STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B026002	A. BUILDING: _____ B. WING _____	C 12/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WILLOW HOUSE	2900 WILLOW STREET HAYS, KS 67601

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S 000	INITIAL COMMENTS The following citation represents the findings of an abbreviated survey for complaints #167556 and #167595 at the above named home plus facility conducted on 12/14/21, 12/15/21, 12/16/21 and 12/20/21.	S 000		
S5026 SS=J	26-42-101 (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 6 residents. The sample included 3 residents reviewed for elopement/wandering risk. Based on record review, observation, and interview for Resident (R)124, Operator/Licensed Nurse (LN) A failed to ensure no resident was subjected to neglect when Operator/LN A failed to provide or coordinate services reasonably necessary to ensure R124's safety and well-being and to avoid harm when the resident was a known wander risk, eloped from the facility, and walked unsupervised to an Inn parking lot where she fell and was transported to the local Emergency Department (ED). This failure placed the resident	S5026		

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S5026	Continued From page 1 and 3 other residents identified as a wandering/elopement risk in immediate jeopardy for harm, injury or death. Findings included: - Review of R124's medical record revealed she admitted to the facility on 06/05/21 with diagnosis of dementia. The admission "Functional Capacity Screen" (FCS) dated 06/03/21 recorded the resident required supervision with transfers, physical assist with mobility or eating, and was unable to perform bathing, dressing and management of medications and treatments. The FCS recorded the resident had short and long-term memory impairment, memory/recall impairment, and impaired decision making. The FCS further recorded the resident was incontinent of urine, was at risk for falls/unsteadiness, had impaired vision, and was at risk for wandering. The undated "Admission Negotiated Service Agreement" (NSA) recorded the resident received one-person assist, as needed for transfers and was independent/assist as needed for mobility. The NSA further recorded the resident was at a high risk for falls, wore glasses for impaired vision, staff were to "monitor" for wandering, and "monitor as needed" for socially inappropriate disruptive behaviors, and impaired decision making. The NSA failed to identify specific interventions or direction to staff to address the resident's impaired cognition and wandering behaviors. The resident's record lacked a "Health Care Service Plan" (HCSP).	S5026		

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S5026	Continued From page 2 The resident's record lacked an "Elopement Risk Assessment". Review of R124's "Nurse's Notes" revealed: On 12/01/21 at 07:57 PM the writer received a call at about 05:00 PM stating R124 was picked up outside of a local Inn. At the time it was reported R124 was taken to the hospital and her family was notified. R124's family called the house at around 04:45 PM when she was notified by the hospital that R124 was there. The writer placed a call to the ED and was notified R124 was being checked for injuries, and the only noted injuries at this time were a skin tear/laceration under her left eye and an abrasion on her left shoulder. The ED also reported they were doing other testing. Staff reported toileting R124 at around 03:00 PM to 3:30 PM. Both aides working reported not hearing the door alarm. At 6:05 PM the resident's family member stated the ED was getting ready to discharge the resident and she was going to bring her home with no additional injuries noted. On 12/01/21 at 10:30 PM recorded the resident's vital signs but lacked the actual time R124 arrived back to facility. The record further lacked a full assessment completed when the resident returned to the facility. On 12/14/21 at 12:00 PM, Operator/LN A confirmed he had no documentation of assessing resident upon arrival back to facility on 12/01/21. The resident's record lacked physician notification of the resident's elopement. The resident's record lacked documentation of	S5026		

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S5026	Continued From page 3	S5026		

education given to staff members to prevent elopement from reoccurring.

The resident's record lacked a system put in place after R124's elopement on 12/01/21 to prevent resident from eloping.

Observation on 12/14/21 revealed R124 wandered in the facility and Certified Nurse Aides (CNA) C and D redirected the resident to common areas of the facility.

Observation on 12/14/21 at 10:54 PM of the facility revealed four entry/exit doors in the dining/ kitchen area of the facility. Three doors lead to an unsecured backyard and one door lead to the garage, which had an entry/exit door to the unsecured backyard. The four entry/exit doors were tested on 12/14/21, which revealed all doors unlocked and unalarmed when opened. Further review of the facility's backyard revealed an unsecured area. The east side revealed a partial brick retaining wall, shrubs/trees and a partial chain linked fence, which was falling over. An approximately two-foot opening between the chain linked fence and the shrubs/ trees was observed. The south side revealed a partial wooden fence and shrubs/trees. All shrubs/ trees were without foliage.

