STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175221	A. BUILDING _____ B. WING _____	C 12/03/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOUNTAINVIEW NURSING & REHAB CENTER	**601 N ROSE HILL ROAD ROSE HILL, KS 67133**

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F 000	INITIAL COMMENTS	F 000		

A complaint survey was conducted by Kansas Department for Aging and Disability Services (KDADS), on behalf of the Centers for Medicare and Medicaid Services (CMS) on 12/03/20 for complaint # KS 158277.

On 12/03/2020 at 05:00 PM the Administrator was provided with the immediate jeopardy template and notified that the facility failed to provide adequate supervision for Resident (R)1, who had known behaviors of wandering and exited the facility through an unsecure, unalarmed door without staff knowledge, and R1 was found by Emergency Medical Services personel after being found outside on the ground.

This deficient practice was cited as past non-compliance on 12/02/2020 at 12:00 PM, when the facility completed the following prior to the surveyor entering the facility on 12/03/2020 at 08:15 AM.

The plan included:

Maintenance Staff Audible door alarms placed on the three dining room doors that enter the dining room. Two additional alarms added to the back of the double doors near long term care and to the back of the double doors leading to the therapy room, on 12/1/20 at 3:00 PM.

All staff education on the facility's "Elopement Policy," initiated on 11/30/20 at 11:30 PM, with the majority of the staff education on 12/02/20 at 12:00 PM. The remaining staff education provided by 11/03/20 at 09:00 before the starting of their shift. In addition, all staff education

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 12/11/2020

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F 000	Continued From page 1 included how to operate the program and expectations that the program monitored at all times. A focused Quality Assurance Performance Improvement (QAPI) initiated on 12/02/20 at 09:00 AM with the Administrator, Director of Nursing Services, Medical Director, and management team. This 2567 was electronically sent to the facility on 12/10/2020.	F 000		
F 689 SS=K	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 42, with three selected for review for elopement (incident which a cognitive impaired resident with poor or impaired decision-making ability & safety awareness leaves the facility without the knowledge of staff). Based on record review, observation, and interview, the facility failed to provide adequate supervision for Resident (R) 1, who had known behaviors of wandering and exited the facility through an unsecure, unalarmed door without staff knowledge. Emergency Medical Services (EMS) personnel	F 689	Past noncompliance: no plan of correction required.	

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F 689	Continued From page 2	F 689		

found R1 outside on the ground. The failure to provide adequate supervision and system management of the unlocked door, placed R1 and nine other residents identified as an elopement risk in immediate jeopardy for elopement.

Findings included:

- R1's electronically signed "Physician Order Sheet" (POS), dated 11/05/20, included the following diagnoses: major depressive disease (major mood disorder), dementia without behavioral disturbance (loss of the ability to think, remember, learn, make decisions, and solve problems), Alzheimer's (progressive mental deterioration characterized by confusion and memory failure), dementia with behavioral disturbance (Four categories' such as mood disorders, sleep disorders [changes in sleep patterns], psychotic disorders (severe mental disorders that cause abnormal thinking and perception) and altered mental status (changes in brain function).

The "Significant Change of Condition Minimum Data Set" (MDS), dated 11/25/20, revealed the resident had a "Brief Interview for Mental Status" (BIMS) score of 99. R1 did not complete the MDS interview. R1 had long and short term memory loss, unable to concentrate, and speaking slowly. R1 experienced acute onset of delirium with her behaviors fluctuating with inattentiveness and disorganized thinking. It was important for the resident to go outside on nice days. Resident had wandering behavior that occurred daily, which placed the resident at significant risk to a potentially dangerous place or significantly intrude on the privacy of activities of

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F 689	Continued From page 3	F 689		

others, and the behavior worsened since the previous assessment completed on 08/31/20. The resident wore a wander/elopement alarm (Wander Guard) bracelet (that sets off an alarm when resident wearing one attempted to exit the building without an escort) daily.

The "Cognitive Loss/Dementia Care Area Assessment" (CAA), dated 12/01/20, documented the resident could make her needs known at times and was able to understand when she required to be redirected. The resident could become aggressive with staff members. The resident was at risk for wandering, and she had Wander Guard placement.

