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	175221	A. BUILDING _____ B. WING _____	C 05/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADVENA LIVING AT FOUNTAINVIEW	**601 N ROSE HILL ROAD ROSE HILL, KS 67133**

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F 000	INITIAL COMMENTS	F 000		

A complaint survey for KS00179935, KS00179898, and KS00180392 was conducted by Kansas Department for Aging and Disability Services (KDADS), on behalf of the Centers for Medicare and Medicaid Services (CMS) on 05/30/23 and 05/31/23.

On 05/30/23 at 05:00 PM, Administrative Staff A was provided the "Immediate Jeopardy Template" and notified the failure to provide a safe environment and adequate supervision to prevent elopement for R1, who was independently mobile and cognitively impaired, placed R1 in immediate jeopardy.

The facility identified and implemented the following corrective actions completed 05/24/23 at 06:10 PM:

1. All staff in-service on facility "Wandering and Elopement" policy on 05/24/23 which ended at 06:10 PM. One staff member was out on FMLA (family medical leave of absence) with an unknown return date. She did return the call at 07:10 PM on 05/24/23 for in-service acknowledgment. All nurses were also in-serviced on the "Medication and Treatment Order" policy on 05/24/23 which was completed at 06:00 PM. Staff have been informed they will not be allowed to work until they sign the in-service form.

2. On 05/24/23 "Wander Risk Assessments" were done on all residents.

3. On 05/24/23 an elopement drill completed on 06:00 AM to 06:00 PM shift at 05:28 PM.

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

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4. On 05/24/23 an elopement drill completed on 06:00 PM to 06:00 AM shift at 06:36 PM.

5. Medication review completed by Physician L, on 05/24/23 at 09:00 AM with medication changes that included the resident to restart Haldol 0.5 mg, three times a day.

6. On 05/23/23 at 08:00 PM, staff checked all alarms on the exit doors of the facility and functioned properly. They were checked again on 05/24/23 at 06:00 AM and functioned properly. All exit doors will continue to be checked twice a day on each shift (12-hour shifts) indefinitely.

7. On 05/24/23 upon return to the facility at approximately 05:20 AM, R1 placed on one on one for staff monitoring and continued until R1 was sent to a behavioral health unit on 05/24/23 at approximately 12:30 PM.

8. The facility installed screws in the windows to keep the windows from going up more than six inches.

9. Night shift (06:00 PM to 06:00 AM) LN D placed on suspension pending completion of the investigation, for failure to follow physician orders. On 05/26/23, the administrative staff terminated LN D.

10. Administrative Nurse I placed on suspension pending the completion of the investigation. On 05/26/23, the administrative staff terminated Administrative Nurse I.

11. On 05/24/23 the "Elopement Risk" binder reviewed and updated as necessary.

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F 000	Continued From page 2 12. The facility will bring this to the next monthly QAPI (Quality Assurance and Performance Improvement) meeting. The surveyor verified the implemented corrective actions while onsite 05/31/23. Due to this, the deficient practice was deemed past noncompliance at a "J" scope and severity. This 2567 was electronially sent to the facility on 06/05/23.	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 45 residents, with 3 residents sampled. Based on observation, interview, and record review, the facility failed to provide a safe environment for cognitively impaired and independently mobile Resident (R) 1 when the resident left the facility without staff supervision or knowledge. On 05/24/23 at around 04:40 AM, while on one-on-one staff supervision, R1 left the facility through a window he attempted to crawl out of prior, on 05/23/23. The staff located the resident 0.3 miles away from the facility, which is located in a heavily trafficked urban area with speed limits of 35 miles per hour.	F 689	Past noncompliance: no plan of correction required.	

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This failure placed the resident in immediate jeopardy.

Findings Included:

- R1's diagnoses from the "Electronic Health Record" (EHR) included dementia (progressive mental disorder characterized by failing memory, confusion), mild cognitive impairment, and anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear).

The 05/15/23 "Admission Minimum Data Set" (MDS) documented a Brief Interview for Mental Status (BIMS) score of 11, indicating moderately impaired cognition. R1 required limited assistance of one staff with all activities of daily living (ADL). R1 was unsteady, but able to stabilize without staff assistance. R1 did not have any range of motion impairments and did not use a wander/elopement alarm (a device/bracelet that sets off an alarm when a resident wearing one attempts to leave the facility without staff supervision).

