STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175348	A. BUILDING _____ B. WING _____	C 09/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLTOP LODGE HEALTH AND REHABILITATION CENTER	**815 N INDEPENDENCE AVENUE, PO BOX 467 BELOIT, KS 67420**

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F 000	INITIAL COMMENTS	F 000		

The following citation represents the findings of complaint investigations #164432, #165208, and #165479.

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 09/14/21. The facility was found not to be in substantial compliance for 42 CFR 483.

On 09/14/21 at 01:30 PM, the Administrator was provided a copy of the IJ template and notified that cognitively impaired Resident (R) 1, who had a history of exit seeking behavior and wandering, eloped from the facility without staff knowledge. On 09/08/21 at approximately 6:00 PM, she used the unlocked/unalarmed double doors to leave the south hall and enter the west hall (which is unoccupied). She exited a door on the west hall that leads to the assisted living by holding down the door handle until the alarm sounded, which allowed her to open and exit. There were no residents or staff on the west hall and none of the staff on the north or south hall heard the alarm. The resident exited a door that opened into a parking lot. The resident was located by an assisted living staff member who saw her outside the window by the assisted living front porch.

The Administrator was informed the immediate jeopardy was determined to be past non-compliance due to the facility implemented in-service education for all staff on 09/09/21 regarding residents at risk for wandering and elopement. The education included identifying which residents are elopement risk, frequent

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 000	Continued From page 1 monitoring of elopement risk residents, staying with a resident that is exit seeking and provide one on one interaction, redirect them to a safe area, and notify the nurse immediately. Due to the facility's identification of the deficient practice and implementation of corrective actions completed on 09/09/21, the deficient practice was deemed past non-compliance at a scope and severity of J.	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 supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: The facility had a census of 58 residents. The sample included five residents, with three reviewed for wandering and elopement. Based on observation, record review, and interview, the facility failed to ensure a safe and hazard free environment for one of three sampled residents, Resident (R) 1. Cognitively impaired, R1 eloped from the facility through unlocked/unalarmed fire doors on the South hall, entered the unoccupied West hall, opened the West hall exit door, which sounded an alarm in an area that could not be heard by staff, then exited through a door that lead to an area outside of the facility, without staff supervision or knowledge. This deficient practice placed R1 in immediate jeopardy.	F 689	Past noncompliance: no plan of correction required.	

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Findings included:

- R1's "Quarterly Minimum Data Set," (MDS), dated 08/03/21, documented the resident had a Brief Interview for Mental Status, (BIMS) score of six, indicating severe cognitive impairment. The MDS documented the resident required extensive assistance of one staff for bed mobility, transfers, locomotion on and off the unit, limited assistance of one staff for walking in her room and corridor, and no wandering behavior.

R1's "Cognitive Loss Care Area Assessment," (CAA), dated 06/03/21, documented the resident had a BIMS score of six, a diagnosis of dementia (progressive mental disorder characterized by failing memory, confusion) and mental illness, and was not always able to make her needs known to staff.

R1's "Elopement Care Plan," dated 06/03/21, directed staff to encourage independence while in the building, but ensure supervision while outside, observe for sign and symptoms of acute illness which may enhance confusion, and provide a picture and description of the resident in the elopement book. The care plan further directed staff to re-direct the resident when she wandered around doors and exits and visualize her whereabouts frequently.

R1's "Wandering Risk Assessments," dated 05/27/21 and 08/27/21, documented a score of 10, indicating at risk for wandering and elopement.

The "Nurse's Note," dated 06/27/21 at 09:45 PM, documented exit seeking behavior at 06:55 PM

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and 07:27 PM through the East door of the North hall. The note documented the alarm sounded and the resident did not go outside the facility.

The "Nurse's Note," dated 08/27/21 at 02:49 PM, documented R1 had a history of wandering. The note documented R1 had a medical diagnosis of dementia/cognitive impairment and a diagnosis impacting gait/mobility or strength. The resident wandered in the facility with no exit seeking behaviors.

The "Nurse's Note," dated 09/07/21 at 05:30 PM, documented R1 wandered around the dining room while she visited with staff, asked where her mother was, and staff were able to redirect her. The note documented R1 wandered throughout the facility and into other residents' rooms with persistent confusion.

The "Nurse's Note," dated 09/08/21 at 07:00 PM, documented staff reported R1 was outside of the Assisted Living, walking East. Upon investigation the resident went through double doors on South Hall, which led to the West Wing. R1 walked up to the far West door that leads to the assisted living and held the door until it released causing an alarm to go off. She then walked out the outside door that separated the nursing facility from assisted living. Staff in the Assisted Living noticed someone walking outside and after a closer look noted the person to be R1. CMA R went outside to assist R1 to the North Wing entrance door, the resident was hesitant to go with her, but did comply. Nursing facility staff assisted R1 into the facility accompanied by CMA R. Staff completed a full skin assessment on R1, and obtained vital signs. All vital signs were within normal limits, no visible signs or symptoms of

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injury were noted, and resident denied any pain or discomfort. R1 actively looked for a way out. Staff placed R 1 on one on one supervision, notified administrative staff, and witness statements obtained. R1 remained on one on one until directed otherwise.

