STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175100	A. BUILDING _____ B. WING _____	C 08/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIA CHRISTI VILLAGE MANHATTAN, INC	2800 WILLOW GROVE ROAD MANHATTAN, KS 66502

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F 000	INITIAL COMMENTS	F 000		

The following citations are the result of abbreviated survey and complaint investigation KS00181583, KS00281697 and KS00181570.

On 08/10/23 at 01:10 PM the facility received a copy of the "Immediate Jeopardy [IJ] Template" and was informed of the IJ for Resident(R)1.

On 07/22/23 at 08:53 PM a visitor entered the code to the locked double doors and R1 followed the visitor through the double doors, exiting the unit. R1 wore a Wander Guard bracelet which caused the alarms of the double doors to sound and Licensed Nurse (LN) G came and silenced the alarm to the double doors but did not perform a search. At 08:54 PM, R1 followed the visitor out of the facility front doors, which caused the front doors alarms to sound. Certified Nurse Aide (CNA) N went to the front doors of the building, saw R1 and the visitor talking in the parking lot, but misinterpreted the visitor looking at her as acknowledgement the resident was okay, and CNA N went back to her shift. At 08:54 PM, the visitor realized R1 should not be outside and left R1 in the parking lot as she went back into the facility to get help. At 09:08 PM, CNA O and CNA R found R1 on the sidewalk. At 09:22 PM, the staff brought R1 back into the facility. The facility failed to provide adequate supervision to prevent an elopement, failed to respond to door alarms, and failed to respond appropriately to the cognitively impaired R1, who was outside without staff supervision. This deficient practice placed R1 in Immediate Jeopardy.

On 07/29/23 the facility completed corrective actions for the deficient practice which included

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

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F 000	Continued From page 1 educations for all staff on policy and procedure for Elopement, Code White, Elopement Search Assignment, Sign Out Logs, Resident attempting to leave Safe Area as well as responding to door alarms, and resident supervision for high-risk residents. All corrective actions were completed prior to the survey therefore the citation was issued as past noncompliance and existed at the scope and severity of "J." The 2567 was sent electronically on 08/22/23	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 identified a census of 79 residents with three residents reviewed for elopements. Based on record review, observation, and interview, the facility failed to provide adequate supervision to prevent an elopement (when a cognitively impaired residents exits the facility without staff knowledge or supervision) for cognitively impaired Resident (R) 1, who also wore a Wander Guard (bracelet which alarms when close to participating doors). Staff further failed to respond appropriately to two door alarms and failed to respond appropriately to the	F 689	Past noncompliance: no plan of correction required.	

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F 689	Continued From page 2	F 689		

cognitively impaired R1. On 07/22/23 at 08:53 PM a visitor entered the code to the locked double doors and R1 followed the visitor through the double doors, exiting the unit. R1 wore a Wander Guard bracelet which caused the alarms of the double doors to sound and Licensed Nurse (LN) G came and silenced the alarm to the double doors but did not perform a search. At 08:54 PM, R1 followed the visitor out of the facility front doors, which caused the front doors alarms to sound. Certified Nurse Aide (CNA) N went to the front doors of the building, saw R1 and the visitor talking in the parking lot, but misinterpreted the visitor looking at her as acknowledgement the resident was okay, and CNA N went back to her shift. At 08:54 PM, the visitor realized R1 should not be outside and left R1 in the parking lot as she went back into the facility to get help. At 09:08 PM, CNA O and CNA R found R1 on the sidewalk. At 09:22 PM, the staff brought R1 back into the facility. The facility failed to provide adequate supervision to prevent an elopement, failed to respond to door alarms, and failed to respond appropriately to the cognitively impaired R1, who was outside without staff supervision. This deficient practice placed R1 in Immediate Jeopardy.

Findings included:

- The Electronic Medical Record (EMR) documented R1 had diagnoses of 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), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), and aphasia (condition with disordered or absent language function).

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The "Admission Minimum Data Set (MDS)," dated 05/15/23, documented R1 had a Brief Interview for Mental Status score of two, which indicated severe cognitive impairment. The MDS documented R1 required supervision to limited assistance of one staff for all of her activities of daily living. The MDS documented R1 had no behaviors.

