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F 000	INITIAL COMMENTS The following citations represent the findings of a partial extended survey for complaint investigations KS00141707 and KS00141860. The 2567 was electronically sent on 6/11/19.	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 had a census of 37 residents. The facility identified 6 residents as at risk for elopement and the sample included 3 of those residents. Based on observation, interview and record review, the facility failed to ensure 1 of 3 residents received adequate supervision to prevent elopement from the facility. (Resident #2) Findings included: - Resident #2's clinical record included a comprehensive diagnosis list which identified the resident with multiple medical diagnoses, including dementia (progressive mental disorder characterized by failing memory and confusion), heart failure and chronic obstructive pulmonary disease (progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing).	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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The 5/20/19 Quarterly MDS (Minimum Data Set) identified the resident with moderate cognitive impairment (Brief Interview for Mental Status score of 10), the presence of delusions (untrue persistent belief or perception held by a person although evidence shows it is untrue), no wandering behaviors, independence with transfers/ambulation, no functional limitations in range of motion of the upper or lower extremities, and no use of wander/elopement alarms.

The 2/16/19 care plan identified the resident as an elopement risk with a history of removing the Wanderguard (bracelet that sets off an alarm when residents wearing it attempt to exit the building without an escort). The care plan included only generic interventions to prevent elopement, such as "offer pleasant diversions, structured activities, food, conversation, television or a book." On 5/29/19, staff reviewed/revised the care plan to note a "recent attempt to leave the facility....do one on one and document every 15 minutes.

Elopement risk assessments identified resident #2 as an elopement risk as follows:

4/30/19: identified as an elopement risk; use of a Wanderguard alarm was not implemented
5/20/19: identified as at risk for elopement for the following reasons - cognitively impaired/independently mobile with a desire to leave the facility, exit seeking with a purpose, has an active mental illness, recent mental status change. According to the assessment, the resident was at risk for elopement, and had his/her picture posted in the elopement book. Use of a Wanderguard alarm was not implemented.

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5/23/19: included exactly the same information as the 5/20/19 assessment.

Progress Notes included:

5/23/19 at 6:09 a.m.: described staff awareness that resident #2 knew the exit code to the door. According to the note, maintenance staff immediately changed the door code to prevent he resident from exiting the building.

5/23/19 at 9:04 p.m: Described the resident's elopement from the facility without staff knowledge. The resident reported he/she got outside through the back kitchen door and was headed to a local club/bar when staff arrived to return him/her to the facility.

5/23/19 at 9:21 p.m.: Described additional information about the resident's elopement and return to the facility. According to that note, someone called the facility to report a resident outside of the facility. In response to that call, staff did a "head count" and did not locate resident #2. Staff then went down the street to get the resident and return him/her to the facility.

5/29/19 at 9:35 p.m.: Described placement of a Wanderguard alarm bracelet on the resident's wrist and the resident's verbalized statement that he/she did not want the alarm. According to the note, the resident reported he/she would "just cut it off later" and leave again via the kitchen door because of a dislike of "being cooped up."

5/30/19 at 2:41 p.m.: Described staff conversation with resident #2 about the possibility of a facility initiated discharge to another facility where the resident would reside on a locked unit.

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The resident told staff he/she "would have to be carried out in a straight jacket because [he/she] wasn't going anywhere." The resident then threatened to call his/her attorney.

During an interview on 6/3/19 at 2:00 p.m., Maintenance Staff G reported staff left the door leading from the dining room into the kitchen unlocked on the evening of 5/23/19 after a staff member went into the kitchen to fix a resident a peanut butter sandwich. On that date, the door leading from the kitchen area to the outside lacked a key pad alarm or Wanderguard alarm.