On 09/08/21 the weather, according to wunderground.com, at the time of the elopement was daylight, 84 degrees Fahrenheit, 32% humidity, winds at 6 miles per hour, clear and no precipitation. Staff found R1 in a parking lot outside the assisted living, away from the main street. The parking lot is located on the northeast side of the assisted living/nursing facility. A busy street runs along the East side of the facility that has a convenience store, grocery store, and other businesses. The parking lot is flat and smooth with no holes or large cracks. There is a privacy fence along the north side of the parking lot.

On 09/14/21 at 07:50 AM, observation revealed R1 ambulated without her walker from the South hall, through the front lobby, and into the dining room. Further observation revealed the resident did not approach the exit doors.

On 09/13/21 at 04:40 PM, Certified Medication Aide (CMA) R stated she worked in the assisted living on 09/08/21. At approximately 06:00 PM, she noticed a woman outside by the assisted living porch. CMA R stated she recognized the woman as R1, so she called the facility as she went out the door to the resident. CMA R stated R1 was in the parking lot and she redirected R1 to the North door of the facility where three staff members were waiting for her. CMA R stated she did not hear any alarm sounding in the assisted living.

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On 09/13/21 at 04:40 PM, Licensed Nurse (LN) G stated the last time she saw R1 was when R1 wandered around the center area of the South hall on the evening of 09/08/21 at approximately 05:20 PM. LN G stated at approximately 06:15 PM on 09/08/21, a staff member on the North hall reported R1 was at the assisted living. LN G stated the doors that lead from the South hall into the West hall were not locked or alarmed, and there was no plan in place to ensure R1 and other residents would not go to the unoccupied West hall. LN G stated there were administrative offices on West hall, but after 05:00 PM, there was nobody over there. LN G stated she did not hear any door alarms.

On 09/13/21 at 05:30 PM, LN H stated on 09/08/21 at approximately 06:15 PM, she was on the phone at the nurse's station in the assisted living and saw a woman outside by the porch. LN H stated she did not recognize the woman at first, but CMA R recognized that is was R1. CMA R went outside and redirected the resident back to the facility. LN H stated she did not hear the West door alarming. The alarm was meant for the skilled staff, so the assisted living staff would not be able to hear it.

On 09/13/21 at 06:00 PM, LN I stated staff notified her that R1 eloped and was found outside of the assisted living. CMA R assisted R1 to the North door. LN I stated she assessed R1 and found no injuries, and all her vital signs were within normal limits. LN I stated the resident had a history of wandering and had tried to exit the facility a few times. LN I stated the doors on the South hall that lead to the West part of the facility were closed, but not locked or alarmed, and

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stated, "I guess we never thought anyone would open them and go over to the West side. We didn't have a plan in place to monitor R1 for that."

On 09/14/21 at 12:10 PM, Administrative Nurse D stated R1 wandered and had exit seeking behavior prior to the elopement. Administrative Nurse D stated staff shut the double doors that lead from the South hall to the West hall, but they were not locked or alarmed, and the facility did not have a system in place to monitor the doors or the West unoccupied hall.

On 09/14/21 at 01:30 PM, Administrative Staff A stated it was not safe for R1 and other at-risk residents to have unlocked and unalarmed doors, which led to unoccupied areas of the facility.

The facility's undated "Elopement and Wandering Residents Policy" documented the facility would ensure residents who exhibit wandering behavior, and/or are at risk for elopement receive adequate supervision to prevent accidents and receive care in accordance with their person-centered plan of care and address the unique factors that contribute to wandering or elopement risk. The policy documented the facility was equipped with door locks and/or alarms to help avoid elopement, and alarms are not a replacement for necessary supervision. The facility would establish and utilize a systematic approach to monitoring and managing residents at risk or unsafe wandering, including identification and assessment risk, evaluation and analysis of hazards and risk, and implement interventions to reduce hazards and risks, monitor for effectiveness and modify interventions when necessary.

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F 689	Continued From page 7 The facility failed to adequately monitor and supervise cognitively impaired, R1 from potential accident hazards when she eloped from the building, though doors that lead to an unoccupied area of the facility, exited and activated the alarm (which staff could not hear) on another door, and then exited a door that lead outside to a parking lot unsupervised. This placed R1 at risk for potentially serious outcomes, harm, or injury. The facility implemented in-service education for all staff on 09/09/21, regarding residents at risk for wandering and elopement. This education included that staff are responsible to identify which residents are elopement risk, a wandering/elopement book at each nurse's station and the front desk and continue frequent monitoring of elopement risk residents. The education also included for staff to stay with a resident that is exit seeking and provide one on one interaction, redirect them to a safe area, and notify the nurse immediately. This deficit practice was identified as past non-compliance and corrected on 09/09/21.	F 689		