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	N087046S	A. BUILDING: _____ B. WING _____	C 06/05/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S 000	INITIAL COMMENTS The following citations represent the findings of complaint investigation #KS00142038. The 2567 was electronically sent to the facility on 6/11/19.	S 000		
S 435 SS=K	28-39-152(i)(2) ACCIDENTS (2) Each resident receives adequate supervision and assistive devices to prevent accidents. This REQUIREMENT is not met as evidenced by: The facility census totaled 26 residents with 5 residents identified as cognitively impaired and at high risk for elopement. Based on observation, interview and record review the facility failed to identify and implement appropriate interventions to prevent the elopement of 1 of the 3 residents sampled. Resident #1 was found 321 feet from the front door of the facility. The resident was located by the facility staff within 50 feet from a heavily traveled road with a speed limit of 40 miles per hour which placed all 5 cognitively impaired resident who are at risk for elopement in immediate jeopardy. (#1) Findings included: - Review of resident #1's physician's progress note dated 3/30/19 revealed the following diagnoses: dementia (progressive mental disorder characterized by failing memory, confusion), psychosis (any major mental disorder characterized by a gross impairment in reality), anxiety mental or emotional reaction	S 435		

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

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characterized by apprehension, uncertainty and irrational fear), agitation (feeling of aggravation or restlessness brought on by a provocation or a medical condition), insomnia (inability to sleep), major depressive disorder (major mood disorder), and restlessness.

Review of the significant change minimum data set (MDS) dated 11/13/18 revealed the resident had brief interview for mental status (BIMS) score of 3 (severe cognitive impairment). The facility coded the resident as independently ambulatory on and off the unit, he/she exhibited verbal behavioral indicators (threatened, screamed and cursed) at others daily, he/she wandered the facility daily and the resident received a physician prescribed antipsychotic and antidepressant medication 7 of the 7 days in the assessment look-back period.

Review of the quarterly MDS dated 5/9/19 revealed the resident had a BIMS score of 3 (severe cognitive impairment). The resident was independently ambulatory on and off the unit, the resident exhibited verbally abusive behaviors directed towards the staff 4-6 days in the assessment look-back period and wandered the facility daily.

Review of the behavioral CAA dated 11/14/18 revealed the resident wandered throughout the facility and asked staff why he/she was in the facility and expressed his/her desire to go home. The resident recently returned from inpatient treatment at the BHU(Behavioral Health Unit) and the resident's behavioral indicators remained unchanged.

Review of the Elopement Risk Assessment dated 5/10/19 revealed a score of 18 (high risk for

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S 435	Continued From page 2 elopement). Review of the care plan last revised on 6/3/19 revealed the resident was a risk for wandering and elopement and the following intervention were in place prior to resident #1's elopement on 5/30/19: The staff were to assess the resident's risk for falls. The staff were to monitor the resident for fatigue. The staff were to ensure all staff were aware of the resident's elopement risk. The resident required a locked building. The staff were to utilize the outside secured courtyard for the resident for safe walking. The staff was reoriented the resident to the place and time, as needed. Th staff were to distract the resident from wandering by offering pleasant diversions, structured activities, food, conversation, television and books. 4/5/19 - The staff were to encourage the resident to help put the table cloths on the tables in the dining room and roll silverware for meals. The resident loved to walk, and the staff were to encourage the resident to walk to help relieve agitation. The staff were to redirect the resident away from the exits when others exited the facility. The staff were to encourage the resident to look at a book created by the family to distract the resident when having behaviors. Review of the progress note dated 5/15/19 at 9:30 PM revealed the resident approached the nurse on shift and was angry he/she was in the facility and exhibited verbally abusive behavior directed towards the staff member.	S 435		

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S 435	Continued From page 3 Review of the resident's progress note dated 5/21/19 at 12:10 AM revealed the resident asked the charge nurse "why am I here?" The charge nurse attempted to redirect the resident without success and the resident demanded the staff call the Police. The resident wandered in and out of other resident's rooms, even the rooms with the doors closed. The resident refused to take the prescribed as needed (PRN) Ativan (antianxiety medication) 1 milligram (mg) for agitation and told the nurse to get his/her meds away from him/her. At 1:50 AM the nurse revealed the resident continued to enter other resident's rooms despite staff redirection and the resident shoved the nurse twice and voiced threats he/she would slap the nurse. Review of the progress note dated 5/24/19 at 6:00 PM revealed the resident's family expressed concerns regarding his/her increased behaviors and the increased amount of time the resident required to de-escalate. The facility contacted nurse practitioner (APRN) I and he/she gave an order for Tylenol 650 mg by mouth twice daily and PRN for pain and to increase the scheduled Ativan (antianxiety medication) to 1 milligram (mg) for agitation. Review of resident #1's progress note dated 5/26/19 during the 6:00 AM to 6:00 PM shift revealed the resident demanded the staff call the Police because he/she was held hostage in the facility. The resident blocked doorways and refused to allow the staff to get past him/her to serve the resident's meal, threatened to "knock the nurse's teeth out", argued with other staff and residents, and resident #1 attempted to exit all doors of the facility. The nurse documented the notification of the resident's behaviors to administrative nurse B.	S 435		

