STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175424	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEPOINT AUGUSTA, LLC	901 LAKEPOINT DRIVE , AUGUSTA, Kansas, 67010

(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) COMPLETION DATE
F0000	INITIAL COMMENTS A partial extended complaint survey KS00196035 was conducted by the Kansas Department for Aging and Disability Services (KDADS), on behalf of the Centers for Medicare and Medicaid Services (CMS) on 07/31/25. The facility was found not to be in substantial compliance with 42 CFR 483 subpart B. On 07/31/25, Administrative Staff A was provided a copy of the "Immediate Jeopardy [IJ] Template" and notified that the facility failed to ensure that a cognitively impaired resident remained free from accident hazards when staff failed to provide adequate supervision and respond appropriately to a door alarm allowing R1 to elope from the facility which placed R1 in immediate jeopardy. On 06/14/25 at 09:20 PM, R1, a cognitively impaired resident at risk for wandering, exited the facility without staff knowledge or supervision. The door alarm sounded, and at 09:26 PM, Certified Nurse Aide (CNA) M cancelled the alarm but did not conduct a search or inspection to identify what triggered the alarm. At 10:00 PM, staff performed rounds and discovered R1 was missing. Staff initiated a search of the areas inside and out and located R1 outside at 10:04 PM. R1 was right outside the door where she exited. Staff found R1 on her knees, wearing only a nightgown. R1 was outside without supervision for 44 minutes. Staff assessed R1 and noted abrasions to her knees and elbow. The facility's failure to provide adequate supervision to prevent unsafe wandering and failure to respond appropriately to the door alarm placed R1 in immediate jeopardy. The facility identified and implemented corrective actions, which were completed on 07/02/25. The surveyor verified the implemented corrective actions on 07/31/25 at 02:30 PM. Due to the facility’s corrective actions completed prior to the surveyor’s arrival onsite, the deficient practice was deemed past non-compliance at a “J” (immediate jeopardy to resident health or safety) scope and severity.	F0000		
F0689 SS = SQC-J	Free of Accident Hazards/Supervision/Devices	F0689	"Past Noncompliance - no plan of correction required"	

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F0689 SS = SQC-J	Continued from page 1 CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: The facility reported a census of 70 residents. The sample included three residents reviewed for accident hazards. Based on observation, interview, and record review the facility failed to ensure an environment free from accident hazards when staff failed to provide adequate supervision and respond appropriately to a door alarm, allowing Resident (R) 1 to elope from the facility. On 06/14/25 at 09:20 PM, R1, a cognitively impaired resident at risk for wandering, exited the facility without staff knowledge or supervision. The door alarm sounded, and at 09:26 PM, Certified Nurse Aide (CNA) M cancelled the alarm but did not conduct a search or inspection to identify what triggered the alarm. At 10:00 PM, staff performed rounds and discovered R1 was missing. Staff initiated a search of the areas inside and out and located R1 outside at 10:04 PM. R1 was right outside the door where she exited. Staff found R1 on her knees, wearing only a nightgown. R1 was outside without supervision for 44 minutes. Staff assessed R1 and noted abrasions to her knees and elbow. The facility's failure to provide adequate supervision to prevent unsafe wandering and failure to respond appropriately to the door alarm placed R1 in immediate jeopardy. Findings included: - Review of the Electronic Health Record (EHR) documented R1 had diagnoses which included dementia (a progressive mental disorder characterized by failing memory and confusion), diabetes mellitus type two (DM2 – when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), dependence on supplemental oxygen, and legal blindness. R1's 05/30/25 "Significant Change Minimum Data Set" (MDS) documented a Brief Interview for Mental Status (BIMS) score of three, which indicated severely	F0689		

