

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/05/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175401		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/23/2024	
NAME OF PROVIDER OR SUPPLIER BONNER SPRINGS NURSING & REHAB CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 520 E MORSE STREET BONNER SPRINGS, KS 66012			
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F 000	INITIAL COMMENTS The following citations represent the findings of complaint investigation #KS00184912. On 01/23/24 at 03:00 PM the facility received a copy of the "Immediate Jeopardy [IJ] Template" and was informed of the immediate jeopardy for Resident (R) 1. On 12/28/23 at 01:45 PM Certified Nurse Aid (CNA) M observed R1 pacing in his room. At 02:13 PM Dietary Staff BB returned to the facility after lunch and observed R1 walking down the street approximately 150 feet from the facility. The temperature outside was approximately 40 degrees Fahrenheit (F) at that time. Staff assessed R1, noted no injuries, returned R1 to his room and saw R1's window was open. R1 stated he jumped (out of the window) when asked how he exited. The facility failed to identify and secure likely avenues of exit for R1, who was at high risk for elopement and severely cognitively impaired. As a result of this failure, R1 eloped from the facility via his bedroom window. The deficient practice placed R1 in immediate jeopardy. The facility completed the following corrective actions by 01/04/24: The windows in the facility were secured with a screw in the window to prevent the window from opening farther then three to four inches and a wooden dowl was placed on the top of the window pan to prevent the window pain from being lifted out of the window frame on 12/28/23. The facility staff have received training on elopements and procedures for handling elopements completed on 01/04/24.			F 000			

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	F 000			
F 689 SS=J	The corrective actions were completed prior to the onsite survey therefore the citation was issued as past noncompliance at the scope and severity of "J." The 2567 was sent electronically on 02/05/24. 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 35 residents. The sample included three residents reviewed for elopement (when a cognitively impaired residents exits the facility without staff knowledge and supervision). Based on observation, record review, and interview, the facility failed to identify likely avenues of exit, including windows, and failed to ensure the windows were secured to prevent cognitively impaired Resident (R) 1, who was at high risk for elopement, from exiting the facility through the window. On 12/28/23 at 01:45 PM Certified Nurse Aid (CNA) M observed R1 pacing in his room. At 02:13 PM Dietary Staff BB returned to the facility after lunch and observed R1 walking down the street approximately 150 feet from the facility. The temperature outside was approximately 40 degrees Fahrenheit (F) at that time. Staff assessed R1, noted no injuries,	F 689	Past noncompliance: no plan of correction required.		

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F 689	Continued From page 2 returned R1 to his room and saw R1's window was open. R1 stated he jumped (out of the window) when asked how he exited. The facility failed to identify and secure likely avenues of exit for R1, who was at high risk for elopement and severely cognitively impaired. As a result of this failure, R1 eloped from the facility via his bedroom window. The deficient practice placed R1 in immediate jeopardy. Findings included: - R1's Electronic Medical Record (EMR), under the "Diagnosis" tab recorded diagnoses of drug induced subacute dyskinesia (inability to execute voluntary movements), other schizoaffective disorder (a mental disorder in which a person experiences a combination of symptoms of schizophrenia and mood disorder), and anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear) disorder. R1's "Admission Minimum Data Set" (MDS) dated 02/27/23 documented a Brief Interview for Mental Status (BIMS) score of zero, which indicated severely impaired cognition. The MDS documented R1 was independent with mobility. R1 had no behaviors nor exhibited wandering behaviors. The "Cognitive Loss/Dementia Care Area Assessment" (CAA) dated 02/27/23 documented R1 had inattention and disorganized thinking. did not always give a verbal response or an appropriate response to the questions asked. The "Falls CAA" dated 02/27/23 documented R1 ambulated independently without a device.	F 689			

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F 689	Continued From page 3 R1's "Quarterly MDS" dated 11/22/23 documented a BIMS score of one, which indicated severely impaired cognition. R1 was independent with no assistance from a staff member for mobility. R1 had no documented behaviors. R1's referral packet, under the "Misc" tab included R1's care plan sent from his previous facility. The plan documented R1 was an elopement risk. The referral packet documented R1 was one-on-one whenever R1 left his room and was on 15-minute checks when he was in his room. The referral packet documented R1's broke a glass door and exited his previous facility. R1's "Wander Risk Assessment" dated 02/20/23 documented he was at high risk to wander. A "Physician Progress Note" dated 02/24/23 at 09:17 PM documented R1 admitted to the facility from another long-term care facility. The note documented R1 had a history of elopement. R1's "Elopement Risk/Wandering Care Plan" initiated on 04/11/23 directed staff to check R1's Wander Guard (bracelet that sets off an alarm when residents wearing one attempt to exit the building without an escort) for function and check Wander Guard placement as directed. Staff were directed to assess R1 for fall risk and provide structured activities such as toileting, walking inside and outside, and reorientation strategies including signs, pictures and memory boxes. The "Notes" sections of R1's EMR documented the following:			F 689			

