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	175499	A. BUILDING _____ B. WING _____	C 06/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAGE AT MISSION	7105 MISSION ROAD PRAIRIE VILLAGE, KS 66208

(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	F 000		

The following citations represent the findings of partial extended suvrey and complaint investigations #KS00172588, KS00172609, KS00172522, KS00172272, KS00172639 and KS00172288.

On 06/29/22 at 04:25PM the facilty was provided with copies of the "Immediate Jeopardy [IJ] Templates" and informed of the immediate jeopardy for Resident (R) 1 and R2.

R1 admitted to the facility on 06/04/22 and attempted to exit the facility on 06/05/22 at 09:30 AM. Afterwards, he was taken to his room and staff were to check on him frequently. R1 had a high risk for elopement when staff observed him pushing on the front door with exit seeking and behaviors noted. On 06/05/22 at approximately 09:30 AM R1 followed facility visitors out of the building. As a result, R1 exited the facility without staff knowledge or supervision and was observed outside 15 minutes later by facility staff. This deficient practice placed R1 in Immediate Jeopardy.

The immediacy was removed on 06/29/22 and the deficicnt practice remained at a scope and severity of a "D"

On 06/15/22 Certified Nurse Aide (CNA) N transferred R2 by himself, using the mechanical lift. During the transfer, the lift tipped, and R2 dropped to the floor with the Hoyer lift landing on top of him. R2 reported pain at an eight to nine out of ten (on a zero to 10 scale with zero representing no pain and 10 being the worst pain imaginable) in his lower back was found to have a

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 07/12/2022

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F 000	Continued From page 1 compression fracture to his thoracic (T) 12 vertebra as a result of the fall. This deficient practice placed R2 in Immediate Jeopardy.The facility completed corrections for this deficient practice prior to the survey event so this deficient practice is past noncompliance. The 2567 was sent electroncially on 07/12/22.	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 33 residents. The sample included three residents reviewed for elopement (when a cognitive impaired resident with little of poor safety awareness exits the facility without staff knowledge) and one resident reviewed for falls. Based on observation, record review, and interview, the facility failed to ensure Resident (R)1 received adequate supervision and appropriate interventions to prevent elopement. R1 admitted to the facility on 06/04/22 and was noted to attempt to exit the facility on 06/05/22 at 09:30 AM, he was taken to his room and staff were to check on him frequently. R1 had a high risk for elopement when staff observed him pushing on the front door with exit seeking and behaviors noted. On 06/05/22 at approximately	F 689		

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F 689	Continued From page 2	F 689		

09:30 AM R1 exited the building behind facility visitors. As a result, R1 exited the facility without staff knowledge or supervision and was observed outside 15 minutes later by facility staff. This deficient practice placed R1 in Immediate Jeopardy. The facility further failed to ensure staff followed Resident (R)2's plan of care to have two staff members assist with transfers using a Hoyer lift (total body mechanical lift used to transfer residents). On 06/15/22 Certified Nurse Aide (CNA) N transferred R2 by himself, using the mechanical lift. During the transfer, the lift tipped, and R2 dropped to the floor with the Hoyer lift landing on top of him. R2 reported pain at an eight to nine out of ten on a zero to 10 scale with zero representing no pain and 10 being the worst pain imaginable) in his lower back was found to have a compression fracture to his thoracic (T) 12 vertebra as a result of the fall. This deficient practice placed R2 in Immediate Jeopardy.The facility completed corrections for this deficient practice prior to the survey event.

Findings included:

- R1's electronic medical record (EMR), under the "Diagnoses" tab recorded diagnoses of altered mental status (state of awareness that was different from the normal awareness of a person), weakness, Parkinson's disease (slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity and weakness), and history of falling.

The "Entry Minimum Data Set" (MDS) dated 06/04/22 documented R1 entered the facility on 06/04/22.

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The "Care Plan" dated 06/04/22 lacked any interventions related to cognition or altered mental status.

The "Behavior Note" dated 06/05/22 at 10:33 AM documented R1 at the exit pushing on the door and trying to leave. R1 stated he felt like he was in prison and wanted to go home. R1 was taken to his room and told to stay for rehab. Approximately 30 minutes later, Administrative Staff A wheeled R1 back into the facility after R1 followed an unidentified visitor out of the facility. Staff were encouraged to do checks on R1 whenever they walked by R1's room.

