STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175500	A. BUILDING _____ B. WING _____	C 04/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILL TOP HOUSE	505 W ELM, PO BOX 248 BUCKLIN, KS 67834

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F 000	INITIAL COMMENTS A complaint survey was conducted by the Kansas Department for Aging and Disability Services (KDADS), on behalf of the Centers for Medicare and Medicaid Services (CMS) on 04/21/22. On 04/21/22 at 01:40 PM Administrative Staff A, Administrative Nurse B, and Administrative Nurse C were provided a copy of the immediate jeopardy (IJ) Template and notified that the failure to provide adequate supervision for Resident (R) 1 led to R1's elopement and constituted immediate jeopardy at F689. The immediate jeopardy also constituted substandard quality of care at 42 CFR 483.25. On 04/15/22 at approximately 08:30 PM, R1 exited the facility by removing an unoccupied bedroom screen and opening the window, allowing him to step out onto the ground. R1 exited the facility without staff knowledge or supervision and was observed at a local convenience store [roughly a six minute walk from the facility] about 30 minutes later by facility staff. This deficient practice placed R1 in Immediate Jeopardy. The facility corrected the deficient practice on 04/20/22, which deemed the deficient practice as past non-compliance.	F 000		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices 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	F 689		

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

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.

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F 689	Continued From page 1 supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: The facility census totaled 21 residents, with three residents reviewed for elopement risk. Based on observation, interview, and record review the facility failed to provide adequate supervision for Resident (R) 1, with a history of exit seeking behaviors (including removing a window screen in October of 2021) and who exited the facility through a window on 04/15/22 at approximately 08:25PM. The facility staff did not know of this until two off duty facility staff members called the facility and reported the resident was at the local convenience store (located six minutes north of the facility and within 500 feet of a major US Highway) and the resident was found scared and tearful. This failure placed R1 in immediate jeopardy. Findings included: - R1's diagnoses from the 09/14/21 "Physician's Orders" in the "Electronic Medical Record (EMR)" revealed dementia (progressive mental disorder characterized by failing memory, confusion) without behaviors. The 09/21/21 "Admission Minimum Data Set" (MDS) revealed a brief interview for mental status (BIMS) of four, indicating severe cognitive impairment. Wandering occurred one to three days of the seven-day look back period. The resident was independent with ambulation. The 09/21/21 "Cognitive and Behavioral Care Area Assessment" (CAA) documented that R1 had a diagnosis of dementia with a BIMS	F 689	Past noncompliance: no plan of correction required.	

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F 689	Continued From page 2	F 689		

indicating severe cognitive impairment. R1 exhibited wandering behavior at night.

The 03/23/22 "Modification of Quarterly MDS" revealed a BIMS of five, indicating severe cognitive impairment. There were no other changes from the previous MDS.

The 04/06/22 "Care Plan" documented R1 ambulated independently. Staff should distract R1 from wandering by offering pleasant diversions, structured activities, food, conversation, and television. On 04/15/22, staff updated R1's care plan to include 15-minute safety checks and to have a Wanderguard (bracelet that sets off an alarm when residents wearing one attempt to exit the building without an escort) placed on the left ankle.

The "Physician Orders" documented the following orders:
On 03/23/22, check the placement of the Wanderguard and ensure the red-light blinks. The provider discontinued (stopped) the order the same day.
On 04/16/22, Ensure the Wanderguard worked by checking for a blinking red light, twice daily.

"Behavior Notes" written by staff throughout 10/08/21 documented R1 becoming increasingly confused and irritated with staff, telling staff he was leaving by "breaking windows" and actively exit seeking by attempting to open facility doors and setting off door alarms, as well as removing the screen from his room window. Staff placed a Wanderguard which caused R1 to become more agitated and verbally aggressive with staff. R1 went to the kitchen asking for a knife to remove the Wanderguard. Administrative Staff A and

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F 689	Continued From page 3	F 689		

Administrative Nurse B removed the Wanderguard due to threatening behavior and staff initiated 15-minute checks.

