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	175383	A. BUILDING _____ B. WING _____	C 08/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESLEY TOWERS INC	**700 MONTEREY PL HUTCHINSON, KS 67502**

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F 000	INITIAL COMMENTS The following citations represent the findings of complaint investigation #132892.	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 83 residents with 3 residents included in the sample 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 identify resident #1 as an elopement risk and place interventions to prevent him/her from eloping from the facility. The resident the eloped from the facility for approximately 19 minutes and traveled approximately 667 feet prior to being found by a passing motorist and returned to the facility. The facility failed to perform elopement risk assessments on residents #1,2, and 3 upon admission and quarterly. Findings included: - Resident #1 diagnosis included recurrent cerebrovascular accident ((CVA) (stroke) - sudden death of brain cells due to lack of oxygen	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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caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain) and Chronic Obstructive Pulmonary Disease ((COPD) - progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing).

Review of the resident's baseline care plan, initiated 8/23/18, advised staff he/she required assistance of 1-2 staff members, a gait belt, and a front wheeled walker (FWW) for transfers due to weakness to the left lower extremity. The resident also required toileting every 2 hours. On 8/27/18, a WanderGuard (bracelet that sets off an alarm when residents wearing one attempt to exit the building without an escort) was placed on the resident's left ankle.

Review of a nurses note, dated 8/23/18, revealed the resident was admitted to the facility at 4 PM and had an unsteady gait with walking with the FWW. He/she did not know what year or his/her location.

Nurses note dated 8/24/18 revealed the resident had been "up and down several times" with an unsteady gait and would forget his/her FWW.

Review of a nurses note dated 8/24/18, revealed the resident was compulsive, but easy to redirect. The resident required assist of 1 staff and FWW if he/she was not already up.

On the fall risk assessment of factors contributing to fall risk dated 8/24/18, revealed the resident had tripped getting out of the car several days prior. Behavior pattern that made the resident unsafe had been identified as being anxious at times, poor safety awareness, and he/she did not

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call for assistance appropriately. The resident's gait pattern changed while walking and he/she had jerking movements and instability. The resident had an inability to understand and/or follow directions with impaired judgement and/or decision-making ability.

An 8/25/18 nurses note revealed the resident did not wander during that shift.

Review of a nurses note, dated 8/26/18, revealed the resident was anxious and wandering at the start of the licensed nurse shift. He/she had been transferring his/herself out of the room and walking without assistance. The resident had a fall alarm (at this facility, a pad that was placed under the resident which would detect when the resident's bodyweight had been removed and send a signal to the direct care staff's pagers) and was frequently visualized by staff.

An 8/27/18 nurses note revealed that the direct care staff had notified the nurse the resident's fall alarm had been activated and he/she was not in his/her room. The facility staff had begun searching the facility and contacted the on-site security. The resident had been located at the front of the independent living facility with no injuries. The licensed nursing staff applied a WanderGuard to the resident.

The point of care charting revealed between 8/23/18-8/29/18, the resident had 6 instances of documented wandering.

Review of the resident's medical record revealed that an elopement and/or wandering risk had not been completed prior to the resident's elopement.

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Review of a facility obtained notarized witness statement from Good Samaritan J over the phone with administrative nursing staff F on 8/29/18 revealed the good Samaritan J had been driving near the facility and seen a person that appeared unstable. He/she then called his/her family member, who was employed by the facility. The good Samaritan stopped and asked the person if help was needed and that person replied they did. By that time the family member, direct care staff C had arrived at the location and they asked the person if he/she lived at the facility. The person said he/she did so they drove him/her to the entry of the independent living facility. At that time, the person they had located stated they were now visiting a client at the facility and could not locate his/her car. While attempting to describe the car, good Samaritan stated they could see his/her confusion. Direct care staff C went to the front desk to see if the person was a resident at that facility and right at that moment two other staff members arrived and reported the person in their care was resident #1. They allowed a staff member in the back of the car and were instructed on where to take the resident and met at the door by the other employee with a wheelchair.

Review of notarized witness statement from direct care staff A revealed he/she had been providing care to another resident and then heard a door alarm sounding. He/she then went to the enunciator display in the commons area and noted it was sounding for the service doors. Staff A went to the services doors, entered the code to turn the alarm off and then looked in the hallway behind the doors. He/she believed that a fellow staff member had forgot to deactivate the alarm prior to entering/exiting.

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Facility obtained notarized witness statement from direct care staff H revealed he/she had been providing care to another resident and had been notified that resident #1's fall monitor had been activated. He/she completed providing care to the resident and then went to provide care for resident #1. He/she reported the resident was not located in his/her room, so staff H went with another staff member to check another hallway in the facility. They notified other direct care staff the resident was not located and asked for assistance locating him/her. While searching for the resident, they notified a licensed nurse the resident was missing and proceeded to search other hallways to search for the resident. About the time direct care staff completed a search of a different hallway, other direct care staff were bringing the resident back to his/her room in a wheelchair.

Facility obtained notarized witness statement from direct care staff K revealed at approximately 8:40-8:45 PM several other direct care staff reported being unable to locate a resident. We were advised of name and physical description and set off to locate the resident. While approaching the front entrance to the independent living facility, an off-duty staff member was noted to be at the entry way with the resident in his/her family members car. Direct care staff K climbed into the back seat of the car and directed the driver to the long-term care facility house entrance. Another staff member met them at the entrance with a wheelchair and they proceeded to return the resident to his/her room.