The progress notes lacked documentation of what R1 wore at the time of the elopement, the temperature, conditions outside, a complete body assessment for injuries, vital signs, and/or notification of R1's medical practitioner.

Administrative Staff A's unnotarized and undated "Witness Statement" documented at approximately 09:45 AM on 06/05/22 he was walking from the parking lot on the north side of the facility. Administrative Staff A documented upon reaching the Southwest corner of the facility R1 was in his wheelchair self-propelling west. R1 was asked what he was doing, to which R1 stated he was going to play golf. R1 was approximately 300 feet from the front door of the facility.

Housekeeper U's unnotarized "Witness Statement" dated 06/05/22 documented an unidentified visitor notified him that R1 was outside of the facility in a wheelchair leaving the property. Housekeeper U documented immediately going out to the R1 and noted Administrative Staff A speaking with R1. R1 was

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then assisted back into the building .

On 06/29/22 at 11:00 AM the sidewalk was noted to run right beside the building with two different handi-capped accessible ramps build into the sidewalk that R1 reportedly self-propelled down, otherwise the side walk was level and lead west towards Mission Road where traffic moved approximately 20 to 30 miles per hour in the urban area.

On 06/29/22 at 11:10 AM Administrative Staff A stated that he located R1 outside on the sidewalk a way down from the front door of the facility. Administrative Staff A revealed that the hospital referral was reviewed and R1 was noted to have confusion, but it was of unknown origin, so the facility staff did not know if it was historical or regular.

On 06/29/22 at 11:37 AM Licensed Nurse (LN) G stated an unidentified staff member informed LN G that R1 was outside. LN G stated herself, an unidentified staff member, and Administrative Staff A coached R1 to come back into the building. LN G revealed that R1 seemed alert and oriented, but had some confusion.

On 06/29/22 at 02:05 Certified Nurse Aide (CNA) M stated if a resident was at the door trying to exit, then staff needed to redirect the resident and tell the nurses. CNA M revealed the Kardex (a medical information system that contains all the care and interventions to care for the resident) told her how to care for residents, interventions, and things to be aware of for each resident.

The facility's "Elopements" policy revised 12/07 documented all residents would be assessed for

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behaviors or conditions that put them at risk for elopement. The policy directed staff to get the resident to shelter, take their vital signs and conduct a complete body assessment for injuries when the resident is found. It further directed staff to notify the resident's medical practitioner.

The facility failed to ensure R1 received adequate supervision and timely appropriate interventions to ensure R1's safety. R1 was able to exit the facility without supervision which presented the likelihood of serious harm or impairment. The facility must take immediate actions to ensure the residents receive the needed supervision to ensure resident safety to prevent further elopements.

The facility removed the immediacy at 06:55 PM on 06/29/22 by taking the following actions:

An audit of residents at risk for elopement in care plans/Kardex was completed on 6/29/2022 to identify other residents who had the potential to be affected.

All clinical staff were educated by Administrative Staff A, Administrative Nurse D and Administrative Nurse E on 6/29/22 on the facility's "Elopement Policy" and on "Elopement Assessments". Education would be ongoing ensuring all staff including agency were educated prior to working a shift.

An elopement risk sssessment would be completed on the day of admission, quarterly, and when changes in behavior or cognition occurred on all residents.

Photographic identification of residents at risk for

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elopement would be placed in the elopement Binder.

All staff were educated by Administrative Nurse D and Admisnitrative nurse E on 6/29/2022.

This deficient practice remained at a scope and severity of a D.

- R2's Electronic Medical Record (EMR), under the "Diagnoses" tab recorded diagnoses of hemiplegia (paralysis of one side of the body) and hemiparesis (muscular weakness of one half of the body) following cerebral infarction (sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain) affection left non-dominate side, Chronic Obstructive Pulmonary Disease (COPD- progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), and generalized anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear) disorder.

The "Quarterly Minimum Data Set" (MDS) dated 02/04/22 documented a Brief Interview (BIMS) score of 13, which indicated intact cognition. R1 required extensive assistance of two staff members for activities of daily living (ADLs) for bed mobility, total dependence of two staff members for transfers, toilet use, total dependence of one staff member for locomotion on and off the unit, and dressing. R2 documented shortness of breath or trouble breathing when lying flat.

The "Annual MDS" dated 05/07/22 documented a

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BIMS score of 14, which indicated intact cognition. R1 required extensive assistance of two staff members for ADLs for bed mobility, total dependence of two staff members for transfers and toilet use, total dependence of one staff member for locomotion on and off the unit, and dressing. R2 documented shortness of breath or trouble breathing when lying flat.

