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 01/10/2024

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**

(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	F 000		

A Partial Extended Complaint survey regarding KS0001834365, KS000184533, KS000184934, KS000184935, KS000184936, and KS000184973, was conducted by the Kansas Department for Aging and Disability Services (KDADS), on behalf of the Centers for Medicare and Medicaid Services (CMS) from 01/08/2024 to 01/10/24. The facility was found not to be in substantial compliance with 42 CFR 483 subpart B.

The facility was provided the Immediate Jeopardy (IJ) Template on 12/19/23 at 04:11 PM, and reviewed with Administrative Staff A and Administrative Nurse B regarding the elopement of R1, a cognitive impaired resident with history of elopement, on 12/31/23 at approximately 06:30 AM. The facility staff did not know R1 was not in the facility until the oncoming nurse, Licensed Nurse (LN) D, asked a Certified Nurse Aide (CNA) G to locate R1. The facility staff could not locate R1 on 12/31/23 at 06:30 AM and LN D started the elopement process. At 07:30 AM, CNA G found R1 outside, at the back of the facility, at the bottom of the concrete stairs. R1 exited the facility through a known malfunctioning exit door in the dark, followed the sidewalk around the building, and attempted to walk down 12 unlit concrete steps, at which time R1 fell and hit his head. When R1 left the facility, the temperature measured approximately 30 degrees Fahrenheit (F) with a wind chill of 20 degrees F. R1 was outside, with his location unknown to staff for approximately 60 minutes in the cold weather.

The facility identified and implemented the following corrective action on 12/31/23 which

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
	175218	A. BUILDING _____ B. WING _____	C 01/10/2024

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

(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	Continued From page 1 included: 1. On 12/31/23 at 07:40 AM, all staff received re-education regarding the facility elopement policy and elopement evaluation. The facility completed training on 01/01/24 at 02:30 PM. 2. The facility identified residents at risk for elopement and an assessment was completed on those residents. 3. A QAPI meeting was completed with the community interdisciplinary team on 12/31/23 at 10:30 AM. 4. Medical director notified of the event on 12/31/23 at 10:00 A 5. Exit doors were evaluated on 12/31/23 and safeguards were placed for staff supervision at the 200 Hall exit door to verify function of door and resident safety on 12/31/23. On 01/01/24 at 10:00 AM the facility had the Mag locking system to secure the 200 hall exit door evaluated. 6. The WanderGuard system and alarms were checked and validated for proper function on 12/31/23 at 09:30 AM with no discrepancies identified. 7. Routine elopement drill's will be scheduled per community policy on varying shifts to confirm staff competency, 8. Quality Assurance plan to monitor facility compliance Director of Nursing will report trends identified with routine reviews to the community QAPI committee for 3 months. Then the QAPI committee will re-evaluate the need for continued monitoring. The surveyor verified onsite the facility completed the above corrective actions on 01/01/24 at 02:30 PM, prior to the onsite survey. Therefore, the deficient practice was deemed past noncompliance at a scope and severity of "J".	F 000		

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 01/10/2024

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

(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	Continued From page 2 The immediate jeopardy first existed on 12/31/23 at 06:30 AM, when the resident eloped from the facility and it was corrected with completion of the above corrective actions on 01/01/24 at 02:30 PM. The 2567 was electronically sent to the facility on 01/23/24.	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 64 residents with three residents identified and reviewed for elopement. Based on interview, observation, and record review the facility failed to provide adequate supervision to prevent cognitively impaired Resident (R)1, with a known history of elopement, from leaving the facility unsupervised and without staff knowledge on 12/31/23 at approximately 06:30 AM. The facility staff did not know R1 was not in the facility until the oncoming nurse, Licensed Nurse (LN) D, asked a Certified Nurse Aide (CNA) G to locate R1. The facility staff could not locate R1 on 12/31/23 at 06:30 AM and LN D started the elopement process. At 07:30 AM, CNA G found R1 outside, at the back of the facility, at the bottom of the concrete stairs.	F 689	Past noncompliance: no plan of correction required.	

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 01/10/2024

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

(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 689	Continued From page 3	F 689		

R1 exited the facility through a known malfunctioning exit door in the dark, followed the sidewalk around the building, and attempted to walk down 12 unlit concrete steps, at which time R1 fell and hit his head. When R1 left the facility, the temperature measured approximately 30 degrees Fahrenheit (F) with a wind chill of 20 degrees F. R1 was outside, with his location unknown to staff for approximately 60 minutes in the cold weather. This deficient practice placed R1 in immediate jeopardy.

Findings included:

- Resident (R) 1's "Physician Orders" dated 01/03/22 revealed a diagnosis of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure).

The "Modification of Annual Minimum Data Set" (MDS) dated 01/17/23 revealed a "Brief Interview for Mental Status" (BIMS) score of two, indicating severely impaired cognition, and identified behavior of wandering that occurred daily. R1 was independent with "Activities of Daily Living" (ADLs).

The "Quarterly MDS" dated 10/18/23 revealed a BIMS score of three, indicating severely impaired cognition. R1's behavior of wandering was not exhibited on the assessment.

The "Care Plan" indicated R1 was at risk for elopement/wandering, wore a WanderGuard (a bracelet that sets off an alarm when residents wearing one attempt to exit the building without an escort), and staff were to check placement and monitor its functioning every shift. Interventions updated on 12/31/23 instructed staff

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 01/10/2024

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

(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 689	Continued From page 4	F 689		

to include R1's picture and information in the elopement book.

