STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046043	A. BUILDING: _____ B. WING _____	C 08/26/2014

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THE HOMESTEAD OF LENEXA	8740 CAENEN LAKE RD LENEXA, KS 66215

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S 000	INITIAL COMMENTS The following citations represent the findings of an abbreviated survey with complaint investigation 77091 conducted at the above named assisted living facility on 8-25-14 and 8-26-14.	S 000		
S3065 SS=J	26-41-200 (a) Resident Criteria (a) The administrator or operator of each assisted living facility or residential health care facility shall ensure the development and implementation of written admission, transfer, and discharge policies that protect the rights of each resident, pursuant to K.A.R. 26-39-102. In addition, the administrator or operator shall ensure that any resident who has one or more of the following conditions is not admitted or retained unless the negotiated service agreement includes services sufficient to meet the needs of the resident: (1) Incontinence, if the resident cannot or will not participate in management of the problem; (2) immobility, if the resident is totally dependent on another person ' s assistance to exit the building; (3) any ongoing condition requiring two or more persons to physically assist the resident; (4) any ongoing, skilled nursing intervention needed 24 hours a day; or (5) any behavioral symptom that exceeds manageability. This REQUIREMENT is not met as evidenced by: KAR 26-41-200(a)(5) The facility reported a census of 39 residents. The sample included 1 resident and 3 closed record review residents. Based on observation,	S3065		

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

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record review and interview for 1 (#1) of 3 closed record review residents, the operator/LPN (licensed practical nurse) failed to ensure that a resident with behavioral symptoms that exceeded manageability was not retained unless the negotiated service agreement (NSA) included services sufficient to meet the needs of the resident when resident #1's NSA failed to address his/her caregiving, wandering and exit seeking behaviors. This failure placed resident #1 in jeopardy for harm and injury. Resident #1 exhibited exit seeking behaviors beginning 1-2-days after admission on 6-17-14. Resident #1 left the facility without staff knowledge (eloped) 7-7-14 and fell down an embankment approximately 15 feet into the creek bed resulting in a head injury requiring staples.

Findings included:

- Record review for resident #1 revealed admission on 6-17-14 with diagnoses Dementia, Hyperlipidemia and Diabetes Mellitus.

The Functional Capacity Screen dated 6-17-14 recorded resident required physical assistance with bathing, dressing, toileting; independent with transfers, walking/mobility and eating; and unable to perform management of medications/treatments. Occasionally incontinent of bladder. Cognition: problems with short term memory, long term memory, memory/recall and decision-making. No current problems/risks identified.

The Negotiated Service Agreement (NSA) dated 6-17-14 provided the following services: physical assistance with bathing twice weekly; physical assistance with dressing; physical assistance with toileting. No assistance with

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transfers, ambulation or mobility and eating. Certified medication aides and licensed practical nurses responsible for all mediation administration and treatments per physician orders.

The NSA lacked revision to address interventions for management of caregiving behaviors, wandering and exit seeking behavior.

Resident record revealed the following related to resident's behaviors:
6-21-14 at 9:28 am: "Staff report that on June 19th during the overnight hours, resident was out in the common area and wandering into other residents apartments wearing only a pull-up. Staff redirected him/her to bed." Signed by administrative nurse A.

6-21-14 at 9:31 am: "Received report from night staff that resident #1 transferred his/her roommate to the toilet independently. Staff report that resident was crawling around on the floor 'working'. Staff report that resident #1 threw water on his/her roommate while the roommate was sleeping. Staff report that resident attempted multiple times to get out the front door. Spoke with family this morning and requested that they start looking for a long term memory care facility." Signed by administrative nurse A.

The record lacked additional documentation of behaviors or interventions to address behaviors until 7-7-14.

7-7-14 at 11:30 pm: "Resident seen this evening talking to others in another resident's room at approximately 8:30 pm. Certified staff on duty discovered resident missing at approximately 9:45 pm. Search of facility began at that time.

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Operator/LPN, administrative nurse A, administrative nurse B, family, police notified. Police phoned facility to inform staff of possible location of resident by paramedics behind facility and staff sent to scene for identification. Positive identification made. Paramedics reported resident found lying in creek with head injury. Ambulance transported resident to hospital emergency room for evaluation and treatment. Operator/LPN phoned facility to report that if resident is released this evening, he/she will stay with family the remainder of this night." Signed by administrative nurse B.

7-8-14 at 2:05 pm: "Resident returned to facility earlier this day escorted by family member. Two staples in place left side of head. Wanderguard in place." Signed by administrative nurse B.

