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F 000	INITIAL COMMENTS An extended health and complaint survey was conducted by the Kansas Department for Aging and Disability Services (KDADS), on behalf of the Centers for Medicare and Medicaid Services (CMS), started on 05/09/22 and concluded on 05/26/22. On 05/26/22 at 11:06 AM, Administrative Staff A and Administrative Nurse B were provided a copy of the immediate jeopardy (IJ) Template and notified that the failure to ensure a safe/secure environment for cognitively impaired, independently mobile Resident (R) 1, with a known history of exit seeking, to prevent him from leaving the facility on 05/20/22 at around 08:00 PM constituted immediate jeopardy at F689. The immediate jeopardy also constituted substandard quality of care at 42 CFR 483.25 . The immediate jeopardy first existed on 05/20/22 when R1 eloped and ended on 05/26/22, after surveyor verified the implementation of the removal of the immediacy plan. The deficient practice remained at a D scope and severity following removal of the immediate jeopardy.	F 000		
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive	F 636		

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

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assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following:
(i) Identification and demographic information
(ii) Customary routine.
(iii) Cognitive patterns.
(iv) Communication.
(v) Vision.
(vi) Mood and behavior patterns.
(vii) Psychological well-being.
(viii) Physical functioning and structural problems.
(ix) Continence.
(x) Disease diagnosis and health conditions.
(xi) Dental and nutritional status.
(xii) Skin Conditions.
(xiii) Activity pursuit.
(xiv) Medications.
(xv) Special treatments and procedures.
(xvi) Discharge planning.
(xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS).
(xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts.

§483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes

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prescribed in §413.343(b) of this chapter do not apply to CAHs.
(i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.)
(iii)Not less than once every 12 months.
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 46 residents, with 12 sampled. Based on observation, interview, and record review, the facility failed to complete a comprehensive, accurate, standardized reproducible assessment within 14 calendar days after admission for Resident (R) 92.

Findings include:

- Review of Resident (R) 92's "Electronic Health Record" (EHR) dated 04/24/22 documented the following diagnosis: Methicillin-resistant Staphylococcus aureus (MRSA; a type of bacteria resistant to many antibiotics) of tracheostomy (opening though the neck into the trachea through which an indwelling tube may be inserted) stoma (surgically created opening of an internal organ on the surface of the body).

The 04/29/22 "Admission Minimum Data Sheet (MDS) documented the assessment was in progress. R92 admitted to the facility on 04/25/22. The assessment should have been completed by 05/04/22 or 14 days after admission.

The "Care Area Assessment" (CAA) due on

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F 636	Continued From page 3 05/04/22 had not been completed for R92. The 04/25/22 "Care Plan" documented R92 had a tracheotomy and needed to use oxygen to assist with breathing. An observation on 05/10/22 at 11:20 AM revealed R92 laid in his bed on his back with the head of the bed elevated and his breathing was unlabored. On 05/12/21 at 12:35 PM Administrative Nurse H confirmed the assessment had not been completed. She further stated she was aware of the requirements and that the facility had a lot of new admissions recently. On 05/12/22 at 01:35 PM Administrative Nurse B stated she had just been made aware of R92's assessment not having been completed. The did not provide a policy regarding facility comprehensive assessments as requested on 05/12/22 at 11:00 AM. The facility failed to ensure the comprehensive assessment was completed timely for Resident (R)92.	F 636		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to--	F 657		

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(A) The attending physician.
(B) A registered nurse with responsibility for the resident.
(C) A nurse aide with responsibility for the resident.
(D) A member of food and nutrition services staff.
(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.
(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.
(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.
This REQUIREMENT is not met as evidenced by:
The facility census totaled 46 residents with 12 included in the sample. Based on observation, interview and record review the facility failed to revise the comprehensive care plan when Resident (R)20 readmitted to the facility to include oxygen use.

Findings included:

- R20's signed physician orders dated 05/02/22 revealed the following diagnoses: dementia (progressive mental disorder characterized by failing memory, confusion), diabetes mellitus (when the body cannot use glucose, not enough insulin is made or the body cannot respond to the insulin), depression (abnormal emotional state characterized by exaggerated feelings of

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sadness, worthlessness and emptiness), and peripheral vascular disease (abnormal condition affecting the blood vessels).

The 03/10/22 "Significant Change in Status Minimum Data Set" (MDS) revealed a "Brief Interview for Mental Status" (BIMS) score of 10, indicating moderate cognitive impairment. The resident required extensive assistance of two staff for daily care. The resident had a urinary catheter. The resident readmitted with three venous and arterial ulcers and received ulcer care. Medications included antipsychotic, and antidepressants. The resident received oxygen therapy (O2).

The 03/10/22 "Care Area Assessment" (CAA) did not address the use of oxygen therapy.

The 03/22/22 "Care Plan" did not address the use of oxygen at three liters per min (L/min) as ordered by the physician on 03/03/22.

Observation on 05/10/22 at 11:30 AM revealed Certified Nursing Assistant (CNA) G and CNA I in the resident room to get resident up for lunch. The lift sling was placed under the resident as he was turned to the side. The resident was turned onto his back and the sling was connected to the lift. The resident was transferred to his wheelchair and the O2 tubing transferred to a tank on the wheelchair. The O2 concentrator had tubing rolled up in a bag on the concentrator. The humidifier bottle was empty. No date was noted on the tubing or bottle with no fluid detected. The concentrator continued to run after resident was taken out of the room.

