STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175385	A. BUILDING _____ B. WING _____	C 08/18/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARAMOUNT COMMUNITY LIVING AND REHAB INC	**200 SW 14TH NEWTON, KS 67114**

(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) COMPLETION DATE
F 000	INITIAL COMMENTS The following citation represent the findings of complaint investigation #164835. This 2567 was electronically sent to the facility on 08/19/21.	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 nine residents that resided in the facility house with three residents sampled that included one resident sampled for elopement. Based on observation, interview and record review, the facility failed to provide supervision necessary for Resident (R) 1, when staff was aware the resident was exit seeking, and left the resident, outside, unattended. The resident left the gated patio, unattended, and without staff knowledge. Findings included: - Resident (R) 1 diagnosis included psychotic disorder (any major mental disorder characterized by a gross impairment in reality testing), schizophrenia (psychotic disorder characterized by gross distortion of reality, disturbances of language and communication and fragmentation	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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F 689	Continued From page 1	F 689		

of thought) and delusional disorders (untrue persistent belief or perception held by a person although evidence shows it was untrue).

The Annual "Minimum Data Set" (MDS), dated 02/09/21, revealed the resident with a Brief Mental Status (BIMS) of 15. The resident was able to self-propel in a wheelchair.

The care plan, dated 08/18/21, guided staff to anticipate the residents needs based on wandering triggers and patterns. Redirect the resident if she appeared agitated and to evaluate facility for potential hazards for the resident.

On 05/05/21, the resident's Quarterly Elopement Risk Assessment documented the resident was a low risk for elopement.

Review of the nursing progress notes on 08/16/21, revealed the nurse was notified at 01:00 PM that R (1) had self-propelled her wheelchair through the gait of the courtyard and was sitting in her wheelchair by the trashcan, approximately 12 feet from the gait, and was non-injured.

According to Wichita, KS Weather History | Weather Underground (wunderground.com), on 08/16/21 at 1:30 PM, the temperature was 86 degree Fahrenheit, zero precipitation and wind was eight to 10 miles per hour.

Observation on 08/18/21 at 08:16 AM, revealed the resident sat in her wheelchair at the dining table, knitting. No signs of wandering or exit seeking.

Observation on 08/18/21 at 02:30 PM revealed

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F 689	Continued From page 2	F 689		

the resident sat in her wheelchair at the dining table, knitting. The resident had no signs of exit seeking.

On 08/18/21 at 10:28 AM Certified Medication Aide S advised that R (1) had not attempted to exit the facility or the courtyard prior to 08/16/21. On 08/16/21, the resident wanted to go to the courthouse to get married. She was in the courtyard visiting with another resident and family member, unattended by staff. When the resident got out of the patio gate, a resident's family member came inside the facility and advised a staff member that R (1) had exited the courtyard gait, by herself, and was sitting by the trash cans.

On 08/18/21 at 10:55 AM, Certified Medication Aide R advised R (1) was insistent that she wanted to go to the courthouse to get married to her imaginary friend. When she had anxiety in the past, she was allowed in the courtyard for fresh air and that calmed her.

On 08/16/21 around 12:55 PM, staff reported she watched the resident through the window, however, she got distracted and did not see the resident unlatch the gate and left. She was notified about the resident leaving when a family member came into the facility to advise staff that R (1) had exited the courtyard gait and was sitting by the trashcans at the end of the sidewalk.

On 08/16/21 at 02:56 PM, Licensed Nurse G, reported she was advised at 01:00 PM that the resident exited the courtyard gait by herself and was sitting in her wheelchair by the trashcans.

On 08/18/21 at 03:33 PM Administrative Nurse D advised R (1) has delusional disorder and the

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F 689	Continued From page 3 resident told staff she was leaving for the courthouse to marry her imaginary friend. On 08/18/21 at 04:15 PM, Administrative Staff A advised maintenance checked the exit gait that R (1) exited through and it is unsure if the gait was not latched properly. The Elopement Prevention and Management facility's policy, dated 01/14/21, will re-evaluate cognitive impaired residents who have successfully left the facility without staff knowledge. The facility failed to provide supervision necessary for this resident, when staff was aware the resident was exit seeking, and left the resident, outside, unattended. The resident left the gated patio without staff knowledge.	F 689		