STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175489	A. BUILDING _____ B. WING _____	C 08/16/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE SUNSET HOME INC	601 E MAIN STREET PRETTY PRAIRIE, KS 67570

(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 citation is the result of complaint investigation 5Z4E11	F 000		
F 323 SS=D	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: The facility had a census of 35 residents with 3 reviewed for accident hazards related to risk of elopement (when a resident leaves the facility without staff's knowledge). Based on observation, interview and record review the facility failed to	F 323		

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175489	A. BUILDING _____ B. WING _____	C 08/16/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE SUNSET HOME INC	601 E MAIN STREET PRETTY PRAIRIE, KS 67570

(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 323	Continued From page 1	F 323		

ensure staff accurately assessed the resident and developed interventions to supervise the whereabouts of a resident with a known history of wandering when resident #1 exited the building without staff's knowledge.

Findings included:

- Review of resident #1's signed physician orders dated 7/31/17 revealed the following diagnoses: Bipolar disorder (major mental illness that caused people to have episodes of severe high and low moods), and psychoactive substance abuse with induced dementia (progressive mental disorder characterized by failing memory, and confusion).

The resident had an admission date of 7/31/17 and had no minimum data set (MDS) at this time

Review of the brief interview for mental status (BIMS) assessment dated 8/4/17 revealed a score of 3 indicating severe cognitive impairment.

Review of the wandering resident assessment completed on 7/31/17 (day of admission) revealed the resident was a high risk for wandering. The assessment did not address the risk of elopement.

Review of the initial care plan with a date of 8/1/17 revealed:

The resident was an elopement risk/wanderer due to disorientation to place, wandering aimlessly, and significantly intruding on the privacy of others. Approaches included:
The resident really enjoyed music, especially 80's rock. If he/she got agitated or restless turning on music for him/her would help redirect the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175489	A. BUILDING _____ B. WING _____	C 08/16/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE SUNSET HOME INC	601 E MAIN STREET PRETTY PRAIRIE, KS 67570

(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 323	Continued From page 2	F 323		

resident.-8/1/17
Distract the resident from wandering by offering pleasant diversions. Resident preferred to go outside for a cigarette or listen to music in his/her room-8/1/17
Identify pattern of wandering; is wandering purposeful, aimless or escapist? Is resident looking for something? Does it indicate the need for more exercise? Intervene as appropriate.-8/1/17
Monitor the resident's location frequently and redirect him/her as needed.-8/1/17
Distract the resident from wandering by offering structured activities, food, conversation, television, and music-8/2/17.
Encourage the resident to do group activities in the day room. 8/2/17
Staff to turn motion alarm on and place outside the resident's room door at night to sound when the resident got up and went out of his/her room.-8/2/17
Provide the resident with a restorative program 3-6 times a week.-8/3/17.
All above interventions were in place at the time of the elopement.
The following intervention developed following the elopement.
Staff was to perform visual checks on the resident every 15 minutes- 8/4/17.

Review of the admission notes dated 7/31/17 revealed the resident admitted from home where he/she lived with a family member who could no longer care for the resident. The resident required 24 hour nursing care and supervision. The current plan was for him/her to remain long term. The resident had a court appointed guardian/conservator. The resident was restless during the admission meeting and refused to stay

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175489	A. BUILDING _____ B. WING _____	C 08/16/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE SUNSET HOME INC	601 E MAIN STREET PRETTY PRAIRIE, KS 67570

(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 323	Continued From page 3	F 323		

in the room. A family member went out of the room with him/her for a while and showed the resident around before returning. The resident then voiced he/she wanted to go for a cigarette. Social service staff assisted the resident out to the courtyard where he/she could smoke. A family member completed the resident's social history during the admission meeting as the resident could not answer some questions. The resident stated, "There is something wrong with my brain." The resident had a flat affect and avoided eye contact.

Review of the social service progress notes dated 7/31/17 revealed the resident did a lot of wandering late this afternoon. The resident required frequent re-direction back to his/her room and staff reminded him/her of when he/she would receive Tylenol. The resident ambulated by him/herself and wandered into other residents' rooms. The nursing staff had to re-direct the resident. The resident inquired multiple times about where the ash trays were in the building and exhibited forgetfulness.