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F0689 SS = SQC-J	Continued from page 2 impaired cognition. The assessment documented other behavioral symptoms not directed towards others occurred daily, and rejection of care occurred one to three days during the look-back period. R1 utilized a walker and/or wheelchair for locomotion. The 05/30/25 “Falls Care Area Assessment” (CAA) documented R1 had dementia with impulsive behavior and lacked safety awareness. R1’s EHR documented “Wander Assessment[s]” performed on 02/24/25, 03/26/25, and 06/14/25 with all indicating R1 as at risk of wandering. R1’s "Care Plan" did not contain interventions related to wandering or elopement prior to 06/14/25. On 06/14/25, after the incident, R1’s “Care Plan” was updated to reflect R1's elopement risk related to disorientation, a history of attempts to leave the facility unattended, and impaired safety awareness. The following “Care Plan” interventions were initiated on 06/15/25: Staff would assess R1 for fall risk. Staff would distract R1 from wandering by offering pleasant diversions, structured activities, food, conversation, television, and books. Staff would identify patterns of R1’s wandering and intervene as appropriate. R1 had a WanderGuard (a bracelet that helps monitor residents who are at risk of wandering) placed on her right ankle (revised 06/16/25). R1's "Progress Note" dated 06/14/25 at 11:38 PM, documented R1 was wandering in and out of rooms and was placed in bed several times. Staff placed R1 at the nurses' station at approximately 09:15 PM. At approximately 10:00 PM, staff realized R1 was not in her room, and staff began a room-to-room search for R1. Staff discovered R1. The note documented R1 appeared to have slipped out of her chair. Staff assessed R1 for injuries and identified abrasions (scraping or rubbing away of skin) on both her knees and her right elbow. Staff placed a WanderGuard. R1’s “Progress Note” dated 06/16/25 at 03:02 PM documented R1 continued to be impulsive and required frequent redirection from staff.	F0689		

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F0689 SS = SQC-J	Continued from page 3 Licensed Nurse (LN) H's "Witness Statement" dated 06/14/25 documented she was at the nurses' station, documenting when a door alarm sounded. LN H documented the alarm did not show up on the screen, and the camera for the hallway was not working. LN H noted she looked up and observed an [unnamed] aide walking down the hall and believed that aide would check the door. LN H noted she was unsure how long the alarm sounded before it was silenced. CNA O's "Witness Statement" dated 06/14/25 documented the nurse stated they could not find R1, and staff had heard a door alarm. CNA O noted staff went to the area where the door had alarmed, opened the door, and found R1 sitting on the ground outside the door; R1's wheelchair was tipped over. CNA N's "Witness Statement" dated 06/14/25 documented R1 was last observed at 09:15 PM; staff discovered she was missing during the rounds at shift-change. CNA N noted staff conducted a brief search where they had heard the door alarm and found R1 outside that door. Certified Medication Aide (CMA) S's "Witness Statement" dated 06/14/25, documented at approximately 10:00 PM on 06/14/25, CMA S was alerted by the nurse R1's location was unknown, and a door alarm was heard. Staff went to where the door alarm sounded, and R1 was banging on the door. CMA S noted the nurse opened the door and staff assisted R1 to her wheelchair; the nurse assessed R1. Administrative Nurse F's "Witness Statement" dated 06/14/25 documented R1 was wandering in and out of rooms all shift. R1 was placed in bed several times but got up and wandered. At approximately 09:00 PM, staff removed R1 from another resident's room and placed her near the nurses' station. Administrative Nurse F then continued with her previous task. At approximately 10:00 PM, an [unnamed] aide notified Administrative Nurse F that R1 was not in her room and a room-to-room search was initiated. Administrative Nurse F documented staff heard a door alarm earlier, and when she and other staff arrived at the door, R1 was on the ground outside the door; R1 was striking the door. CNA M's "Witness Statement" dated 06/14/25 documented between 09:00 and 09:15 PM, she heard the back door alarm sounding. CNA M looked for the residents on her assigned hall with wandering behavior, located them, and turned the alarm off. CNA M's "Witness Statement" did not indicate if the area around or outside the door was searched for residents. Observation on 07/31/25 at 08:00 AM revealed the area	F0689		

