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 02/10/2021

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 # 159577. This 2567 was electronically sent to the facility on 02/12/21.	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 41 residents with three selected for review for elopement. The facility identified five residents at risk for elopement. Based on observation, record review, and interview, the facility failed to provide appropriate interventions for Resident (R)1, identified as a high risk for elopement, left the facility, without staff knowledge, when staff failed to respond to the door alarms. In addition, the facility failed to provide an alternative placement for the wander guard alarm, after the resident's feet were swollen, and the resident was no longer wearing her shoes, with the wander guard alarm attached to her shoe. Findings included: - R 1's signed "Physician Order Sheet" (POS), dated 01/04/21, documented the following	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.

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 02/10/2021

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 689	Continued From page 1	F 689		

diagnoses: edema (swelling resulting from an excessive accumulation of fluid in the body tissues), restlessness (the inability to rest or relax as a result of anxiety or boredom) agitation (feeling of aggravation or restlessness brought on by a provocation or a medical condition), wandering (traveling aimlessly from place to place, anxiety mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure) and dementia (progressive mental disorder characterized by failing memory, confusion).

The Admission "Minimum Data Set" (MDS), dated 08/20/20, documented the resident admitted on 08/20/2018. The resident had a "Brief Interview for Mental Status" (BIMS) score of six, that indicated the resident had severely impaired cognition. The resident required cueing with repetition of words, temporal orientation, and recall. The resident had wandering behaviors in the previous three days which placed the resident at significant risk of getting to a potentially dangerous place. It was very important for the resident to go outside to get fresh air when the weather was good. The resident wore a wander/elopement alarm (Wander Guard) bracelet (that sets off an alarm when resident wearing one attempted to exit the building without an escort) daily.

The "Cognitive Loss/Dementia Care Area Assessment" (CAA), dated 09/02/20, documented the resident was cognitively impaired with a BIMS score of six. She had diagnosis of dementia, Alzheimer's, and anxiety. She required cueing and task segmentation for

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 02/10/2021

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 689	Continued From page 2	F 689		

most of her Activities of Daily Living (ADLs), with supervision to limited staff assistance.

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

The "Cognition/Memory" care plan dated 08/20/20, documented the resident's cognitive status would vary, and the resident would forget she lived in the facility. She would become agitated (feeling or appearing troubled or nervous.) if she thought she needed to go back to her apartment.

The "Safety" care plan, dated 08/20/20, documented the resident could look for a door that would lead her back to her independent apartment. The facility educated staff to check on the resident frequently for resident's wants and needs.

The "Safety" care plan, revision dated 01/17/21, (after the elopement) 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.

The "Mobility" care plan, documented the resident was steady on her feet and was able to ambulate without staff assistance. The resident preferred to be bare-foot and it was difficult to get the resident

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 02/10/2021

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 689	Continued From page 3	F 689		

to wear her shoes.

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 the Treatment Administration Record (TAR), from 02/12/21-02/17/21, documented staff checked the Wander Guard placement every shift, located on the resident's right shoe. However, staff identified the resident had swollen feet, and would not wear her shoes.

According to https://www.wunderground.com/history/daily/us/ks/st.-paul/KJLN, the outside temperatures were as follows:

On 01/16/21 at 03:53 PM, the outside temperature was 41 degrees Fahrenheit (F), with wind speed at 13 miles per hours (MPH) and no precipitation.

On 01/16/21 at 04:53 PM, the outside temperature was 40 degrees Fahrenheit (F), with wind speed at five miles per hours (MPH) and no precipitation.

Review of the "Nurse Progress Notes", located in the resident's clinical record, on 01/16/21, documented the was made aware that the resident out of the facility, in the apartment complex. The resident wore a Wander Guard alarm on her right shoe, "Although she did not have them on at the time." The resident reported "She went to a softball game because she likes to watch games ..." The resident was unable to

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 02/10/2021

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 689	Continued From page 4	F 689		

recall going to the apartment complex. When staff reported the elopement to the resident's family, it was reported, by the family, that the resident did not like to wear shoes.

On 01/16/21, "Root Cause Analysis" located in the resident's assessment clinical records, revealed R 1 was found in the eight-plex apartments where the resident previously resided in an apartment. The resident did not remember she no longer lived in the apartments, due to her cognitive impairment. The facility validated the root -cause analysis was if the resident had worn her shoes that her Wander Guard device was located on, that was on her right shoe, the resident would not have left the facility.

Review of the notarized witness statement of Certified Nursing Assistant (CNA) P documented she had her pager on, however failed to look at the pager until she completed taking care of an unidentified resident.

Review of the notarized witness statement of CNA Q, documented he was aware the "Chapel door" alert sounded on his pager; however, he was in another resident's room, and provided care to the unidentified resident.

Observation, on 02/10/21 at 09:38 AM, revealed R1 ambulated with a staff member. The resident had the Wander Guard alarm on her right wrist. The resident wore non-skid socks.

Observation, on 02/10/21 at 01:11 PM, revealed the resident ambulated with a staff member in the hallway. The resident wore a Wander Guard alarm on her right wrist. The resident wore non-skid socks.

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 02/10/2021

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 689	Continued From page 5 On 02/10/21 at 08:48 AM, Administrative staff A, reported R1 left the facility, unsupervised at 03:56 PM. An apartment resident called the facility to notify the facility staff that the resident was at the apartment. On 02/10/21 at 11:37 PM at Licensed Nurse (LN) H reported she did not hear the door alarms when the resident exited the building. The resident left the facility at approximately 03:56 PM. The resident had a Wander Guard device on her right shoe, but she doesn't like to wear her shoes. She reported staff previously attempted for the resident to wear the alarm on her ankle and her wrist but was unsuccessful with keeping the alarm on. After staff returned the resident to the facility, the immediate intervention was to apply her shoes (with the alarm). Staff "Educated" the resident to wear her shoes, however,the resident had severely impaired cognition. On 02/10/21 at 11:56 AM CNA M stated R1 did not exit seek during the day. She does not wear her shoes, due to edema in her feet. The resident wore a Wander Guard alarm on her right shoe. We would have heard the Wander Guard alarm if she had her shoes on, but she did not have on her shoes. Staff should carry pagers, and both The Wander Guard alarm and the exit door alarm alerts staff when the doors open. On 02/10/21 at 12:09 AM, CNA N reported the resident does not wear her shoes. If the resident had her shoes on, with the Wander Guard attached, staff would have been alerted the resident was near the double hall doors. On 02/10/21 at 11:47 AM, Administrative Nurse D	F 689		

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 02/10/2021

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 689	Continued From page 6	F 689		

stated that R1 wandered in the halls. She previously had the alarm on her left wrist, but she found scissors in another resident's room and cut it off. She did not like to wear her shoes due to the edema to her left foot. The Wander Guard was on her right shoe. Administrative Nurse stated that if the resident were wearing her shoes, staff would have heard the Wander Guard alarm on their pagers, as well as the alarm on the exit doors of the facility, when she exited the building.

The facility's revised "Unsafe Wandering/Elopement Policy," dated 01/19/21, documented the facility should ensure that 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 risk.

The facility failed to provide appropriate interventions for this confused, mobile resident, when she left the facility, without staff knowledge, when staff failed to respond to the door alarms. This placed five residents, identified as having high risks for elopement, for the risk of elopement. In addition, staff failed to provide an alternative placement for the wander guard alarm, after the resident's feet were swollen, and the resident was no longer wearing her shoes, with the wander guard alarm attached to her shoe.