STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175468	A. BUILDING _____ B. WING _____	C 03/31/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE MISSION RETIREMENT VILLAGE	242 CARROLL STREET SAINT PAUL, KS 66771

(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 compmlaint investigation # 161310. This 2567 was electronically sent to the facility on 04/05/21.	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 42 residents, with three of the five residents identified with elopement risks, reviewed for elopement. Based on observation, interview, and record review, the facility failed to provide adequate supervision to prevent one residents (R)1 of the three residents reviewed for possible elopement, from leaving the facility without staff knowledge. R1 wearing a Wander Guard bracelet left the facility without staff knowledge, with the staff failure to respond for approximately five minutes, when the Wander Guard and door alarms at the "Chapel" exit door sounded and came across the pager alert. Any of the five residents identified for elopement risk could have exited without staff knowledge. However, this resident walked across the pavement to an eight-plex apartment, where she lived prior to being admitted to the long term care unit, before the staff found her seated on a couch	F 689		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 04/05/2021

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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in the apartment complex. This same resident and type of incident occurred approximately ten weeks prior to this elopement.

Findings included:

- Resident (R)1's medical record "Admission Sheet" documented the resident re-admitted to the facility on 01/12/21. The primary care physician (PCP) listed diagnoses of Alzheimer's Disease with behaviors (progressive mental deterioration characterized by confusion and memory failure) and anxiety disorder (nervousness, or tension).

The Admission "Minimum Data Set" (MDS), dated 02/05/21, documented the resident with a "Brief Interview for Mental Status" (BIMS) score of 05/15, which indicated she had severely impaired cognition. The resident had wandering behaviors daily. On 02/14/21 staff completed a wandering evaluation and scored her at high risk for elopement, with a score of 12. The resident wore a Wander Guard bracelet on her right wrist at all times.

The "Behavior Care Area Assessment" (CAA), dated 01/19/21, assessed the resident used prescription glasses, had cataracts, used Ativan (anti-anxiety medication), required cueing and supervision with task segmentation. She also required limited assistance for most activities of daily living (ADLs). R1 used a Wander Guard due to her cognition.

The Quarterly "Minimum Data Set" (MDS), dated 11/13/20, documented the resident had a BIMS score of six. The resident required cueing with repetition of words, temporal orientation, and

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recall. The resident had not exhibited wandering since the previous assessment. The resident wore a wander/elopement device daily.

The "Cognition" care plan, dated 01/19/21 instructed the staff that R1's personality was pleasant and joking unless she got mad. R1 had Alzheimer's with behavioral issues and depressive features, and her cognitive status varied and appeared to get worse in the afternoon and evening hours. R1 would forget she lived at the facility. When she looked out the window or doors and saw the 8-plex (apartments she lived in previously) it sometimes made her think she needed to return there. If she could not find someone to answer her questions it increased her anxiety. She could get agitated if she thought she needed to get back to her apartment even when staff provided her with redirection and reassurance.

The "Safety" care plan, revision dated 01/17/21, (after R1's previous elopement, on 01/16/21) included the resident wore a Wander Guard device on her shoe to alert staff when the resident was close to an exit door. The resident would occasionally remove/cut off her wander guard alarm. The facility educated staff to remind the resident to wear her shoes when she was in the hallway. Additional update on 02/14/21 instructed the staff to check the placement of her Wander Guard every four hours and check the function daily. Staff were also to document her whereabouts every 15 minutes.

The "Mobility" care plan, documented the resident was steady on her feet and was able to ambulate without staff assistance.

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The "The Physician's Order", dated 01/04/21, directed staff to ensure proper functioning of the resident's Wander Guard daily on every shift. Staff were to check placement of the Wander Guard on the resident daily on every shift.

Review of "Progress Notes," dated 01/16/21 revealed, the resident previously eloped on 01/16/21, out the same door and to the same apartment complex.

Maintenance personal D provided documentation of his routine weekly alarm checks and also of the last elopement drill, conducted on 02/10/21 a 04:49 PM.

The facility "Self Investigation" dated 03/28/21, completed by Administrative staff A included, on 03/28/21 at 8:16 PM, the Chapel area wander guard alarm and exit door alarm both sounded. Three staff assigned on the Chapel area hallway were assisting a resident in a resident room, and were aware of the alarms sounding. However, all three staff failed to answer and turn the alarms off for five minutes. When they answered the alarms, they went directly across the driveway into the eight-plex apartment and located R1 sitting on the couch. Prior to her admission to the long term care facility the resident lived in that complex. The resident walked back across the area and returned to the facility with staff. The resident was assessed without any injury. She was fully dressed, with shoes. The temperature outside was 53.6 degree Fahrenheit and clear. The resident reported she was looking for her room.

Interview with Administrative Licensed Nurse Staff B, on 03/31/21 at 1:30 PM, revealed the nursing staff did document visual checks on R1 at

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the last time of 07:45 PM on 02/28/21. The resident was last seen seated in the hallway, with other residents, near the medication cart, just prior to all three hallway staff going into the other residents' room to provide care for him.

On 03/31/21 at 03:50 PM, Certified Nursing Aide E verified the alarms sounded and came across her pager, when the two certified nursing staff were in the process of transferring another resident with a mechanical lift. After they secured the resident in bed they checked the door and outside and then found the resident across the paved drive in her old apartment complex.

Licensed Nurse Staff C was also in the other resident's room with the certified nurse aides during the resident's elopement. On 03/31/21 at 04:10 PM, she reported she was involved with the resident's feeding tube preparation and oxygen placement and could not leave the room to check on the exit door alarms.

Observation, on 03/31/21 off and on throughout the day, from 11:00 AM to 05:30 PM, revealed R1 walked in her room and in the hallway without need for assistance or assistive devices. She wore a Wander Guard on her right wrist.

The facility's "Unsafe Wandering/Elopement Policy," dated 01/19/21, documented the facility should ensure the residents who exhibit wandering behavior and/or are at risk for elopement receive adequate supervision to prevent accidents, and receive care in according with their person-centered plan of care addressing the unique factors contributing to wandering or elopement risks.

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F 689	Continued From page 5 The facility failed to provide adequate supervision for the five residents with elopement risk, including this confused mobile resident. The facility failed to respond to the exit door alarms and the pager alert for five minutes, when R1 left the facility without staff knowledge, and walked to the eight plex apartment.	F 689		