On 12/14/21 at 10:57 AM, Operator/LN A confirmed the four doors, which lead to the unsecured backyard, were not locked and not alarmed when opened.

Interview with R124 on 12/14/21 at 11:05 AM revealed the resident unable to communicate or answer yes and no questions. Resident near front entrance during interview. CNA C redirected R124 back to the living room when she noticed

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the resident wandering.

Interview with CNA C on 12/14/21 at 10:27 AM revealed she was unaware of the exact time R124 was last seen and confirmed she did not hear the front door alarm, which would have notified staff R124 exited out the front door. CNA C stated after toileting R124, she assisted three additional residents in toileting and was unloading groceries in the kitchen when she received a phone call from R124's family member notifying the facility R124 was in the ED. CNA C confirmed she was unaware R124 was out of the facility until she received the phone call.

Interview on 12/14/21 with Operator/LN A confirmed he had no policy and procedure or documentation of a system in place to ensure the functionality of the front door alarm and further confirmed R124 did not have a personal alarm in use at the time of the elopement or currently. The facility did not put in routine monitoring or checks until after R124 eloped.

"Weather Underground History" reported the following temperatures, events, and conditions for 12/01/21 at 03:56 PM; the temperature was 68 degrees F (Fahrenheit), 13 mile per hour wind from the southwest, no precipitation, mostly sunny.

R124 eloped and was found 0.9 miles away from the facility in the parking lot of an Inn and on the ground. R124 would have likely crossed two streets. The Inn is located next to an interstate (75 mile per hour traffic) as well as a heavily traveled street.

On 12/14/21, facility's "Missing Resident Policy and Procedure" obtained, which recorded, "any

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S5026	Continued From page 5 staff member observing a resident attempting to leave the facility shall attempt to prevent such departure. Should the attempt fail, or a resident is determined missing on scheduled checks, the following should be done: the operator and licensed nurse shall be notified. All available staff will be directed to search the premises ...Upon return of the resident to the facility, the licensed nurse or person in charge shall: examine the resident for injuries and contact the attending physician and report findings and conditions of the resident. Follow orders. An incident report shall be written and signed by the person in charge. The person in charge shall be responsible for documenting the incident in the nursing notes of the resident's chart. All documentation must be concise and reflect the actual facts as they relate to the incident including: times, person contacted, condition of the resident upon return to the facility, physician notification and orders, family notification, any other pertinent information." The facility failed to ensure no resident was subjected to neglect when Operator/LN A failed to provide or coordinate services reasonably necessary to ensure R124's safety and well-being and to avoid harm when the resident was a known wander risk, eloped from the facility, and walked unsupervised to an Inn parking lot where she fell and was transported to the local Emergency Department (ED). This failure placed the resident and 3 other resident's identified as a wandering/elopement risk in immediate jeopardy for harm, injury or death. The jeopardy was removed on 12/14/21 at 1:56 PM when the following abatement plan was accepted by the State Agency.	S5026		

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S5026	Continued From page 6 Action already taken: Alarm on front door placed on continuous alarm. Staff have been instructed to check the door every time alarm goes off. The resident was evaluated by her Primary care Physician and received a medication change. The facility planned to continue doubling staff between the hours of 08:00 AM-10:00 PM. Met with a fencing contractor and plan on installing a backyard fence and front fenced area around the front entrance with code locks for exiting the fenced area of the back door. Future action: Will place on all useable exits an alarm to notify staff of exits being used. Will have installed alarms on doors by 12/16/21. Will have 15-minute checks of all residents until the alarms are installed. Will also have a second person on at nights until alarms are installed. If no other staff were available, the operator would be the second staff at night. Once alarms on doors are placed the facility will begin hourly checks on all residents until the time, they have the yard areas fenced in. Will have a staff training sheet to cover how to observe exits and checking exits when door alarms are sounded. Education started 12/16/21 and will have staff all read and trained by 12/23/21. A code lock on the front door to go with the alarm in place already will be added. We will decide the lock and order it by 12/16/21. Once the lock arrives on property it will be installed within two business days. System failure was a lack of alarms on doors to monitor exiting residents. This will be fixed with alarms on all exit doors. As an extra barrier Fencing the back yard and around the front exit	S5026		

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S5026	Continued From page 7 will provide extra security for elopement long term."	S5026		