Review of the nurse's notes dated 8/1/17 at 8:52 a.m. revealed since 6:00 a.m. the resident had intruded into 3 resident rooms and staff re-directed the resident. The resident stood at the exit doors in the hallway and watched people come in and out and begged staff and visitors to open the door for him/her so the resident could find his/her friend and go to the lake. Staff re-directed him/her at least every 10 minutes. The resident wandered in hallways and picked up items lying around on a counter or a table. The resident did not appear to know his/her boundaries and imposed him/herself into other's activities and conversations. Staff monitored the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175489	A. BUILDING _____ B. WING _____	C 08/16/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE SUNSET HOME INC	601 E MAIN STREET PRETTY PRAIRIE, KS 67570

(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 323	Continued From page 4	F 323		

resident closely.

Review of the nurse's notes dated 8/1/17 at 1:58 p.m. revealed the resident continued to go into other residents' rooms and became resistive at times when staff redirected him/her back out of the room. Licensed nurse F explained to the resident he/she could only go in his/her own room without permission. Other residents watched and told staff if he/she went in an area he/she should not be in, or if the resident bothered other residents. The resident continued to pace throughout the facility this shift.

Review of the nurse's notes dated 8/1/17 at 9:22 p.m. revealed the resident was in and out of residents' rooms often this shift until 6:00 p.m. The resident was in resident #7's room at 3:10 p.m., out to smoke at 3:20 p.m., in resident #8's room at 3:30 p.m., resident #6's room at 3:50 p.m., resident #9's room at 3:53 p.m., attempted to go out the facility's front door at 3:45 p.m., and in resident #9's room at 4:20 p.m. The resident retired to his/him/her room about 6:00 p.m. and rested quietly so far at that time. Other residents were becoming angry. Re-direction sometimes worked and at other times angered the resident.

Review of the nurse's notes dated 8/1/17 at 10:00 p.m. revealed the resident went into resident #9's room, turned on the ceiling lights and sat in the glider. Resident #9 called staff to assist with walking the resident out of his/her room.

Review of the nurse's notes dated 8/2/17 at 4:19 a.m. revealed the resident went into resident #4's room and woke the resident to ask for the location of the bathroom. Resident #4 alerted staff. The resident followed resident #4 out into

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175489	A. BUILDING _____ B. WING _____	C 08/16/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE SUNSET HOME INC	601 E MAIN STREET PRETTY PRAIRIE, KS 67570

(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 323	Continued From page 5	F 323		

the hall.

Review of the nurse's notes dated 8/2/17 at 2:09 p.m. revealed the resident wandered throughout facility today, with staff having to constantly redirect him/her. The resident followed re-direction after much persistence from staff. At noon, he/she went to the dining room, took items out of the China cabinet and tried to put them in a dirty dish tub. Nursing staff intervened and the resident sat in the living room for a while listening to music. He/she sat for short periods, but then got up and wandered the facility again. Staff constantly took him/her out of a room of another resident or an office. Staff tried to distract him/her but his/her attention span was short and he/she did not focus on any one activity for very long. The resident had not shown aggression this shift, but could be resistive when he/she did not want to follow staff direction.

Review of the nurse's notes dated 8/3/17 at 10:58 a.m. revealed staff redirected the resident several times throughout the shift after entering other residents' rooms. The resident did not take any personal items from other rooms. Staff observed the resident in the dining room and the resident could not sit for long periods and ambulated through the dining room placing his/her uneaten food on other residents' plates.

Review of the elopement investigation on 8/3/17 revealed:
Notarized witness statements dated and signed on 8/4/17 of direct care staff L revealed on August 3rd at 8:50 p.m. he/she turned the corner to go down 300 hall. He/she saw a pink robe just outside the door at the end of 300 hall. He/she immediately called for assistance down the 300

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175489	A. BUILDING _____ B. WING _____	C 08/16/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE SUNSET HOME INC	601 E MAIN STREET PRETTY PRAIRIE, KS 67570

(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 323	Continued From page 6	F 323		

hall doors. Staff L started running and when he/she opened the 300, hall door the resident was just stepping onto the street. Staff L went up to the resident just stepping onto the street and staff L stood in front of him/her and the resident was saying he/she was going to his/her family member. The resident wanted staff L to take him/her to the lake. Staff L told the resident his/her family member was not over there and they needed to go back inside. The resident was not injured and staff L tried to stay in front of him/her so the resident did not go anywhere. Two staff arrived and assisted the resident back into the building.

