STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087046S	A. BUILDING: _____ B. WING _____	C 09/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK WEST PLAZA	505 N MAIZE ROAD WICHITA, KS 67212

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS The following citation represents the findings of complaint investigation KS00165364 and KS00164093 conducted by the Kansas Department for Aging and Disability Services concluded on 09/07/21. On 09/02/21 at 01:17 PM Administrative Staff A and Administrative Nurse B were provided an IJ template and notified the facility failed to ensure a safe/secure environment for cognitively impaired, independently mobile Resident (R) 1, identified by the facility to be a high risk for elopement and R1 exited the secured LTC unit through a coded gate on 07/17/21 without staff knowledge for approximately 15-20 minutes, in an area within 250 feet of a 4 lane 40 mph speed limit busy road and within 100 feet of a wooded creek (Cow skin Creek). This failure placed R1 and 3 other residents identified by the facility at risk for wandering, in immediate jeopardy. The immediate jeopardy was noted to first exist on 07/17/21 and ended on 07/17/21 when the facility immediately changed the door codes on all locked doors and increased the volume to the alarms on all the doors in case they were opened and not properly closed. The facility further provided Elopement training/safety immediately through in-service and online staff training regarding Elopement training beginning on 07/17/21. The deficient practice was deemed a "K" (patterned, immediate jeopardy to resident's health and safety) scope and severity at S0430.	S 000		
S 430 SS=K	28-39-152(i)(1) ACCIDENTS (i) Accidents. The facility shall ensure both of the	S 430		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087046S	A. BUILDING: _____ B. WING _____	C 09/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK WEST PLAZA	505 N MAIZE ROAD WICHITA, KS 67212

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 430	Continued From page 1 following: (1) The resident's environment remains free of accident hazards. This REQUIREMENT is not met as evidenced by: The facility reported a total of 27 residents with three included in the sample for wandering, and four residents identified as cognitively impaired and at risk for elopement. Based on observation, interview, and record review the facility failed to ensure a safe/secure environment for a cognitively impaired, independently mobile resident identified by the facility to be a high risk for elopement when facility staff exited the secured LTC unit and through a coded gate on 07/17/21 and did not ensure the doors closed and locked behind them, allowing R1 to leave the facility without staff knowledge for 15-20 minutes in an area within 250 feet of a 4 lane 40 mile per hour speed limit busy road and within 100 feet of a wooded creek (Cow skin Creek). This failure placed R1 and 3 other residents identified by the facility at risk for wandering, in immediate jeopardy. Findings included: - R1's 08/24/21signed "Physician Orders" revealed a diagnosis of dementia with behaviors (progressive mental disorder characterized by failing memory, confusion behavior way on person may act towards others). The 08/27/21 "Significant Change Minimum Data Set" (MDS) revealed a Brief Interview for Mental Status (BIMS) score of three, indicating severely	S 430		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087046S	A. BUILDING: _____ B. WING _____	C 09/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK WEST PLAZA	505 N MAIZE ROAD WICHITA, KS 67212

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 430	Continued From page 2	S 430		

impaired cognition. R1 exhibited one to three days of verbal behavioral symptoms directed towards others during the assessment period. R1 wandered daily and placed the resident at significant risk of getting to a potentially dangerous place. The MDS noted R1 as independent with ambulation.

The 07/06/21 "Quarterly Minimum Data Set" (MDS) revealed a BIMS score of two, indicating severely impaired cognition. R1 wandered daily and with independent mobility this placed R1 at significant risk of getting to a potentially dangerous place.

The "Cognitive Care Area Assessment" (CAA) dated 08/28/21 revealed R1 had a diagnosis of dementia with behaviors and chronic pain. R1 usually understood others, but had a hard time making his needs known. R1 wandered, looking for exits, shook door handles, and was a high risk for elopement. R1 occasionally wandered into the wrong room and the staff quickly redirected him.

The "Elopement Assessment" indicated if the score was 14 or above the resident was a high risk for elopement and would warrant the need for extra supervision and interventions. The "Elopement Assessment" completed on the following dates revealed:
03/26/21, score of 17
04/08/21, score of 16
07/01/21, score of 16

The "Care Plan" dated 07/07/21 prior to the elopement on 07/17/21 revealed R1 as an elopement risk and the staff were to maintain safety, make sure all staff were aware of R1's elopement risk, modify the environment outside

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087046S	A. BUILDING: _____ B. WING _____	C 09/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK WEST PLAZA	505 N MAIZE ROAD WICHITA, KS 67212

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 430	Continued From page 3	S 430		

(secure courtyard for safe walking, safe walking path), and distract R1 from wandering by offering pleasant diversion, structured activities, food conversation, television, or book.

The 07/12/21 at 06:50 PM "Nurse Notes" revealed at approximately 06:00 PM resident number four spotted R1 outside of her room. Staff searched the facility and the outside property with surrounding areas. At 06:09 PM the nurse writer Licensed Nurse (LN) C notified 911 and continued searching outdoors. At 06:13 PM Certified Medication Aide (CMA) H returned to the facility with R1 and reported she found him working on an air conditioner at the nearby daycare. The staff placed R1 on 15-minute observations. CMA H reported seeing R1 at approximately 06:00 PM in the south side dining area conversing with the other residents.

