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	175386	A. BUILDING _____ B. WING _____	C 04/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCHOWALTER VILLA	200 W CEDAR PO BOX 5000 HESSTON, KS 67062

(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 #161509 and a partial extended survey conducted by the Kansas Department for Aging and Disability Services (KDADS), on behalf of the Centers for Medicare and Medicaid Services (CMS) on 04/08/21. On 04/08/21 at 05:05 PM, Administrative Nurse D was informed that they were in immediate jeopardy status and provided the "Immediate Jeopardy Template" for failure to provide adequate supervision and perform 30 minute checks to provide safety to the resident, at risk for elopement. The facility provided evidence the immediate jeopardy had been removed and the survey team validated the removal of the immediate jeopardy as of 04/05/2021 at 9:48 PM. As a result, the facility was cited in past non-compliance. The immediate jeopardy was cited at a scope and severity of a J (isolated immediate jeopardy to the residents health or safety). The 2567 was electronically sent to the facility on 04/13/21.	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	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 accidents. This REQUIREMENT is not met as evidenced by: The facility reported a census of 97 residents with 19 of those residents identified at risk 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 staff). Based on interview and record review, the facility failed to provide adequate supervision of Resident (R)1 when staff left the resident in the unlocked, outside courtyard area unsupervised. Furthermore, facility staff failed to perform 30 minute checks of the resident's whereabouts as care planned. R1 exited the open gate in the courtyard without staff knowledge, ambulated around the outside of the facility campus, crossed a residential street with a speed limit of 30 miles per hour, and was found approximately a block away from the street she crossed by an off duty staff member who assisted R1 back to the facility. This deficient practice placed this resident in immediate jeopardy. Findings included: - The "Order Summary Report," dated 04/06/21, for Resident (R)1, included diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), need for assistance with personal care, weakness, generalized muscle weakness, difficulty in walking, anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear) disorder, dementia (progressive mental disorder characterized by failing memory, confusion) other chronic pain, osteoarthritis (degenerative	F 689	Past noncompliance: no plan of correction required.	

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changes to one or many joints characterized by swelling and pain), and pain in the left hip.

The "Annual Minimum Data Set" (MDS), dated 11/12/20, assessed R1 had a "Brief Interview of Mental Status" (BIMS) score of 12, indicating moderate cognitive impairment, delusions (untrue persistent belief or perception held by a person although evidence shows it was untrue), verbal behavior symptoms one to three days of the assessment period, and had no episodes of wandering. She was independent with transfers and ambulation, she walked out of her room one or two times without assistance, and used a walker for mobility. Her balance was unsteady while walking, but she could stabilize herself without assistance. R1 required a wander/elopement alarm to be used daily.

The "Cognitive Loss/Dementia Care Area Assessment" (CAA), dated 11/23/20, revealed R1 had a diagnosis of Alzheimer's disease and dementia, she was unable to manage her cares independently, and required supervision and care due to the progression of her diagnoses. She had moderate cognitive impairment and was independent with ambulation with use of her four-wheeled walker.

The "Activities of Daily Living [ADL] CAA," dated 11/23/20, revealed R1 had difficulty with balance, was independent with her four-wheeled walker, and generally independent with her ADLs.

The "Quarterly MDS," dated 01/27/21, assessed R1 had a BIMS score of 11, indicating moderate cognitive impairment, no delusions, verbal behaviors, or wandering. She was independent with transfers and ambulation, walked out of her

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room one or two times without assistance, and used a walker for mobility. Her balance was unsteady while walking, but she could stabilize herself without assistance. R1 required a wander/elopement alarm to be used daily.

The "Care Plan," dated 03/08/21, revealed R1 had cognitive deficits and demonstrated impairments with memory, decision making abilities, safety awareness, and orientation to time related to dementia. She displayed wandering behaviors and was at risk for elopement due to dementia. She had a code alert alarm on her walker, staff was to distract her from wandering by offering pleasing diversions such as structured activities, food, conversation, television, or a book. The care plan included the staff were to check on her location every 30 minutes, and if she went out into the courtyard, they were to come out and check on how she was doing every 30 minutes.

