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 09/26/2023

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

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F 000	INITIAL COMMENTS The following citations represent the findings of complaint investigation #183025. On 09/26/23 at 04:30 PM Administrative Staff A was provided a copy of the immediate jeopardy (IJ) template and informed of the IJ for failure to ensure the safety of R1 when she left the facility, unsupervised, and without staff knowledge. The deficient practice was cited as past non-compliance as the facility implemented the following corrective actions beginning on 09/23/23: 1. The facility reviewed all residents in the facility at risk for elopement to verify preventative interventions were in place, as indicated. 2. Current facility staff were re-educated by Administrative Nurse D/or designee regarding the facility's Elopement policy and Elopement Evaluation process. Staff were required to complete the education prior to working their next scheduled shift. 3. A Quality Assurance Improvement Plan (QAPI) meeting was completed with the interdisciplinary team where the corrective plan was developed on 09/23/23. 4. The facility's medical director was notified of the incident on 09/23/23 at 07:56 AM. 5. The exit doors were evaluated and noted to be functioning without discrepancy. The numerical code to the front door was changed and communicated to the community staff.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 09/28/2023

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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F 000	Continued From page 1 6. Any resident identified with a new risk for elopement or change in elopement risk will be reviewed by the clinical interdisciplinary team to verify elopement risk assessment accuracy. The resident's physician will be notified, and preventative interventions will be put into place, as indicated. If discrepancies are identified immediate correction will be completed and one on one education will be completed as indicated. 7. Any resident identified with a change in elopement risk or who have had an elopement attempt will be reviewed during the routine risk meeting by clinical interdisciplinary team. 8. Routine elopement drills will be scheduled periodically on varying shifts to confirm staff competency. Findings of elopement drills will be reported to the facility administrator and reviewed at the following morning meeting. If discrepancies are identified, immediate correction will be completed and one on one education will be provided, as indicated. Due to the correction measures implemented by the facility prior to the onsite complaint investigation on 09/26/23, the deficient practice was deemed past non-compliance. The deficient practice remained at a "J" scope and severity. This 2567 was electronically sent to the facility on 09/28/23.	F 000		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents.	F 689		

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F 689	Continued From page 2 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 57 residents with three sampled for elopement. Based on observation, interview, and record review, the facility failed to ensure staff provided a safe and secure environment for cognitively impaired Resident (R)1. On 09/23/23 at approximately 07:05 AM, Licensed Nurse (LN) I walked in the front doors of the facility to report for her shift while R1 walked out of the front doors. LN I assumed R1 was a visitor or employee. The facility staff did not realize R1 was missing until 07:45 AM (40 minutes later), at which time the facility staff began searching for R1. Around 10:00 AM the family notified the facility R1 was found deceased by the train tracks at approximately 08:30 AM, after being struck by a train. R1 had walked approximately eight city blocks away, crossed a busy four lane street/highway with speed limits of 30 miles per hour, and onto heavily trafficked train tracks. This deficient practice placed R1 in immediate jeopardy. Findings included: - Review of R1's Electronic Medical Record (EMR) revealed a diagnosis of small cell lung carcinoma (cancer) with metastases (when cancer had spread to other parts of the body from the original location) to the brain.	F 689	Past noncompliance: no plan of correction required.	

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The "Entry Minimum Data Set" (MDS), dated 09/19/23, documented the resident admitted to the facility on 09/19/23 from an acute care hospital.

The "Care Plan" for cognition, dated 09/19/23, documented the resident had impaired cognition due to metastatic brain cancer.

The "Care Plan" for behaviors, dated 09/19/23, instructed staff the resident would occasionally pace in the halls and had difficulty sleeping at times.

The "Care Plan" dated 09/19/23, lacked staff instruction for monitoring the resident for an elopement risk.

Review of the resident's EMR revealed an Elopement assessment, completed 09/19/23, which indicated the resident was not at risk for elopement.

Review of the resident's EMR revealed an incomplete "Brief Interview for Mental Status" (BIMS-a screening tool used to assess cognition) assessment, dated 09/20/23.

Review of the resident's EMR and information provided by the facility revealed the following:

On 09/23/23 at 07:05 AM, Licensed Nurse (LN) I reported to work at the facility. As LN I approached the front door of the facility, she witnessed the resident walking out of the building, unaccompanied.

During shift report on 09/23/23 at 07:45 AM, LN I

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and LN R were in the nurse's station when it was determined the resident had possibly eloped (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). LN I and LN R immediately notified all staff, who then conducted a head count of all the residents and searched the premises inside and out for R1. LN I and LN R got into their cars and searched a one-mile radius in opposite directions searching for the resident with no success.

On 09/23/23 at 07:47 AM, LN I notified Administrative Nurse D of the possible elopement. Administrative Nurse D requested the facility call the police department to notify them of the possible elopement.

On 09/23/23 at 07:50 AM, the facility notified the resident's family and durable power of attorney (DPOA) the resident could not be located, and the facility had contacted/notified the authorities.

On 09/23/23 at 08:00 AM, the local police department arrived at the facility and were provided with a printed picture and a detailed description of the resident. The facility staff continued their search for missing resident, R1.

On 09/23/23 at 10:00 AM, the resident's family notified the facility the resident R1 was found deceased.

The resident walked down paved, populated streets in a residential area and across a busy four lane highway in which the speed limited was posted at 30 miles per hour, to gain access to the highly trafficked train tracks, about eight blocks

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away.

On 09/26/23 at 12:18 PM, Activity staff Z stated the resident had confusion. She could walk on her own and was independent. Activity staff Z stated she had never seen the resident attempt to exit the facility on her own, but stated she would not have been able to leave the facility unassisted, due to her confusion.