The "Cognitive Loss/Dementia Care Area Assessment (CAA)," dated 05/15/23, documented R1 had memory problems, impaired decision-making skills, and impaired ability to comprehend. The CAA directed staff to call R1 by her name, orient R1 daily to facility routines and activity schedules, use environmental cues to stimulate R1's memory and promote appropriate behaviors, provide cues to promote independence and ensure R1's safety, and provide consistent physical environment and daily routines.

The "Communication CAA," dated 05/15/23, documented after R1's cerebral infarction R1 had difficulty remembering conversations, was English speaking prior to the cerebral infarction, but now spoke mostly Spanish.

The "Cognitive Loss/Dementia Care Plan," dated 05/22/23, directed staff to call R1 by her name, provide daily orientation to the facility routines and activity schedules, and provide cues to promote independence and ensure R1's safety.

The "Safety Care Plan," revised 06/09/23, documented R1 was at risk for increased behavioral expressions, altered mood, and impaired adjustment to her new environment. The

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care plan directed staff to follow the community elopement evaluation and monitoring process, orient R1 to the community layout, routines, and schedules, and ensure R1 had a Wander Guard on her left wrist.

The "Facility Incident Report," dated 07/27/23, documented on 07/22/23 at approximately 08:45PM, R1 sat in the atrium on the first floor. At 08:53 PM, a visitor entered the code to the double doors and R1 followed her out the double doors of the long-term care (LTC) unit. R1 wore a Wander Guard, and the alarms of the double doors did alarm. Licensed Nurse (LN) G came and silenced the alarm to the double doors but did not perform a search. At 08:54 PM R1 followed the visitor out of the front doors. Again, the door alarms sounded. Certified Nurse Aide (CNA) N went to the front doors of the building, saw R1 and the visitor talking in the parking lot, and asked if they were okay. The visitor looked at CNA N and CNA N took that as acknowledgement that the resident was okay and went back to her shift. At 08:54 PM the visitor realized R1 should not be outside but did not think she could get R1 back to the building. The visitor left R1 in the parking lot and went back into the building to get help. At 09:02 PM the visitor went to Court A and informed CNA M R1 was out in the parking lot. At 09:03 CNA M from A Court exited the front doors and searched for R1. At 09:08 PM, CNA N and CMA R from B Court found R1 on the sidewalk over by the independent living houses. At 09:22 PM, R1 was brought back into the facility.

CNA N's "Witness Statement," dated 07/22/23, documented CNA N was going downstairs to find a laundry basket when she heard the long-term

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care alarms going off. CNA N stated by the time she got to the double doors, someone else had already cleared the alarm to the double doors. CNA N exited the long-term care doors and then heard the alarms to the front doors sounding. CNA N went to the frond doors and silenced the alarm. CNA N walked outside to check and saw R1 on the sidewalk with what CNA N thought was a friend and CNA N asked if they were okay. CNA N stated the lady with R1 turned and looked at her which CNA N took as acknowledgement they were okay. CNA N then returned to her shift.

LN G's "Witness Statement," dated 07/22/23, documented on 07/22/23 at approximately 09:10 PM, LN G was at B court when CMA R notified her R1 eloped. After obtaining the details of the resident and elopement, LN G stated she went through the main entrance to the building and scanned over the front of the facility parking lot and then made her may towards the side of the facility towards the independent houses. CNA M, CNA O, and CMA R were already outside in the area searching for R1. Before reaching the independent houses, LN G agreed that one of the CNAs should start a searching in a vehicle. As LN G moved closer to the independent houses, CNA M walked towards LN G and stated they found R1. LN G continued to walk toward the independent houses until R1 was in sight. CNA O and CMA R were walking with R1, who was walking with her walker. R1 appeared calm and was cooperative with CMA R, who was brought R1 back to the facility. R1 was fully clothed with house slippers on both feet. LN G, who understood Spanish, asked R1 what she was doing while heading back into the facility. R1 was placed in a wheelchair for safety. R1 stated she was looking at the houses hoping to find

