STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175541	A. BUILDING _____ B. WING _____	C 10/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TALLGRASS CREEK, INC	13760 METCALF AVENUE OVERLAND PARK, KS 66223

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F 000	INITIAL COMMENTS	F 000		

The following citations represent the findings of complaint investigations #KS00183313 and KS00179003.

On 10/16/23 at 04:15 PM, Administrative Staff A receieved a copy of the "Immediate Jeopardy [IJ] Template" and was infmroed of the IJ for R1.

On 10/06/23 at 06:21 PM Resident (R)1 pressed on an exit door for 30 seconds, which opened the door. The door alarm sounded, but the staff failed to promptly respond to the alarm. R1 wore a WanderGuard (bracelet that sets off an alarm when residents wearing one attempt to exit the building without an escort) on her wheelchair, which alarmed as well, but staff failed to respond. An Independent Living (IL) resident in the parking lot saw R1 outside of the facility and brought R1 back into the facility near the kitchen, where Dietary staff BB then escorted R1 to the nurse's station. R1 was outside unattended for approximately four minutes, and it was seven minutes before staff were aware of her exit. The facility's failure to respond to the door alarm which allowed cognitively imapired R1 to exit the facility without staff knowledge into an unsupervised location placed R1 in immediate jeopardy.

The facility put the following corrections into place by 10/12/23:
1. Updated R1's care plan after 10/06/23.
2. Security completed daily door checks starting on 10/06/23.
3. Completed staff education regarding "Alarms Response and Missing Resident" from 10/09/23 to 10/11/23.

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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F 000	Continued From page 1 4. Conducted a Quality Assurance and Performance Improvement (QAPI) meeting on 10/12/23 with discussion of elopement on 10/06/23. Due to the corrective measures implemented and completed prior to the onsite survey, this deficient practice was cited as past noncompliance at a "J" scope and severity. The 2567 was sent electronically on 10/26/23.	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 identified a census of 43 residents. The sample included two residents reviewed for elopement (when a cognitively impaired resident leaves the facility without the knowledge or supervision of staff) risk. Based on observations, record review, and interviews, the facility failed to provide adequate supervision to cognitively impaired Resident (R) 1, who was at risk for elopement and exited the facility. On 10/06/23 at 06:21 PM R1 pressed on an exit door for 30 seconds, which opened the door. The door alarm sounded, but the staff failed to promptly respond to the alarm. R1 wore a WanderGuard (bracelet that sets off an alarm when residents wearing one	F 689	Past noncompliance: no plan of correction required.	

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attempt to exit the building without an escort) on her wheelchair, which alarmed as well, but staff failed to respond. An Independent Living (IL) resident in the parking lot saw R1 outside of the facility and brought R1 back into the facility near the kitchen, where Dietary staff BB then escorted R1 to the nurse's station. R1 was outside unattended for approximately four minutes, and it was seven minutes before staff were aware of her exit. The facility's failure to respond to the door alarm which allowed cognitively impaired R1 to exit the facility without staff knowledge into an unsupervised location placed R1 in immediate jeopardy.

Findings included:

- R1's Electronic Medical Record (EMR) documented a diagnosis of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure).

The "Significant Change Minimum Data Set (MDS)" dated 08/24/23, documented R1 had a Brief Interview for Mental Status (BIMS) score of three, which indicated severe cognitive impairment. R1 wandered daily. She required extensive assistance with one staff for bed mobility, transfers, locomotion off unit, dressing, toileting, and personal hygiene; and limited assistance with one staff for locomotion on unit.

The "Falls Care Area Assessment" dated 08/24/23, documented R1 needed assistance for transfers and mobility and factors that placed her at risk included a balance probably and assistance needs for support during transfers.

The "Care Plan" dated 08/18/23, documented R1

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could propel herself in her wheelchair within the unit, sometimes went to the exit doors, and she had a WanderGuard hooked to her wheelchair that alarmed if she went too close to the exit doors. The "Care Plan" directed to check R1's WanderGuard weekly on Wednesdays.