Historical weather information for 07/17/21 at 06:00 PM recorded by Wunderground.com revealed the temperature was 79 degrees Fahrenheit (F) and no extreme weather at this time.

The "Facility Investigation" regarding the elopement of R1 on 07/17/21 revealed at approximately 06:00 PM a resident number four reported to CMA H of a man she saw outside her window near the trash dumpster. CMA H reported this to the nurse and the staff conducted a resident count per protocol R1 was not located for the count. The staff immediately searched the whole building and searched outside. CMA H found R1 near the Long-Term Care (LTC) building and safely returned to the building at 06:14 PM. An unidentified staff member reported seeing R1 at 05:50 PM near the dining area and Dietary Aide I reported she went out the door (northwest

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087046S	A. BUILDING: _____ B. WING _____	C 09/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK WEST PLAZA	505 N MAIZE ROAD WICHITA, KS 67212

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 430	Continued From page 4	S 430		

area, near the laundry room) from the LTC building and through the locked gate at the front to obtain some additional orders from the kitchen at the Assisted Living between 05:30 PM and 05:55 PM. All the gates and doors were checked and found functioning properly the door codes were changed immediately a new mechanism spring added to the gate to ensure it closed after being opened.

Observation on 09/01/21 at 02:45 PM revealed R1 calmly sat in a small alcove looking out the windows, with no exit seeking behavior noted.

Observation on 09/01/21 at 04:54 PM revealed R1 sat in the dining room with his family member, and displayed no exit seeking at the observed time.

Observation on 09/01/21 at 03:00 PM with Administrative Staff A of the door R1 used to leave the facility, revealed the alarm on the door would not shut off, until someone closed the door properly. Administrative Staff A provided a tour of the outside of the facility which revealed the location of the Cow Skin Creek with its steep embankment and the busy four lane road which is approximately 250 feet from the facility.

Interview with LN C on 09/2/21 at 09:00 AM revealed when R1 eloped from the building LN C reported working on the South hall and did not know R1 left the building. LN C said as soon as they knew, the staff went outside to locate the resident and called 911. LN C went out to the back area of the facility and down to the stop sign but could not locate R1. Another staff member (CMA) H, who was in her car, noted R1 was found by the daycare building, working on an air conditioner. LN C said R1 had no injuries upon

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087046S	A. BUILDING: _____ B. WING _____	C 09/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK WEST PLAZA	505 N MAIZE ROAD WICHITA, KS 67212

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 430	Continued From page 5	S 430		

assessment and the staff placed him on 15-minute checks. Maintenance Staff J increased the volume on the alarms and changed the setting on the door, so the alarm will not shut off unless the door closed fully. LN C stated the codes for all the doors were changed. LN C said R1 displayed exit seeking daily.

Interview with LN D on 09/02/21 at 12:52 PM revealed R1 wandered and attempted to open the doors. Staff tried to redirect him.

Interview with Certified Nurse Aide (CNA) F on 09/02/21 at 09:32 AM revealed after R1 finished with his meal he went back to his hall at 6:00 PM shortly after that another resident put on her call light and stated that there was a man wearing black over by the dumpsters. Staff then started the resident check and could not find R1. CNA F reported it all happened within 15 to 20 minutes. CNA F further stated R1 liked to walk around and look in the other residents' rooms

Interview with CNA E on 09/02/21 at 12:40 PM revealed R1 was very confused, was easier to redirect in the morning, and became harder to redirect towards the end of the shift. CNA E stated R1attempted to leave the facility, pushed on the doors, wandered a lot, and was known to go into other residents' rooms.

Interview on 09/02/21 at 11:00 AM with Administrative Nurse B reported the staff notified her immediately regarding R1's elopement and the facility placed him on 15-minute checks. Administrative Nurse B said the facility started the training on "Elopement" that evening, both verbally and with the online training program. Maintenance Staff J increased the volume on the door alarm and adjusted the gate to ensure it

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087046S	A. BUILDING: _____ B. WING _____	C 09/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK WEST PLAZA	505 N MAIZE ROAD WICHITA, KS 67212

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 430	Continued From page 6 closed appropriately. The undated facility policy "Managing Wandering and Elopement" revealed if a resident has tendency to which may place him/her at risk for potential negative consequence. The Healthcare Coordinator or Resident Director shall develop a "Managed Risk Agreement" that must be clearly communicated to the staff. The facility failed to ensure a safe/secure environment for R1 who a cognitively impaired, independently mobile resident, and identified by the facility to be a high risk for elopement. R1 exited the secured LTC unit through a coded gate on 07/17/21 without staff knowledge for 15-20 minutes. The facility immediately changed the door codes on all locked doors and added increased volume to the alarms on all the doors in case they were opened and not properly closed. The facility provided Elopement training/safety immediately through in-service and Relias Elopement training (computer-based education). The deficient practice remained at a "K" (patterned immediate jeopardy to resident's health and safety) scope and severity.	S 430		