STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175242	A. BUILDING _____ B. WING _____	C 03/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW VILLAGE	13840 W 91ST TERRACE LENEXA, KS 66215

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F 000	INITIAL COMMENTS The following citations represent the findings of a complaint investigations #KS00170507 and KS00167034. On 03/29/22 at 02:00 PM the facility was provided a copy of the "Immediate Jeopardy (IJ) Template" and notified of the IJ for Resident (R) 1. The facility failed to provide adequate supervision to prevent elopement for Resident (R) 1, who was independently mobile and cognitively impaired. R1 was at high risk for elopement, wore a Wanderguard and had a recent history of agitation, exit seeking and behaviors. On 03/26/22 at approximately 06:18 PM R1 exited the unit through an unattended door left slightly ajar from a visitor. R1's Wanderguard triggered the safety alarm as she exited. Staff responded to the alarm, but canceled the alarm without assessing the presence of all residents at risk and without reviewing the display which notified staff which Wanderguard triggered the alarm. As a result, R1 exited the facility without staff knowledge or supervision and was observed outside 10 minutes later by facility staff. This deficient practice placed R1 in Immediate Jeopardy. The facility corrected the deficient practice on 03/28/22 so the deficient practice was cited as past non-compliance. The 2567 was sent electronically on 03/31/22.	F 000		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)	F 689		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 03/31/2022

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 §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 identified a census of 93 residents. The sample included three residents reviewed for elopement (when cognitively impaired resident with little or poor safety awareness exits the facility without staff knowledge). Based on observation, record review, and interview, the facility failed to provide adequate supervision to prevent elopement for Resident (R) 1, who was independently mobile and cognitively impaired. R1 was at high risk for elopement, wore a Wanderguard (bracelet that sets off an alarm when residents wearing one attempt to exit the building), and had a recent history of agitation, exit seeking, and behaviors. On 03/26/22 at approximately 06:18 PM R1 exited the unit through an unattended door left slightly ajar from a visitor. R1's Wanderguard triggered the safety alarm as she exited. Staff responded to the alarm but canceled the alarm without assessing the presence of all residents at risk and without reviewing the display which notified staff which Wanderguard triggered the alarm. As a result, R1 exited the facility without staff knowledge or supervision and facility staff observed the resident outside 10 minutes later. This deficient practice placed R1 in Immediate Jeopardy. Findings included:	F 689	Past noncompliance: no plan of correction required.	

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F 689	Continued From page 2	F 689		

- R1's Electronic Medical Record (EMR) recorded diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), dementia (progressive mental disorder characterized by failing memory, confusion), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), and major depression disorder (major mood disorder).

The "Admission Minimum Data Set" (MDS) dated 01/20/22 documented a Brief Interview for Mental Status (BIMS) score of eight, which indicated moderately impaired cognition. R1 required supervision with set up help only for locomotion on and off the unit, and in the corridor. She walked independently in her room. The MDS recorded R1 wandered four to six days, but less than daily during the look back period.

The "ADL Functional Care Area Assessment" (CAA) dated 01/20/22 documented R1 had impaired cognitive abilities with short term memory and poor safety awareness.

The "Behavioral Symptoms CAA" dated 01/20/22 documented R1 refused care, wandered, and had both verbal and physical behaviors directed toward staff.

The "Falls/Safety Care Plan" initiated 01/27/22 documented R1 had problems with remaining safe in her environment related to dementia, depression, anxiety, and exit seeking. It directed staff to redirect R1 when she was exit seeking or take R1 for a walk. The plan of care further documented R1 wore a Wanderguard.

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The "Elopement Assessment" dated 01/13/22 documented R1 had a score of 18, which indicated at risk for elopement.

The "Progress Note" dated 03/14/22 at 12:02 PM documented R1 continued to go to the doors and tried to exit out the doors. Staff redirected R1 and R1 was resistive to redirection. R1 asked to leave to go home and take care of her husband and staff told R1 she would not be able to leave, but her husband would come visit.

The "Progress Note" dated 03/14/22 at 04:59 PM documented R1's Wanderguard was not on her person. A new Wanderguard was placed on R1's left wrist.

The "Progress Note" dated 03/19/22 at 09:47 AM documented R1 lacked her Wanderguard that morning, and staff were unable to find the Wanderguard in R1's room. Staff applied a new Wanderguard to R1's right ankle.

The "Progress Note" dated 03/19/22 at 09:48 AM documented R1 had her coat on and stated, "I am leaving to go see my husband who is sick." Staff attempted to redirect R1 but were unsuccessful.

The "Progress Note" dated 03/21/22 at 11:51 AM documented R1 attempted to "get out" all morning. Staff told R1 many times that R1's husband would be there to visit R1 at 01:00 PM. R1 responded to the redirection for a short time but continued her attempts to leave. Staff convinced R1 to go to the dining room for lunch.

The "Progress Notes" dated 03/26/22 at 09:37 PM documented an unidentified staff member

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called over to the unit at 06:45 PM on Saturday 3/26/22. The unidentified nurse reported R1 went out of the door of the care center and was seen outside of the building, trying to get back in at the main doors. Staff notified Administrative Nurse D immediately and an investigation was started into what happened that allowed the resident to get out the doors.