During an interview on 6/3/19 at 12:10 p.m., resident #2 reported he/she "eloped" from the facility "about a week ago." The resident reported he/she didn't mean to cause so much trouble but was "just so tired of being kept inside all the time like a prisoner." The resident reported he/she had thought about leaving the facility without staff knowledge many times and in many ways, including crawling a window in one specific room or creating a diversion which would occupy staff while he/she then found a way to get outside. Resident #2 reported he/she started noticing that dietary staff failed to lock the door leading from the dining room directly into the kitchen "about 5 of 7 days a week" so he/she determined that might be the easiest way to get outside. The resident also reported he/she watched dietary staff and knew they all left and went home by 7:30 p.m.. On the evening of 5/29/19, resident #2 reported he/she checked the door leading into the kitchen "sometime after 7:30 p.m." and found it unlocked "as usual." The resident reported he/she walked into the kitchen and found an unalarmed door which led into an area behind the building. He/she exited the building via that door

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and then ambulated with his/her walker along the building, into a back parking lot, and then to the sidewalk which ran in front of a strip mall. The resident reported he/she "headed West" on the sidewalk and got approximately 1 1/2 blocks away before staff pulled up in a car and tried to talk him/her into returning to the facility. The resident reported he/she really did not want to return to the facility because it felt so good to be outside but he/she eventually agreed to return. Again, the resident reported he/she likes the facility and has good friends there, but "hates" being "guarded" and kept inside the building all the time. The resident reported he/she frequently asks to go outside but staff say that isn't allowed unless staff accompany him/her, not even if he/she goes into the courtyard area. According to the resident, this makes him/her feel like a "prisoner in a jail somewhere."

During an interview on 6/4/19 at 2:15 p.m., Licensed Nurse E reported resident #2 frequently makes comments about wanting to leave the facility or missing people in his/her family. According to Nurse E, the resident also frequently talks about wanting to go outside but, when offered the opportunity to go outside with a group, usually refuses to go. Licensed Nurse E reported staff attempted to place a Wanderguard on the resident prior to the 5/23/19 elopement but the resident didn't like the bracelet and cut it off. Nurse E could not verbalize any interventions other than the Wanderguard implemented by staff in an attempt to satisfy the resident's desire to be outside and to prevent elopement.

During an interview on 6/4/19 at 3:00 p.m., Direct Care Staff F reported resident #2 had a Wanderguard bracelet in the past but he/she

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removed it. Staff F verbalized a belief that the resident is "lonesome" and misses his/her family and that's why he/she eloped from the facility. According to Staff F, the resident wanted to go outside often but is not allowed to be outside unless there's an activity or a staff person to accompany him/her. Staff F could not verbalize any interventions other than the Wanderguard implemented by staff in an attempt to satisfy the resident's desire to be outside and to prevent elopement.

During an interview on 6/4/19 at 4:30 p.m., Administrative Staff A confirmed a staff member failed to ensure the door leading from the dining room into the kitchen was locked securely on the evening of 5/23/19, and resident #2 used that door to gain access to the kitchen and then the outside during his/her elopement. According to Administrative Staff A, resident #2 had a strong desire to be involved with his/her family and to be outside of the facility occasionally. Staff A could not verbalize any interventions attempted by the facility to meet the resident's desire for family involvement and outings. Following the elopement, Administrative Staff A reported administrative staff determined the resident would be more appropriate for a locked unit due to his/her elopement risk and history and subsequently asked another facility to evaluate the resident for placement on their unit.

During an observation on 6/3/19 at 12:10 p.m., resident #2 had no signs of cognitive impairment although he/she reported an onset of confusion late each day or in the evening. The resident clearly communicated his/her thoughts and desires to go outside and be involved in activities outside of the facility. The resident reported the

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F 689	Continued From page 6 ability to transfer from the recliner to a standing position and ambulate without assistance of staff. The facility's undated "Elopement" policy included, "....Residents who are at risk of elopement shall be provided at least one of the following safety precautions by the facility: Door alarms on facility exits, a personal safety device that will alert staff when the resident has left the building without supervision of staff supervision either by visual contact or by video camera ....." The facility failed to ensure resident #2 received adequate supervision to prevent elopement from the facility when staff failed to develop/implement appropriate interventions to meet the resident's desire to go outside and to participate in events outside of the facility. The facility also failed to ensure a door leading from the dining room into the main kitchen and then to the outside remained securely closed and locked to prevent resident access. Resident #2 eloped from the facility via that unlocked door.	F 689		
F 760 SS=J	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: The facility had a census of 37 residents with 5 residents selected for sample. Based on observation, interview, and record review, the facility failed to ensure 1 of 5 residents (resident #1) remained free of significant medication errors when staff failed to appropriately process a physician's order for Dilantin, a medication used	F 760		

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to control/prevent seizures which resulted in failure to administer Dilantin for a time period of 35 days. After 35 days without Dilantin, the resident experienced a seizure which lasted approximately 20 minutes which necessitated transfer and admission to the hospital. The facility's failure to administer medication as ordered by the physician resulted in a significant medication error which placed resident #1 in immediate jeopardy.

