STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N052007	A. BUILDING: _____ B. WING _____	05/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWIN OAKS ASSISTED LIVING	657 EISENHOWER LANSING, KS 66043

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S 000	INITIAL COMMENTS The following citations represent the findings of a resurvey with complaints 195305, 197427, 198588 and facility self-reported incident 198012 at the above named Assisted Living conducted on 05/04/26, 05/05/26 and 05/06/26.	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: 3026 KAR 26-41-101(f)(1)(B) The facility reported a census of 30 residents. The facility identified two residents at risk for elopement. Based on observation, interview, and record review the operator failed to ensure resident (R)101 was not subjected to neglect by the failure to ensure implementation of interventions for resident safety. This resulted in immediate jeopardy when facility staff entered the code to the front entrance keypad alarm allowing cognitively impaired R101 to exit the facility and walk down a sidewalk adjacent to a busy road without supervision from either staff or	S3026		

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

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S3026	Continued From page 1 family. Findings included: - R101's medical record revealed the resident moved into the facility on 11/08/25 with a diagnosis of Alzheimer's Disease. R101's "Functional Capacity Screen/ Negotiated Service Agreement" (FCS/NSA) dated 01/19/26 revealed he was independent with transfers and mobility without the use of an assistive device, had a cognitive score of three (indicating he was cognitively impaired with short-term memory, memory/recall and decision-making impairments). R101 was also identified at risk for wandering and had a Wanderguard (a monitoring device) in place. Review of R101's medical record revealed the following: The 01/19/26 "Informed Risk Agreement" documented R101 had been assessed as being at risk for elopement related to one or more of the following: Cognitive impairment, memory loss, or confusion, poor safety awareness and judgement. History of wandering or exit-seeking behaviors, inability to recognize unsafe environments or consequences. Negative outcomes included, but were not limited to serious injury or death, exposure to extreme temperatures, traffic accidents, getting lost or unable to return safely. The Wanderguard bracelet was a safety device that may alert staff if R101 attempted to exit secured areas. This device may cause alarms or delays when approaching exit doors.	S3026		

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S3026	Continued From page 2 The 02/06/26 "Occurrence Note" by Licensed Nurse (LN) B documented staff were alerted at 01:08 PM that someone had observed a possible resident walking out in front of the facility with items in his hands and looked like he was headed down the sidewalk. Review of video footage revealed at 12:54 PM, R101 went to the front entrance of the facility. A family member of another resident and movers attempted to exit the facility with some furniture. R101 asked if they were going out and stated, "I am going out with you guys." The family member attempted to enter the code but was unsuccessful. Housekeeping Staff C staff assisted the visitors by entering the keypad code and R101 exited the facility with the visitors. R101 had a Wanderguard on and set off the alarm which Housekeeping Staff C reset. An observation on 05/05/26 at 09:45 AM revealed the facility was located in a mixed residential/commercial neighborhood. The streets were paved with concrete sidewalks located on both sides of the streets. The posted speed limit for the main road adjacent to the facility was 40 miles per hour. The facility is located on a busy east/west street approximately one-half mile west of an intersection with a busy north/south four-lane road. There were streetlights and crosswalks with pedestrian signs in place. Weather conditions at the time of the elopement as verified on https://www.wunderground.com revealed it was still light outside, the temperature was approximately 52 degrees Fahrenheit, and there was no noted precipitation at that time. On 05/05/26 at 09:58 AM Housekeeping Staff C	S3026		

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S3026	Continued From page 3	S3026		

stated she was hired about a month prior to the incident involving R101's elopement. Housekeeping Staff C stated she was unaware that R101 had a Wanderguard on and that she never received any education concerning specific residents that were elopement risks. Housekeeping Staff C stated she thought R101 was with the group of men at the front door, and she went to help these people out of the front door because they were having some trouble getting the keypad to work. Housekeeping Staff C stated that she put in the code, the door opened and R101 walked out with the men.

On 05/05/26 at 11:55 AM an observation of the resident sign-out notebook revealed a page that listed residents at risk for elopement to include R101.

On 05/05/26 at 11:00 AM LN B stated she and Administrative Staff A were doing an assessment at a nearby hospital when they received a call from staff and were informed R101 was not in the building and was observed walking down the sidewalk headed east. LN B immediately left the hospital with Administrative Staff A and drove down the road and found R101 standing at the crosswalk at a busy intersection. Staff were stopped in traffic several cars west of the intersection and witnessed R101 cross the street when the traffic light changed. Staff drove the car to the other side of the intersection and LN B got out of the car and walked over to R101 and later transported him back to the facility.

On 05/05/26 at 01:22 PM LN B stated she did not specifically educate Housekeeping Staff C as to which residents were at risk for elopement. LN B

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S3026	Continued From page 4 stated during quarterly meetings with staff she reviewed that there was a notebook that identified residents at risk for elopement, but she had never reviewed with staff which residents were at risk for elopement. The undated "Elopement" policy documented, "3. If the assessment determines that a resident is at risk for elopement, the licensed nurse is to add the resident's name to the list of residents who have potential for elopement. The list and resident photograph(s) shall be kept in an area accessible to staff members. 4. The RCC /licensed nurse is to notify all staff that the resident is at risk for elopement." On 05/05/26 at 02:00 PM Administrative Staff A and LN B were informed of the findings, which resulted in immediate jeopardy regarding a cognitively impaired resident who exited the facility, failure of staff to ensure all facility staff were informed R101 was at risk for elopement and ensured interventions were followed to keep R101 safe from exiting the building unsupervised. Administrative Staff A submitted an abatement plan which included the following: A staff in-service was held on 02/06/26 and staff were educated on elopement procedures. Staff are to ensure families signed the residents in and out when they left the building. The regular and escort codes for the front door were changed. Staff were educated that there was a list in the back of the sign-out book which staff were supposed to check to see if residents were on the wander guard list. If the resident was on the list, the staff were to call the Executive Director or "Resident Care Coordinator" (RCC)	S3026		

