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	175348	A. BUILDING _____ B. WING _____	C 11/20/2024

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HILLTOP LODGE HEALTH AND REHABILITATION CENTER	815 N INDEPENDENCE AVENUE BELOIT, KS 67420

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F 000	INITIAL COMMENTS The following citations are the result of abbreviated suvrey and complaint investigation KS000191556. On 11/20/24 at 12:29 PM Administrative Staff A received a copy of the "Immediate Jeopardy [IJ] Template" and was informed of the IJ for Resident (R)1. On 08/08/24 and 10/28/24 the facility assessed and documented R1 was at high risk for elopement but did not implement any interventions or update R1's plan of care to alert staff regarding R1's elopement risk. On 10/30/24 staff last saw R1 at 07:30 AM. At approximately 10:30 AM, the facility received a phone call from a community member stating there was an elderly man walking on the grounds of the facility. The facility started a head count and realized R1 was not in the facility. His window was open and R1 had chiseled the wooden blocks that were screwed into the windowsill with a butter knife, allowing him to open and exit the window. While staff performed a search for R1, the facility received a phone call from a farm store indicating R1 was there. The store was 0.3 miles away, a seven-minute walk from the facility. R1 had to cross a busy highway with lots of truck traffic, up and down two steep ditches to reach the store. When staff got to the store, R1 was talking to the local police and was sharing with the police officer that the facility was holding him captive. R1 returned to the facility at the persuasion of Law Enforcement but refused assessment. The failure to identify and implement interventions and provide adequate supervision to prevent an elopement for R1 placed R1 in immediate	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 11/26/2024

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 jeopardy. The facility completed the following corrections on 10/30/24: R1 was placed on one-to-one staff. The facility notified R1's primary care physician and responsible party of the situation. A new wandering assessment was completed for R1. The elopement book was reviewed and updated. R1's "Care Plan" was updated. An ad hoc meeting was held with the medical director on 10/30/24 at 05:00 PM. E Maintenance secured the windows in R1's room. Maintenance checked all of the windows in the facility to ensure stoppers were in place on 10/30/24. Education was provided to all staff on elopement and abuse, neglect, and exploitation on 10/30/24. All corrections were completed prior to the onsite survey therefore the deficient practice was deemed past noncompliance. The scope and severity remained at a "J." The 2567 was sent electronically on 11/26/24.	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:	F 689		

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F 689	Continued From page 2 The facility identified a census of 69 residents with three residents reviewed for elopements. Based on record review, observation, and interview, the facility failed to identify and implement interventions and failed to provide adequate supervision to prevent an elopement for Resident (R) 1, who was cognitively impaired and at high risk for elopement. On 08/08/24 and 10/28/24 the facility assessed and documented R1 was at high risk for elopement but did not implement any interventions or update R1's plan of care to alert staff regarding R1's elopement risk. On 10/30/24 staff last saw R1 at 07:30 AM. At approximately 10:30 AM, the facility received a phone call from a community member stating an elderly man was walking on the grounds of the facility. The facility started a head count and realized R1 was not in the facility. His window was open and R1 had chiseled the wooden blocks that were screwed into the windowsill with a butter knife, allowing him to open and exit the window. While staff performed a search for R1, the facility received a phone call from a farm store indicating R1 was there. The store was 0.3 miles away, a seven-minute walk from the facility. R1 had to cross a busy highway with lots of truck traffic, and up and down two steep ditches to reach the store. When staff got to the store, R1 was talking to the local police and was sharing with the police officer that the facility was holding him captive. R1 returned to the facility at the persuasion of Law Enforcement (LE) but refused assessment. The failure to identify and implement interventions and provide adequate supervision to prevent an elopement for R1, placed R1 in immediate jeopardy. Findings included:	F 689	Past noncompliance: no plan of correction required.	

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- R1's Electronic Medical Record (EMR) documented that R1 had diagnoses of frontotemporal neurocognitive disorder (a rare progressive brain disease that affects the frontal and temporal lobes of the brain), dementia (progressive mental disorder characterized by failing memory, and confusion), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), homicidal ideations (thoughts of murder), and suicidal ideations (thoughts of suicide).

The "Quarterly Minimum Data Set (MDS)," dated 08/08/24, documented R1 had a Brief Interview for Mental Status (BIMS) score of eight which indicated moderately impaired cognitive function. The MDS documented R1 was independent with most of his activities of daily living. The MDS lacked any documentation of behaviors.

The "Cognitive Loss/Dementia Care Area Assessment (CAA)" dated 05/30/24, documented R1 had short-term and long-term memory loss and a BIMS score of eight. The CAA documented R1 had diagnoses of dementia and depression and was at risk for isolation and further cognitive decline.