Findings included:

- Resident #1's clinical record included a comprehensive diagnosis list which identified the resident with multiple medical diagnoses, including cerebral palsy (progressive disorder of movement, muscle tone or posture caused by injury or abnormal development in the immature brain, most often before birth) and convulsions (involuntary series of contractions of a group of muscles).

The 3/18/19 Quarterly MDS (Minimum Data Set) identified the resident with moderate cognitive impairment (Brief Interview for Mental Status score of 8) and total dependence on staff for ADLs (activities of daily living) such as bed mobility and transfers.

The 3/15/19 Care Plan noted the resident's seizure disorder (violent involuntary series of contractions of a group of muscles) and directed staff to give medications as ordered. The care plan also directed staff to monitor/document the effectiveness of the medication, monitor labs, and report any sub-therapeutic or toxic results to the physician.

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Physician orders included a 2/21/19 order for Phenytoin Sodium (Dilantin) 300 mg (milligrams) daily for seizures. Dilantin is a medication used to control/prevent seizures. The resident also had an order for Dilantin 200 mg in the evening.

Laboratory results dated 4/12/19 indicated a "critical high" Dilantin level of 33 mcg/ml (micrograms per milliliter) (normal range 10-20). In response to the critical high Dilantin level, the physician directed staff to discontinue the evening dose of 200 mg of Dilantin and recheck the Dilantin level in 2 weeks.

MARs (medication administration records) for April 2019 showed staff held the 8:00 a.m. doses of Dilantin 200 mg on 4/18/19 and 4/19/19. The clinical record lacked a physician's order to hold the Dilantin on those dates/times and lacked staff documentation of why they held the Dilantin doses.

Laboratory results dated 4/19/19 indicated a continuing high Dilantin level of 28. The clinical record lacked evidence of physician response to the 4/19/19 high Dilantin level, but the facility produced a screen shot of a text message from Licensed Nurse C's personal cell phone on 4/19/19 at 8:12 p.m. which showed a text exchange between the Physician D and Nurse C. According to the text exchange, the physician wanted to change resident #1's Dilantin order by decreasing the daily dose to 100 mg daily at 5:00 p.m. Review of the clinical record revealed no evidence staff processed or implemented that order.

A follow up lab test done on 4/24/19 indicated the resident's Dilantin level was now 13 and within

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desirable limits. The clinical record lacked evidence staff notified the physician of the 4/24/19 Dilantin level results.

According to a 5/23/19 notarized statement written by Physician D, resident #1's primary care provider, facility staff failed to notify him/her of the results of the 4/24/19 Dilantin level and failed to request orders related to Dilantin. In the statement, Physician D reported staff faxed the 4/24/19 Dilantin level results to the clinic's medical billing office rather than to the appropriate location and facility staff failed to provide the on-call provider with updates.

A notarized witness statement written by Licensed Nurse C on 5/24/19 described a text exchange with resident #1's physician on 4/19/19 related to a critical high Dilantin level and subsequent receipt of an order to decrease the daily Dilantin dosage to 100 mg daily in the evening and recheck the Dilantin level in 4 days. According to the statement, Licensed Nurse C had difficulty entering the new order into the computer system and was unsuccessful each time. Nurse C recalled he/she communicated the new orders to the oncoming nurse at the end of the shift and included, "I was sure I had put a note in the progress notes."

MARs (medication administration records) for April 2019 and May 2019 showed resident #1 received no Dilantin in the time period from 4/17/19 - 5/22/19, a time period of 35 days.

Progress Notes dated 5/22/19 at 12:26 p.m. described a prolonged seizure experienced by resident #1 which was unrelieved by intramuscular injection of Ativan, an antianxiety

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medication. The progress noted described the duration of the seizure activity as "5+ minutes" prior to transfer to the hospital via ambulance.

