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	N087037	A. BUILDING: _____ B. WING _____	03/19/2024

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S 000	INITIAL COMMENTS The following citation represents the findings of an Abbreviated Survey with complaint investigation 186005 for the above named Assisted Living Faciity conducted on 03/18/2024 and 03/19/2024.	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 29 residents. The sample included one closed record review. Based on observation, interview, and record review the executive director failed to ensure a window stop device was in place on cognitively impaired Resident (R)3's window to prevent her from being able to open it enough to crawl out. This failure put R3 in immediate jeopardy when R3 crawled out of the window on 02/21/24 with her suitcase and other personal belongings, then walked for at least three miles unsupervised, through heavily trafficked streets, with speed limits of up to 40 miles per hour. Depending on	S3026		

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

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the route R3 took she would have had to cross multiple busy inner-city streets with four to six lanes. R3 was unaccounted for by the facility for approximately 4.5 hours.

Findings included:

- Review of R3's medical record revealed she moved into the facility on 08/09/22 with diagnoses of dementia with behavioral disturbance, major depressive disorder (major mood disorder), and generalized anxiety.

Review of R3's "Functional Capacity Screens" (FCS) revealed the following:

On 09/07/22 R3 was independent with Activities of Daily Living (ADLs), had a cognition score of 3, indicating cognitive impairment and she had impaired decision-making ability.

On 03/07/23 R3 was independent with Activities of Daily Living (ADLs), had a cognition score of 3, indicating cognitive impairment and she had impaired decision-making ability.

On 09/12/23 R3 remained independent with all ADLs, but now had a cognition score of a 1, with only her short-term memory identified as a problem, and the assessment no longer noted the resident had a problem with impaired decision-making ability.

R3's "Negotiated Service Agreement" (NSA) dated 09/12/23 revealed she was not always oriented to place or time, which could impact her decision-making ability. It directed staff to were use validation techniques to redirect R3 as she

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was oriented to self only and had a "Brief Interview for Mental Status" score of 7, indicating severe cognitive impairment. She had decision making and recall impairment and paranoia involving her family. The NSA lacked services related to the resident making comments that she needed to go take care of her husband, was going to Kansas City, or that she kept a bag packed in her room.

Review of the "TELS" maintenance task system provided by Administrative Staff A on 03/19/24 at 11:53 AM showed a monthly task for inspecting the resident room window stops. The system did not indicate if the tasks were completed or not. Administrative Staff A stated the system only kept track of tasks if it was a required regulatory task.

Review of "Medical Provider's Note" dated 01/24/24 recorded R3 had poor insight, was oriented to person with memory problems such as forgetting conversations and repeating questions/statements and R3 misplaced items more than usual.

Review of facility "Progress Notes" revealed the following:

09/07/22 - The facility discussed family concerns noting the resident became anxious and delusional during their visits. Adjustments were made to the dosage of R3's Seroquel (antipsychotic medication).

09/19/22 - The resident's family called with concerns of the resident getting upset during phone calls and stating the facility allowed her to leave. The Licensed Nurse (LN) explained to

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R3's family the resident could not leave until her agitation, anxiety. and verbal aggression was under control to make sure her medications were adjusted correctly.

01/27/23 - The resident entered the nurse's office upset and stating she needed to leave because her husband had cancer. The LN able to calm the resident and administered her as needed (PRN) Ativan (antianxiety).

03/24/23 - The resident's Seroquel was decreased due to stable behaviors.

09/13/23 - The resident's Seroquel was decreased as behaviors recently improved.

12/27/23 - The resident's medical provider was in the facility and increased R3's Seroquel to 25 mg (milligrams) at bedtime. The record lacked documentation of symptoms requiring the medication increase.

02/21/24 - At approximately 11:50 AM the Certified Medication Aide (CMA) called the resident to come to lunch and she did not respond. Staff went to check on R3 and she was not in her room. The CMA informed other staff members they could not find R3, so they looked within the community and immediately outside and the resident was not found. R3 was last seen between 10:30 AM and 11:00 AM in her room by the CMA. The Executive Director was notified, a search was conducted, police were notified, and a "Silver Alert" was issued. While looking for the resident staff noted R3 had pried off the lock on her window and the screen was found on the ground outside her window. At 03:49 PM,

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approximately four hours later, facility staff observed the resident carrying loose clothing and walking by a very busy intersection approximately 2.4 miles from the facility. When the resident returned to the facility she was crying and stated she was thirsty. R3 stated she was going home to see her husband because someone told her he was sick. Initially arriving back at the facility her blood pressure was 135/74 millimeters of mercury, and her pulse was 125 beats per minute (over 100 is considered high) with respirations of 16 and a body temperature 98.5 degrees Fahrenheit . After drinking some water, the Licensed Nurse rechecked R3's pulse and it had gone down to 105 beats per minute (still higher than normal range). The resident then went to the emergency room for evaluation with family for potential admission to a behavior health unit and the resident returned to the facility with a new order for an antibiotic and diagnosis of urinary tract infection. From that point on the facility provided one-on-one supervision until the resident moved to another facility for residents who had dementia.

Review of Activity Staff H's notarized statement dated 03/18/24 revealed she left with Administrative Staff G to go pick up R3 after she left the facility unsupervised. Activity Staff H got out of the van, asked R3 what she was doing, and R3 said she was going home to see her husband because her daughter told her he was dying. Activity Staff H told R3 they were going to take her home and she turned and looked at the van and said, "I guess that means you're taking me back". Activity Staff H said they were going to take her to get some water and R3 got into the

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van and started to sniffle and cry on the way back to the facility.