The "Care Plan" dated 08/18/23, documented due to R1's confusion she explored her environment in her wheelchair. The "Care Plan" instructed staff to redirect R1 and involve her in activities, staff listened to her and provided her comfort when she became confused and agitated, communicated with her in manner that promoted mental and psychological well-being, and provided an environment conducive to mental and psychological well-being.

The facility's report, dated 10/13/23, documented on 10/06/23, R1 was able to exit through a secured back door with a 30 second delated egress that led to the IL Clubhouse. It was 54 degrees Fahrenheit (F) and she wore a red long-sleeve shirt, pants, socks, and shoes. At 06:12 PM, R1 was seen on camera heading towards the nurse's station in the East hallway. At 06:13 PM, she turned back around and headed towards the dining room, the nurse was on the phone at that time. At 06:15 PM, R1 turned around and headed back down to the East nurse's station and appeared to try and talk to the nurse, she was then viewed from another camera coming back down the hallway. At 06:16 PM, R1 wheeled herself down the hallway and turned the corner towards the exit. At 06:21 PM, R1 was seen on camera rolling down the walkway in her wheelchair and coming to rest in the mulch on the sidewalk. At 06:24 PM, a man parked his car in the visitor parking lot and saw R1. At 06:25 PM,

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the man walked over to her. At 06:27 PM, the man came into view on the camera pushing R1 toward the kitchen area back inside the facility. At 06:28 PM, Dietary BB appeared at the end of the hallway talking to the man. At 06:29 PM, Dietary BB took R1 to the nurse's station. It was determined that no one let R1 out of the door as she was able to push on the delayed egress crash bar which released the door and she was able to exit.

In a witness statement, not dated, Dietary BB stated after dinner on 10/06/23, R1 was brought to the kitchen by an unknown individual. He asked Dietary BB if he knew where R1 went, and Dietary BB said yes and asked R1 how she was doing. Dietary BB stated he took R1 to the nurse's station and told them what happened.

In a witness statement on 10/12/23, Licensed Nurse (LN) G stated R1 was last visualized between 06:00 PM and 06:15 PM. She was propelling self in her wheelchair as she normally did. LN G stated a staff member brought resident and informed her that R1 had been outside the IL exit doors.

In a witness statement on 10/12/23, LN H stated she last saw R1 at approximately 06:00 PM on 10/06/23. R1 was attempting to find her family and wondering how everything was being paid for. LN H stated she explained to R1 her sons had already taken care of everything. LN H stated she did not remember seeing her again until R1 returned.

According to the "Kansas State University Historical Weather" website, the temperature on 10/06/23 at 06:00 PM was 57.3 degrees

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Fahrenheit (F) and at 07:00 PM, it was 52.2 degrees F.

On 10/16/23 at 11:26 AM, Administrative Staff A showed the surveyor the door R1 exited on 10/06/23. The surveyor pushed on the door and an alarm sounded. After about 30 seconds, the door lock released, and the door opened. Observation of the area outside the door revealed a clean sidewalk in good repair with mulch located to the left as you exit the door. The sidewalk continued down a decline towards the IL clubhouse and at the end of the decline, there was a path that turned left, towards the back of the building, and led to the parking lot.

On 10/16/23 at 01:47 PM, R1 sat in her wheelchair in the day area and conversed with visitors. A WanderGuard was attached to the right side of her wheelchair.

On 10/16/23 at 03:22 PM, R1 wanted to go outside, and staff told her to wait a little bit. She was easily redirected, and staff brought her to an area to listen to music.

On 10/16/23 at 03:28 PM, staff assisted R1 outside to get some fresh air.