The 10/12/21 "Wandering Risk Scale" assessment documented R1 was a high risk for elopement, due to removing a window screen in a room and exit seeking.

The 12/21/21 "Wandering Risk Scale" assessment documented R1 was a high risk for elopement, due to continued wandering of the facility in the evening and discussing his desire to leave the facility by "climbing out the window." The assessment documented that R1 wore a Wanderguard on his ankle.

The 03/23/21 "Wandering Risk Scale" assessment documented R1 was a high risk for elopement, due to his attempts to leave the facility by pushing on the front door and setting off the alarm, as well as his continued discussion about wanting to leave the facility. The assessment documented that R1 wore a Wanderguard on his ankle.

"Behaviors Notes" written by staff between 04/05/22 and 04/12/22 documented R1 attempted to exit the building through doors and attempted to remove the screen from a bedroom. R1 shook the doors and set off the alarms. R1 was also found in the soiled utility room on one occasion and demanded staff get out when staff attempted to redirect him out of the room.

On 04/21/22 at 12:00PM, the surveyor and Administrative Nurse C walked the route most likely taken by R1 on 04/15/22 for the elopement. Behind the facility was a dirt field and gravel

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F 689	Continued From page 4	F 689		

roads surrounded the other three sides of the facility. There was no traffic present throughout the walk through. The convenience store was located at the end of the main gravel road, a six-minute walk from the facility.

On 04/21/22 at 12:23PM, an observation of R1 revealed a Wanderguard on the left ankle. R1 was pleasant and talked with staff in the hallway as he walked toward the dining room for lunch. R1 wore shoes and clothing was appropriate for the weather.

Interview on 04/21/22 at 09:00AM with Administrative Staff A revealed Administrative Nurse B reviewed the surveillance camera to see what happened. R1 was seen going into a vacant resident room and did not come out. They discovered that R1 opened the window in the room and went out through it. R1 was found at the local convenience store and was brought back to the facility by staff. R1 was afraid that he would be in trouble with the facility staff. Prior to the elopement, R1 refused to wear a Wanderguard, but upon returning to the facility, R1 agreed to the Wanderguard for safety. Administrative Staff A stated that the window screens were screwed in and the window knobs were removed from each window to help prevent R1 and other residents from exiting the facility via the window.

Interview on 04/21/22 at 09:31AM with Administrative Nurse C revealed that when R1 admitted to the facility as an elopement risk and staff placed a Wanderguard on R1. R1 had a "meltdown" and tried to cut the device off with a knife. Staff removed the Wanderguard the same day and staff initiated 15-minute safety checks for

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F 689	Continued From page 5	F 689		

four or five days. After the elopement on 04/15/22, R1 agreed to wear a Wanderguard on his ankle for safety. Administrative Nurse C stated that R1 was found at the local convenience store by Certified Nurse Aide (CNA) G and Dietary Aide H. Administrative Nurse B went to the convenience store and drive R1 back to the facility. Staff placed on R1 on 15-minute safety checks upon arrival and he remained on them since his return. The night of 04/15/22, the weather was breezy with temperatures in the 60s and no severe storms.

Interview on 04/21/22 at 02:47PM with CNA E, revealed staff checked R1's Wanderguard daily for placement and ensured it worked properly. R1 has not tried to remove the Wanderguard since having it placed on 04/15/22. CNA E stated that R1 tried to elope at least once per shift when she worked, but was only successful once on 04/15/22.

Interview on 04/21/22 at 04:18PM with Licensed Nurse (LN) D, revealed R1 was on 15-minute safety checks since his elopement, but she tried to keep R1 with her for one-to-one visual monitoring while she worked. R1 had a history of sun downing (condition where a person tends to become confused or disoriented toward the end of the day). She offered R1 a Pepsi or beer in the evening and it would occasionally calm him down. LN D stated that R1 had a Wanderguard upon admission, but it caused him to have behaviors and staff removed the device. After the elopement, staff placed a Wanderguard for safety. LN D stated that R1 would exit seek frequently, but staff easily redirected him by talking about his family.