Notarized witness statement from direct care staff

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B revealed that staff from the hall the resident resided on advised him/her they were looking for the resident. Staff B then proceeded to search the activities room, kitchen, and 300 hallway for the resident. While he/she was on the 300 hallway, direct care staff A recalled deactivating the door alarm for the service hall door just not to long before. Direct care staff B went out the service door's and then the exterior doors and searched the parking lot, but he/she did not see resident #1. He/she went back inside and begin to walk the hallways to the entrance of the independent living. Upon arriving at the entrance, there was an off duty staff member and his/her family member with the resident in their car. Fearful of him/her being tired and weak, they were asked to drive the resident to the entrance of the long term care house the resident was residing and staff B met them at the entrance with a wheelchair. He/she recalled that after getting the resident back to his/her room and returning to his/her assigned hall, it was 9:11 PM.

Facility obtained notarized witness statement from direct care staff C revealed he/she received a phone call at 9:02 PM from his/her family member who stated they had seen and older person struggling to walk and did not appear to be in good shape. He/she asked what they should do and wondered if they could be a resident of the facility. The family member stopped and asked the person if they needed help and they said they did, so the family member got them into their car and waited for staff C to arrive, which was less than 5 minutes. The person advised they lived at the facility, so they drove to the front of the facility and at that time 2 direct care staff members were arriving saying that a resident was missing. Staff C told them he/she believed they

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had the resident in his/her car and they confirmed it after looking in the car. After that, the resident changed his/her story and advised he/she was visiting a client at the facility and could not find his/her car. They drove him/her back to the entry of the long term care house he/she resided in and the other direct care staff met us out front with a wheelchair.

During an interview with direct care staff H on 8/29/18 at 5:28 PM revealed he/she had been providing care to the resident the night he/she eloped. He/she had been providing care to another resident when resident #1's silent alarm went off. He/she finished providing care to the resident he/she was with and less than 5 minutes was in resident #1's room to check on him/her. He/she stated they had seen the resident approximately 5-10 minutes prior to the alarm being activated sitting in his/her recliner in his/her room. Upon his/her arrival into the resident's room, the resident was not present. The resident was new to the facility and this was his/her first night of providing care to that resident, so he/she did not know if the resident wandered prior. He/she stated the only other item they could think of different from the notarized witness statement was that staff did not deactivate the silent alarm until the resident was back in the recliner.

Interview with direct care staff C on 8/29/18 at 2:09 PM revealed he/she had no changes from his/her above notarized witness statement and he/she had never provided care to the resident.

Interview with direct care staff B on 8/29/18 at 1:36 PM revealed he/she had forgotten to place in his/her witness statement that the resident had been too weak to get out of the car at the main

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entry way and they was why he/she asked for him to be driven around to the entry of the long term care house and why he/she had brought out the wheelchair.

Interview with direct care staff A on 8/30/18 at 9:43 AM revealed after deactivating the alarm on the service door, he/she had checked the hallway behind the service door and then proceeded to some glass doors approximately 50 feet to the right of the other exterior doors and peered outside. He/she did not see anyone or anything in the parking lot and then proceeded on with his/her duties. Less than 5 minutes after deactivating the alarm was when he/she was advised of the missing resident. He/she agreed with his/her notarized witness statement.

Interview with licensed nursing staff I on 8/29/18 at 2:35 PM revealed he/she was the nurse providing care for the resident the evening he/she eloped. The resident had multiple family members visiting that evening and staff I had been advised by one of them that the resident believed he/she was going home with them. Staff I then proceeded to walk with the resident to the front door of the house to say goodbye to his/her family members and then walked back to the recliner in his/her room with no concerns noted. Staff I did report the resident had wandered in the facility before but was usually related to him/her looking for a bathroom. After the resident returned to the facility from being out, staff I performed a head to toe assessment and did not see any indications of the resident having fallen which had been a primary concern since he/she had left the facility without his/her FWW.

During an interview with administrative staff G

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and administrative nursing staff F on 8/29/18 at 10:55 AM revealed the resident was discovered while still on the facility campus (per Google maps estimate the resident had traveled approximately 667 feet from potential exit point) and had been located by a family member of an off-duty staff member. The family and staff member had brought the resident to the front door of the facility and right at that time, several of the direct care who had been searching for the resident arrived and they were able to identify the resident. Staff had reported that a door alarm had gone off and after looking at the enunciator panel, it had been found to be the service door. The staff peered out and reported they had not seen any residents. Then the silent alarm had been triggered and after pulling the records, the alarm had been triggered at 8:47 PM and staff reported they had not reset the alarm until the resident was back in his/her room and the alarm was deactivated at 9:06 PM (total of 19 minutes). Administrative staff had determined the causal factor was that an elopement assessment had not been completed upon the resident's admission.

During an interview with administrative staff G on 8/30/18 at 4:10 PM revealed he/she had found that elopement risk assessments had not been completed on the residents per the policy when they started to perform the investigation into how resident #1 had eloped.

Review of the policy entitled Elopement Risk Prevention or Response, last revised 6/17, revealed that all resident were screened for elopement risk upon the first day of admission, quarterly, change of condition, or after attempted elopement and utilized in the care planning

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F 689	Continued From page 9 process. The facility failed to develop interventions for resident #1 to ensure he/she did not elope from the facility after demonstrating signs of wandering prior to his/her elopement. The facility also failed to ensure residents #1,2,and 3 were screened for elopement risk quarterly and upon admission in an effort to prevent elopement from occurring.	F 689		