STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175472	A. BUILDING _____ B. WING _____	C 02/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLSIDE VILLAGE OF DE SOTO	33600 WEST 85TH STREET DE SOTO, KS 66018

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F 000	INITIAL COMMENTS The following citation represent the findings of complaint investigation #KS 00111993	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 identified a census of 48 residents, with 7 residents identified as an elopement risk. The sample included 3 residents reviewed for risk of elopement. Based on observation, record review, video review and staff interview, the	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.

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facility failed to assure the staff responded to the door alarm, allowing resident #1, a cognitively impaired and independently mobile resident identified at risk for elopement by the facility, to leave the building without staff knowledge.

Findings included:

- The physician's electronic clinical record for resident #1 documented diagnoses including dementia (chronic or persistent disorder of the mental processes of the brain marked by memory disorders personality changes and impaired reasoning) and traumatic subdural hemorrhage (Blood gathers between the inner layer of the dura mater and the arachnoid mater of the brain).

The Admission Minimum Data Set (MDS) dated 12/23/2016 documented a brief interview for mental status (BIMS) score of 7, which indicated severely impaired cognition, the resident was independent with bed mobility, transfers, walking in room/corridor, supervision oversight with locomotion on/off unit, mobility with his/her walker.

The re-admission 14 day MDS dated 02/06/2017 documented a BIMs score of 6, which indicated severely impaired cognition, the resident required extensive assistance of one person with activities of daily living (ADLs), and was mobile with his/her wheel chair and/or walker.

The CAA (care area assessment) dated 12/23/2016 documented the resident with impaired mobility, an unstable gait and balance and required assistance with ADL's.

The care plan dated 12/27/2016 documented the

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resident at risk for falls related to unsteady gait and balance.

The care plan dated 02/14/2017 identified the resident at risk for injury due to elopement, and directed staff to distract the resident from wandering by offering diversions such as structured activities, conversation and food. Staff were directed to identify the resident's pattern of wandering and ask where he/she was going or what he/she was looking for outside, intervene as appropriate, and monitor his/her location frequently. The resident now had a wander guard bracelet (signaling device that alerts when passes through the monitored area). The care plan lacked interventions to prevent elopement prior to the elopement incident on 2/11/2017.

The elopement risk assessments documented the following: On 12/12/2016 score 4.0, indicated low risk; On 01/18/2017 score 3.0, indicated low risk; On 01/23/2017 score 5.0, indicated moderate risk; and on 02/11/2017 (day of elopement) score 9.0, indicated moderate risk.

On 2/23/2017 at 9:45 A.M. review of the video for 2/11/2017 at 8:31 A.M. showed the resident walked out of the dining room, down the hall past the nurse's station. The nurse observed on his/her personal cell phone as the resident pushed the door bar, and exited the facility while the alarm was heard on the video. No staff responded to the resident leaving the building. At 8:45 AM the video recorded a staff member ran down the same hall and opened the same door, resident #1 was seen standing outside the door trying to enter, staff assisted the resident back into the building at that time.

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The Health Status Nursing Note dated 2/11/2017 at 5:01 P.M. documented at approximately 8:45 A.M. a CNA (certified nursing assist) notified this nurse that the resident was outside the hall door trying to get in. Staff yelled the resident's name and assisted the resident into the building and the nurse obtained his/her wheel chair. The resident stated "I was looking for my boy, I can't find the car." The resident was taken to the nurse's station and a head to toe assessment was completed with no injuries noted.

On 2/23/2017 at 7:30 AM staff helped the resident get dressed for the day. He/she sat in the wheel chair, a wander guard bracelet visible on the left wrist.

On 2/23/2017 at 10:05 A.M. direct care staff O stated that he/she was assigned to Resident #1 every day and as soon as he/she heard the bed monitor sound he/she went to the room quickly to get the resident up because he/she has had some falls. He/she further stated that he/she had not seen the resident wander to the doors or heard him/her talk about leaving since that Saturday (2/11/17). Staff O stated the resident did converse very well and was alert to conversations. He/she was determined to walk on his/her own.

On 2/23/2017 at 4:11 P.M. direct care staff P stated that on 2/11/2017 he/she was the staff who saw the resident outside at the door at the end of the hall and ran down to let him/her in the door. Staff P stated as he/she ran by the nurses station he/she yelled to let the nurse know and the nurse went to the dining room and obtained the resident's wheel chair as he/she had left it there at lunch. Staff P stated the resident was

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very tired when he/she let him/her back in the door.

On 2/23/2017at 1:36 P.M. licensed nursing staff H stated that on 2/11/17 he/she had not noticed the resident going towards the door, mainly he/she headed towards his/her room. Staff H stated the resident was usually easily redirected but within 5 to 10 minutes he/she would go off and do his/her own thing. Staff H noticed a difference since the resident's spouse was in the hospital, he/she would go looking for the spouse.

On 2/23/2017 at 3:27 P.M. administrative staff A stated there was not an elopement care plan in place prior to 2/11/2017 as he/she had not shown exit seeking behavior, he/she now had a wander guard bracelet on, and staff were monitoring his/her location.

On 2/23/2017 at 3:51 P.M. licensed staff I stated the facility did an elopement assessment and monitored his/her behaviors and the resident had shown no indication of exit seeking toward the doors. At the time of the elopement, the facility put him/her on
1:1 with staff until he/she calmed down from being stressed for looking for his/her car and son and then he/she was placed on 15 minute checks. Staff continue to monitor his/her location frequently.

The undated facility Long-Term Door Notification Policy documented the doors are equipped with an alarm to alert staff that doors have been forced opened (caused to open by holding the handle in for 15 seconds, which is a safety feature to release locks in case of an emergency) while the handle is being pushed in the alarm will

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sound and beep for 15 seconds until the lock is released. At that point the door will sound an alarm until the lock is reset by punching the code on the keypad next to the door. The doors will also send a message to all of the pagers and will continue to go to the pagers until the door is reset. Wander guard sensor/alarm on all exit doors, the resident must be out of range of the sensor for the alarm to be reset. Anytime the alarm is sounded, all staff members should respond immediately, if you are the person resetting the door you must investigate what caused the alarm to go off. This includes exiting the building and doing a thorough check of the surrounding area, walks around the building on both sides if you do not see anyone in the immediate area to ensure a resident has not exited. Any concerns on the safety of the resident or improper exiting should be reported to the charge nurse on duty immediately.

The facility failed to provide adequate supervision to prevent an elopement for this cognitively impaired and independently mobile resident, identified at risk for elopement, who exited the facility without staff knowledge.