On 09/26/23 at 12:37 PM, Social Service staff X stated she was responsible for completing the BIMS assessments with residents. When she attempted to complete the assessment with the resident on 09/20/23, the resident was unable to focus her attention to answer the questions of the assessment.

On 09/26/23 at 01:00 PM, Certified Nurse Aide (CNA) M stated the resident had confusion due to having brain cancer. There had been a few times when the resident stood by the door and looked outside, but no one thought the resident would try to elope. The resident was not considered to be an elopement risk and did not have a wander guard (a device often worn as a bracelet resident's wear which alerts staff when a resident wanders too far or breaches a perimeter).

On 09/26/23 at 01:12 PM, CNA N stated she had not seen the resident the morning of the elopement. CNA N stated the resident was confused but did not have a wander guard.

On 09/26/23 at 10:23 AM, Administrative Nurse E stated the resident was intermittingly confused. Administrative Nurse E stated the door code would need to be entered for someone to open the door to go outside.

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On 09/26/23 at 12:28 PM, LN G stated the resident was confused. Her family visited her often and would take her outside to sit. LN G confirmed that staff should be the only ones who know the code to the front door.

On 09/26/23 at 01:34 PM, LN H stated the resident had lung cancer which had metastasized to her brain. The resident was very confused and forgot things quickly. She was able to ambulate around the facility on her own. LN H stated she considered the resident to be at risk for elopement due to her confusion and being able to ambulate independently. LN H stated she had not done an elopement risk assessment with the resident and confirmed the resident did not wear a wander guard at the time of her elopement.

On 09/26/23 at 02:14 PM, LN I stated she reported to work at the facility on 09/23/23 at 07:05 AM and as she approached the front door, a woman walked out of the door wearing a decorative surgical cap and they exchanged pleasantries. LN I stated she believed the woman was a staff member going outside for a break. LN I did not recognize the woman as a resident as she had not worked at the facility since the resident admitted on 09/19/23. While receiving report at 07:45 AM, LN R described the newly admitted resident to LN I. LN I stated it was at that time, she realized the woman who had walked out of the door when she entered, was a resident. LN I stated they immediately did a head count of the residents in the building and then began the search for the resident. LN I stated there was no one in the lobby by the front door who could have opened the door for the resident, and LN I was unsure of how the resident knew

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the code. LN I stated the facility changed the door code frequently.

On 09/26/23 at 03:02 PM, Administrative Nurse D confirmed the resident had confusion but the elopement risk assessment, completed on 09/20/23, found her to not be at risk for elopement. Administrative Nurse D stated at approximately 08:30 AM, someone informed them a body had been discovered by the train tracks, but they did not receive confirmation until 10:00 AM from the resident's family. Administrative Nurse D stated the facility began their corrective measures immediately on 09/23/23 and would complete the education on 09/26/23. No staff members were allowed to work until the elopement education was completed. The facility reviewed all of the residents elopement assessments, to ensure accuracy.

The facility policy for "Elopements", reviewed 05/2023, included: It is the policy of the facility that all residents are afforded adequate supervision to provide the safest environment possible. All residents will be assessed for behaviors or conditions that put them at risk for elopement. All residents so identified will have these issues addressed in their individual care plans.

The facility failed to ensure staff provided a safe and secure environment for cognitively impaired Resident (R)1. On 09/23/23 at approximately 07:05 AM, R1 walked out the front door of the facility as LN I arrived for work. The facility staff did not realize R1 was missing for 45 minutes. R1 walked approximately eight city blocks, crossed a busy four lane street/highway with speed limits of 30 miles per hour, and onto heavily trafficked

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train tracks. Around 10:00 AM R1's family notified the facility she had been found deceased by the train tracks at approximately 8:30 AM. This deficient practice placed R1 in immediate jeopardy.

On 09/26/23 at 04:30 PM Administrative Staff A was provided a copy of the immediate jeopardy (IJ) template and informed of the IJ for failure to ensure the safety of R1 when she left the facility, unsupervised, and without staff knowledge.

The deficient practice was cited as past non-compliance as the facility implemented the following corrective actions beginning on 09/23/23:

1. The facility reviewed all residents in the facility at risk for elopement to verify preventative interventions were in place, as indicated.

2. Current facility staff were re-educated by Administrative Nurse D/or designee regarding the facility's Elopement policy and Elopement Evaluation process. Staff were required to complete the education prior to working their next scheduled shift.

3. A Quality Assurance Improvement Plan (QAPI) meeting was completed with the interdisciplinary team where the corrective plan was developed on 09/23/23.

4. The facility's medical director was notified of the incident on 09/23/23 at 07:56 AM.

5. The exit doors were evaluated and noted to be functioning without discrepancy. The numerical code to the front door was changed and

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F 689	Continued From page 9 communicated to the community staff. 6. Any resident identified with a new risk for elopement or change in elopement risk will be reviewed by the clinical interdisciplinary team to verify elopement risk assessment accuracy. The resident's physician will be notified, and preventative interventions will be put into place, as indicated. If discrepancies are identified immediate correction will be completed and one on one education will be completed as indicated. 7. Any resident identified with a change in elopement risk or who have had an elopement attempt will be reviewed during the routine risk meeting by clinical interdisciplinary team. 8. Routine elopement drills will be scheduled periodically on varying shifts to confirm staff competency. Findings of elopement drills will be reported to the facility administrator and reviewed at the following morning meeting. If discrepancies are identified, immediate correction will be completed and one on one education will be provided, as indicated. Due to the correction measures implemented by the facility prior to the onsite complaint investigation on 09/26/23, the deficient practice was deemed past non-compliance. The deficient practice remained at a "J" scope and severity.	F 689		