The "ADL Functional Care Area Assessment" (CAA) dated 05/07/22 directed that R2 required nearly total assistance for ADL performance.

The "Falls CAA" dated 05/07/22 documented R2 required a Hoyer lift for transfers and was a low risk for falls related to this.

The "ADL Care Plan" initiated 06/06/21 directed staff that R2 required total assistance with transfers, the use of a Hoyer lift, and two staff member participation.

The "Fall Risk Data Collection" assessment dated 04/22/22 documented R2 scored a six on the assessment, which indicated he was a low fall risk.

The "Emergency Department Discharge Paperwork" dated 06/15/22 documented the resident had a T12 compression fracture.

The "Health Status Note" dated 06/15/22 at 04:15 PM documented R2 was on the ground in his room. R2 observed laying on the sling, on his back, in the middle of the floor. CNA N reported R 2 started to slip out of the lift and had to be lowered to the floor. CNA N stated R2 did not hit his head. Staff assessed R2 and he reported pain at an eight to nine out of ten for pain in his lower

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back. When asked about the fall, R2 stated the lift turned over and he fell to the floor hitting his back, but could not recall if R2 hit his head. R2 requested to go the ED to get an X-ray.

Review of the unnotarized interview of CNA N dated 06/15/22 documented CNA N made it clear during the interview that he was aware of the policy, which required two staff members for Hoyer transfers.

Review of the unnotarized witness statement dated 06/15/22 revealed Licensed Nurse (LN) G stated R2 was supine on the floor in a Hoyer sling with the sling attached to the lift. LN G stabilized the lift and unattached the sling from the lift. LN G assessed R2 and he stated he had pain in his back and the side of his head.

The "Health Status Note" dated 06/15/22 at 10:42 PM documented R2 returned from the ED with a Thoracic 12th vertebra compression fracture related to the fall.

Review of unnotarized transcription of a phone call dated 06/21/22 with CNA N from Administrative Nurse D and Administrative Nurse E documented CNA N stated he should have waited for a second person before he attempted to transfer R2 alone.

On 06/29/22 at 01:15 PM R2 laid in his bed with his eyes closed. R2 opened his eyes for a minute when asked questions, then would audibly breath in, exhale forcefully, and then start to talk. R2 stated the day he fell there was only one staff member working the lift. R2 described being transferred from his chair to the bed, and the Hoyer lift tipped over. R2 further revealed that

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when the Hoyer lift tipped, he dropped to the ground and the Hoyer lift landed on top of him. R2 stated he could hardly breath and passed out. R2 then stated when he awoke he was in pain and asked to go to the hospital. R2 reported he had a lot of pain since the fall happened and he would like nothing more than the pain to go away.

On 06/29/22 at 02:05 PM CNA M stated she had training on how to properly use the Hoyer lift and when using a lift there was always supposed to be two staff members.

On 06/29/22 at 02:30 PM Administrative Nurse D stated R2 was being transferred from his wheelchair to bed. CNA N informed Administrative Nurse D that the Hoyer lift started tipping and R2 was lowered to the floor. Administrative Nurse D stated staff should never use the lift alone and staff knew that and if they did not the information was in the Kardex (a medical information system that contains all the care and interventions to care for the resident) on how to transfer residents. Administrative Nurse D stated she expected staff to use two staff members for transfers with the use of a mechanical lift.

The "Safe Lifting and Movement of Residents" policy reviewed 02/21 documented staff responsible for direct resident care will be trained in the use of manual and mechanical lifting devices. It further documented staff would be observed for competency in using mechanical lifts and observed periodically for adherence to policies and procedures regarding use of equipment and safe lifting techniques.

The facility failed to ensure staff followed R2's

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F 689	Continued From page 10 plan of care to have two staff members assist with transfers when using a mechanical lift. During a transfer the lift tipped and R2 dropped to the floor with the Hoyer lift landing on top of him. R2's fall resulted in a compression fracture to his vertebra. This deficient practice placed R2 in Immediate Jeopardy. This deficient practice was deemed as past non-compliance when the facility implemented the following corrective actions on 06/20/22, prior to the surveyor entering the facility: CNA N was terminated from providing cares at the facility. Facility administrative staff provided training to all clinical staff on use of two person for Hoyer lifts, and following resident's plan of care. Competencies were completed on use of the Hoyer lift for all clinical staff.	F 689		