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F 689	Continued From page 4 A "Physician Progress Note" dated 02/24/23 at 09:17 PM documented R1 admitted to the facility from another long-term care facility. The note documented R1 had a history of elopement. A "Social Services Progress Note" dated 04/06/23 at 11:29 AM documented R1 wandered the halls at night. A "Physician Progress Note" dated 11/02/23 at 03:22 PM documented R1 ambulated in the hallways as R1 frequently did. A "Physician Progress Note" dated 11/28/23 at 01:25 PM documented R1 was frequently seen ambulating in the hallway making uncontrollable gestures; R1 sometimes had difficulty with his mobility. The "Physician Progress Note" dated 12/06/23 at 11:26 AM documented R1 ambulated in the hallway as he frequently did. A late entry "Nursing Progress Note" dated 12/28/23 at 03:00 PM documented the notification of R1's elopement to R1's representative at 03:00 PM. R1's representative revealed R1 had a history of jumping out of windows. An "Incident Follow Up Note" dated 12/28/23 at 03:00 PM documented at 02:13 PM, CMA R received a call from Dietary Staff BB. Dietary Staff BB stated R1 was outside the building on the sidewalk. CMA R proceeded to go outside and redirect R1 back into the facility. When R1 arrived back to the facility staff walked R1 back to his room for a full body assessment. R1 stated he jumped out of the window when staff asked him how he got out .	F 689			

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F 689	Continued From page 5 The facility investigation dated 01/05/24 documented staff observed R1 walking back and forth from R1's bathroom to his bed. R1 frequently paced throughout the facility and in R1's room. Staff witnessed R1 walking outside on the sidewalk. Nursing staff went to R1 who was outside on the sidewalk of the same street as the facility, on the facility side of the street. Staff redirected R1 back to the facility with no resistance or behaviors. R1 returned to the facility and was assessed with no noted injuries. R1 was placed on one-on-one monitoring. Staff checked the facility doors and noted the Wander Guard system functioned appropriately. Facility staff noted that R1's bedroom window was open, and the screen was removed from the window frame. All windows were secured in the facility and R1 was then removed from one-on-one monitoring. CNA M's undated "Witness Statement" documented CNA M last saw R1 a little after 01:45 PM. R1 walked back and forth from his bathroom to his bed. Dietary Staff BB's "Witness Statement" dated 12/28/23, documented on 12/28/23 at 02:13 PM Dietary Staff BB headed back to work from lunch. Dietary Staff BB approached the stop sign down the street, took a left turn, and saw R1 outside walking down the street with his jacket on, and a cup in his hand. Dietary Staff BB called CMA R and asked if CMA R knew that R1 was gone. CMA R stated "no" and went to get R1. CMA R's "Witness Statement" dated 12/28/23, R documented on 12/28/23 at 02:13 PM Dietary Staff BB called to see if any staff knew that R1 was out of the building walking down the street.	F 689			

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F 689	Continued From page 6 CMA R hung up and went outside. CMA R saw R1 walking towards the building. CMA R ran and helped R1 back to the facility. CMA R recalled she last saw R1 during lunch. LN G's undated "Witness Statement" documented on 12/28/23 at 02:13 PM, CMA R received a call from Dietary Staff BB stating R1 was outside on the sidewalk. CMA R went outside and redirected R1 back into the facility. Once R1 returned into the facility, LN G walked with R1 back to R1's room and performed a full body assessment. R1 had no skin issues noted and reported he had no pain. On 01/23/24 at 10:53 AM R1 walked independently in the hallway with no balance issues. On 01/23/204 at 10:55 AM observations revealed the window in R1's room had a screw placed in the bottom of the window track roughly four inches away from the glass pain preventing the window from fully opening. There was a small wooden dowl at the top of the windowpane to prevent pulling out the glass pane. R1's window faced the front side of the building. The window was approximately two to two and one-half feet off the floor and/or ground on the inside and outside of the building. The area right under the window had loose rock landscaping. The road where R1 walked had a gradual downward slope. R1 had to cross a street that was perpendicular to the street R1 walked along which had a posted speed limit of 30 miles per hour. On 01/23/24 at 01:55 PM CMA S stated R1 had a history of trying to open doors in the past, but	F 689			

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F 689	Continued From page 7 staff redirected him. CMA S stated that R1 was easily redirected. CMA S revealed that R1's representative had informed facility staff that R1 eloped from his previous facility and that R1 could potentially elope. CMA S stated the facility staff knew to keep eyes on R1 and watch out for him since they knew about his potential to elope. On 01/23/24 at 02:07 PM CMA R stated Dietary Staff BB called her and asked if staff knew that R1 was walking down the street. CMA R revealed R1 was walking down the side of the street that the facility was on but was one street over. CMA R she was unaware of R1's history of eloping or jumping out of windows. On 01/23/24 at 03:03 PM Administrative Nurse D stated he was unaware of R1's eloping history. Administrative Nurse D stated that R1 walked the halls and was known to pace in his room. On 01/23/24 at 03:08 PM Administrative Staff A stated R1 walked the hallways and was not very verbal. Administrative Staff A stated that upon arriving to the facility she reviewed this event to see what had been done or needed done for R1. Administrative Staff A revealed that she had read the referral for R1 and thought it might have said something about elopement. The facility's policy "Wandering and Elopements" revised Oct 2021 documented that if a resident was identified as a risk for wandering, elopement, or other safety issues, the resident's care plan would include strategies and interventions to maintain the resident's safety. The facility failed to identify and secure likely avenues of exit for R1, who was at high risk for	F 689			

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F 689	Continued From page 8 elopement and severely cognitively impaired. As a result of this failure, R1 eloped from the facility via his bedroom window. The deficient practice placed R1 in immediate jeopardy. The facility completed the following corrective actions by 01/04/24: The windows in the facility were secured with a screw in the window to prevent the window from opening farther then three to four inches and a wooden dowl was placed on the top of the window pan to prevent the window pain from being lifted out of the window frame on 12/28/23. The facility staff have received training on elopements and procedures for handling elopements completed on 01/04/24. The corrective actions were completed prior to the onsite survey therefore the citation was issued as past noncompliance at the scope and severity of "J."	F 689			