STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175500	A. BUILDING _____ B. WING _____	C 02/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILL TOP HOUSE	505 W ELM, PO BOX 248 BUCKLIN, KS 67834

(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 KS00150167.	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 totaled 27 residents with three residents sampled 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 observation, interview, and record review the facility failed to ensure resident (R)1 did not leave the facility without staff knowledge for 57 minutes. Findings included: - Review of "Medication Review Sheet", signed by physician on 12/05/19, revealed R1's diagnoses included dementia (progressive mental disorder characterized by failing memory, confusion) and chronic obstructive pulmonary disease (COPD, a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing). Review of the "Annual Minimum Data Set"	F 689		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 02/13/2020

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
	175500	A. BUILDING _____ B. WING _____	C 02/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILL TOP HOUSE	505 W ELM, PO BOX 248 BUCKLIN, KS 67834

(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		

(MDS), dated 10/09/19, revealed a "Brief Interview for Mental Status" (BIMS) score of seven, indicating severe cognitive impairment. He had no documented episodes of wandering during the seven-day review period and he was independent for locomotion on/off the unit.

The "Cognitive Loss/Dementia Care Area Assessment" (CAA), dated 10/09/19, reported R1 had impaired short- and long-term memory.

Review of the "Quarterly MDS", dated 01/08/20, reported a "BIMS" of 10, indicating moderate cognitive impairment. There were no documented episodes of wandering during the seven-day review period and he required supervision of one staff member for locomotion on unit and was independent for locomotion off the unit.

R1's "Care Plan" advised staff on 07/22/18 to monitor his location every 30 minutes during the day hours and every hour during the night. Staff were to document wandering behavior and attempt diversional interventions in the behavior log. The "Care Plan" revision on 05/23/19 included guidance that he believed he could live at home independently and his family believed he required 24-hour supervision due to his history of wandering, confusion, and lack of safety awareness. On 10/24/19, staff were advised he had a Wanderguard (bracelet that sets off an alarm when residents wearing one attempt to exit the building without an escort) which he wore in his pant pockets and staff were to check the location twice a day.

A "Wandering Risk Scale" completed by the facility on 01/08/20 indicated the resident as a high risk to wander.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175500	A. BUILDING _____ B. WING _____	C 02/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILL TOP HOUSE	505 W ELM, PO BOX 248 BUCKLIN, KS 67834

(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		

Review of a "Behavior Note", dated 02/02/20, revealed R1 talked with his roommate and stated they were living in a prison because they were trying to get out "to go to town" and they were advised they had to have someone go with them.

Review of a "Behavior Note", dated 02/02/20, revealed the resident spoke with the unidentified licensed nursing (LN) staff about his finances. During the conversation, he reported feeling like he was in prison and how he would like to get his own apartment. The unidentified LN staff asked the resident if it would help him feel better if he was routinely taken downtown every now and again. The resident reported "Someone would still have to go with me, I would still be supervised. I just want to be able to go do stuff on my own without supervision. If I feel like going and sitting at the park, I could go sit at the park". The unidentified LN staff did send a fax to the resident's physician about possible depression and awaited a response.

Review of "Incident Note", dated 02/08/20, revealed the resident was upset during the morning and then after lunch, he was seen in the front lobby putting in the code to the keypad. He was redirected at that time. About 01:10 PM staff reported they were unable to locate R1 and staff began looking but were unsuccessful. The staff then searched the grounds and found R1 walking towards the facility at the northeast corner. His vital signs were within normal limits and he appeared without distress or signs of injury. R1 denied falling, shortness of breath, or pain.

Review of the facility's provided investigation revealed on 02/08/20 at 12:26 PM certified

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175500	A. BUILDING _____ B. WING _____	C 02/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILL TOP HOUSE	505 W ELM, PO BOX 248 BUCKLIN, KS 67834

(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		

nursing staff (CNA) A witnessed R1 at the front door entering the code on the keypad. CNA A redirected him back to the family room and then, per video surveillance, R1 exited the front door at 12:35 PM. He was found 57 minutes later approximately 50 yards from the front door. The facility staff did not know if the resident left the facility grounds. The Wanderguard device was in a drawer in his room and the staff assigned to perform the 30-minute checks were assisting another resident.

Review of "Witness Statement", dated 02/08/20, from licensed nurse (LN) E revealed the resident was "wound up" all morning regarding some family concerns. While LN E was providing care to R4, CNA A reported she had witnessed R1 pushing the code into the lobby door keypad but she was able to redirect him. After finishing with R4, LN E advised staff she was taking a 20-minute food break. Upon her return, she provided care to R5 and at approximately 01:25 PM, CNA A reported they could not locate R1. LN E had CNA A start checking the grounds. LN E wrote the staff found R1 with his coat, shoes, khaki pants, and a T-Shirt on and with no shortness of breath noted.

Interview with CNA A on 02/11/20 at 10:31 AM revealed she last saw the resident approximately 10-15 minutes prior to him leaving and he was in the process of entering "44" into the keypad. She reported the code at that time as "4488*" to open the door, prior the code change on 02/08/20. CNA A could redirect him to the activity room but as she was on her way to speak to LN E, she noted the resident coming out of the room, then redirected himself back into the room. She reported the resident was upset about cough

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175500	A. BUILDING _____ B. WING _____	C 02/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILL TOP HOUSE	505 W ELM, PO BOX 248 BUCKLIN, KS 67834

(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		

drops and so she advised the nurse about the resident entering part of the code and his desire for cough drops. She then next saw R1 approximately 5-10 minutes after the missing resident code announcement and found him outside on the front sidewalk. CNA A reported R1 did not appear in any distress or display any signs of shortness of air.

During an interview with Administrative Staff B on 02/11/20 at 02:26 PM she revealed there was the belief LN E should have delayed her break until LN E ensured maintenance were contacted to change the code for the keypad and assigned a staff member to stay with the resident at all times until the code change occurred.

Review of the policy entitled "Elopement Policy", dated 09/2016, revealed an elopement bracelet would be placed on every resident at risk for elopement.

The facility failed to implement immediate interventions after witnessing R1's attempt to enter the code to the front door which allowed R1 to elope and remain out of the facility unaccounted for 57 minutes.