The 05/15/23 "Cognitive Loss/Dementia Care Area Assessment" (CAA) documented R1 had dementia, could make his needs known, and used his call light.

The 05/09/23 "Care Plan" documented on 05/25/23, staff added additional guidance that staff were to encourage R1 to participate in activities of interest and distract R1 with food, conversation, television, or books. Staff were to give medications as ordered. R1 had a wander/elopement alarm in place, staff were to complete an elopement risk evaluation, R1 had

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an actual elopement, R1 was to have one-on-one supervision, and R1 had been added to the elopement book, after the elopement.

The 05/09/23 "Elopement Risk" assessment documented R1 was an elopement risk.

The 05/09/23 "Physician Orders" documented an order for haloperidol 0.5 milligrams (mg) twice daily, discontinued on 05/21/23, and restarted on 05/24/23 for three times a day. As of 05/25/23, staff were to check placement and functionality of the wander/elopement alarm for R1, each shift.

The "Progress Note" dated 05/23/23 at 06:30 PM documented R1 ambulated down the hall, became agitated, and yelled that another resident who stepped on his foot. Licensed Nurse (LN) D walked to the nurse's station and R1 followed her. LN D asked a Certified Nurse Aide (CNA) to keep R1 occupied while she called the provider. LN D got an order for haloperidol five mg one time only and to put R1 on one-to-one observation. An order for a psychiatric evaluation on 05/24/23.

The "Progress Note" dated 05/23/23 at 06:54 PM, LN E documented that R1 wandered all day and staff took R1 outside for walks. The note documented R1 tore out the screen from a window in the sunroom and at approximately 06:00 PM, R1 climbed out the window. The staff brought him back into the building and noted R1 had no injuries.

The "Progress Note" dated 05/24/23 at 02:30 AM, documented while R1 was on one-on-one staff observation, an unidentified CNA observed R1 turn around and slip away from the CNA. The staff found R1 in his room putting his shoes on.

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Another time the staff went to help another resident and R1 slipped away again. The unidentified CNA went to the bathroom and staff found R1 at the window in the sunroom with one leg outside. LN D then looked in the emergency pharmacy kit for the previously ordered one time dose of Haldol 5 mg. LN D found no 5 mg so she called the pharmacy and faxed the order to them for immediate delivery.

The "Progress Note" dated 05/24/23 at 03:30 AM revealed staff gave R1 a snack and he was calm and pleasant. R1 continued to walk up and down the halls.

The "Progress Note" dated 05/24/23 at 04:30 AM, revealed R1 remained with one-on-one observation at the nurse's station. The staff CNAs were beginning their last rounds when LN D asked them to take turns occupying R1, while LN D completed her charting. CNA F was first. Approximately 15 minutes later when CNA G, came to the nurse station and asked where R1 was, LN D looked around and CNA F was walking down the hall and R1 was nowhere in sight. LN D and CNA G began looking around the building, and when R1 was not found, they went to the window R1 had previously taken the screen out of, noticed the window was open even though they were certain they had closed it earlier, and noticed a motorcycle parked outside was tipped over. LN D gathered the staff and gave them flashlights and assignments in the search grid, to cover the perimeter of the building. As LN D went back into the facility, she noted Business Office Manager (BOM) C's car pulling into the driveway with R1 in the passenger seat. LN D and CNA G assisted R1 back into the facility.

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The "Witness Statement" for the incident on 05/24/23, for R1 by CNA F, documented while doing her rounds she overheard the nurse and another CNA asking if they had seen R1, who had previously eloped on day shift. They checked rooms and then the nurse gave flashlights to walk around the outside of the building. When walking back into the building, they were told another staff member, on her way to work, picked up R1 and brought him back to the building. It was about 04:45 AM.