Prehospital Care Report by emergency medical services stated:
7-7-14: "Dispatched to a creek bed next to the noted address for patient complaining of a head injury [at 9:45 p.m.]. Patient was found at the bottom of a creek bed with fire department at care. Patient has a laceration to the left side of his/her head approximately 1 inch long, bleeding had stopped prior to arrival. Patient has no other visible injuries and is moving all extremities. Patient is awake and alert but very confused. He/She gave several names initially and states he/she is in Arizona out looking for boyfriend. He/She also asked responders to call his/her parents several times. Head to toe assessment only finds some mild pain in pelvis but stable. Events prior to incident: Patient is a resident at a nearby facility. At some point today patient wandered away from the facility. Patient appeared to have tumbled down an embankment into the creek bed approximately 15 feet. The

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slope was gradual. There were several large boulders at the bottom and two to three small pools of dried blood in the area where the patient was found. 911 caller states he/she heard something around 6:00 pm but it stopped so he/she didn't go to look. When it started later, he/she found the patient and called 911 immediately."

Observation on 8-25-14 at 10:35 am with operator/LPN of area behind facility revealed a grassy yard with a gradual slope down to an apartment complex. Slightly south of the apartments and facility there was a small creek with minimal water flowing, several large boulders on either side and a stand trees where it ended toward the facility. Approximately a 10 to 15 foot drop downward to the creek bed. The creek ran under the street to the other side. Operator/LPN stated the fire truck and ambulance were parked on the street next to the creek and workers were "in the back between the buildings (facility and apartments) with the resident lying on the ground when he/she arrived.

Confidential Written Statement #1: "Resident was admitted to facility. Assessments were done at that time; however, many significant behaviors were not noted immediately. Within 24-48 hours following admission all significant behaviors were noted/observed: 1) wandering the halls; exit seeking. 2) making rounds on other residents at various hours of the night; 3) other care related aspects of (caregiving to) other residents; 4) going into the kitchen area to prepare meals; 5) moving equipment and possessions from other residents room, etc. On duty staff were aware of these problems and brought them to the attention of the licensed nurses who in turn brought these concerns to the operator/LPN. Suggestions were

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made at that time for one on one care, a 'safer environment' transfer possibly and even an increase in facility staff for safety of resident. No actions were taken other than one facility coming in to assess the resident. Admission to that facility was denied."

Confidential Written Statement #2: "Upon assessment of resident #1, short term and memory/recall deficits noted. Resident answered most questions appropriately. Resident's family and boyfriend present. Family did not disclose that they were blocking all exits at home until the exit seeking started here. Initially my concern was resident #1's providing care to his/her roommate such as transferring roommate to the toilet, changing roommate's brief in the bed, trying to bathe roommate and doing rounds to all rooms in the middle of night wearing only a pull-up. Reported numerous times to Operator/LPN these issues and concerns. He/She told me to call the family and request they look for alternate placement. Moved resident to private room. Staff started to report resident #1 was exit seeking. Reported daily to Operator/LPN. At some point operator/LPN placed wanderguard but didn't notify staff. Resident continued exit seeking and staff continued to report to operator/LPN. No system in place to check (door) alarms prior to this incident. At time of the incident, door alarm #5 not sounding. Since time of incident all alarms are fixed and systems in place to check alarms."

Confidential Written Statement #3: "I had concerns about resident #1 being a resident here because I noticed certain behaviors that made me nervous about him/her being in my facility with other residents and trying to 'go home' or 'go to my car'. He/she was a door tryer. Most of the

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time we redirected him/her...I have told and complained to my higher nursing staff and they took some action by having wanderguard and added door alarms even telling family but it was still not enough."

Confidential Written Statement #4: "I was doing my trash round probably around 7:30 pm or 8:00 pm (on 7-7-14) when I saw resident #1 in another resident's room talking with that resident and a staff member from hospice."

Confidential Written Statement #5: "I saw resident #1 around 7:30 pm in another resident's room talking with that resident and a staff member from hospice. I passed by the room after (giving a shower). I went to the laundry room after. I then went to put a resident to bed. Around 7:50 pm I came back out to the main front room to talk to certified staff F. I had seen resident #1 again around that time. Resident #1 was not near the door around the time I was talking to certified staff F. (A resident and visitor) were sitting watching TV in the front. I went back to (a resident's) room. I got done with him/her and continued to put the people I was assigned to bed. I got done with my people around 9:00 pm. About 9:30 pm I noticed I had not seen resident #1 in a while. I went to ask certified staff G if he/she had seen resident #1 and he/she said no. I went to resident #1's room and he/she wasn't there. About 9:45 pm is when I went and asked certified staff H if he/she had seen resident #1. Certified staff H said no. After that, certified staff H took care of everything else."

