STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175309	A. BUILDING _____ B. WING _____	C 08/31/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARKANSAS CITY PRESBYTERIAN MANOR	1711 N 4TH STREET ARKANSAS CITY, KS 67005

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F 000	INITIAL COMMENTS The following citations represent the findings of complaint investigation # 164442. This 2567 was electronically sent to the facility on 09/02/21. A revision 2567 was sent to the faclity on 09/09/21.	F 000		
F 689 SS=D	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 reported a census of 39 residents, with three residents selected for review for elopement (an incident in which a cognitively impaired resident with poor or impaired decision-making ability/safety awareness leaves the facility without the knowledge of the staff). Based on record review, observation, and interview, the facility failed to monitor and provide adequate supervision for one Resident (R) 1, who had a high risk for elopement and a history of wandering. Findings Included: - The signed "Physician Order Sheet" (POS) for Resident (R1), dated 08/05/21, revealed the	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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following diagnoses; Alzheimer's Disease (progressive mental deterioration characterized by confusion and memory failure), delusional disorder (untrue persistent belief or perception held by a person although evidence shows it was untrue), dementia (progressive mental disorder characterized by failing memory, confusion), anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), and major depressive disorder (major mood disorder).

The quarterly "Minimum Data Set", dated 07/20/21, revealed the resident had a "Brief Interview Mental Status" (BIMS) score of 99. The resident was moderately impaired with decision making, with poor decisions and required cues/supervision. She required two-person extensive assist with transfers and ambulation. The resident used a wheelchair as a mobility device.

The annual "Minimum Data Set", dated 02/09/21, revealed the resident had a BIMS score of two, indicating severely impaired cognition.

The "Cognitive Loss/Dementia Care Area Assessment" (CAA), dated 02/16/21, documented the resident was unable to complete the BIMS interview. The resident had problems with short-term and long-term memory. The resident had disorganized thinking and unable to complete most of her tasks.

The "Activities of Daily Living/Functional Care Area Assessment" (CAA), dated 02/16/21, documented the resident required extensive assistance with ambulation and transfers.

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The behavioral care plan dated 08/02/21, guided staff to redirect the resident when wandering in the halls.

Review of the nursing progress notes from 10/25/21 to 09/01/21, revealed the resident had a history of exit seeking and had a Wander Guard (bracelet that sets off an alarm when residents wearing one attempt to exit the building without an escort) from 10/27/21 until staff discontinued the Wander Guard on 01/03/21.

On 08/01/21 at 08:58 AM, the resident exited the facility's health care unit (where the resident resided) through the south exit door into the facilities assisted living unit, without staff knowledge. After the resident eloped, staff re-applied a Wander Guard.

On 08/31/21, review of the facility's surveillance video, revealed on 08/01/21 at 08:58 AM, the resident exited the unlatched door when Certified Nurse Aide (CNA) G exited the south exit door of the facility's health care unit. The resident was behind her and exited the south exit door, without staff knowledge, and entered the adjoined facility's assisted living.

At 08:59 AM, Administrative staff for facility's assisted living AA entered the assisted living front entrance and observed R1 self-propelling into the lobby, unattended and without staff knowledge.

Observation, on 08/31/21 at 09:29 AM, revealed R1 was in the family room during an activity with staff member reading a book to the residents. R1 sat in a straight back chair. The resident had a Wander Guard on her right ankle.

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On 08/31/21 at 10:48 AM, revealed R1, in her wheelchair, self-propelling herself in the hallway.

On 08/31/21 at 01:33 PM revealed R1 lying in her bed resting in bed with eyes closed.

On 08/31/21 at 09:38 AM, Licensed Nurse D advised when staff exit the doors, staff should look around to ensure residents are not near exit doors prior to exiting the doors. After the resident eloped, staff applied a Wander Guard to alert staff if the resident attempted to elope.

On 08/31/21 at 11:33 AM, Administrative staff for facility's assisted living AA advised when she entered the front entrance of the Assisted Living Unit, she observed R1 sitting in her wheelchair in the lobby, without staff.

On 08/31/21 at 11:55 AM, Certified Medication Aide R advised the resident followed staff members into other resident's room and required redirection. The resident would wander, and the resident would self- propel herself into other residents room and would lay down on other residents' bed and would be found by staff asleep in their beds.

On 08/31/21 at 03:04 PM, Certified Nurse Aide M advised she was unaware the resident had followed her out the exit door. She reported she did not look around to see if any residents were around the door. She verified she should have slowed down, turned around, and ensure there was not a resident behind her before exiting the health care unit.

On 08/31/21 at 02:55 PM, Licensed Nurse H advised staff should ensure the safety of the

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residents. Staff should stop and redirect the resident if the resident attempted to leave the unit.

On 08/31/21 at 04:12 PM, Certified Nurse Aide N advised R1 had been an elopement risk for a very long time. R1 wanders aimlessly daily because of her confusion. The resident had a potential to exit seek because of her confusion. The resident had a Wander Guard earlier this year, but the Wander Guard was discontinued. Staff should always look prior to exiting any of the exit doors and to ensure any resident was not present at that time.

On 08/31/21 at 04:33 PM, Administrative Nurse D, advised that the charge nurses should complete an elopement evaluation on admission and quarterly. The care plan team would discuss the elopement evaluation, and a score greater than ten would place the resident at a high risk for elopement. If a resident had no signs of exit seeking, staff did not necessarily care plan the resident for an elopement risk. R1 would roam the halls. Staff discontinued the resident's Wander Guard on 01/03/21. The resident did self-propel herself into her previous room, however she was unaware the resident wandered into other resident's rooms.

The facility's policy for "Hazardous Wandering and Elopement (Unwitnessed Exit)" revised June 2001, revealed the resident will be monitored by assessment-based observation with Elopement Risk Screen on the Matrix on admission, quarterly and with any significant change of condition. These behavioral patterns will be reflected in the care plan for residents with known history of wandering and the potential for unwitnessed exits.

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F 689	Continued From page 5 The facility failed to monitor and provide adequate supervision for this confused, mobile resident, when the resident left the facility health care and entered the facility's adjoining assisted living, thru exit doors, without staff knowledge.	F 689		