The "Quarterly MDS," dated 08/31/20, documented the resident had a BIMS score of 00 indicating she had severely impaired cognition. The resident rarely made decisions on her own due to her short-term and long-term memory impairment. The resident required a Wander Guard .

The "Care Plan" dated 12/16/19, revealed the resident had an elopement risk and wandered related to impaired safety awareness. Her goal included she would not leave the facility unattended without the presence of the staff and her safety would be maintained. Staff educated regarding elopement risks and how to direct 1:1. Staff should monitor the Wander Guard alarms every shift and monitor the exit doors daily. Staff should keep the Wander Guard book at the nursing desk and update the book as needed. The Wander Guard was on R1's left wrist. Staff should monitor the Wander Guard for placement and function every shift.

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F 689	Continued From page 4	F 689		

The revised "Care Plan" dated 06/26/20, directed staff to cover doorknobs, handles and tape on the floor. Staff members should distract the resident from wandering by offering pleasant diversions, structured activities, food, conversation, television or a book. Staff should identify patterns of wandering and provide structured activities.
Review of the "Quarterly Wander Risk Assessment", dated 11/30/20, located in R1's electronic medical records (EMR), indicated her score was 13, which placed the resident at risk for elopement.

According to https://www.wunderground.com/history/daily/KICT/date/2020-11-30, the outside temperatures were as follows:

On 11/30/20 at 07:53 PM, the outside temperature was 32 degrees Fahrenheit (F), with wind speed at 0 miles per hour (MPH) and no precipitation.

On 11/30/30 at 08:53 PM, the outside temperature was 31 degrees F, with wind speed of 10 MPH, and no precipitation.

Interview on 12/03/20 at 08:33 AM, Administrative Nurse D reported she was notified by staff at the facility that R1 left the facility unsupervised at 09:20 PM when Law Enforcement notified the facility by phone that officers were at the front entrance of the facility with R1. Officers reported that a passerby called 911 where the resident had been visually seen lying on the ground next to the bench on the facilities property. Emergency Medical Services (EMS) arrived to assess R1. After EMS assessed R1, EMS transported R1 into the facility. The road in front of the facility

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F 689	Continued From page 5	F 689		

was a two-lane highway that was moderately (less extreme) traveled at night. The speed limit on the road was 35 miles per hours.

On 11/30/20 Licensed Nurse G completed the resident's "Nursing Elopement Assessment" due to R1 exited the facility unsupervised. The assessment found in R1 electronic medical records (EMR) documented staff obtained the resident's vitals and R1's temperature was 97.7 F (Fahrenheit) her heart rate was 102 beats per minute, her respirations were 18 per minute, her oxygen saturation was 96 percent and her blood pressure was 132/78 MmHg (millimeters of mercury) . EMS transferred R1 to her room and placed her on her bed. LN G completed a neurological check (level of consciousness, pupil size & verbal response, extremity strength and movement, vital signs) and was within normal limits. Staff assessed the resident and observed the resident had a hematoma (collection of blood in the tissues of the body outside of the blood vessels) on the palm of her right hand and a hematoma on her face, under her right eye. At the time of the assessment, R1was relaxed, smiling, with occasional moaning or groaning due to pain.

The "Physical Assessment," located in in the resident's clinical records, revealed R1 wore a long sleeve purple shirt, black sweater, thick socks, and what appeared to be snow boots at the time she exited the facility.

Review of the "Elopement Investigation Witness statements," revealed on 11/30/20, Certified Medication Aide (CMA) R reported the last time she visually saw the resident was at 08:30 PM.

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F 689	Continued From page 6	F 689		

On 11/30/20 Certified Nursing Assistant (CNA) O reported R1 paced the halls and facility in the evening of her elopement. R1 was last visually seen at 8:45 PM by CNA O and CNA P. Staff members redirected R1 to her room. Staff did not hear door alarms to indicate the resident exited the facility unsupervised.

Review of the facility "Investigation," on 12/03/20 , R1 obtained x-rays on 12/01/20 of her right hand and right wrist due to R1 complaining of pain and hematoma. Abnormalities were not found on the x-rays.

Observation on 12/03/20 at 10:19 AM revealed R1 sat in a chair, with her cane on her right side. The resident was pleasant, and she participated in coloring activities. The resident had a Wander Guard on her left wrist.