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S 435	Continued From page 4 Review of the progress note dated 5/26/19 at 6:00 PM revealed the resident made threats he/she would hit other residents and family members in the facility. The resident yelled out "call the Police", he/she threw a glass of water at another resident, and refused to take his/her medication. Review of the progress note date 5/27/19 at 11:00 AM revealed the resident argued with the staff, became upset and voiced a concern his/her spouse wanted to break up with him/her. The facility contacted the BHU with the resident's intake information and the BHU accepted the resident for admission. The facility contacted the resident's family and the family informed the charge nurse they wanted to wait until after the care plan meeting the facility requested on 5/29/19. The charge nurse informed the family if resident #1 hit another resident he/she would have to be admitted to the BHU and educated the family a bed may not be available at the BHU on 5/29/19, after the care plan meeting was held. At 1:00 PM an addition made to the progress note revealed the resident lost his/her balance and sat on the floor without injury. Review of the progress note dated 5/28/19 at 11:00 AM revealed resident #1 was in great spirits when he/she woke up. The resident got upset at 9:00 AM, stated he/she was supposed to meet his/her sibling and the facility held him/her hostage and he/she could not go. The note revealed a staff member took resident #1 outside where he/she de-escalated and the facility had a care plan meeting scheduled with resident #1's family the morning of 5/29/19. Review of the progress note dated 5/29/19 at	S 435		

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S 435	Continued From page 5 7:10 AM revealed the resident attempted to follow staff members into other resident's rooms, slapped doors with his/her palm, placed his/her fist in the charge nurse's face, attempted to exit the facility via the front door, had exit seeking behaviors and checked every door on the long-term care unit. Review of the care plan meeting progress note dated 5/29/19 at 10:00 AM revealed the meeting was held with the resident's family. The only concerns at the time of the meeting was the resident's increased behaviors. The family did not want the resident to be admitted to the BHU at that time. The physician was contacted and scheduled a time on 5/30/19 to assess the resident and the family agreed. Review of the resident's progress note dated 5/30/19 at 11:00 AM revealed the physician assessed the resident and wrote new medication orders. The physician contacted the resident's son/daughter and discussed the medication adjustments, the resident's need to be admitted to the BHU for the safety of the other residents, staff and the resident if the medication was not effective. The physician explained to resident #1's family a 15-minute physician's visit would not solve the problems with the resident behavior. Review of the resident's progress note dated 5/30/19 at 3:15 PM revealed the nurse was informed by a direct care staff H the resident was found outside and the activity staff brought him/her back into the facility. The resident was unable to verbalize how he/she eloped from the facility. The resident walked to the dietary entry door, attempted to open the door, and kicked the door when he/she realized the door was locked. The staff notified administrative nurse B and the	S 435		

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resident's family and asked if the family could come to the facility and provide one on one monitoring to the resident. The staff completed a skin assessment and the resident's vital signs. The resident's family agreed to the admission at the BHU and the resident discharged from the facility via Emergency Medical Services (EMS) at 6:15 PM for admission to the BHU.

The historical weather information for 5/30/19 at 3:00 PM recorded by Wunderground revealed the temperature at 3:00 PM was 82 degrees with a humidity of 29%.

Observation on 6/4/19 at 2:15 PM revealed the front door to the facility was key pad coded, and a sign above the key pad which directed the staff and visitors to exit the facility with caution to ensure a resident did not follow the visit out the door. The observation revealed the facility front door was not visible from the common area of the facility and did not have a staff member located in foyer to monitor the front door.

Observation on 6/4/19 at 3:00 PM revealed the staff located the resident 321 feet east of the front entrance to the facility, standing next to a trash dumpster. The resident was within 50 feet west of a heavily traveled road with a speed limit of 40 MPH (miles per hour). The facility was located behind two businesses, with one business observed to have multiple cars entering and exiting the parking lot during the observation. The resident was on a sidewalk that sloped downwards towards the parking lot and was not a level walking surface. A creek bordered the facility with access to the creek edge within 65 feet from the front entry door.

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Review of the facility's elopement investigation for resident #1 revealed the following:

On May 30th, 2019 at approximately 3:14 PM, resident #1 was found outside of the facility by another associate direct care staff G of the memory care building and long-term care Staff H located and escorted the resident back into the facility. Licensed nurse D completed an assessment with no findings or concerns identified. The resident's family and physician were notified and orders were received to admit the resident to the BHU for evaluation and treatment. The facility made arrangement for his/her admission to the BHU and the staff provided one on one monitoring until the resident transported to the BHU at approximately 6:15 PM per EMS.