Review of the nurses notes dated 8/3/17 at 8:55 p.m., Nurse G received a call for help outside of hall 3. Nurse G went outside and found the resident in the pa rking lot of the cottages refusing to come inside stating he/she had to get his/her family to go to the lake. This writer and 2 other staff members assisted the resident back inside. The resident again began wandering room to room. Nurse G notified administrative nurse B of the incident.

Review of the nurse's notes dated 8/3/17 at 10:22 p.m. revealed the resident had multiple behaviors this shift. The call light for resident #9 went off while staff were in the dining room assisting residents with the evening meal. Resident #9's family member came out to the dining room and requested help to get resident #1 out of resident 9's room. Nurse G went to resident #9's room and resident #1 refused to leave the room. Nurse G assisted resident #1 out of the room talking and explaining that nurse G would show the resident to his/her room.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175489	A. BUILDING _____ B. WING _____	C 08/16/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE SUNSET HOME INC	601 E MAIN STREET PRETTY PRAIRIE, KS 67570

(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 323	Continued From page 7	F 323		

Review of the notarized statement signed and dated 8/4/17 revealed direct care staff M reported seeing the resident after supper on hall 200 where the resident sat watching TV until 8:30 p.m. and at that time the resident went back to the long-term care halls. Staff M reported he/she let the nurse know the resident was back on the 200 hall watching TV.

Review of the nurse's notes dated 8/4/17 at 1:53 a.m., revealed the resident slept for about 2 hours that night. He/she required 1:1 care for re-direction from going into other residents' rooms.

Review of the social service notes dated 8/4/17 at 12:59 p.m. revealed social service staff D had a 1:1 visit with the resident and the resident wanted to go outside and "get in the truck and go to the lake". Staff D walked with the resident to the glass doorways at the end of hallways and he/she pushed on the door, and when it did not move, the resident told staff D to open it. The resident looked down during all instances with staff D and never noticed the key pad and therefore never attempted to push any buttons to try and get the door opened.

Review of the social service notes dated 8/4/17 at 5:17 p.m. revealed social service staff D called the resident's family about the incident the prior evening when he/she went outdoors. Staff D further explained other behaviors that occurred: wandering into other resident rooms, eating other residents' food, and explained the resident wanting to go outdoors but not attempting to use the key pad, enjoying listening to/singing along with music. Staff D explained administration felt the resident needed a memory care unit to meet

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175489	A. BUILDING _____ B. WING _____	C 08/16/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE SUNSET HOME INC	601 E MAIN STREET PRETTY PRAIRIE, KS 67570

(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 323	Continued From page 8	F 323		

his/her needs. Staff D planned to make referrals to other facilities with memory care units for possible admission elsewhere.

Review of the nurse's notes dated 8/8/17 at 1:04 p.m. revealed nursing staff documented the location and visual check of the resident every 15 minutes due to elopement risk and wandering in the facility. The staff re-directed the resident often and the resident needed visual supervision when not in his/her room asleep.

Review of a flow sheet dated 8/8/17 indicated a staff member assigned to provide 1:1 supervision for the resident.

Observation on 8/8/17 at 10:10 a.m. revealed the resident wandered into the conference room with the surveyor in the room. The resident wanted the water cup on the table and did not understand why it was not his/hers. Shortly after an administrative staff person removed the resident from the room. The resident cooperated with re-direction.

Observation on 8/8/17 at 12:35 p.m. revealed a staff member took the resident from the dining room to his/her room and turned on some loud music for him/her and left the room. Within a minute, the resident wandered down the hall and off the unit. The resident followed the staff back to the dining room and sat down and began to eat the rest of his/her lunch.

Observation on 8/8/17 at 3:06 p.m. revealed the resident up and about and into another resident's room. An office staff witnessed the resident going into the other resident's room and redirected him/her to the nurses' station and took the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175489	A. BUILDING _____ B. WING _____	C 08/16/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE SUNSET HOME INC	601 E MAIN STREET PRETTY PRAIRIE, KS 67570

(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 323	Continued From page 9	F 323		

resident out to smoke on the patio.

Observation on 8/9/17 at 10:00 a.m. revealed the resident wandered in the hall asking different residents if they could open the door for him/her. Direct care staff I stayed with the resident and re-directed him/her to the smoker patio and the resident cooperated.

