STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175387	A. BUILDING _____ B. WING _____	C 05/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKSIDE HOMES	**200 WILLOW RD HILLSBORO, KS 67063**

(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 citations represent the findings of complaint investigation # KS 162234. This 2567 was electronically sent to the facility on 5/13/21.	F 000		
F 689 SS=E	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 26 resident, and identified five as confused with self-mobile, with three sampled for review of elopement. Based on observation, interview, and record review the facility failed to ensure an adequately functioning exit door alert system to prevent one of the three sampled residents, Resident (R) 1, from exiting the facility without staff knowledge, during the night. The staff noted the resident standing outside of the exit door and escorted him back into the facility. The inadequately functioning exit door alert system revealed any of the five confused and self-mobile resident could have exited the facility without staff knowledge over the previous week. Findings included: - Resident (R) 1's Admission Record, dated	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		

12/13/2019, documented diagnoses of Parkinson's Disease (slowly progressive neurological disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity and weakness) and Hypertension (high blood pressure).

The "Minimum Data Set" (MDS), dated 3/16/21, documented the resident with a Brief Interview for Mental Status (BIMS) score of 09/15, that indicated moderate cognitive impairment. The resident required supervision with ambulation with his front wheeled walker. He had no functional limitations in range of motion ability.

The "Care Area Assessment" (CAA), dated 03/19/21, for activities of daily living, included the resident was not steady walking but was able to stabilize without staff assistance. His psychosocial assessment included, spends much of his day in bed watching TV, and with his wife per his choice. She resides in the facility in a room next to his.

The "Care Plan" (CP), dated 05/04/21, included his need for the front wheeled walker for mobility and a potential for falls related to his Parkinsons.

Per interview on 05/10/21 at 10:25 AM, Administrative Staff A reported that on 04/27/21 at 03:53 AM, R1 went out the hall B exit door. The door alarm sounded at the B hall exit door but failed to sound at the nurse's desk and failed to show an opened exit door on the pagers carried by the staff members. The staff were down another hall, doing cares for residents, from the B hallway at the time. At 04:31 AM (four minutes later) "Certified Nurse Aide" (CNAs) D

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F 689	Continued From page 2	F 689		

and E heard the alarm, looked down Hall B and noted R1 standing outside of the exit door and wanting back inside. The aides let the resident inside and called "Licensed Nurse" (LN) C who assessed the resident without injury. The resident had a temperature of 97.7 and oxygen saturation of 98% on room air. R1 told the staff he was looking for his room.

According to www.weather wunderground, the outside temperature on 05/03/21 at 04:00 AM, was 46 degrees and clear. The "Facility Investigation," dated 05/04/21, included the resident wore flannel pajama bottoms, t-shirt and gripper socks.

On 05/05/21 at 11:00 AM, Administrative Nurse B verified the resident had not been considered an elopement risk and had made no previous exit seeking attempts.

On 05/05/21 at 11:15 AM, observation revealed the resident and his spouse sat at the dining room table, finishing breakfast. The resident could not remember previously exiting the building. His spouse provided directions for him related to finishing his breakfast. He wore a wanderguard bracelet on his right wrist.

On 05/05/21 at 02:20 PM, Maintenance Staff F verified the facility previously hired a company to upgrade their call light and camera systems. They started the work and then they left the door alarm notification turned off to the nurse's desk, and off to the staff members' pagers. The facility staff lacked knowledge of this issue which happened approximately one week prior to this elopement. This allowed R1 and any resident

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who may become confused to elopement from the facility without the staff knowledge. Maintenance Staff F reported he could not find a date of the last elopement drill for staff completed in the facility.

The facility policy for, "Elopement Management" last revised 01/20/20, included that approaches for the prevention of elopement will be utilized and may include door alarms. Prevention included environmental approaches such as but not limited to door alarm. Also to provide education on the various alarm systems utilized for residents that wander will be provided to all staff members.

The facility failed to ensure an adequately functioning exit door alarm system to notify staff when a resident left the facility without staff knowledge. In the previous week any of the 5 residents identified with confusion and self-mobile could have exited without staff knowledge and R1 did leave the facility without staff knowledge.