The "Wandering Risk Scale," dated 02/03/21, scored R1 as having a high risk to wander. She could follow instructions, was ambulatory, could communicate, had a history of wandering, had a medical diagnosis of dementia/cognitive impairment, and had no reported episodes of wandering in the past three months.

The "Progress Notes," located in the electronic medical record (EMR), dated 04/02/21 at 08:45 AM, indicated R1 was exit seeking and was going to go out the exit door of the 300 hall, when staff told her she could not go out that door R1 responded that it was okay, she would walk around. The staff directed her to the courtyard at that time.

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The "Progress Notes," located in the EMR, dated 04/02/21 at 04:15 PM, indicated that the staff visualized R1 attempting to pull the fire alarm and stated she would like to go outside. R1 was heading towards the exit door on the 400 hall (her hall of residence) and the staff redirected her towards the courtyard.

The untitled form, used by the facility staff for the 30 minute checks, dated for 04/02/21, indicated R1 was outside at 04:30 PM. The form lacked a location and staff initials for the times of 05:00 PM, 05:30 PM, and 06:00 PM. The facility failed to perform 30 minute checks for R1 who was deemed a high risk to wander.

The "Facility Investigation," still in progress on 04/08/21, indicated that a staff member let R1 into the courtyard area on 04/02/21 at 04:40 PM. R1 walked out of the gate and went for a walk down the street on the sidewalk, approximately one block from the campus, and then an off-duty staff spotted her walking by herself at 06:00 PM and brought her back to the facility.

The "Progress Notes," located in the EMR, dated 04/02/21 at 08:16 PM, indicated the charge nurse received a call at 06:09 PM from the front desk that an off-duty staff member recognized R1 on the sidewalk about two blocks away walking with her walker. The facility staff met the off-duty staff member and assisted R1 out of the staff person's van. R1 reported pain to her legs from waking too far and had a history of hip pain. She was scheduled to have hip surgery on 04/20/21. R1 reported to staff when questioned where she was going that she needed to get out of here, she should not have done that, and she walked too far.

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On 04/08/21 at 08:25 AM, Administrative Nurse D stated that the courtyard had an exit gate that the facility would unlock around 04:00 PM to allow for window visits for those residents that had rooms with windows to the courtyard. A staff member forgot about the gate being unlocked at 4:00 PM and had let R1 out to the courtyard after 04:00 PM. Later an off-duty staff that lived near the facility found her and brought her back to the facility. R1 exited the courtyard and went around the block of the campus and crossed the street. She could ambulate by herself with the use of her wheeled walker.

On 04/08/21 at 11:32 AM, Certified Medication Aide (CMA) R, stated that no specific staff were assigned to the courtyard 30 minute checks, an alert goes to their work phones, so any nursing staff can perform the check. We sign our initials when we do the check, we walk around the area and check the gate, the steps that are back there, and check on anyone that is out there to make sure they are doing okay. The completed sheets are given to Administrative Staff A.

On 04/08/21 at 11:47, Administrative Staff A stated that maintenance locked the courtyard gate around 08:30 AM and unlocked it around 04:00 PM. Staff completed the courtyard checks between those hours. R1 liked to go out to the courtyard a lot and she would try to go out the door to the courtyard by herself.

On 04/08/21 at 12:00 PM, Maintenance Staff U stated that the facility cannot allow outside visitors in the courtyard the same time as the residents, so he shut the courtyard gate in the morning and unlocked it around 04:00 PM after making sure

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there are no residents in the courtyard area. Since R1 exited the area on 04/02/21 without staff knowing, the facility now locked the gate at all times.

