STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N018010	A. BUILDING: _____ B. WING _____	C 08/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDERBROOK VILLAGE	402 E WINDSOR RD ARKANSAS CITY, KS 67005

(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 the licensure resurvey with attached complaint number 198922 for the above named facility conducted on 08/10/26 and 08/11/26.	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: K.A.R. 26-41-101(f) (1) (B) The facility reported a census of 32 residents with 3 residents included in the sample. Based on record review and interviews, the facility failed to ensure Resident (R) 1 did not leave the facility without staff knowledge of her whereabouts, overnight and for approximately 13.75 hours. On 05/27/26 at approximately 07:30 PM, R1, who had impaired short-and long-term memory and schizoaffective disorder, requested to leave the facility and Certified Medication Aide (CMA) A entered the code into the front entry keypad, allowing R1 to leave the facility on foot without any staff assistance or supervision. CMA A failed to notify Operator/Licensed Nurse (LN) C on 05/27/26 at 08:30 PM to report R1 was not in the facility during scheduled medication rounds. R1	S3026		

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

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S3026	Continued From page 1	S3026		

was found approximately 1.9 miles away from the facility on 05/28/26 at approximately 08:44 AM at a local park after being out of the facility all night. These failures placed R1 in immediate jeopardy.

Findings included:

- Review of R1's record revealed she admitted to the facility on 03/16/26 with diagnoses of unspecified dementia, depression, anxiety disorder, hallucinations, and other schizoaffective disorder.

Review of R1's "Functional Capacity Screen" (FCS) dated 03/17/26 revealed R1 was independent with bathing, dressing, toileting, transferring, walking/mobility, and eating and was unable to manage her own medications and medical treatments. R1 had impaired short-term and long-term memory, memory/recall impairment, and impaired decision-making. R1 was able to make herself understood and understood others. R1 used no walking mobility device.

Review of R1's combined "Negotiated Service Agreement" (NSA) / "Health Service Plan" (HSP) dated 03/17/26 instructed facility staff to administer R1's medications. It was documented R1 liked to walk.

Review of R1's "Daily Log" revealed an entry on 05/25/26 at 12:34 PM signed by CMA D, which noted R1 told CMA D her son was picking her up on 05/25/26 and she was moving out. R1 reported to CMA D she was being kept at the facility against her will.

Review of the undated facility policy titled "Resident Rounds" revealed facility rounds were

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S3026	Continued From page 2	S3026		

to be conducted frequently during the night to ensure residents' needs were being met. For those residents who requested not to be checked during the night, the request would be documented in the nurse's notes in the resident record and on their personal service plan.

R1's record lacked documentation of the request to not be disturbed during the nighttime.

Review of the facility provided investigation dated 05/28/26 revealed R1 confirmed CMA A put the code in the keypad located at the front door and allowed R1 to freely exit the facility on foot. R1 reported she walked to a local gas station and asked a person to give her a ride to the park where she remained, while out of the facility. Interview on 08/10/26 at approximately 05:45 PM with CMA D revealed she documented comment made by R1 regarding leaving the facility and being held against her will, because they were not normal comments for R1 to make. CMA D stated when she came on duty the morning of 05/28/26, CMA A failed to report that R1 did not receive her nightly scheduled medications on 05/27/26 due to R1 not being in the facility. CMA D reported when she attempted to pass R1's scheduled morning medications she discovered R1 was not in the facility and she called Operator/LN C to report R1 was not in the building.

Interview on 08/10/26 at approximately 05:35 PM with Certified Nurse Aide (CNA) B confirmed on 05/27/26, CMA A informed him she was unable to pass R1's medications, and R1 was not in the facility. CNA B continued to confirm Operator/LN C and R1's family were not contacted when CMA A and CNA B confirmed R1 was not in the facility.

Interview on 08/11/26 at approximately 11:15 AM

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S3026	Continued From page 3 Operator/LN C confirmed CMA A sent an electronic mail on 05/28/26 self-terminating her employment. Operator/LN C confirmed she performed an assessment on R1 upon her return to the facility on 05/28/26, and R1 stated the "voices" told her to leave the facility. The facility failed to ensure R1 did not leave the facility without staff knowledge of her whereabouts, overnight and for approximately 13.75 hours. Staff failed to identify R1 was missing from the facility, and they further failed to notify Operator/LN C to report R1 had left the facility. R1 was found approximately 1.9 miles away from the facility at a local park after being out of the facility all night. These failures placed R1 in immediate jeopardy. The facility provided an IJ removal plan, which included the following: 1. A staff meeting on 05/28/26 at 02:00 PM that included the following topics: Elopement Prevention Procedures, Resident Supervision, Expectations, Resident Identification and Monitoring Processes, Visitor Monitoring, and Exit Awareness, Immediate reporting Requirements, and Overnight Monitoring Expectations. 2. On 05/29/26 R1 was seen by her medical provider. 3. On 06/23/26 R1 was seen by a mental health provider. 4. An "Air Tag" was purchased by family.	S3026		