STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175471	A. BUILDING _____ B. WING _____	C 01/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTY COMMUNITY CARE HOME	**105 N HIGHWAY 99 WESTMORELAND, KS 66549**

(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 The following citations are the result of abbreviated survey an complaint investigation KS00185393. On 01/31/24 at 12:30 PM the facility received a copy of the "Immediate Jeopardy [IJ] template" and was informed of the IJ for Resident (R) 1. R1 was cognitively impaired, lived on a secured memory unit, and had a history of wandering; though, the latest elopement assessment performed on 01/08/24 indicated the resident had no wandering and was at low risk for elopement. On 01/24/24 at approximately 12:05 PM R1 moved her couch and a table away from her window, opened the window and screen, and exited the facility via the window. The alarm on the window did not sound and R1 proceeded to walk down a steep hill to the sidewalk which went around the building, towards the front of the building. Certified Nurse Aide (CNA) M observed that R1 was outside, from the kitchen window. CNA N continued to watch R1 from the window while another staff went outside and talked R1 into coming back into the building. Staff assessed R1 and noted no injuries. The facility failed to adequately identify elopement risk and failed to ensure interventions in place to prevent elopement were fully functional. This deficient practice placed R1 in immediate jeopardy. On 01/25/24 the facility identified and completed the following corrective actions: education with all staff regarding the Elopement Policy/Missing Elder Policy, the facility-initiated window checks/alarm checks on all of the windows on the memory care unit, Elopement Drill was	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 02/12/2024

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 performed, and education presented regarding the Elopement Risk Binder found at the nurse's desk, screws were placed in the outside windows to only allow the windows to raise 4 inches. All corrective actions were completed before the onsite survey; therefore, the deficient practice was deemed past noncompliance and remained at a "J" scope and severity. The 2567 was sent electronically on 02/12/24.	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 identified a census of 33. The sample included three residents reviewed for elopement (when a cognitively impaired resident leaves the facility without staff knowledge and supervision). Based on observation, record review, and interviews, the facility failed to ensure interventions used to prevent elopement (window alarms) were functional and tamper-resistant. The facility further failed to accurately assess and identify Resident (R)1's elopement risk. R1 was cognitively impaired, lived on a secured memory unit, and had a history of wandering; though, the latest elopement assessment performed on 01/08/24 indicated the resident had no wandering	F 689	Past noncompliance: no plan of correction required.	

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F 689	Continued From page 2	F 689		

and was at low risk for elopement. On 01/24/24 at approximately 12:05 PM R1 moved her couch and a table away from her window, opened the window and screen, and exited the facility via the window. The alarm on the window did not sound and R1 proceeded to walk down a steep hill to the sidewalk which went around the building, towards the front of the building. Certified Nurse Aide (CNA) M observed that R1 was outside, from the kitchen window. CNA N continued to watch R1 from the window while another staff went outside and talked R1 into coming back into the building. Staff assessed R1 and noted no injuries. The facility failed to adequately identify elopement risk and failed to ensure interventions in place to prevent elopement were fully functional. This deficient practice placed R1 in immediate jeopardy.

Findings included:

- The Electronic Medical Record (EMR) documented R1 had diagnoses of major depressive disorder (major mood disorder), restlessness and agitation, and age-related cognitive decline.

The "Quarterly Minimum Data Set," dated 01/12/24, documented R1 had a Brief Interview for Mental Status (BIMS) score of eight, which indicated moderately impaired cognition. The MDS documented R1 had behaviors not directed towards others (pacing, rummaging, vocal symptoms) one to three days during the look back period. The MDS documented R1 had wandered one to three days during the look back period.

The "Cognitive Loss/Dementia Care Area

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Assessment (CAA)," dated 04/11/23, documented R1 exhibited confusion, disorientation, and forgetfulness.

The "Falls CAA," dated 04/11/23, documented R1 had impaired balance during transitions and impaired balance to maintain a seated position.

The "Activity of Daily Living/Rehabilitation Potential CAA," dated 04/11/23, documented R1 had changing cognitive status and mood decline. R1 required assistance with her activities of daily living due to weakness, poor coordination, and poor balance.

R1's "Care Plan" documented R1 was an elopement risk and directed staff to distract R1 from wandering by offering pleasant diversions, structured activities, food, conversation, television, or books (04/30/23). The plan also directed staff to try toileting, walking inside or outside, reorientation strategies including signs, pictures and memory boxes. R1's "Care Plan" documented R1 required cueing and minimal assistance with activities of daily living.

The "Elopement Risk Evaluation," dated 01/08/24, documented R1 had a score of eight and was a low risk for elopement. The facility failed to documented R1 had a history of elopement.

The "Behavior Note," dated 04/30/23, documented R1 followed behind a visitor and exited the building. Staff saw R1 exit the building and brought her back inside.

The "Behavior Note," dated 01/23/24, documented R1 had shown a very noticeable

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increase in exit seeking behaviors. R1 had become aggressive with other residents and had become physically aggressive towards staff when staff did not let R1 off of the secured memory unit. R1 stood directly behind the entry door into the memory care unit and attempted to push past staff to exit the memory care unit.