R1's "Care Plan" documented R1 required supervision or touch assistance for ambulation, eating, and bathing (05/24/24). The care plan documented R1 tended to exhibit behavioral issues: being easily agitated, loud, disruptive, and anxious due to dementia. Staff were to anticipate and meet R1's needs, assist R1 in developing appropriate coping skills to alleviate behaviors, explain all procedures to R1, allow him to process and decrease his confusion, and administer medication as ordered (05/24/24). The care plan

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documented R1 had safety concerns related to a history of falls and staff were to be sure R1's call light was in reach and encourage R1 to use it for assistance and educate R1 about safety reminders (05/31/24).

R1's "Care Plan" lacked any documentation of interventions aimed to protect R1 from wandering or elopement until after the incident on 10/30/24.

On 10/30/24, R1's "Care Plan" recorded a focus created on 10/30/24 with an effective date of 05/24/24 that stated R1 was at risk for elopement. Interventions were created on 10/30/24, effective 05/24/24, which directed staff to educate healthcare decision-makers and staff of elopement potential, triggers, and preventative measures. The plan directed staff to encourage R1's independence, while in the building but to ensure he is supervised while outside. The interventions created on 10/30/24, effective 05/24/24, included keeping R1's information in the elopement book, keeping his routine as consistent as possible, and redirecting when wandering around doors or exits. An intervention created on 10/30/24, effective 05/24/24, directed staff that R1's family must sign him out of the facility before R1 exits the facility.

The "Elopement/Wandering Risk Assessment," dated 05/24/24, documented R1 had a score of 12 which indicated R1 was a high risk for wandering/elopement.

The "Elopement/Wandering Risk Assessment," dated 10/28/24, documented R1 had a score of 12 which indicated R1 was a high risk for wandering/elopement.

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The "Morse Fall Scale," dated 10/28/24, documented R1 had a risk score of 35 which indicated R1 was at moderate risk for falls.

The "Incident Note," dated 10/30/24, documented an assisted living nurse received a phone call at approximately 10:30 AM from a local person regarding an older gentleman outside of the facility. The assisted living nurse contacted the facility, and an immediate head count was performed and R1 was unaccounted for. While the facility staff performed a search of the facility and grounds, the facility received a call from the local farm store across the street stating R1 was at the store. Licensed Nurse (LN) G and LN H went to the store. Upon entering the store, R1 was observed visiting with a police officer. R1 was dressed in a T-shirt, khaki shorts, shoes, and socks. R1 was reluctant to talk to LN G and LN H. The police officer reported R1 felt the facility was holding him captive. The police officer convinced R1 to return with him to the facility, willingly got into the police officer's car, and was transported back to the facility without difficulty. R1 refused to talk to any staff member after his return. R1 was placed on one-to-one (1:1) with staff. R1 told the police officer he had removed the blocks from his window and left through the window.

The "Wandering Risk Scale Note," dated 10/30/24, documented R1 was able to follow instructions, ambulatory, able to communicate, had a history of wandering, had a medical diagnosis of dementia/cognitive impairment, a diagnosis impacting his gait, mobility, or strength, and wandered aimlessly, and made attempts to exit the facility.

The "Therapy Screen Note," dated 10/30/24,

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documented the therapist had been requested to complete an urgent BIMS on R1. R1 was in his room with a "Do Not Disturb" sign on the door. The therapist entered and introduced themselves and R1 immediately started in erratic conversation about knowing this was going to happen with multiple people coming to his room because of this stuff. R1 presented with hypomanic (a condition that involves a period of extreme mood swings, increased energy, and unusual activity levels) and paranoid thoughts about his family. Empathetic listening and reflection were tried and R1 refused to answer a couple of quick questions. The therapist was able to get R1 to respond to some orientation questions and was unable to state the year, date, day of the week, or town he was located in.

The "Facility Incident Report," dated 10/31/24, documented an assisted living nurse received a phone call at approximately 10:30 AM from a local person regarding an older gentleman outside of the facility. The assisted living nurse contacted the facility and an immediate head count was performed and R1 was unaccounted for. While the facility staff performed a search of the facility and grounds, the facility received a call from the local farm store across the street stating R1 was at the store. Licensed Nurse (LN) G and LN H went to the store. Upon entering the store, R1 was observed visiting with a police officer. R1 was dressed in a T-shirt, khaki shorts, shoes, and socks. R1 was reluctant to talk to LN G and LN H. The police officer reported R1 felt the facility was holding him captive. The police officer convinced R1 to return with him to the facility, willingly got into the police officer's car, and was transported back to the facility without difficulty. R1 refused to talk to any staff member after his return. R1 was

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placed on one-to-one staff. R1 told the police officer he had removed the blocks from his window and left through the window. The facility notified R1's primary care physician and responsible party of the situation and no new orders were received. An assessment of R1 will be completed when R1 allows. Maintenance secured the windows in R1's room. Maintenance checked all of the windows in the facility to ensure stoppers were in place. The facility provided education to all staff on elopement and abuse, neglect, and exploitation. The facility completed a new wandering assessment for R1, reviewed and updated the elopement book, updated R1's "Care Plan", and had an ad hoc meeting with the medical director.