During an interview on 8/8/17 at 4:00 p.m., direct care staff L reported on 8/3/17 at around 8:40 p.m. he/she completed bedtime accu-checks (test to measure sugar in the blood) and went to hall 300. As soon as he/she entered the hall, he/she saw a resident in a pink robe standing outside the exit door on hall 300. Staff L then used his/her walkie- talkie and called for help to 300 hall. Staff L just stood in front of the resident to keep him/her from going in the street. The resident heard voices of family talking outside one of the cottages and told staff it was his/her family member. Two staff including the charge nurse came out and took the resident by the hand and the resident came in willingly and stated he/she was tired. The weather was nice out and was not dark yet he/she believed it to be around sunset. The resident was in no distress so he/she let the resident go with the nurse and he/she and the other staff member went back to work. The key pad on the door was red so he/she reported the resident had not used the key pad to exit. There were visitors in the facility though staff L did not pay attention to whom they were or when they left.

During an interview on 8/9/17 at 8:00 a.m. social services staff D stated he/she called the incident in to State and remembered staff L told him/her it was dusk and not dark yet. Staff L told staff D the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175489	A. BUILDING _____ B. WING _____	C 08/16/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE SUNSET HOME INC	601 E MAIN STREET PRETTY PRAIRIE, KS 67570

(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 323	Continued From page 10	F 323		

motion sensor light came on outside and staff L saw the resident. Staff D reported it did not have to be dark out to trigger the light. At dusk the light would activate.

During an interview on 8/9/17 at 8:30 a.m. direct care staff L reported the resident was only about a foot outside the door and it was partially dark but not real dark out yet. The motion sensor at the door activated and that was when he/she saw the resident's pink robe.

During an interview on 8/8/17 at 2:40 p.m. licensed nurse G reported the night the resident got out the door he/she worked on another hall and got a call on his/her walkie-talkie from staff L reporting a resident was outside 300 door. Nurse G went directly out there and staff L stood behind the resident with his/her hands full of accu-ckeck equipment so nurse G and another staff member took the resident by the hands and the resident came back in willingly. The resident stated he/she was going over there pointing at the cottages, looking for his/her family member because he/she was going to take the resident to the lake. That was the first time he/she left the building. The resident was tired and let staff assist him/her to bed. All the doors were checked and nurse G put the resident on 15 minute checks. Nurse G reported not taking the resident's vital signs when the resident re-entered the facility but the resident remained in his/her normal state with no distress noted. Nurse G stated he/she notified the family and administrative nurse B of the incident.

During an interview on 8/9/17at 5:15 p.m., licensed nurse F reported there was a wandering assessment done on admission, quarterly and as needed per the wandering policy, but the facility

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175489	A. BUILDING _____ B. WING _____	C 08/16/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE SUNSET HOME INC	601 E MAIN STREET PRETTY PRAIRIE, KS 67570

(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 323	Continued From page 11	F 323		

had no specific elopement policy.

During an interview on 8/9/17 at 5:30 p.m., administrative nurse B reported the wandering assessment completed for the resident indicating the resident was a high wandering risk but it was all they had. The facility did not have an assessment dealing with elopement risk.

During an interview on 8/9/17 at 5:40 p.m. administrative staff A reported the facility had cameras but when he/she reviewed the video, it did not capture the resident outside or what door he/she went out. Staff A acknowledged the seriousness of the situation and reported the board of directors had already approved for the update of the exit doors so another elopement did not occur.

Review of the facility policy regarding elopement/wandering/missing residents effective 8/2017 revealed it was the facility policy to assess all residents on admission, quarterly and with a significant change who were at risk for elopement and wandering behavior. Prior to or at the time of admission, each resident would be assessed for the potential for elopement/wandering. Interventions were to be in the plan of care and should address specific behavioral patterns of the resident. Residents at risk for elopement would be assessed by the care plan team and individualized measures would be implemented and addressed on the comprehensive care plan. A picture of the resident and information needed for missing person profile (police requested material) would be obtained. In the event a resident did elope, the charge nurse should notify the administrator, and the director of nursing. The policy was in effect at the time of the elopement.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175489	A. BUILDING _____ B. WING _____	C 08/16/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE SUNSET HOME INC	601 E MAIN STREET PRETTY PRAIRIE, KS 67570

(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 323	Continued From page 12 The facility failed to ensure staff accurately assessed the resident and planned interventions to supervise the whereabouts of a resident with a known history of wandering when resident #1 exited the building without staff's knowledge.	F 323		