The "Progress Note" dated 03/26/22 at 09:50 PM LN G documented at 06:33 R1 entered the unit with CNA M. The CNA stated R1 was seen in front of the main door entrance to the facility and was trying to get in. CNA M happened to know R1, so CNA M brought R1 back up to the second floor, where R1 resided. LN G conducted a full skin assessment, no physical injuries were noted. R1 reported right hip pain. R1 denied falling while outside. R1's elopement interventions were reviewed, and LN G assessed the functioning of R1's Wanderguard and placed a second Wanderguard on R1. LN G further implemented visual identification of R1's location and activity every 15 minutes and performed a teachable moment on identifying which resident set off the door alarm before resetting the door code.

In a "Witness Statement" dated 03/28/22, Certified Nurse Aide (CNA) M stated around 06:30 PM, when coming back from a lunch break, CNA M found R1 wandering at the main entrance door. CNA M documented R1 asked to be let into the facility. CNA M wrote that, because he knew R1, he opened the door to the building, and assisted R1 to the second floor. CNA M stated he reported the situation first to Licensed Nurse (LN) G.

In a "Witness Statement" dated 03/28/22 LN G

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stated he observed R1 around 06:05 PM in the living area of the second floor. LN G documented he reset the door alarm around 06:18 PM with the thought that another resident set it off. LN G noted an unidentified staff member, unidentified resident, and unidentified family member around the door area.

In a "Witness Statement" dated 03/28/22 CMA R stated she observed R1 walking around the unit at 05:10 PM. At 06:15 PM the door alarm went off. CMA R reported she cleared the alarm. CMA R stated she observed an unidentified resident and family member enter the unit. CMA R stated she did not observe any residents on the other side of the door when she looked through the window of the door leading onto the unit.

On 03/29/22 at approximately 10:30 AM, observation revealed the location of the facility was off the main road and on the side of the building community campus. There was a road along the front of the doorway with a posted speed limit of 20 miles per hour (mph). The neighborhood around the facility grounds had posted speeds of 30 mph. The road in front of the facility door was parallel and across the street from the parking area.

On 03/29/22 at 11:30 AM R1 laid on the top of the covers in her bed. R1 seemed confused but was pleasant and discussed her cat figurines. R1 had a Wanderguard present on her right ankle.

On 03/29/22 at 11:33 AM LN H stated that staff were to ensure R1 had her Wanderguard on every shift. R1 was crafty and could remove her Wanderguard very quickly. LN H further stated that if a door alarm sounded, staff were to check

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the screen that showed what time the alarm triggered and what Wanderguard number triggered the alarm. LN H stated there was a list of Wanderguard numbers assigned to each resident at the nurse's desk. LN H further stated staff were to make sure the residents were visualized where they were supposed to be before canceling the alarm.

On 3/29/22 at 11:38 AM Administrative Nurse D reported she expected the staff to look at which Wanderguard band triggered the alarm and then go look for the resident assigned to that Wanderguard. CMA R looked out the window and did not see anyone, the nurse then looked at the alarm screen, and then went over talked with CMA R. CMA R told LN G "everything was good." LN G thought the alarm went off because another resident, who also wandered quite a bit, was near the door. Neither LN G nor CMA R looked to see which Wanderguard numbers triggered the alarm. Administrative Nurse D stated the facility alarm sounded when a Wanderguard was near and signaled the specific resident's Wanderguard that set off the alarm. She further stated families had a door key to get in to see residents and the keys were coded to indicate who entered the facility. Administrative Nurse D said she contacted the family member that keyed in when R1 exited and that person could not recall any residents near the door when the unidentified family member entered. Administrative Nurse D reviewed the video and noted R1 was right beside the door but stated R1 looked very "put together" and might not have appeared to be a resident.

On 03/29/22 at 04:00 PM LN G and CMA R remained unavailable for interview.

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The facility's "Electronic Monitoring System for Exit Doors" policy revised 03/30/09 documented the electronic monitoring system for exit doors for all neighborhoods would be operational so that residents who wander do not leave the neighborhood without an appropriate escort.

The facility failed to ensure R1's received the necessary supervision to prevent an elopement and failed to ensure staff responded to safety alarms appropriately when the staff canceled the alarm without assessing the presence of all residents at risk and without reviewing the display which notified staff which Wanderguard triggered the alarm. R1 was able to exit the facility without supervision which presented the likelihood of serious harm or impairment.

On 03/28/22 the facility completed the following corrections:
Education to all facility staff reiterating that anytime an alarm went off on the roam alert system, staff should always check to ensure the resident was safe prior to clearing the alarm. The education included direction to staff to never clear the alarm prior to identifying the resident's location. Elopement drill performed and completed within two minutes.
LN G received written reprimand which indicated no roam alerts were to be cleared until LN G confirmed the resident was safe inside the facility. If unsure of the resident, LN G needed to view the photo in the book with pictures of all residents that have a Wanderguard.
CMA M received written reprimand was suspended and received written reprimand. CMA R was educated with demonstrated understanding and return demonstration on how to look up roam alert numbers, review profile

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F 689	Continued From page 8 book with residents that have a Wanderguard and view resident names on roam alert computer. This deficient practice was cited as past non-compliance.	F 689		