The "Elopement Assessment" dated 12/31/23 indicated R1 was cognitively impaired, independently mobile, and had a history of elopement. R1 desired to leave the facility, was exit seeking with a purpose, had a diagnosis of Alzheimer's disease or dementia, and wore a WanderGuard.

The "Nurses Notes" dated 12/31/23 revealed at 06:30 AM Licensed Nurse (LN) D asked Certified Nurse Aide (CNA) G to locate R1. The staff member could not locate R1 and notified LN D. LN D then started the elopement process with a resident head count and LN D instructed the other staff members to walk around the outside of the building to look for R1. LN D then notified Law Enforcement, the director of nursing, and family. At 07:30 AM, CNA G found R1 who fell down 12 concrete stairs at the back of the building. LN D assessed R1, applied a C-collar, and assisted R1 up the stairs to a gurney, where "Emergency Medical Service" (EMS) transported R1 to the hospital for evaluation and further treatment.

The "Nurses Note" dated 12/31/23 at 11:30 AM, documented R1 returned to the facility from the hospital visit. LN D observed 11 staples at the top of R1's scalp, and abrasions to R1's third, fourth, and fifth knuckles on the right hand.

An outside observation on 01/08/24 at 09:25 AM, of the 12 concrete steps in the back of the building where R1 fell on 12/31/23, revealed the second step from the bottom had gray colored hair attached to the step, which was left from R1's head wound (8 days prior).

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 01/10/2024

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

(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 689	Continued From page 5	F 689		

Observation on 01/08/24 at 11:34 AM, revealed R1 sat in the dining room visiting with family, and R1 had 11 staples on the top of his head. R1's abrasions on his right hand were in the healing process. R1's family member stated R1 had been a wanderer for a long time, and further stated R1 was always an exit seeker.

Interview with Administrative Nurse B on 01/08/24 at 10:55 AM revealed the staff checked the WanderGuard system daily to make sure it was functioning properly.

Interview with Administrative Staff A on 01/08/24 at 11:00 AM revealed the door at the end of the 200 Hall had been malfunctioning for the last month. Administrative Staff A explained the door did latch properly, but at times the door would bounce off of the door frame and the mag lock would not secure the door closed completely.

Interview with CNA G on 01/08/24 at 11:50 AM revealed when she came into work on 12/31/23 at 06:00 AM the charge nurse asked her to locate R1. When she could not locate R1, the charge nurse started the elopement procedure with a head count completed, then CNA G and other staff members started looking for R1. She decided to look around back of the facility and about 07:30 AM she found R1 outside at the bottom of the concrete stairs to the basement.

Interview with LN D on 01/08/24 at 12:30 PM revealed during the morning report R1 usually wandered around the facility and was not wandering around at that time, so LN D asked CNA G to locate R1. When staff could not locate R1, the elopement procedure was started and

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 01/10/2024

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

(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 689	Continued From page 6	F 689		

staff completed a head count, notified law enforcement, director of nursing, and R1's family. The other staff members in the facility attempted to help locate R1. CNA G found R1 at the bottom of the basement steps behind the facility. R1 received an injury to the top of his head, which required 11 staples.

The facilities Elopement Policy dated 2002 revealed 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 with have these issues addressed in their individual care plans. The Purpose of this policy "missing residents" shall be defined to mean a resident who has left the facility grounds without signing him/herself out of the facility. Resident who are at risk for elopement shall be provided at least one of the following safety precautions by the facility. Door alarm on facility exit and or a personal safety device that will alert facility staff when the resident has left the building without supervision and or staff supervision. Maintenance will check all door alarms for proper function on a weekly basis.

The facility failed to provide adequate supervision to prevent cognitively impaired R1 with a history of elopement from leaving the facility unsupervised and without staff knowledge. R1 exited the facility unsupervised, in the dark, and fell down 12 concrete steps causing a laceration to the head, which required 11 staples to close. This failure placed R1 in immediate jeopardy.

On 01/08/24 at 05:01 PM Administrative Staff A and Administrative Nurse B were provided the

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 01/10/2024

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

(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 689	Continued From page 7 Immediate Jeopardy Template. The facility identified and implemented the following corrective action on 12/31/23 which included: 1. On 12/31/23 at 07:40 AM, all staff received re-education regarding the facility elopement policy and elopement evaluation. The facility completed training on 01/01/24 at 02:30 PM. 2. The facility identified residents at risk for elopement and an assessment was completed on those residents. 3. A QAPI meeting was completed with the community interdisciplinary team on 12/31/23 at 10:30 AM. 4. Medical director notified of the event on 12/31/23 at 10:00 A 5. Exit doors were evaluated on 12/31/23 and safeguards were placed for staff supervision at the 200 Hall exit door to verify function of door and resident safety on 12/31/23. On 01/01/24 at 10:00 AM the facility had the Mag locking system to secure the 200 hall exit door evaluated. 6. The WanderGuard system and alarms were checked and validated for proper function on 12/31/23 at 09:30 AM with no discrepancies identified. 7. Routine elopement drill's will be scheduled per community policy on varying shifts to confirm staff competency, 8. Quality Assurance plan to monitor facility compliance Director of Nursing will report trends identified with routine reviews to the community QAPI committee for 3 months. Then the QAPI committee will re-evaluate the need for continued monitoring. The surveyor verified the facility implemented the	F 689		

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 01/10/2024

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**

(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 689	Continued From page 8 above corrective actions prior to the onsite survey. Therefore, the deficient practice was deemed past noncompliance at a scope and severity of "J".	F 689		