Review of Administrative Staff G's notarized statement dated 03/18/24 revealed she and Activity Staff H took the facility vehicle to go get the resident after she was found unsupervised and outside of the facility. Administrative Staff G reported when they arrived to get the resident, she was pale and "really hot". R3 carried some sort of bedding and clothes and got in the van without difficulty. R3 said she was trying to go see her husband and then cried on the way back to the building.

Review of Maintenance Staff L's notarized statement dated 03/19/24 revealed, upon investigation, R3's room window lacked the upper bar in the rail to restrict the opening to four inches. Maintenance Staff L reported he checked four or five rooms per week for a monthly check of the window stops and must have just missed catching that R3's window did not have a window stop bar.

Review of Administrative Staff A's notarized statement dated 03/19/24 revealed on the day R3 eloped out of the window of her apartment he was informed the window stop (which should be a 1-inch by 1/2-inch wood block) was missing from the window. Administrative staff A looked at the window and did not find the wood block that was supposed to be in place and had maintenance staff then put in a wooden stop to prevent the window opening into the room.

Observation on 03/18/24 at 03:05 PM the surrounding area of the facility revealed multiple

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directions the resident could have traveled, each with their own hazards present. Directly behind the facility and just east of the resident's room was a public golf course with hilly terrain, sand traps, and water hazards. The street directly south of the resident's room was a busy, highly traveled four-lane road with a 40 mile per hour (MPH) speed limit. If she had crossed the street when she left the facility she would have gone through residential areas, business areas, and would have had to cross many roads with both four-lane and two lanes to get to the busy intersection where she was found. If she took the most direct route, west of the facility and stayed on the sidewalks, she would have had to cross six lanes of very heavy inner-city traffic. Based on interview with CMA D who initially saw the resident, she stated the resident walked an additional eight blocks in the grass because there was not a sidewalk on the north side of the street, which is also a busy, highly traveled street with a 40 MPH speed limit.

According to Wunderground.com, the weather when she crawled out of the window was 50 degrees (F) Fahrenheit and by the time she was found it was up to 71 degrees F.

Observation/interview on 03/18/24 at 02:46 PM with R3 at the locked facility revealed she appeared disheveled, hair uncombed, and not fully dressed for the day. She reported she had no idea how long she had lived at the new home, did not remember going for a long walk a few weeks ago, and she did not know she was in Kansas. She thought she was from Oklahoma and could not tell the surveyor where she lived before her current location.

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S3026	Continued From page 7 On 03/18/24 at 09:58 AM Certified Nurse Aide (CNA) F reported the resident had early signs of dementia and staff had to constantly remind her to come to meals or activities and she would often go back to her room. R3 would also think that a family member was coming to get her and then staff would call that person to clarify if they were coming or not. On 03/18/24 at 10:19 AM Certified Medication Aide (CMA) D reported R3 was independent with cares and walked throughout the facility without an assistive device. R3 talked about going home every now and again. CMA D worked the day R3 crawled out the window and stated she was cleaning and restocking bathrooms. At around 10:30 AM on 02/21/24 CMA D observed R3 laying in her bed. CMA D called R3's room to have her come to lunch around 11:50 AM and R3 did not answer so CMA D went to check on her, but R3 was not in her room. CMA D said facility staff then searched the inside of the facility and could not find her and when they searched the outside, they found the window screen on the ground and noted the window was shut. CMA D stated they did not do any kind of safety checks for her during the day other than calling her for meals and activities and if she did not respond they went to check on her. Interview on 03/18/24 at 02:05 PM with CMA I reported she joined the search for R3 around 03:45 or 04:00 PM. While she was getting gas at a gas station, she looked up and saw R3 who had just finished crossing a busy intersection. Administrative Staff A told CMA I to follow the resident and additional staff would come and	S3026		

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help get her back to the facility. CMA I proceeded to follow the resident about 500 feet behind her. As CMA I got closer, the resident would occasionally stop, look around as if confused and then continue walking. Activity staff H and Administrative Staff G pulled up to the resident and she got right in the car with them, and they took her back to the facility.

Interview on 03/18/24 at 02:24 PM with CMA E reported the resident was very energetic and would talk about going to Kansas City and wanting to go see her husband. CMA E reported R3 kept a bag packed in her room and would often hide things.

Interview on 03/19/24 at 10:23 AM Administrative Staff A reported all windows in the facility had a piece of board in the track to prevent the window from opening more than five inches and R3's window did not have one.

The facility's executive director failed to ensure a window stop device was in place on cognitively impaired R3's window to prevent her from being able to open it enough to crawl out and leave the facility without staff knowledge. R3 kept a bag packed by her door from the time she moved into the facility, frequently asked if she was going home tonight, tell staff she needed to go home and take care of her sick husband, or say that she was going to Kansas City. On 02/21/24 R3 crawled out of her bedroom window and walked unsupervised for at least three miles through heavily trafficked streets with speed limits of up to 40 miles per hour and remained unaccounted for by the facility for approximately 4.5 hours.

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S3026	Continued From page 9 The Immediate Jeopardy was removed on 02/21/24 at 04:10 PM when the resident returned to the facility and was placed under one-on-one supervision with family and/or facility staff. R3 remained under one-on-one supervision until she moved to a secured sister facility for dementia. The following actions were documented in the "Abatement Plan" and accepted by the department on 03/19/24 at 03:58 PM. 1. All community windows were inspected by the Administrative Staff A and Maintenance Staff L to verify all community windows are unable to be opened more than five inches. 2. R3 was placed on one-on-one supervision upon her return to the community from the emergency room, on 02/21/24 until she was placed in a memory care facility on 02/23/24. 3. Administrative Staff retrained all staff regarding the Elopement policy, Community Security Procedures, which included window security and resident transport safety on 02/22/24. 4. Safety Committee will monitor for completion of checking all window safety features monthly for six months.	S3026		