Interview on 8-25-14 with certified staff C stated staff could not hear the door alarms when in the kitchen or laundry room prior to resident's elopement. (Note: screecher alarms place on all

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outside doors which can be heard all over the building after incident.)

Interview on 8-25-14 with certified staff D stated resident was "confused...a hard resident for us. Wanting to go places...always trying to leave, stayed up all night." Confirmed resident was always exit seeking, the front door mainly and "besides the front door, also the door to back hallway" next to kitchen and outside door. "We had to catch him/her all the time." Confirmed he/she notified the operator/LPN.

Interview on 8-25-14 with certified staff E stated he/she did not know if resident #1 had a wanderguard on or not, had not been inserviced about it. Further stated, "we were not checking the doors everyday. Now, of course, we do it constantly."

Interview on 8-25-14 at 2:10 pm with operator/LPN stated the he/she heard "resident was exit seeking from staff 1-2 days after he/she moved in. Confirmed he/she conducted the functional capacity screen and initial interview with resident and family.

Interview on 8-25-14 at 3:45 pm with administrative nurse B stated he/she was not a participant during the initial functional capacity screening conducted with the resident and family member, but confirmed he/she did co-sign it with the operator/LPN.

Interview on 8-25-14 at 3:50 pm with operator/LPN confirmed he/she did not increase staff to provide one-on-one monitoring of resident until placement could be found. Stated, "I'm not sure there was somebody with him/her, "a friend did come in and sit with her...but I think that was

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after the incident." Confirmed he/she lacked documentation that doors were monitored prior to elopement. Confirmed he/she was unable to remember how often the staff spoke with him/her about resident #1's behaviors and exactly when he/she placed the wander guard on the resident. Stated, "that was so long ago, I can't tell you."

The facility failed to provide documentation of date/time wanderguard was initially placed and documentation of inservicing of staff on use of the wanderguard prior to resident's elopement on 7-7-14.

Interview on 8-25-14 at 3:50 p.m. with operator/LPN stated that after the elopement, door alarms were checked and serviced by an outside provider, system was put in place to monitor doors/alarms, screecher alarms were added to doors, staff was inserviced on elopement/behaviors and resident received one-on-one monitoring by facility staff and outside agency until discharged on 7-9-14.

Resident #1 exhibited exit seeking behaviors beginning 1-2-days after admission on 6-17-14 and staff reported the behaviors were ongoing. Resident #1, who was wearing a wanderguard, left the facility without staff knowledge sometime after 8:30 p.m. on 7-7-14 [timeanddate.com report susset at 8:48 p.m. with civil twilight requiring artificial illumination to carry on ordinary outdoor activities at 9:20 p.m.]. A community member heard something, looked for the source of the sound and called 911 at 9:45 p.m. to report Resident #1in a creek bed at the bottom of a 15 foot embankment where he/she was found by paramedics. Paramedics reported there were several large boulders at the bottom of the embankment and 2 or 3 small pools of dried

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S3065	Continued From page 9 blood in the area where Resident #1 was found. The temperature at the time of the elopement as recorded by wunderground.com was approximately 83 degrees with a heat index of 91. Resident #1 was transported to the hospital and received staples for a head laceration. For Resident #1, the operator/LPN failed to ensure that a resident with behavioral symptoms that exceeded manageability was not retained unless the negotiated service agreement (NSA) included services sufficient to meet the needs of the resident when resident #1's NSA failed to address his/her caregiving, wandering and exit seeking behaviors. This failure placed Resident #1 in immediate jeopardy. The jeopardy was removed on 7-8-14 when the resident received one-on-one monitoring until discharged on 7-9-14.	S3065		
S3081 SS=D	26-41-201 (c) Functional Capacity Screen Reassessment (c) Designated facility staff shall conduct a screening to determine each resident ' s functional capacity according to the following requirements: (1) At least once every 365 days; (2) following any significant change in condition as defined in K.A.R. 26-39-100; and (3) at least quarterly if the resident receives assistance with eating from a paid nutrition assistant. This REQUIREMENT is not met as evidenced by: KAR 26-41-201(c)(2)	S3081		

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The facility reported a census of 39 residents. The sample included 1 sample resident and 3 closed record review residents. Based on record review and interview for 1 (#1) of 3 closed record review residents, the operator/LPN (licensed practical nurse) failed to ensure the functional capacity screening was conducted following a significant change in condition as defined in K.A.R. 26-39-100.