LN I's "Witness Statement," dated 10/30/24, documented LN I saw R1 around 07:30 AM walking into the dining room.

Certified Nurse's Aide (CNA) N's "Witness Statement," dated 10/30/24, documented CNA N talked to R1 at 07:15 AM when he asked CNA N for ointment for his bottom. CNA N stated R1 was in a great mood and joking.

On 11/20/24 at 10:00 AM, observation of R1's room revealed the windows were screwed shut from the outside. Observation outside of R1's window revealed a bush, large air conditioning units, and a parking lot full of cars. The most direct route to the farm 0.3 miles away from the facility revealed a busy highway with lots of truck traffic and posted speeds of 30 miles per hour. There were also two steep ditches between the facility and the store.

On 11/20/24 at 10:00 AM, Administrative Staff A

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stated R1 was seen on camera about 10:00 AM and then the Assisted Living facility received a phone call from the hospital about a resident being out. Assisted Living staff then called the facility to inform them about 10:30 AM and a head count was started and realized R1 was not in the facility. R1's window was open and R1 had chiseled the wooden blocks that had been screwed into the windowsill to prevent the windows from opening with a butter knife. Administrative Staff A stated he felt R1's BIMS was not accurate because R1 just would not answer the questions and that R1 was more alert and oriented than the BIMS evaluation showed. Administrative Staff A stated that before the elopement, R1 was allowed outside of the facility to walk around but after this incident, the privilege was taken away Administrative Staff A stated the facility staff followed the elopement policy.

On 11/20/24 at 10:15 AM, Administrative Nurse D stated she was unaware R1 did not have an elopement intervention in his care plan prior to the elopement. Administrative Nurse D said that after the elopement on 10/30/24, R1 was placed on 1:1 with staff until R1's windows could be secured. Education with all staff was performed on the Elopement Policy and ANE Policy and audits of elopement risk assessments were completed and any resident with a score of nine or higher was ensured elopement interventions were in their care plan on 10/30/24.

On 11/20/24 at 10:30 AM, LN G stated R1 had paranoia and at times was perfectly lucid, and then it was like a switch was flipped and he was accusing his sisters of keeping him captive in a basement and forcing him to take pills. LN G stated R1 was at risk for wandering but he never

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wandered in the facility. LN G stated she thought R1 had been care planned for elopement before the incident but was not sure.

On 11/20/24 at 10:45 AM, CNA M stated she never had any problems with R1. He was independent with all of his ADLs. CNA M stated that R1 would come out, get ice water, and go back to his room. CNA M stated right after the elopement, R1 began to become threatening and had a lot of behaviors.

On 11/20/24 at 11:00 AM, CNA N stated she saw R1 the morning he eloped, and he appeared to be in a good mood and was joking with her. CNA N stated she saw R1 at about 07:15 AM that morning. CNA N stated she was unaware if R1 had any wandering behaviors.

The facility's "Elopements and Wandering Residents Policy" documented the facility ensures residents who exhibit wandering behavior and/or are at risk for elopement receive adequate supervision to prevent accidents and receive care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering or elopement risk. The facility shall establish and utilize a systematic approach to monitoring and managing residents at risk for elopement or unsafe wandering, including identification and assessment of risk, evaluation, and analysis of hazards or risks, implementing interventions to reduce hazards and risks, and monitoring for effectiveness and modifying interventions when necessary.

On 11/20/24 at 12:29 PM Administrative Staff A received a copy of the "Immediate Jeopardy [IJ] Template" and was informed that the failure to

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F 689	Continued From page 10 identify and implement interventions and failed to provide adequate supervision to prevent an elopement for R1 placed R1 in immediate jeopardy. The facility completed the following corrections on 10/30/24: R1 was placed on one-to-one with staff. The facility notified R1's primary care physician and responsible party of the situation. A new wandering assessment was completed for R1. The elopement book was reviewed and updated. R1's "Care Plan" was updated. An ad hoc meeting was held with the medical director on 10/30/24 at 05:00 PM. E Maintenance secured the windows in R1's room. Maintenance checked all of the windows in the facility to ensure stoppers were in place on 10/30/24. Education was provided to all staff on elopement and abuse, neglect, and exploitation on 10/30/24. All corrections were completed prior to the onsite survey therefore the deficient practice was deemed past noncompliance. The scope and severity remained at a "J."	F 689		