On 04/08/21 at 12:36 PM, Certified Nurse Aide (CNA) M stated that on 04/02/21, R1 was at the end of the hall trying to go outside then was getting ready to pull the fire alarm when he intervened. CNA M took R1 outside and watched her sit down, then he returned inside to do his work. CNA M reported it was around suppertime, from 05:00 PM to 06:30 PM, and the floor was busy, he got sidetracked, and forgot R1 was out in the courtyard. Then, around 06:00 PM the nurse asked CNA M if he had seen her, he started looking for R1, but then someone picked her up and brought her back. CNA M stated he forgot the courtyard gate was open at that time.

On 04/08/21 at 01:01 PM, Administrative Nurse D stated that when reviewing the facility camera videos, it showed that the courtyard gate was unlocked at 04:25 PM by Maintenance Staff U and that R1 walked out the open courtyard gate and stood on the sidewalk around 05:00 PM. Then around 05:15-05:20 PM, R1 crossed the street. Administrative Nurse D confirmed that the CNAs/CMAs should check on the wanderer's location every 30 minutes and document per the policy.

On 04/08/21 at 01:15 PM Administrative Nurse D confirmed that the staff failed to complete the 30 minute checks on 04/02/21 at 05:00 PM, 05:30 PM, and 06:00 PM.

On 04/08/21 at 01:46 PM, Licensed Nurse (LN) G, who was on duty on 04/02/21, stated that R1

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was at risk for elopement prior to 04/02/21 and that she should be on 30 minute location checks. The location checks were not assigned, but all the CNA's on duty were responsible for doing them. LN G revealed that she was not aware that R1 was missing, was not aware that R1 went out to the courtyard, and was not aware that the 30 minute checks were not being completed. LN G revealed that prior to R1 going out to the courtyard she was trying to pull the fire alarm so she could go outside, and another CNA redirected her. LN G then went into another resident room. Later, the front desk called her and said they had a resident at the back door that had been walking out at the sidewalk.

On 04/08/21 at 02:28 PM, CNA N stated she last saw R1 around 04:00 PM on 04/02/21 when she started her shift. R1 was in her room, then later she heard R1's voice going down the hall with CNA M and heard she was trying to pull the fire alarm. She revealed that all of the CNA's were responsible for completing the wanderer 30 minute checks. It is normally discussed at the beginning of the shift who is going to do it when, but that she worked 4:00 PM to 09:00 PM, so staff discussed it before she got there.

The facility policy "Wandering Resident Protocol," dated 10/05/20, indicated that the duties of CNAs/CMAs were to check on the wanderer's location every 30 minutes and documents that it was done.

The facility policy "Court-Yard Philosophy," dated 09/15/16, indicated that when residents with a code alert tag on are in the courtyard, the staff must speak to them in person every 30 minutes to determine if they need assistance, or a drink,

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or more sunscreen.

The facility failed to provide adequate supervision of Resident (R)1 when staff allowed her out in the unlocked courtyard area and failed to perform care planned 30 minute checks, allowing this resident to exit the facility courtyard without staff knowledge, cross a residential street with a speed limit of 30 miles per hour, and was found by an off-duty staff member 45 minutes later. This deficient practice placed the resident in immediate jeopardy.

On 04/08/21 at 05:05 PM, Administrative Nurse D was informed that they were in immediate jeopardy status and provided the "Immediate Jeopardy Template" for failure to provide supervision and perform 30 minute checks to provide safety to the residents at risk for elopement.

This deficiency was cited as immediate jeopardy, past non-compliance as the facility completed the following, as of 04/05/21 at 9:48 PM:

1. A mechanical intervention of locking the courtyard gate at all times was immediately put into place on 04/02/21 at 6:30 PM

2. Education was provided to all facility staff regarding elopement and risk for elopement residents. The education was initiated immediately on Friday 04/02/21 at 8:49 PM. The employees completed the education by 04/05/21 at 9:48 PM and all employees who were on vacation or were not available to receive the education will complete the education prior to

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F 689	Continued From page 9 working or as they arrive to work prior to beginning of their shift. 3. On 04/02/21 at 8:00 PM after the incident was reported, the QAA committee met by phone and in person regarding the elopement. Immediate action was taken with interventions and an education plan which was implemented the same day.	F 689		