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F0689 SS = SQC-J	Continued from page 4 around the facility had a residential street approximately 200 feet away with light residential traffic. There was a hedge line at the southeast corner of the facility, which led to a parking lot. The facility was located approximately one-half mile from a large lake. During an observation on 07/31/25 at 10:59 AM, R1 rested in bed. Further observation revealed a WanderGuard on R1's right ankle. During an observation of the area where R1 eloped on 07/31/25 at 11:45 AM with Administrative Nurse D, the doorway was in an alcove to the side of a junction between two halls and not fully visible from either hallway. From the doorway outside, approximately 30 feet to the south, was a tree row with fencing that bordered a residential property. Approximately four feet to the side of the door was a window where the entire area outside the door was visible from the inside. On 07/31/25 at 11:25 AM, CMA R revealed if a door alarm sounded, staff should respond to the door and perform a visual check of the area in and outside of the door before silencing the door alarm. CMA R stated one staff member should walk the perimeter of the building. CMA R confirmed she has received additional elopement training since the elopement on 06/14/25. On 07/31/25 at 11:50 AM, Administrative Nurse D reported after CNA M cancelled the alarm, CNA M did rounds on the residents on that side of the building who had wandering behaviors and did not find that any were missing. Admin Nurse D confirmed that CNA M did not completely search the area on the other side of the door to ensure that no residents were present. Administrative Nurse D confirmed the window next to the door allowed an observer to fully view the area outside the door. On 07/31/25 at 12:22 PM, CNA Q stated if a door alarm sounded, all staff in the area who were available should respond and search the area to ensure that no residents were outside. CNA Q reported she had received training related to door alarms and elopement since 06/14/25. On 07/31/24 at 12:25 PM, LN G stated that if a door alarm sounded, all staff who were available would respond to the area and would treat the situation as an elopement. LN G said staff were sent in opposite directions along the perimeter of the building while the staff inside would start a head count of the	F0689		

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F0689 SS = SQC-J	Continued from page 5 residents to make sure everyone was accounted for. LN G said after all residents were accounted for, the door alarm would be reset. LN G confirmed she received training related to responding to alarms and elopement since 06/14/25. On 07/31/25 at 01:15 PM, Administrative Nurse F said R1 had been restless, up and down and in and out of bed the whole shift; eventually, staff ended up putting her in her wheelchair at the nursing station in the common area so everyone could keep an eye on her. Administrative Nurse F said she went to administer medications on another hall, and when that task was completed, R1 was not at the nurse's station, and Administrative Nurse F assumed the CNA staff put R1 to bed. Administrative Nurse F said staff then noted R1 was missing during the 10:00 PM shift change, and that is when the door-to-door head count was initiated down the hall that R1 lived on, and then about halfway to the other side of the building. Administrative Nurse F said staff had heard the door alarm, and when CNA staff inspected that door area, they found R1 on the ground outside the door. R1's wheelchair was on its left side. Administrative Nurse F said staff placed a WanderGuard immediately after R1 was assessed for injuries. Administrative Nurse F said the training was initiated and given to second shift personnel who were on shift. On 07/31/25 at 01:28 PM, Administrative Nurse E said she took report from Administrative Nurse F and then initiated education to the staff related to elopement and clearing door alarms and WanderGuard alarms, as well as the appropriateness of clearing the door alarms. On 07/31/25 at 01:30 PM, Administrative Staff A stated all staff had received reeducation that included training on the correct procedures to follow in the event of an elopement or if the door alarms or Wanderguard alarms were triggered. The facility's undated "Wandering and Elopements" policy documented that the facility would identify residents who were at risk of unsafe wandering. If a resident was identified as at risk for wandering, elopement, or safety issues, the care plan would include strategies and interventions to maintain the resident's safety. On 07/31/25 at 03:00 PM, Administrative Staff A received a copy of the "Immediate Jeopardy [IJ] Template" and was informed of the IJ for R1. The facility's corrective measures, fully completed on	F0689		

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F0689 SS = SQC-J	Continued from page 6 07/02/25, included the following, which were verified by the surveyor on-site during the investigation: 1. On 06/14/25 at approximately 10:10 PM, Administrative Nurse F placed a WanderGuard on R1's right ankle. 2. On 06/14/25 at approximately 10:30 PM, Administrative Nurse F completed reeducation for second shift staff who were in the building. 3. On 06/15/25, Administrative Nurse E completed reeducation for third shift staff who were in the building. 4. On 06/15/25, Administrative Nurse D, Administrative Staff A, Maintenance U, and Dietary CC initiated reeducation of their respective departments, completed 07/02/25 at the July 2025 staff meeting. 5. On 06/15/25, Maintenance U increased the volume of door alarms to be audible on adjoining hallways. 6. On 06/17/25, the facility held an ad-hoc Quality Assurance and Performance Improvement (QAPI) meeting. All corrections were completed prior to the onsite survey; therefore, the deficient practice was cited as past noncompliance at a scope and severity of "J."	F0689		