The "Health Status Note," dated 01/24/24, documented Licensed Nurse (LN) G viewed camera footage and witnessed R1 go into her room. CNA M went directly to R1's door and opened it to make sure R1 was in her room. At 12:07 PM a report came across the radio R1 was outside. A code green was called. CNA N was instructed to keep her eyes on R1. R1 was outside walking along the fence the along the building approximately twenty-five feet from her window. Staff went downstairs from the assisted living building and was able to bring R1 back into the facility without difficulty. It was calculated by cameras and staff R1 was outside no longer than two minutes. R1 had on a long sweater. The temperature was 37 degrees Fahrenheit (F). R1's primary care physician and responsible party were notified.

The "Alert Note," dated 01/28/24, documented R1 attempted to elope out of her window again. The window alarms sounded and staff successfully diverted R1's attention away from the window.

The "Facility Incident Report," dated 01/24/24, documented on 01/24/24 at approximately 12:05 PM, R1 had left the hallway of the memory care unit after talking to CNA M. R1 entered her room and closed the door. R1 moved her couch and table away from the window, turned off the window alarm, opened the window and screen,

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and went out the window. According to video footage, CNA M walked to the kitchen and looked out the window and saw R1 walking outside. CMA M quickly went outside and brought R1 back to the building. R1 was at the door outside of the assisted living building. R1 wore a long light blue cardigan with a long sleeved gray shirt underneath, navy pants, and black shoes. The outside temperature was 36 degrees F and skies were cloudy without wind. A skin assessment was performed immediately after which revealed intact skin without bruises or other abnormalities.

CNA N's "Witness Statement," dated 01/24/24, documented CNA N had seen R1 enter her room at 12:05 PM. CNA N then went back to the kitchen and CNA M followed her. CNA M noticed R1 outside. R1 wore a blue knitted cardigan with a gray shirt underneath, navy blue slacks, and black shoes. CNA M and CNA N ran down the hall. CNA N radioed there was an elopement. CNA N went into R1's room and noticed R1's window was open and her couch was moved away from the wall/window. CNA N monitored R1 out the window until other staff made contact with R1.

CNA M's "Witness Statement," dated 01/24/24, documented at approximately 12:05 PM CNA M saw R1 walking into her bedroom. CNA M walked back to the kitchen for dinner/lunch service and as CNA turned towards the window on the east wall of the dining room saw R1 walking outside along the wall on the west side of the assisted living wing. CNA M told CNA N to radio for help and CNA M headed outside. CNA M ran around the back of the facility down the north road and toward R1. R1 was making her way down the hill and toward the lower-level assisted living door.

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R1 attempted to make entry into the door. CNA M assisted R1 into the lower level of the assisted living building. R1's clothing appeared clean with no signs of mud or water or other indications of having fallen.

LN G's "Witness Statement," dated 01/24/24, documented at 12:07 PM it was reported over the radio R1 was outside. LN G called a code green. LN G instructed CNA N to keep her eyes on R1. LN G instructed other staff members to go outside and around the building from different directions. R1 was witnessed walking around the building. Another licensed nurse was able to get to R1 first and she assisted R1 back into the building. R1 had not been outside more than two minutes. The temperature was 37 degrees F. R1 had a long sweater and tennis shoes on.

On 01/31/24 at 09:30 AM, observation revealed R1 up and wandering the hallway on the secure memory unit. R1 complained of back pain and wanted her dirty clothing taken to the laundry. R1 went in and out of her room numerous times in a short period.

On 01/31/24 at 09:45 AM, observation revealed the window alarms were working, the windows were only able to be raised approximately four inches, and tape had been placed over the window alarm to help deter residents from turning the alarms off.

On 01/31/24 at 10:45 AM, CNA M stated R1 wandered frequently. CNA M stated she saw R1 out the kitchen window on 01/24/24 and she was walking unsteadily down the hill.

On 01/31/24 at 11:00 AM, Administrative Nurse D

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stated the facility had not been checking to make sure the alarms on the windows were working prior to this elopement. Administrative Nurse D stated she didn't even know the windows had alarms on them. Administrative Nurse D stated all staff had been educated regarding elopements, window alarms, and how to open the windows on the secure memory unit in case of emergency. Administrative Nurse D stated the window alarms are now checked on every shift to ensure they are functioning.

The "Elopement Policy," dated 10/23/23, documented it was the facilities wish to ensure the safety of those residents that have been identified as being at risk for elopement. It is the policy of this facility to identify those residents at risk for elopement and take precautions to ensure their safety. Special secure living units are provided by the facility and additional security including WanderGuard door locking system is provided.

The facility failed to adequately identify elopement risk and failed to ensure interventions in place, to prevent elopement, were fully functional. This deficient practice placed R1 in immediate jeopardy.

On 01/25/24 the facility identified and completed the following corrective actions: education with all staff regarding the Elopement Policy/Missing Elder Policy, the facility-initiated window checks/alarm checks on all of the windows on the memory care unit, Elopement Drill was performed, and education presented regarding the Elopement Risk Binder found at the nurse's desk, screws were placed in the outside windows to only allow the windows to raise 4 inches.

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F 689	Continued From page 8 All corrective actions were completed before the onsite survey; therefore, the deficient practice was deemed past noncompliance and remained at a "J" scope and severity.	F 689		