STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175402	A. BUILDING _____ B. WING _____	C 06/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHEL HEALTH CARE CENTER	**3000 IVY DRIVE NORTH NEWTON, KS 67117**

(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 #130410.	F 000		
F 689 SS=J	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 54 residents, with 3 sampled for review of elopement. Based on observation, interview and record review, the facility failed to ensure 1 (#01) of the 3 sampled residents, did not exit the facility without staff knowledge. The resident exited the facility main entrance door on 6/12/18 at 6:22 PM, crossed a residential street, and was found by a neighbor on a back patio area at 7:15 PM. The facility staff lacked knowledge of the resident's elopement (leaving without staff knowledge), for approximately 1 hour, until the police returned the resident to the facility. This deficient practice placed the resident in immediate jeopardy. Findings included: - Resident #01's electronic medical record revealed the resident admitted on 5/2/18, with diagnosis of Alzheimer's disease (a progressive mental deterioration characterized by confusion and memory failure).	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 admission MDS (minimum data set), dated 5/11/18, revealed the resident experienced severe cognitive impairment and unable to score a BIMS (brief interview for mental status). The resident had a history of wandering behavior and was at risk for elopement (leaving without knowledge of staff). The resident walked without assistance or devices.

The care plan, dated 5/14/18, included instructions to the staff, regarding behaviors of wandering and resisting cares. The plan provided redirection or diversional activities to correct his/her problem of boredom or searching for something familiar. The resident liked to walk and walked for miles routinely for years. The plan included the need for physical activity to reduce the need to wander. The plan also included opportunities for mental stimulation that matched his/her past likes. On 5/2/18, the facility placed a WanderGuard bracelet (device that sets off an alarm when residents wearing one attempt to exit the building without an escort) to the resident's wrist.

The care plan documented, that on 5/11/18 and again on 5/30/18 documented the resident cut the WanderGuard bracelet off. The staff decorated the WanderGuard to as a bracelet and replaced it on his/her wrist. On 6/7/18, the resident became violet when unable to remove the device from the wrist. Then the facility removed the bracelet, placed a WanderGuard inside a teddy bear and in a purse carried by the resident.

Per interview with licensed nursing staff B and nurse's notes, on 6/12/18 at 7:35 P.M., the police department called the facility and reported

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F 689	Continued From page 2	F 689		

neighbors found the resident approximately ½ mile from the facility, on their shady patio. The police returned the resident to the facility.

According to interview, on 6/14/18 at 11:15 A.M., with licensed nursing staff B, the facility was unaware the resident left the building, until the police called. The reviewed door video, revealed a visitor entered the facility and allowed the resident to leave out the door at 6:22 P.M. The resident returned with the police at 7:40 P.M., (1 hour and 18 minutes later). Licensed nursing staff C assessed the resident without injury and a temperature of 98.1 degrees Fahrenheit.

Nurses notes on 6/12/18, noted a family member arrived at the same time as the resident returned. The family member convinced the resident to let the nursing staff put a WanderGuard device on his/her ankle and shoe, by telling him/her it was a health monitoring device ordered by his/her doctor.

Observation on 6/14/18 at 11:45 A.M., revealed the resident walked in the hallway with the WanderGuard on his/her left ankle and shoe. The resident ambulated with a steady gait without need for assistance or assistive devices.

The facility Policy and Procedure for Elopement and Missing Resident, dated 6/2017, included procedures for wanders and missing residents.

The facility failed to provide adequate supervision and or assistive devices, to keep this known high-risk elopement wandering resident from exiting the facility without staff knowledge. The resident wandered from the building, crossed one residential street and onto a patio approximately

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½ mile from the facility. This deficient practice placed the resident in immediate jeopardy.

The investigation revealed the facility abated the immediate jeopardy on 6/14/18 at 10:00 A.M., when the facility completed the following:

1.) The facility immediately placed the resident on 15-minute checks, upon return to the facility on 6/12/18 at 7:30 P.M.

2.) Staff updated the care plan, to include more diversional activities and family involvement.

3.) The family agreed to help and convinced the resident his/her physician had ordered the WanderGuard device as a health monitoring device and guard was placed on the resident's shoe and ankle.

4.) An all staff letter was e-mailed, to remind staff the resident was considered high risk for elopement and the need to keep resident's safe. Elopement re- training was starting for all staff.

5.) An all staff review and retraining was completed on 6/14/18 at 10:00 A.M.

6.) The facility held a risk management/QA (quality assurance) meeting on 6/14/18 at 10:00 A.M. with 8 staff members present and the medical director contacted per phone. The staff reviewed the elopement and response as well as the plan of correction and staff education.

The deficient practice remained at the scope and severity of a D.