Observation on 12/03/20 at 10:45 AM, revealed Consultant staff HH ambulated the resident with a gait belt and a cane.

Observation on 12/03/20 at 02:09 PM, revealed R1 showed no signs of wandering or exit seeking. R1 sat on the couch and rested with her eyes closed. The resident had a Wander Guard on her left wrist.

Interview on 12/03/20 at 08:40 AM Maintenance Staff II stated there had been alarms on all the exit doors. The monitor located at the nurse's desk must always remain open to monitor the exit doors. We have a Wander Guard alarm at the front main exit door. He reported there were additional magnetic alarms on the double doors . Maintenance Staff II did not keep a log for the alarms. Maintenance could not confirm when the

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F 689	Continued From page 7	F 689		

exit doors where last checked.

Interview, on 12/03/20 at 08:48 AM, Administrative Nurse D reported staff saw the resident at approximately 08:45 PM. Staff was unaware which of the three dining room doors that R1 exited, however the facility had only one Wander Guard, at the front door, and staff determined the resident exited through the double exit doors by the dining room. Staff failed to close the double doors exiting hall 100/200 at 06:00 PM and failed to turn on the magnetic alarm and failed to close the entrance to the dining room and failed to turn on the magnetic alarm. The resident had increased restlessness and agitation. In the investigation, it was identified if the three exit doors located in the dining room were breeched or forced open, the alarm would no longer sound on the panel located at the nurse's station. Also, the computer program that notified staff of a "forced door" or door breach was not actively running on the nursing station computer at the time of the elopement. The functioning alarm log revealed at Dining Room door 2 there was a "forced" or door breach at 8:36 PM.

Interview on 12/03/20 at 10:47 AM, CMA R reported the resident could ambulate without staff assistance. The door alarms should function by alerting staff if the exit doors opened. She was found by someone driving by and they called EMS. Staff was not aware she was gone until EMS and law Enforcement arrived at the facility, with the resident, to clarify if the resident lived at the facility.

Interview on 12/03/20 at 02:48 PM CNA M stated R1 wandered frequently. R1 required supervision

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F 689	Continued From page 8	F 689		

by staff and required staff to keep her occupied with individual activities. CNA M verified the resident would walk towards exit doors but was unsure if she had attempted to exit the building.

Interview on12/03/20 at 02:57 PM CNA S stated R1 appeared to be bored and had confusion to changes in her routine due to COVID -19 (Coronavirus). Her behaviors increased since COVID-19.

Interview, on 12/03/20 at 03:11 PM, CNA O stated she felt R1 had a very hard time with the facility locked down due to COVID-19.

The facility's revised "Elopement Policy," dated 12/04/20, documented the facility should ensure the safety of residents who were identified at risk for elopement, and staff should take precautions to ensure the resident's safety and well-being.

The facility failed to provide adequate supervision for this resident, who had known behaviors of wandering, and exited the facility through an unsecure, unalarmed door without staff knowledge. R1 was found by a passerby, who called EMS, who found the resident outside on the ground. This placed this resident and nine other residents identified as elopement risk in immediate jeopardy.

This deficient practice was cited as past non-compliance on 12/02/2020 at 12:00 PM, when the facility completed the following prior to the surveyor entering the facility on 12/03/2020 at 08:15 AM.

The plan included:

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	175221	A. BUILDING _____ B. WING _____	C 12/03/2020

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F 689	Continued From page 9	F 689		

Maintenance Staff Audible door alarms placed on the three dining room doors that enter the dining room. Two additional alarms added to the back of the double doors near long term care and to the back of the double doors leading to the therapy room, on 12/1/20 at 3:00 PM.

All staff education on the facility's "Elopement Policy," initiated on 11/30/20 at 11:30 PM, with the majority of the staff education on 12/02/20 at 12:00 PM. The remaining staff education provided by 11/03/20 at 09:00 before the starting of their shift. In addition, all staff education included how to operate the program and expectations that the program monitored at all times.

A focused Quality Assurance Performance Improvement (QAPI) initiated on 12/02/20 at 09:00 AM with the Administrator, Director of Nursing Services, Medical Director, and management team.