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S3026	Continued From page 5 for the override code and escort residents to the car. A "Detex" alarm (a security and life safety device designed to alert when a door is opened, helping prevent unauthorized access)was placed on the front doors as a secondary alarm. The RCC updates the wander guard list with any changes. The Executive Director will educate all new hires on the elopement procedure. The immediate jeopardy was abated on 05/05/26 at 03:29 PM based on the facility's plan of correction and approved by the department.	S3026		
S3211 SS=E	26-41-205 (g) (3) OVER THE COUNTER DRUGS (3) A licensed nurse or medication aide may accept over-the-counter medication only in its original, unbroken manufacturer ' s package. A licensed pharmacist or licensed nurse shall place the full name of the resident on the package. If the original manufacturer ' s package of an over-the-counter medication contains a medication in a container, bottle, or tube that can be removed from the original package, the licensed pharmacist or a licensed nurse shall place the full name of the resident on both the original manufacturer ' s medication package and the medication container. This REQUIREMENT is not met as evidenced	S3211		

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S3211	Continued From page 6 by: 3211 KAR 26-41-205 (g)(3) The facility reported a census of 30 residents. Based on observation the operator failed to ensure a licensed pharmacist or licensed nurse placed the full name of the resident on the original package of over the counter (OTC) medications. Findings included: - On 05/06/26 at 04:28 PM an observation of the medication cart revealed the following OTC medications were not labelled with the full name of the resident: One bottle of Equate Low Dose Aspirin One bottle of Senokot One bottle of Nature Made D3 One bottle of Nature Made Magnesium One bottle of Flintstone Gummies Immunity Support A policy for OTC medication labeling was requested but the facility failed to provide one. The operator failed to ensure all OTC medications were labeled by a pharmacist or licensed nurse with the resident's full name.	S3211		
S3215 SS=F	26-41-205 (h) Medication Storage (h) Storage. Licensed nurses and medication aides shall ensure that all medications and biologicals are securely and properly stored in accordance with each manufacturer ' s	S3215		

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S3215	Continued From page 7 recommendations or those of the pharmacy provider and with federal and state laws and regulations. (1) Licensed nurses or medication aides shall store non-controlled medications and biologicals managed by the facility in a locked medication room, cabinet, or medication cart. Licensed nurses and medication aides shall store controlled medications managed by the facility in separately locked compartments within a locked medication room, cabinet, or medication cart. Only licensed nurses and medication aides shall have access to the stored medications and biologicals. (2) Each resident managing and self-administering medication shall store medications in a place that is accessible only to the resident, licensed nurses, and medication aides. (3) Any resident who self-administers medication and is unable to provide proper storage as recommended by the manufacturer or pharmacy provider may request that the medication be stored by the facility. (4) A licensed nurse or medication aide shall not administer medication beyond the manufacturer ' s or pharmacy provider ' s recommended date of expiration. This REQUIREMENT is not met as evidenced by: 3215 KAR 26-41-205(h) The facility reported a census of 30 residents. Based on observation and interview, the operator	S3215		

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S3215	Continued From page 8 failed to ensure all medications and biologicals were properly stored in accordance with each manufacturer's recommendations. Findings included: - On 05/06/26 at 10:08 AM an observation of the medication room refrigerator revealed one vial of Tuberculin was opened and dated 02/20/26. On 05/06/26 at 11:54 AM Licensed Nurse B acknowledged the vial of Tuberculin was opened and past the expiration date and stated there have been resident admissions since this vial was opened. The vial of Tuberculin, the original packaging it came in and the product insert all documented the vial should be discarded after 30 days if it had been entered and in use. The operator failed to ensure medications and biologicals were stored in accordance with manufacturer's recommendations.	S3215		
S3320 SS=E	28-39-254 CONSTRUCTION (a) The assisted living facility or residential health care facility shall be designed, constructed, equipped and maintained to protect the health and safety of residents, personnel and the public. (b) All new construction, renovation, remodeling and changes in building use in existing buildings shall comply with building and fire codes, ordinances and regulations enforced	S3320		

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S3320	Continued From page 9 by city, county, and state jurisdictions, including the state fire marshal. (c) New construction, modifications and equipment shall conform to the following codes and standards: (1) Title III of the Americans with disabilities act, 42 U.S.C. 12181, effective as of January 26, 1992; and (2) "Food Service Sanitation Manual," health, education, and welfare (HEW) publication no. FDA 78-2081, as in effect on July 1, 1981. This REQUIREMENT is not met as evidenced by: 3320 KAR 28-39-254 (a) The facility reported a census of 30 residents. Based on observation and interview the operator failed to ensure staff secured all chemicals to maintain the safety of all residents, staff and visitors. Findings included: - An observation during the initial facility tour on 05/04/26 at approximately 01:15 PM a lockable cabinet near the 600-hallway used by the activities director contained: Numerous bottles of nail polishrevealed the following unlocked chemicals: One 236 milliliter container of ONYX 100 percent acetone nail polish remover	S3320		

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S3320	Continued From page 10 One eight fluid ounce bottle of TSM Brands Luxury nail polish remover On 05/05/26 at approximately 04:25 PM "Licensed Nurse" (LN) B acknowledged the activities supply cabinet was left unlocked and contained chemicals labeled with a KEEP OUT REACH OF CHILDREN warning labels. The "Chemical and Hazardous Material Storage" policy dated November 27, 2018, documented "All chemicals and hazardous items will be stored in a manner as to protect residents." The operator failed to ensure staff kept chemicals locked for residents, staff and visitor safety.	S3320		