The "Witness Statement" for the incident on 05/24/23 for R1, by CNA G, documented R1 was exit seeking all night. At 04:45 AM, CNA G went to go start round and was getting ready to do her last person, and asked the nurse if she had seen R1, she said no. CNA G came to the window that R1 had tried to get out of all night. CNA G noticed the window was cracked, went out front and noticed a motorcycle was pushed over. CNA G ran and got the nurse, they went out front and started searching for R1. BOM C pulled in and said she had R1. R1 kept telling the staff that he was sorry and he just wanted to walk.

The "Witness Statement" for the incident on 05/24/23 for R1, by CNA H, documented at approximately 04:48 AM CNA H attended to her rounds and call lights. When CNA H threw away her trash, the nurse gathered the staff to grab flashlights and to help find R1, who went out through the window.

The "Witness Statement" for the incident on 05/24/23 for R1, by BOM C, documented on her way to work at 05:05 AM she noticed R1 walking in the grass with a jacket on and a red broom in his hands. BOM C turned around and pulled into

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a parking lot where BOM C got out of her car and walked towards R1. BOM C called R1 by his name and asked if he needed a ride. R1 stated he was on his two mile walk that he did every day. BOM C explained to R1 it was not safe to walk in the dark and R1 agreed. BOM C talked R1 into a ride and R1 got into the car. R1 asked BOM C if she was taking him back to the building, BOM C asked R1 if that would be okay, R1 said yes. BOM C called the facility and when she did not get an answer, she called Administrative Staff A to let him know of the situation. BOM C and R1 arrived at the facility at approximately 05:15 AM, and staff were in the parking lot looking for R1. BOM C assisted R1 out of her car, and the facility staff assisted R1 into the building.

The "Witness Statement" for the incident on 05/24/23 for R1, by Administrative Nurse I, documented on 05/23/23 at approximately 07:28 PM, LN D called Administrative Nurse I, to inform him of R1 exit seeking. Administrative Nurse I recommended LN call the on-call provider for instructions or orders. At approximately 08:44 PM, LN D called again and stated the on-call provider ordered Haldol, 5 mg, by mouth once, and to follow up with a psychiatric consult tomorrow (05/24/23). LN D stated R1 was refusing any further medications, including oral, intramuscular injections, etc. Administrative Nurse I instructed LN D to keep R1 on one-on-one monitoring for the fore-seeable future. LN D acknowledged understanding of this. LN D also stated R1 was easily redirected and she suspected he would fall asleep soon. Administrative Nurse I instructed LN D to continue redirecting R1 during exit seeking episodes and to continue monitoring him one-to-one regardless of R1's behavior. LN D

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sent via text message at 06:06 AM to Administrative Nurse I stating R1 had eloped. Administrative Nurse I was told the emergency pharmacy kit did not contain the Haldol, but that the medication was being delivered STAT (urgent/ rush). Administrative Nurse I called LN D at 06:08 AM to confirm R1 was safe, that the one-to-ones were ... (no further statement provided).

On 05/30/23 at 09:30 AM through 05/31/21 at 10:00 AM R1 remained at the Behavioral Health Unit (BHU, a specialized unit for serious and unstable symptom management to prevent harm to them or others). Observation of the window R1 eloped from revealed two screws on both sides of the windowsill, which prevented the window from opening up all the way.

On 05/30/23 at 03:30 PM, Administrative Nurse B revealed at the time of the elopement was not at the facility. Administrative Nurse B stated her first contact with R1 was the morning of 05/24/23, and when she spoke with R1 he was very apologetic and remorseful. R1 stated he did not want to leave the facility, and he just wanted to go for a walk. When asked why he went out the window R1 stated "they had pissed him off" and he just wanted to show them he could do it himself. Administrative Nurse B confirmed her expectations of staff were to follow provider orders, provide the care as ordered, and act in a professional caring manner, always.

On 05/30/23 at 02:47 PM, Business Office Manager (BOM) C stated on the morning of 05/24/23, she was on her way to work early. It was dark. The street had some well-lit areas and some dark areas. She knew it was 05:05 AM as she had looked at the clock. She noticed the car

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in front of her go toward the center of the road and as she passed the same area, she saw R1, walking on the grass on the side of the road. R1 was in front of the fire station, which was one of the well-lit areas. BOM C did a U-turn and pulled into a parking lot. She got out of her car and approached R1. R1 did not appear to be hot or cold, nervous, or angry, shaken or flushed. R1's speech was clear and easily understood. R1 was properly dressed and carrying a red broom. BOM C asked R1 if he wanted a ride, and he said yes. R1 got in the car. BOM C called the facility and with no answer, so she called Administrative Staff A to inform him of the situation. BOM C and R1 arrived back at the facility and the staff assisted R1 into the building.

