey for complaint # 193455 of the above named facility conducted on 03/17/25.	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 37 residents. The sample included 1 "Resident" (R). Based on observation, interview, and record review, the Administrator neglected to provide services for R1 when she experienced a change of condition with her cognition. R1 exited the facility on 02/08/25 at 05:22PM through an unalarmed south dining room door without staff knowledge. The facility staff received a phone call from R1's family stating R1 had been picked up by the local police department after a concerned citizen called the local police department with a concern for R1 after seeing her out walking. Facility staff were unaware R1 was not at the facility until, over an hour later at 06:45 PM. R1 experienced	S3026		

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

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a change of condition with her cognition on 02/06/25 and was away from the facility without staff knowledge for approximately 83 minutes placing her in immediate jeopardy until 02/10/25 when staff training was completed, and interventions were placed for R1 addressing her change of condition with her cognition.

Findings included:

- Record review for R1 revealed an admission date of 03/16/24 with diagnoses of essential hypertension, cognitive communication deficit, and atherosclerotic heart disease of native coronary artery.

Review of R1's "Functional Capacity Screen" (FCS) dated 03/16/24 revealed R1 required supervision with bathing, and was independent with dressing, toileting, transferring, waling/mobility, and eating. She lacked the ability to manage her own medications and was usually continent. R1 scored with impaired short-term memory and was able to make herself understood and she understood others. R1 required no mobility device and was not identified as having any current problems or risks.

Review of R1's "Negotiated Service Agreement" (NSA)dated 03/16/24 identified the facility would manage and administer R1's medications and provide supervision with bathing. Under the section titled Activities/Socialization Services" it was handwritten "Attends activities of choice, likes to ambulate hallways several times a day and in courtyard".

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S3026	Continued From page 2 Review of R1's Health Service Plan (HSP) lacked any instruction to facility staff for monitoring R1 when she was outside in the courtyard. Review of R1's electronic "Medical Record" under the "Forms" tab lacked a form for an elopement risk assessment. Under the tab identified as "Progress Notes" were the following entries: On 01/30/25 at 05:07PM a "Nurse Practitioner" (NP) note revealed ...R1 liked living at the facility and enjoyed walking. R1 reported she was at the facility due to her memory and stated she had dementia. The "Neurological" portion of the NP assessment identified that R1 had "mild confusion" and, "Patient with multiple morbidities requiring intensive management. Patient with functional impairments that are likely to require frequent medication changes and/or re-evaluations." On 02/06/25 at 07:47AM a "Nursing Note" revealed "This morning resident is more confused, has difficulty finding words, did not get dressed this morning, came out in night gown, this is unusual for resident." Family transported the resident to the local hospital emergency room for evaluation and treatment. On 02/06/25 at 11:09AM a "Nursing Note" revealed R1 returned from the local hospital emergency room after receiving an intravenous antibiotic, and an order for Cefdinir 300 milligrams twice daily for seven days that was to be started on 02/07/25.	S3026		

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S3026	Continued From page 3 The record lacked documentation on R1's increased confusion upon return from the local hospital emergency department and, the notes further lacked interventions for R1 while she experienced a change of condition with her cognition. On 02/08/25 at 07:56PM a "Wellness Note" revealed at 06:47 PM the writer of the note received a call from the facility staff who reported R1's family called the facility. The family reported to the facility that a local police officer reported that R1 "was walking on 15th street", and she had been picked up and taken to the police department. R1's family reported they would bring R1 back to the facility. R1 had mud on her pants and hands and R1 stated she had fallen. R1 told the writer she did not know why she went outside, "but was probably just to walk". The resident's family member reported R1 told him she went out because it was nice, and she must have fallen in the mud". The facility discussed a plan for 15-minute checks with the resident's family member and, he stated he hoped it was the urinary tract infection causing "more confusion and that it would clear soon". Review of R1's medical record revealed a document titled "After Visit Summary" from a local hospital and was dated 03/06/24. Under the section titled "Other instructions" it was typed that R1 completed the "Saint Louts University Mental Status" (SLUMS) examination and earned a score of 05 out of 30, which indicated severe neurocognitive deficit and placed her within the dementia category. This was a one-point decrease of her SLUMS scores from 05/01/23.	S3026		

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"Areas of difficulty included memory, attention, mental manipulation, and problem solving. Her memory deficits were very apparent throughout the assessment as she often needed instructions repeated to her shortly after the initial explanation". R1 was likely has the cognitive capacity to independently complete basic activities of daily living but would require assistance with more complex task. The note continued to state R1 was "Note safe to stay at home alone" with her diagnosis of dementia. R1 would "Need 24-hour care" while at home. The Case Manager (CM) provided a list of "Memory Care" facilities in R1's area.

