Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N080004	A. BUILDING: _____ B. WING _____	11/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY LIVING OF LYONS	502 S MILES STREET LYONS, KS 67554

(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 complaint #197273 at the above named facility conducted on 11/04/25.	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 18 residents. The sample included 1 focused record review resident. Based on record review, observation, and interview for Resident (R) 1, Operator/ Certified Medication Aide (CMA) 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 unalarmed exit door, left the building walking unsupervised and was found on a road approximately 0.4 miles 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 11/04/25 from Licensed Nurse (LN) B recorded R1 was a wander risk. - Review of R1's medical record revealed she admitted to the facility on 06/11/25 with diagnoses of early onset Alzheimer's Disease, hypertension and hypokalemia. The "Functional Capacity Screen" (FCS) dated 06/11/25 recorded the resident was independent with transfer, walk/ mobility and eating, required supervision with bathing, dressing, and toileting, and was unable to perform management of medications and treatments. The FCS recorded the resident had short-term memory impairment, memory/recall impairment and impaired decision making. The FCS further recorded the resident was at risk for wandering and had impaired vision and hearing. R1 used no assistive devices for ambulation. The combined "Negotiated Service Agreement" (NSA)/ "Health Care Plan" (HCP) dated 06/11/25 recorded the resident received assistance from staff in entering and exiting the shower safely, washing areas resident unable to reach, assistance as needed with dressing and reminders to use the bathroom before meals and activities. The NSA/HCP recorded R1 was independent with transfers and walk/ mobility and certified staff set up and administered medications. The NSA/HCP further recorded staff gave reminders for meals, activities and activities of daily living, staff were to monitor for any exiting behaviors due to confusion and redirect	S3026		

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S3026	Continued From page 2	S3026		

resident as needed. A wanderguard was in place to alert staff when R1 got close to an exit door.

An "Amended Negotiated Service Agreement" dated 08/18/25 recorded R1 requested to remove wanderguard after self-removing it two times, family agreed to remove, qualified staff to continue two-hour safety checks and monitor for exit seeking behaviors while in the facility living area.

The resident's "Elopement Risk Assessment" dated 06/11/25 recorded R1 was disoriented daily, was complacent and ambulatory, had full mobility, had no significant medication that altered mental status and she wandered the facility but did not exit seek, resulting in a score of 16. The" Elopement Risk Assessment" recorded resident was an elopement risk if score was 10 or greater.

Per facility obtained "Task History" R1 was visually observed on 10/22/25 at 04:20 PM by CNA C.

Per facility obtained statement from Certified Nurse Aide (CNA) C, R1 was last seen on 10/22/25 at 04:15 PM walking towards her room.

Per facility obtained statement from CMA D, R1 was last seen on 10/22/25 at 04:10 PM.

Interview on 11/04/25 at 09:30 AM with Operator/ CMA A stated she was informed at approximately 04:45 PM by facility staff that they were unable to locate R1 and a search of the facility and premises was immediately conducted. Operator/ CMA A stated she received a phone call from

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S3026	Continued From page 3 R1's family member at 05:01 PM, stating R1 was found by a family friend at approximately 04:55 PM walking toward the family member's home and had R1 in her custody. Operator/ CMA A stated R1 was wearing a shirt, pants, and shoes. Operator/ CMA A confirmed R1 did not have a wanderguard on at the time of elopement and further confirmed it was removed on 08/18/25. Interview on 11/04/25 at 10:50 AM with Operator/ CMA A stated R1 was not to leave the facility without staff knowledge. Interview on 11/04/25 at 11:08 AM with Operator/CMA A confirmed the front and back door of the facility were not alarmed. Interview on 11/04/25 at approximately 12:00 PM with Operator/ CMA A stated per R1's family member, resident was found on a road, adjacent to a supply store. Interview on 11/04/25 at approximately 12:00 PM with LN B confirmed R1 was found approximately 0.4 miles from the facility. LN B stated R1 would have likely traveled down two different dirt roads before turning onto a 2-lane road, which led to the supply store where R1 was found by a family friend. "Weather Underground" reported the following temperatures, events, and conditions for 10/22/25 at 04:52 PM; the temperature was 71 degrees F (Fahrenheit), 8 mile per hour wind from the north/ northeast, no precipitation. Observation of the area revealed the resident would have likely traversed down two dirt roads	S3026		

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S3026	Continued From page 4	S3026		

with no sidewalks, which led to a 2-lane road, which had a 40 mile per hour speed limit and no sidewalk.

Facility's "Elopement Prevention" policy dated 2016 recorded, "All residents are informed in writing upon admission, of the building's method for accounting for residents who leave the building. Residents are asked to sign out when leaving the building and/or grounds."

Operator/CMA A failed to protect R1 from neglect when she exited the building without staff knowledge through an unalarmed door and was found approximately 40 minutes later by a family friend, who notified R1's family.

The Immediate Jeopardy was removed on 10/22/25 at approximately 04:55 PM when the resident was found by a family friend, who notified R1's family and brought her to her family's home.

The following actions were taken by the facility on 10/22/25 to protect the resident:
1. Wanderguard placed to right wrist with functionality checks twice a day.
2. Thirty-minute checks were put in place from 10/22/25 through 10/29/25 and then two-hour visual checks were initiated.
3. The resident was engaged in personalized activities of interest until memory care placement was secured.
4. Elopement prevention training to be conducted for all staff members on 11/19/25.