On 10/16/23 at 11:18 AM, Administrative Staff A stated on 10/06/23, an IL resident saw R1 stuck in her wheelchair in the mulch, 20 feet from the back door. He brought her back in, went to the kitchen, and asked if R1 belonged over there. Dietary BB said hey to R1 and brought her to nursing. Administrative Staff A saw R1 around 06:10 PM and 06:14 PM, and she was going back and forth around the East nurse's station. R1 went down the hallway and was not seen on the

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wall-phone camera, which went to the concierge and security if someone pushed the button. She stated it determined R1 pushed on the doors which alarmed then released and she ended up getting out of the door. Administrative Staff A stated the alarm sounded for about eight minutes. R1 had a roam alert that was alarming and roam alerts were sent to the nurse call system which wound vibrate on the phones the call lights go to and had a message with where the alarm was going off at. Administrative Staff A stated there was another resident actively passing away in that time frame and it was right around the time staff were getting residents out of the dining room and helping them into bed.

On 10/16/23 at 01:55 PM, LN I stated when the door alarms went off, staff located the resident and called the front desk. She stated if a resident with a WanderGuard got close to a door, a page was sent to the phones.

On 10/16/23 at 01:58 PM, Certified Nurse Aide (CNA) M stated if the door alarms went off, she checked her phone to see which door it was to make sure it was not a wander alarm. She stated if a wander alarm went off, the alert on the phone said the resident's room number and which door was alarming for staff to check it out.

On 10/16/23 at 02:21 PM, LN J stated on 10/06/23, she saw R1 propelling through the halls and dining area, but she never tried to exit any doors. She stated the doors beep if someone is holding it down then it turned to a steady beep. If a resident had a WanderGuard then the wander alarm also beeped and sent an alert to the call system on their phones with the door that was alarming. LN J stated usually if R1 was wandering

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around and it was not close to mealtime, staff engaged with her too see if she needed to use the restroom, if she wanted to join activities, or if she wanted to call her sons. She stated if R1 said she was looking for her family, she told her they had not been in yet, and took her to the nurse's station to call one of her sons.

On 10/16/23 at 02:27 PM, Administrative Nurse D stated on 10/06/23, she received a call that R1 had exited the door going towards IL and was back inside. She stated there had been a resident actively passing away so R1's nurse was attending to that resident and a few CNAs had been assisting residents out of the dining room. Administrative Nurse D stated when the door alarms, staff could hear the door alarm and an alert was sent to the monitor at the nurse's station and their individual phones. She stated R1 had a WanderGuard as well because she liked to explore her environment. Administrative Nurse D stated if a door alarm went off, she expected staff to respond immediately and if they were with another resident, they made sure that resident was safe and then checked on the alarm.

On 10/20/23 at 11:56 AM, LN G stated R1 used to get agitated after dinner but it was progressively getting earlier, and she was getting really anxious. LN G stated R1 was difficult to redirect and fought staff so they let her wander which she was usually safe to do. She stated on 10/06/23, she found out R1 had exited the facility when Dietary BB informed her R1 had been outside. She stated she saw R1 about 20 minutes prior to her exit, when R1 was propelling around the nurse's station then down the hallways and she was pretty agitated. LN G stated she did not hear the alarm going off and the alarm was not

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audible at the nurse's station at that time but had since been changed to make a sound. The door itself was too far from the nurse's station to hear the beeping on the door. She stated she carried the call system phone on her at all times, but the roam alerts were the same sound as call lights so there was no differentiation between call light alerts and roam alerts. LN G stated when she received a roam alert, she looked at the location in the alert then went to the location to check.

The facility's "Alarms Response" policy, dated May 2021, directed when a continuing care exit alarm sounded or wander alert device had been activated, staff immediately checked the doors in the alarming area and ensured all residents were within the neighborhood or their whereabouts were known. The "policy" directed if a wander alert device of exit alarm was triggered for an unknown/unwitnessed cause, within five minutes staff from that neighborhood promptly responded to the door that was alarming; a staff member was designated to conduct an immediate count of all residents; a staff member was designated to search the exit area; and if a resident was determined to be missing, elopement of a resident procedure was initiated.

The facility failed to provide adequate supervision to promptly respond to a door alarm and intercept R1 when she exited the facility on 10/06/23. This deficient practice placed R1 in immediate jeopardy.

The facility put the following corrections into place by 10/12/23:
1. Updated R1's care plan after 10/06/23.
2. Security completed daily door checks starting on 10/06/23.

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