Review of the facility provided a screen shot of the facility video footage date stamped on 02/08/25 at 05:22PM showed R1 getting ready to walk out the south door of the facility dining room.

Review of the facility provided screen shot of the facility video footage date stamped 02/08/25 at approximately 05:22PM from the camera located on the outside of the southwest corner of the building, showed R1 walking across the grass to the south of the building to the parking lot, she was wearing what appeared to be jeans, and a long sleeve heavier material type shirt, with closed toe shoes.

Review of the local police department provided document titled "Call Sheet" revealed at 06:23PM a citizen reported seeing a female approximately 70 years old, with her wallet in her pocket, and noted she "doesn't remember much of anything". At 06:26PM a local officer arrived and made contact with R1.

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S3026	Continued From page 5 Review of the website wunderground.com/history for the temperature on 02/06/24 at 04:53PM it was 40 degrees Fahrenheit with 18 mile per hour (mph) winds from the "North- Northwest" (NNW), at 05:53PM it was 39 degrees Fahrenheit with 16 mph NNW, and at 06:53PM it was 35 degrees Fahrenheit with 14 mph winds from the North. Review of the facility provided investigation revealed R1 was wearing jeans and a long sleeve thermal top with "appropriate shoes". Review of the facility provided signed and notarized document titled "Witness Statement" dated 02/10/25 revealed "Certified Medication Aide" (CMA) A wrote she last saw R1 between 05:15PM and 05:30 PM on Saturday evening after she was finished with her dinner. CMA A wrote "I saw her leave the table" and she did not see her exit the building. Observation on 03/17/25 at approximately 02:45 with Administrator B and "Licensed Nurse" (LN) C confirmed the table R1 sat at for meals. This table was on the southeast side of the door of the dining room that led to the outside. The dining room table was approximately 12 feet from the door located on the south wall of the dining room, the dining room door to the outside freely opened, and an alarm did not sound that the door had been opened. The door opened to a small patio approximately eight feet by eight feet square. There was a chair sitting next to the door. It was 513 steps from the back door to the intersection that was identified in the local police department call sheet. The intersection is in a residential area with the north and south road	S3026		

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being a 2-lane road with a speed limit of 45 miles per hours. The east and west street were in a residential area.

Interview 0n 03/17/25 at approximately at approximately 02:45 PM with Administrator B and LN C confirmed the exit doors are alarmed. They continued that the alarms were not always on and that they turn them on "when there is a need".

On 03/17/25 at 03:25 PM Administrator B and LN C were informed that R1 was in Jeopardy when they neglected to provide services to R1 after a change of condition with her cognition and left the facility without staff knowledge.

The Administrator neglected to provide services for R1 when she experienced a change of condition with her cognition on 02/06/25. R1 exited the facility on 02/08/25 at 05:22PM through the unalarmed south dining room door without staff knowledge. The facility staff received a phone call from R1's family stating R1 had been picked up by the local police department after a concerned citizen called the local police department. Facility staff were unaware R1 was not at the facility until 06:45 PM. R1 was out of the facility for approximately 83 minutes after experiencing a change of condition with her cognition wearing jeans, a heavy long-sleeved shirt and closed toe shoes and an outside temperature between 35- and 40-degrees Fahrenheit, placing her in immediate jeopardy.

The facility abatement plan included the following;

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S3026	Continued From page 7 Immediate actions taken were: Door alarms at all exits were activated upon R1's return to the facility. Upon R1's return to the facility 15-minute checks on R1 were implemented. Staff were in-serviced regarding R1's elopement and safety plan was implemented. On 02/10/25 an all-staff in-service on Elopement and Abuse Neglect and Exploitation was completed On 02/19/25 R1 discharged to another facility for a higher level of care. Door alarms on all exit doors are no to always be on.	S3026		