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somewhere to stay while she looked for her son. R1 became emotional and said, "I did not mean to do anything bad, that is all I was doing." Once inside the facility, LN G asked R1 how she got through the doors. R1 stated when she reached the doors, they were locked and when a lady from upstairs opened the doors, R1 went through the doors and stated the lady kept looking at her while walking towards the front entrance. R1 told her to wait a minute and the lady kept the front doors open for her and R1 went through and was outside. LN G assessed R1 for any pain or signs and symptoms of any injuries and none were noted or reported. Fifteen-minute location checks were initiated for R1.

CMA R's "Witness Statement," dated 07/22/23, documented CMA R was passing medications when a family member told CNA M that R1 was outside in a wheelchair and could not speak English. CMA R went outside to look for R1 and did not see her. CMA R came back inside and told LN G and looked in R1's room. R1 was not in her room. CMA R called the on-call to inform her of the situation. CMA R went back outside and looked for R1 next door and found R1 in the cul-de-sac with her walker.

CNA O's "Witness Statement," dated 07/22/23, documented a visitor came to CNA O and told her R1 was outside. CNA O and CMA R went outside with the visitor. The visitor told CNA N R1 went up by the houses. CNA O and CMA R went over by the houses and then found R1 just standing there. CNA O went and got a wheelchair for R1 to help her get back to the facility.

On 08/10/23 at 10:45 AM, observation revealed R1 slept in bed. R1 had a Wander Guard on her

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left wrist.

On 08/10/23 at 10:00 AM, Administrative Nurse D stated R1 went through the double doors out of the long-term care unit behind a visitor. The alarms to the double doors alarmed and LN G deactivated the alarm but did not do a search. Administrative Nurse D stated R1 continued to follow the visitor out of the front doors of the facility. The door alarms did sound, and CNA M went to the front doors, and turned off the alarm. She said the CNA saw R1 and the visitor in the parking lot but did not go out and investigate the situation and ensure R1 was safe. Administrative Nurse D stated she expected all staff to respond to door alarms and search the area for the resident who set the alarms off.

On 08/10/23 at 11:30 AM, LN H stated R1 wandered the facility frequently. LN H stated R1 had not adjusted well to being in the facility and they moved her several times to different courts to make R1 feel more comfortable. LN H stated R1 spent a lot of time in the atrium sitting and people watching.

On 08/10/23 at 01:15 PM, Administrative Staff A stated R1 had a hard time adjusting to living in the facility. R1's son had placed her in the facility after R1 suffered a stroke because the facility had staff that spoke Spanish. Administrative Staff A stated R1 did not want to be at the facility and wanted to go back to her home. Administrative Staff A stated the staff at the facility did not search the unit and surrounding area when the door alarms sounded, which resulted in R1 being alone in the parking lot.

The facility's "Elopement Response Policy," dated

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July 2022, documented staff of the facility shall investigate and report all cases of missing residents. Staff shall promptly report any resident who tries to leave the premises or is suspected of being missing to the Charge Nurse or Director of Nursing. If a staff member discovers that a resident is missing from the community, he/she shall: determine if the resident is out on an authorized pass; if the resident was not authorized to leave, initiate a search of the building(s) and premises. When the resident returns to the community the Charge Nurse shall examine the residents for injuries, contact the resident's attending physician and report findings; notified the residents legal representative, complete and file an event report, and report per State reporting guidelines.

The facility failed to ensure staff responded appropriately and provided adequate supervision to prevent an elopement for cognitively impaired R1, who wore a Wander Guard. This deficient practice placed R1 in Immediate Jeopardy.

On 07/29/23 the facility completed corrective actions for the deficient practice which included educations for all staff on policy and procedure for Elopement, Code White, Elopement Search Assignment, Sign Out Logs, Resident attempting to leave Safe Area as well as responding to door alarms, and resident supervision for high-risk residents.

All corrective actions were completed prior to the survey therefore the citation was issued as past noncompliance and existed at the scope and severity of "J."