According to the previously mentioned notarized witness statement written by Physician D on 5/23/19, the seizure experienced by resident #1 on 5/22/19 was a "generalized tonic/clonic" seizure (a generalized seizure that produces muscle contractions on both sides of the body) which lasted 20 minutes.

The 5/22/19 Hospital Admission Note for resident #1 noted the resident's low Dilantin level of 0.5 mcg/ml at the time of admission, with a desired therapeutic range of 10-20 mcg/ml. Admission diagnoses listed included, "Seizures, likely from not receiving Dilantin at facility.....Dilantin level is low on admission."

During an observation on 6/4/19 at 11:10 a.m., resident #1 lay in bed watching television. The resident had limited movement of his/her right arm/hand and had the capacity to respond appropriately to questions. According to the resident, he/she had a "seizure problem" all his/her life and takes medications to control the condition. The resident reported he/she required hospitalization "a week ago" because of a seizure, but is doing better now.

During an interview on 6/4/19 at 8:40 a.m., Administrative Nurse B confirmed Licensed Nurse C failed to enter the 4/19/19 physician's order for Dilantin 100 mg daily at 5:00 p.m. into the computer system. As a result of that failure, staff failed to administer Dilantin to the resident in the time period from 4/17/19 - 5/22/19, a time period of 35 days. Administrative Nurse B also

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confirmed staff failed to use the appropriate process to notify resident #1's physician of the normal Dilantin level on 4/24/19 so that the physician could then review current Dilantin orders and determine the dosage required to maintain the resident's Dilantin level in normal ranges.

Although requested, the facility did not provide a policy related to the proper processing/implementation of physician orders.

The facility failed to appropriately process a physician's order for Dilantin for resident #1 which resulted in staff failure to administer Dilantin for a time period of 35 days. After 35 days without Dilantin, the resident experienced a seizure which lasted approximately 20 minutes which necessitated transfer and admission to the hospital. Facility failure to administer medication as ordered by the physician resulted in a significant medication error which placed resident #1 in immediate jeopardy.

The facility removed the immediate jeopardy on 6/4/19 at 1:00 p.m. by implementing the following measures:

Notification to the facility Medical Director of the incident on 5/22/19

1) Education of 100% of nursing staff on 5/23/19 as follows:

Expectations/facility policy related to processing of physician orders.
Physician and family notification of lab results and documentation of the notification in the progress notes

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F 760	Continued From page 12 Requirement to call the physician rather than text him/her Placement of all new medication orders for all residents in the EHR (electronic health record) under the communications tab Requirement to write the current medication orders on all drug related lab results prior to sending the lab results to the physician 2) Identification of 4 other facility residents who currently received anti-seizure medication to ensure all laboratory results were current and had been communicated to the physician, and ensured all four residents currently received anti-seizure medication as ordered by the physician. Staff completed this task on 6/4/19 at 1:00 p.m. After removal, the deficient practice remained at a scope/severity of "G."	F 760		
F 868 SS=F	QAA Committee CFR(s): 483.75(g)(1)(i)-(iii)(2)(i) §483.75(g) Quality assessment and assurance. §483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; §483.75(g)(2) The quality assessment and assurance committee must: (i) Meet at least quarterly and as needed to identifying issues with respect to which quality	F 868		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175218	A. BUILDING _____ B. WING _____	C 06/04/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTVIEW OF DERBY	**445 N WESTVIEW DR DERBY, KS 67037**

(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 868	Continued From page 13	F 868		

assessment and assurance activities are necessary.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 37 residents. Based on interview and record review, the facility failed to ensure the QAA (Quality Assessment and Assurance) committee met at least quarterly and was attended by required members of the committee.

Findings included:

- Review of QAA (Quality Assessment and Assurance) meeting sign in sheets revealed the facility failed to hold a QAA meeting with the required members present in the nearly 5 month time period from 9/11/18, the date of completion of the last annual resurvey, to 2/7/19.

During an interview on 6/4/19 at 4:50 p.m., Administrative Staff A reported he/she could not locate QAA sign in sheets for 2018 and therefore had nothing to provide which would show evidence of QAA meetings during that time period.

The facility failed to ensure the QAA (Quality Assessment and Assurance) committee met at least quarterly and was attended by required members of the committee.