On 05/30/23 at 02:20 PM, Maintenance Staff K stated after the incident he placed screws in the windowsills of all the windows in the resident's rooms as well as in the sunroom, to limit the opening to six inches. Maintenance Staff K confirmed this was completed after the elopement, though he said some of the resident's rooms had had them because of residents that attempted to leave through them.

On 05/30/23 at 10:26 AM, Physician Extender J confirmed she received a call from the facility regarding the elopement at the time of elopement, at which time she gave an order to send R1 to the emergency room for evaluation and treatment due to violent behaviors. She stated she believed he had sustained no injury, per the facility staff report.

The facility's reviewed 05/24/23 "Wandering and Elopement" policy, outlined steps for staff to follow in the event of a resident becoming

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unaccounted for including who to notify and when (including law enforcement and other appropriate agencies). The policy further directed staff to perform wandering and/or elopement assessments on admission/readmission, quarterly, and at significant changes in condition and to revise care plans as indicated. The care plan will include the use of wander alert bracelet, interventions, and times or conditions that increase the risk of elopement.

The facility failed to provide a safe and secure environment for R1 who had impaired cognition and exit seeking behaviors, when he exited the facility, unsupervised, out of a window in the sunroom, and BOM C located him 0.3 miles away and returned R1 to the facility.

On 05/30/23 at 05:00 PM, Administrative Staff A was provided the "Immediate Jeopardy Template" and notified the failure to provide a safe environment and adequate supervision to prevent elopement for R1, who was independently mobile and cognitively impaired, placed R1 in immediate jeopardy.

The facility identified and implemented the following corrective actions completed 05/24/23 at 06:10 PM:

1. All staff in-service on facility "Wandering and Elopement" policy on 05/24/23 which ended at 06:10 PM. One staff member was out on FMLA (family medical leave of absence) with an unknown return date. She did return the call at 07:10 PM on 05/24/23 for in-service acknowledgment. All nurses were also in-serviced on the "Medication and Treatment Order" policy on 05/24/23 which was completed

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at 06:00 PM. Staff have been informed they will not be allowed to work until they sign the in-service form.

2. On 05/24/23 "Wander Risk Assessments" were done on all residents.

3. On 05/24/23 an elopement drill completed on 06:00 AM to 06:00 PM shift at 05:28 PM.

4. On 05/24/23 an elopement drill completed on 06:00 PM to 06:00 AM shift at 06:36 PM.

5. Medication review completed by Physician L, on 05/24/23 at 09:00 AM with medication changes that included the resident to restart Haldol 0.5 mg, three times a day.

6. On 05/23/23 at 08:00 PM, staff checked all alarms on the exit doors of the facility and functioned properly. They were checked again on 05/24/23 at 06:00 AM and functioned properly. All exit doors will continue to be checked twice a day on each shift (12-hour shifts) indefinitely.

7. On 05/24/23 upon return to the facility at approximately 05:20 AM, R1 placed on one on one for staff monitoring and continued until R1 was sent to a behavioral health unit on 05/24/23 at approximately 12:30 PM.

8. The facility installed screws in the windows to keep the windows from going up more than six inches.

9. Night shift (06:00 PM to 06:00 AM) LN D placed on suspension pending completion of the investigation, for failure to follow physician orders. On 05/26/23, the administrative staff terminated

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F 689	Continued From page 12 LN D. 10. Administrative Nurse I placed on suspension pending the completion of the investigation. On 05/26/23, the administrative staff terminated Administrative Nurse I. 11. On 05/24/23 the "Elopement Risk" binder reviewed and updated as necessary. 12. The facility will bring this to the next monthly QAPI (Quality Assurance and Performance Improvement) meeting. The surveyor verified the implemented corrective actions while onsite 05/31/23. Due to this, the deficient practice was deemed past noncompliance at a "J" scope and severity.	F 689		