The conclusion of facility's accident investigation revealed resident #1 exited the facility through the main entrance door at the front of the community between 2:50 PM and 3:10 PM per witness statements obtained from the facility staff. Staff H located the resident along the sidewalk of the long-term care (LTC) facility, on community property. Staff H responded to the elopement and stayed with the resident until he/she was safely returned to the LTC. The resident's medical records revealed he/she had pronounced changes in his/her behavior days prior to the incident which was observed and reported to the physician by the LTC staff. The facility initiated several interventions as the facility attempted to keep resident #1 in the facility. The facility explored and discussed placement in a BHU and discussed with the care team and the resident's family two days prior to the incident, however other interventions were selected for the resident's behavior management. The immediate

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intervention already stated was initiated at the time of the occurrence and a comprehensive investigation was completed to determine the causal factors during the investigative period. The facility determined resident #1 exited the facility without the LTC staff's knowledge.

Interview on 6/5/19 at 10:01 AM with direct care staff E revealed the resident was hard to redirect and the resident became verbally and physically aggressive with the staff and at times was verbally aggressive with other residents. Staff E revealed the resident wandered from door to door in the facility on the day he/she eloped and the staff were unable to redirect him/her. Staff E revealed he/she was unsure how the resident eloped from the facility and revealed he/she had not received any education regarding the elopements until the morning of 6/5/19. Staff E said the facility staff were unable to visualize the front door of the facility while providing care to the residents, the door only alarmed if it was held open too long, and the facility did not have a Wanderguard (an electronic monitor system).

Interview on 6/5/19 at 12:35 PM with licensed nursing staff D revealed the resident's behavior had been an issue for several weeks prior to his/her elopement from the facility. The resident had exit seeking behaviors in the days prior 5/30/19, the day resident #1 eloped from the facility. Staff D revealed the facility staff had not been educated that the resident required one on one monitoring after the family care plan meeting was held on 5/29/19. Staff D revealed the facility had not provided him/her with any education regarding resident #1's elopement at the time of the interview.

Interview on 6/4/19 at 1:00 PM with administrative

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nurse B and administrative nurse C revealed the facility identified the resident had increased agitation and behavioral indicators which included wandering. The facility held a care plan meeting on 5/29/19 with the family and discussed the need for a medication review and possible medication changes. The facility discussed with the family the need for a private sitter or the need for the family to provided one on one and the possibility of admission to BHU. The family denied the need of a sitter or one on one monitoring and admission to BHU. Staff B and C confirmed the resident's behavior changed and the facility educated the staff on 5/29/19 that resident #1 required one on one monitoring related to his/her increased wandering and behavioral indicators. Staff C confirmed the resident's elopement risk assessment completed on 5/10/19 score was 18 and indicated the resident was at high risk for elopement.

Interview on 6/4/19 at 1:33 PM with administrative nurse C revealed the facility tested the integrity of all the doors and tested the mag lock (an electromagnetic lock), all of which worked without issues. Staff C confirmed the facility was aware the front door was not visible from the common working area of the facility, the facility did not have a door alarm, did not have a wander guard system or video monitoring system to help alert the staff a resident attempted or left the facility unaccompanied by the staff. He/she revealed the staff was unaware the resident eloped from the facility. He/she revealed the resident most likely followed a visitor or a staff member out the front door.

Review of the facility policy last revised 4/30/19 revealed a resident was considered missing when he/she was not accounted for during a meal time,

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routine check, or at any other time when an associate member became aware that a resident was not in his/her expected location within the residence.

The facility failed to provide adequate supervision of resident #1 to prevent the resident from eloping from the facility on 5/30/19. The facility failed to implement immediate interventions before and after the elopement to prevent and protect resident number #1 for elopement which placed resident #1 and 4 other cognitively impaired residents with wandering behavior and at risk for elopement in immediate jeopardy.

A meeting was held with administrative staff B and C on 6/5/19 at 12:07 PM. The facility was informed the investigation of the elopement for resident #1 was determined to be immediate jeopardy related to the facility failure to identify and implement appropriate interventions to reduce the risk of resident #1 eloping and placed 4 other residents at risk for immediate jeopardy.

The facility removed the Immediate Jeopardy on June 5th, 2019 at 3:30 p.m. when they:

1. The facility obtained a bid for installation of a secondary door to the front commons area of the LTC to prevent the residents from wandering close to an exit door which was unable to be visualized from the care delivery area.
2. The facility staff provided supervision of the front door until the installation of the new entry way doors.
3. The facility completed an audit for all other residents to ensure the risk for elopement was identified and present on the care plan.
4. The facility developed and provided additional education to the community staff for elopement

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prevention and identifying a change in the resident's behaviors.
5. The facility created an Elopement risk binder to assist the facility staff with recognition of the residents at risk for elopement from the different campus locations.
6. The facility developed education for the families and the community visitors and would be provided by the clinical staff on an on-going basis.
7. The facility changed the door codes to all the exit doors and increased the code complexity.
8. The facility will provide on-going monitoring for Elopement. The Elopement risk assessments will be completed upon admission to the facility and for all current resident on an on-going basis and the results will be recorded on the resident's care plan along with interventions for mitigation of risk.

Additionally, the results of the incident will be reviewed by the Quality Assurance Process Improvement meeting and additional interventions will be initiated as warranted.

The deficient practice cited at a K and was abated to an E and remained at an E on 6/5/19.