Findings included:

- Record review for resident #1 revealed admission on 6-17-14 with diagnoses Dementia, Hyperlipidemia and Diabetes Mellitus.

The Functional Capacity Screen dated 6-17-14 recorded resident required physical assistance with bathing, dressing, toileting; independent with transfers, walking/mobility and eating; and unable to perform management of medications/treatments. Occasionally incontinent of bladder. Cognition: problems with short term memory, long term memory, memory/recall and decision-making. No current problems/risks identified. The FCS lacked documentation of revision following a significant change.

The Negotiated Service Agreement (NSA) dated 6-17-14 provided the following services: physical assistance with bathing twice weekly; physical assistance with dressing; physical assistance with toileting. No assistance with transfers, ambulation or mobility and eating. Certified medication aides and licensed practical nurses responsible for all mediation administration and treatments per physician orders.

Resident record revealed the following related to

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resident's behaviors:
6-21-14 at 9:28 am: "Staff report that on June 19th during the overnight hours, resident was out in the common area and wandering into other residents apartments wearing only a pull-up. Staff redirected him/her to bed." Signed by administrative nurse A.

6-21-14 at 9:31 am: "Received report from night staff that resident #1 transferred his/her roommate to the toilet independently. Staff report that resident was crawling around on the floor 'working'. Staff report that resident #1 threw water on his/her roommate while the roommate was sleeping. Staff report that resident attempted multiple times to get out the front door. Spoke with family this morning and requested that they start looking for a long term memory care facility." Signed by administrative nurse A.

The record lacked documentation of additional behaviors or interventions until 7-7-14 when the record recorded the resident eloped from the facility.

Confidential Written Statement #1: "Resident was admitted to facility. Assessments were done at that time; however, many significant behaviors were not noted immediately. Within 24-48 hours following admission all significant behaviors were noted/observed: 1) wandering the halls; exit seeking. 2) making rounds on other residents at various hours of the night; 3) other care related aspects of (caregiving to)other residents; 4) going into the kitchen area to prepare meals; 5) moving equipment and possessions from other residents room, etc. On duty staff were aware of these problems and brought them to the attention of the licensed nurses who in turn brought these concerns to the operator/LPN. Suggestions were

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made at that time for one on one care, a 'safer environment' transfer possibly and even an increase in facility staff for safety of resident. No actions were taken other than one facility coming in to assess the resident. Admission to that facility was denied."

Confidential Written Statement #2: "Upon assessment of resident #1, short term and memory/recall deficits noted. Resident answered most questions appropriately. Resident's family and boyfriend present. Family did not disclose that they were blocking all exits at home until the exit seeking started here. Initially my concern was resident #1's providing care to his/her roommate such as transferring roommate to the toilet, changing roommate's brief in the bed, trying to bathe roommate and doing rounds to all rooms in the middle of night wearing only a pull-up. Reported numerous times to administrator these issues and concerns. He/She told me to call the family and request they look for alternate placement. Moved resident to private room. Staff started to report resident #1 was exit seeking. Reported daily to administrator. At some point administrator placed wanderguard but didn't notify staff. Resident continued exit seeking and staff continued to report to administrator. "

Confidential Written Statement #3: "I had concerns about resident #1 being a resident here because I noticed certain behaviors that made me nervous about him/her being in my facility with other residents and trying to 'go home' or 'go to my car'. He/she was a door tryer. Most of the time we redirected him/her...I have told and complained to my higher nursing staff and they took some action by having wanderguard and added door alarms even telling family but it was still not enough."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046043	A. BUILDING: _____ B. WING _____	C 08/26/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HOMESTEAD OF LENEXA	8740 CAENEN LAKE RD LENEXA, KS 66215

(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
S3081	Continued From page 13 Interview on 8-25-14 at 2:10 pm with operator/LPN stated the he/she heard "resident was exit seeking from staff 1-2 days after he/she moved in. Confirmed he/she conducted the functional capacity screen and initial interview with resident and family. Further confirmed a screening was not conducted after discovering resident was having behaviors which included wandering, exit seeking, and caregiving. Interview on 8-25-14 at 3:45 pm with administrative nurse B stated he/she was not a participant during the initial functional capacity screening conducted with the resident and family member, but confirmed he/she did co-sign it with the operator/LPN. For resident #1, the operator/LPN failed to ensure the functional capacity screening was conducted following a significant change in condition as defined in K.A.R. 26-39-100.	S3081		