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F 689	Continued From page 6	F 689		

Interview on 04/25/22 at 09:29AM with Dietary Aide H, revealed she was unaware that R1 left the facility until she walked into the convenience store and found R1 inside the store on 04/15/22 around 09:00PM. It was dark outside, and the traffic was slow and mostly empty of cars on the roads. Dietary Aide H stated that R1 said he walked out of the facility and could not get back in, so he walked to the convenience store. R1 did not have any injuries and did not appear to be scared. Dietary Aide H stated that CNA G notified the facility that R1 was at the convenience store and that Administrative Nurse B arrived shortly to drive R1 back to the facility.

Interview on 04/25/22 at 10:25AM with CNA F, revealed she was working at the facility the evening of 04/15/22. When R1 returned to the facility, staff checked his vital signs and assessed for injuries. R1's vital signs were normal, and he did not have any injuries. CNA F stated she did not know if R1 had a Wanderguard in place at the time of the elopement. When R1 returned to the facility, staff placed a Wanderguard to his ankle and staff checked the device daily.

Interview on 04/25/22 at 10:32AM with Administrative Nurse B, revealed she received a call from LN I stating R1 was at the local convenience store. Administrative Nurse B told LN I to notify Administrative Staff A [who immediately went to the facility]. Administrative Nurse B got to the convenience store one-minute later and found Dietary Aide H and CNA G waiting with R1. R1 told Administrative Nurse B that he had been looking for her and that he wanted to go home. Once in Administrative Nurse B's truck, R1 cried and asked her not to tell anyone about what happened. Administrative Nurse B discussed

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F 689	Continued From page 7	F 689		

safety with R1 on the drive back to the facility. R1 said he wanted to go for a walk outside and got locked out. Administrative Nurse B stated that when staff placed a Wanderguard on R1 in the past, he became upset and it was ultimately removed with family approval. Upon R1's return to the facility, staff discussed the Wanderguard with R1 and he agreed to have one placed on his ankle. Staff assessed the resident for injuries and checked his vital signs. Administrative Staff A reviewed surveillance footage to determine how R1 eloped without the door alarms being triggered. R1 was seen wandering around the facility talking to both staff and residents and ended up in a vacant room and did not come back out. Administrative Nurse B and Administrative Staff A determined R1 exited the facility through a window and asked staff working to check all windows in the facility for evidence. The window screen was found outside the window in the grass and the window open. Staff initiated on 15-minute safety checks and placed all other residents at risk for elopement on hourly checks.

The 03/2020 "Elopement Risk Policy" documented that staff were always to monitor resident's whereabouts including monitoring of responses/reactions to events/activity in surroundings at time of aimless wandering and report behaviors to supervisor immediately.

The failure to provide R1 with adequate supervision, allowed R1 to leave the facility through a window and walk approximately six minutes to the local convenience store. This placed R1 in immediate jeopardy.

On 04/20/22 the facility completed the following

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F 689	Continued From page 8	F 689		

corrections:

1. The facility immediately initiated 15-minute safety checks for R1 and hourly rounding on all elopement risk residents.
2. All residents at risk for elopement were reevaluated and assessments were updated.
3. A wander guard was placed on R1's left ankle.
4. All window screens were screwed in place and the window cranks were removed from all windows.
5. The facility identified the need for staff education on the elopement policy, drills and plan of action and completed an in-service on 04/20/22 with all facility staff. All staff members not in attendance must complete education with either Administrative Nurse B or Administrative Nurse C prior to working the floor of their next shift.
6. Elopement drills were completed and are on going with staff.
7. A Performance Improvement Plan (PIP) committee was created for elopement prevention and response.

This deficient practice was cited as past non-compliance.