Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N085010	A. BUILDING: _____ B. WING _____	07/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE SALINA FAIRDALE	2251 E CRAWFORD SALINA, KS 67401

(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 citation represents the findings of an abbreviated survey for complaints #195710 and #194794 at the above named facility conducted on 07/09/25.	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 21 residents. The sample included 1 resident. Based on record review, observation, and interview for Resident (R) 1, when Operator/ Licensed Nurse (LN) 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 alarmed exit door, left the building walking unsupervised and was found at an apartment complex across the street from the facility. 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 07/09/25 from Regional Nurse B revealed R1 was no longer a resident in the facility as of 04/15/25. - Review of R1's medical record revealed she admitted to the facility on 02/03/25 with diagnoses of dementia, delusional disorder, sleep disorder, diabetes mellitus type II and hyperlipidemia. The "Functional Capacity Screen" (FCS) dated 03/01/25 recorded the resident was independent with dressing, toileting, transfer and eating, required supervision with bathing and walking/ mobility, 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, impaired decision making and was sometimes understood/ sometimes understandable. The FCS further recorded the resident was at risk for wandering and used a walker to ambulate. The combined "Negotiated Service Agreement" (NSA)/ Health Care Service Plan (HCSP) dated 03/01/25 recorded the resident received supervision from staff with bathing, used a walker for ambulation and staff administered medications and treatments. The NSA/ HCSP recorded the resident required additional time to assist with interpretation due to language barrier, time to encourage to be social due to cognitive deficit and history of mental health issues required assistance with reassurance and reminders of time of day and night. The NSA/	S3026		

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S3026	Continued From page 2	S3026		

HCSP further recorded R1 paced in the building when she became uncertain, and staff were to remain calm and reassure resident of changes.

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

Per facility obtained statement from Certified Nurse Aide (CNA) D, R1 was last seen on 04/14/25 at approximately 08:45 PM at the doorway of her room. At approximately 09:15 PM, CNA D heard the alarm on the breakroom door, located on the east side of facility, going off. CNA D stated she looked outside and reset the door alarm and did not inform any other staff members.

Per facility obtained statement from Certified Medication Aide (CMA) E, R1 was last seen on 04/14/25 at approximately 08:50 PM in the activity area in the facility.

Interview on 07/09/25 at 11:26 AM with Administrative Staff C confirmed facility staff were to search the premises and then conduct a head count of residents if a door alarm goes off without staff observance.

"Weather Underground History" reported the following temperatures, events, and conditions for 04/14/25 at 09:53 PM; the temperature was 50 degrees F (Fahrenheit), 5 mile per hour wind from the north, no precipitation, sunset was at 08:04 PM, dark at 08:34 PM.

Observation of the breakroom door revealed a keypad lock on the inside and outside of the door.

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S3026	Continued From page 3 Observation of the area revealed the resident would have likely traversed across a 4-lane road, which had a 40 mile per hour speed limit. The terrain from the facility to the apartment complex included portions of the street with sidewalks and portions of the street without sidewalks. R1 was wearing a shirt, pants, socks, shoes, and a zip-up jacket. Facility's "Resident Call System and Door Alarm Response" policy dated 05/2023 recorded, "when a door alarm sounds, associates should respond immediately and follow the procedures below: Immediately go to the area where the door alarm has sounded; complete a visual check within the vicinity of the door ...Close the door and reactivate the alarm; notify other associates of the door alarm status; verify whereabouts of all residents in the community, using a current resident roster as a guide; investigate alternative explanations for the resident's absence ... If any residents(s) cannot be located, initiate the procedures described in the Missing Resident Policy ..." Facility's "Missing Resident Policy" dated 03/2025 recorded, "Follow the steps below until the resident is found. 1. Check the sign-in/ sign-out book. Conduct thorough interior search of community ...If not found, continue to the next step. Associates should initiate a head count of all residents ...Conduct thorough exterior search of the immediate grounds." Operator/LN A failed to protect R1 from neglect when R1 exited the building without staff knowledge through an alarmed door, was not	S3026		

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S3026	Continued From page 4 accounted for as being gone by staff for approximately 1 hour and was found approximately 2 hours and 15 minutes later. The Immediate Jeopardy was removed on 04/15/25 at 11:30 PM when the facility initiated on-on-one supervision, upon her return to the facility by police. The following actions were taken by the facility on or before 04/15/25 to protect the resident: 1. Continuous one-on-one supervision was provided until resident discharged from facility. 2. The family was notified immediately. A meeting was scheduled for 04/15/25 to inform them that memory care placement would be necessary. 3. The resident was engaged in personalized activities of interest until memory care placement was secured. 4. CNA D was immediately suspended pending the outcome of an internal investigation. Associate is no longer employed by facility. 5. Elopement prevention training was conducted for all associates on 04/15/25, which covered protocols for supervising residents with cognitive impairments, identifying exit-seeking behaviors, and following established elopement policies and procedures.	S3026		