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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakepoint Augusta, LLC	901 Lakepoint Drive Augusta, KS 67010

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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 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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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 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. 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