Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N093004	A. BUILDING: _____ B. WING _____	05/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENWOOD PLAZA INC	607 E 1ST AVENUE ST JOHN, KS 67576

(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 #195353 at the above named facility conducted on 05/20/25.	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: KAR 26-41-101 (f) (1) (B) The facility reported a census of 26 residents. The sample included 1 resident.. Based on record review, observation, and interview for Resident (R) 1, Operator A failed to ensure no resident was subjected to neglect when Operator A failed to provide or coordinate services reasonably necessary to ensure R1's safety and well-being and to avoid harm when the resident was a known wander risk, eloped from the facility without staff knowledge through an unlocked and unalarmed door, left the building walking unsupervised and was found at a residential home. This failure placed the resident in Immediate Jeopardy.	S3026		

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

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S3026	Continued From page 1 Findings included: - Review of the "Resident Roster" obtained on 05/20/25 from Operator A recorded R1 wandered. - Review of R1's medical record revealed she admitted to the facility on 03/31/25 with diagnosis of major depressive disorder, hypertension and disorder of thyroid. The "Functional Capacity Screen" (FCS) dated 03/31/25 recorded the resident required supervision with toileting, transfer, walk/ mobility, required physical assistance with bathing and dressing and was unable to perform management of medications and treatments. The FCS recorded the resident had short- and long-term memory impairment, memory/recall impairment, and impaired decision making. The FCS further recorded the resident was at risk for falls/unsteadiness and wandering and had impaired decision making. R1 did not use an assistive device to ambulate. The combined "Negotiated Service Agreement" (NSA)/ Health Care Service Plan (HCSP) dated 03/31/25 recorded the resident received supervision from staff with toileting, transfer, and walk/ mobility, received physical assistance from staff with bathing, dressing, eating and management of medications and treatments. The NSA/ HCSP recorded the resident required reminders; had moderate disorientation or difficulty recalling/ retaining information; displayed deficits in judgment, had moderate dementia with significant short-term memory and possibly long-term memory loss, required	S3026		

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S3026	Continued From page 2	S3026		

reminders for activities and meals. The NSA/ HCSP further recorded R1's safety would be maintained; R1 would not leave the community unattended; if R1 wanted to leave staff were to encourage her to join an activity, watch television, or sit in the recliner and enjoy some music on the radio. Safety checks every 2-3 hours were to be completed by staff. If R1 headed toward an exit door, staff were to redirect her to her room.

The resident's record lacked an "Elopement Risk Assessment".

Per interview and observation on 05/20/25 at 09:20 AM of the facility video surveillance footage with Operator A revealed R1 exiting through the unlocked, unalarmed front door on 05/12/25 at 12:42 PM. Resident was last seen on 05/12/25 at 12:41 PM when Administrative Staff E walked by R1 in the dining room.

Interview on 05/20/25 at 10:37 AM with Licensed Nurse (LN) B confirmed two-hour visual checks in place from 03/31/25 until elopement on 05/12/25 were not documented every 2 hours.

Interview on 05/12/25 at 10:46 AM with Operator A confirmed a new front door was installed on 03/06/25 and there had not been an alarm on that door since the new door was installed.

The facility failed to have a system in place to monitor the front door after the alarm was removed on 03/06/25 with a known wander risk resident (R1) in their facility.

Observation on 05/20/25 at 09:25 AM in R1's

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S3026	Continued From page 3	S3026		

room revealed resident lying in bed. Observed R1 get out of bed and ambulate in room without assistive device. R1 had a laceration to her left eyebrow/ temple area. R1 stated she fell but was unable to give details.

Review of the facility obtained "witness statement" signed by Operator A dated 05/14/25 recorded, "[LN B] called my phone as I was cooking this day. He stated [R1] had gotten out of the building and was on 2nd street. Wanted me to go to the scene while he called the family. I went to the scene, approximately ¾ block from facility. EMS [emergency medical services] was there. [R1] recognized me and called me by name, I asked what happened. The owner of the house stated [R1] knocked on the door and asked to look at the flowers, then tripped over the landscaping rock. He called 911. The EMS drivers stated they were going to take her to the hospital for a CT scan ... a couple hours later she [R1's family member] brought [R1] back to the facility. R1's family member] sat by [R1] through supper and then went home."

Review of the facility obtained "witness statement" signed by LN B dated 05/14/25 recorded, "I received a call at 01:30 PM [R1] had fallen and hit her head. She had a small laceration above her left eye. EMS was going to take her to the ER [emergency room]. Call placed to [R1's] contacts ... about 02:00 PM found out how [R1] fell, she had fallen while bending over to look at some flowers, she lost her balance and hit her head ... [R1] and her [family member] returned to the facility around 04:30 PM, no significant injuries noted. She had a small laceration on the left eyebrow. This area

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S3026	Continued From page 4	S3026		

had one stitch in it ... vitals checked ... PCP [primary care physician] informed. Staff will assist [R1] back to her room after meals and will do visual checks every two hours. I will review documentation weekly and monitor to assure this is done."

"Weather Underground History" reported the following temperatures, events, and conditions for 05/12/25 at 12:56 PM; the temperature was 68 degrees F (Fahrenheit), 17 mile per hour wind from the east/ southeast, no precipitation, mostly sunny.

Observation of the area revealed the resident traversed approximately 0.2 miles on a 2 lane residential street from the facility to a residential home. The terrain from the facility to the residential home included portions of the streets with sidewalks and portions of the streets without sidewalks. The resident would have crossed one street. R1 was wearing a long sleeve shirt, pants and shoes.

Facility's "Elopement/ Missing Resident" policy dated 06/2018 recorded, "The facility must appropriately assess the risk of elopement and strive to recognize patterns and consider that changes in their regular supervision may be required to coordinate with changes in those patterns ...Residents will be assessed upon admission, yearly and PRN [as needed] for elopement risk (FCS and BIMs will be completed."

Operator A failed to protect wander risk resident R1 from neglect when she exited the building without staff knowledge through an unlocked,

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S3026	Continued From page 5 unalarmed door and was found approximately 48 minutes later. The Immediate Jeopardy was removed on 05/20/25 at 12:15 PM when the State Agency accepted the facility's abatement plan. The following abatement plan was accepted by the State Agency: Certified Nurse Aide (CNA) C and Certified Medication Aide (CMA) D assigned to R1 until alarm installed with 15-minute documented visual checks, LN B went to the store to obtain a door alarm for the front door, Two-hour visual checks continued after door alarm placed, Door alarm on constantly, 24 hours a day, Written in-service for staff on door alarms conducted at the start of each shift, Elopement and door alarm education to be conducted on 05/22/25.	S3026		