Observation on 05/11/22 at 07:42 AM revealed

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the resident sat in his wheelchair and was assisted with the breakfast meal. The resident was being assisted by CNA F. The resident had O2 running per nasal cannula and had a small O2 tank. The O2 tank was on refill indicating it was low on O2 and needed to be changed. CNA F reported she did not check the tank when she put the resident on the O2.

During an interview on 05/10/22 at 2:35 PM, CNA E reported the resident had O2 on at all times and used a cpap (continuous positive airway pressure) at night. The night nurse changed the tubing on the night shift. CNA E was not sure who was responsible for ensuring there was water in the bottle, but he would fill it since it was empty.

During an interview on 05/12/22 at 10:00 AM, CNA F reported it was everyone's job to keep water in R20's O2 bottle and to keep an eye on when the small tank needed to be replaced.

During an interview on 05/11/22 at 2:00 PM, Licensed Nurse D reported the resident had a big decline since he went into the hospital. R20 was on O2 continuously since returning from the hospital. R20 was totally dependent on staff for daily cares.

On 05/12/22 at 12:30 PM Administrative Nurse H reported the MDS and care plans were behind. Administrative Nurse H stated the facility admitted a lot of residents at one time and she was not caught up on all the changes.

On 05/12/22 at 01:30 PM Administrative Nurse B reported she had just been informed of the care plan not being updated when the resident returned to the facility. His MDS was done but

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F 657	Continued From page 7 she did not know why his care plan wasn't updated. A policy was requested for Care Plans was requested on 05/12/22 at 11:00 AM The facility failed to revise the comprehensive care plan when the resident readmitted to the facility to include oxygen use.	F 657		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: The facility had a census of 46 residents with 12 included in the sample. Based on observation, interview and record review the facility failed to provide bathing and grooming for three residents reviewed for bathing, as evidenced by lack of documentation on the bath record, long facial hair and dirty and long fingernails for Resident (R)25, R26, and R27. Findings include: - Resident (R) 25's signed physician orders dated 04/28/22 revealed the following diagnoses: Chronic Obstructive Pulmonary Disease (COPD; progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), bipolar disorder (major mental illness that caused people to have episodes of severe high and low moods), schizophrenia (psychotic disorder characterized	F 677		

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by gross distortion of reality, disturbances of language and communication and fragmentation of thought), and anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear).

The 12/23/21 "Annual Minimum Data Set" (MDS) revealed a "Brief Interview for Mental Status" (BIMS) score of three indicating severe cognitive impairment The resident was incontinent of bowel and bladder and required limited assist of one with dressing, toilet extensive assist of one and no bathing documented on the assessment. The resident received antipsychotic and antidepressant medications seven days of the observation period.

The 03/24/22 "Quarterly MDS" revealed no significant changes from the annual MDS done on 12/23/21.

The 12/23/21 "Activities of Daily Living (ADL) Care Area Assessment" (CAA) revealed the resident required staff assistance with bed mobility, transfers, walking, locomotion, dressing, eating, toileting, and personal hygiene.

The 03/21/22 "Care Plan" revealed the resident required staff assistance with activities of daily living (ADL's) related to changing cognitive status and medication use.
Approaches include-The resident was independent with bathing andneeded limited assistance of one staff for bed mobility. He required extensive assistance of one staff for dressing and extensive assistance of one with toileting.

The 04/14/22 to 05/12/22 "Bathing"

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documentation revealed the resident received approximately one bath a week with no refusals. The form had no area to chart fingernail care or shaving.

An observation on 05/09/22 09:11AM the resident was unshaved and fingernails long and dirty.

An observation on 05/10/22 at 12:30 PM revealed the resident at the dining table as he finished his lunch meal. The resident ate approx 1/2 of his spaghetti and meatballs, vegetables and all his cake. The resident ate independently then ambulated with a walker back to his room. The resident had whiskers noticeable on his face along with dirty fingernails.

An observation on 05/12/22 at 7:30 AM revealed the resident sat eating breakfast at the dining table. The resident was eating and drinking independently. The resident continued to have long dirty nails and facial hair that was unshaven.

On 05/12/22 at 07:30 AM, the resident reported he was not trying to grow a beard and just needed to be shaved. The resident gave no other statements.

During an interview on 05/10/22 at 2:20 PM. Certified Nursing Assistant (CNA) E reported the residents were to get at least two baths a week but since the facility had so many agency staff it was hard to follow behind them and double check everything was getting done. The baths were supposed to be charted in the tasks section on the tablet.

On 05/12/22 at 10:00 AM, CNA F reported she always shaved the men when she bathed them.

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She was not sure agency CNA's did that. Baths were to be charted on the tablet if a bath was given or refused. When she had a resident refuse, she reported that to the charge nurse and would try again later. R25 was on her list for 05/12/22 and she would make sure she looked at his nails and shaved him.

On 05/12/22 at 11:00 AM, Licensed Nurse (LN) D reported all residents should get at least two baths per week. Two days a week they had a bath aide to get any baths that were missed. He thinks the baths were being done but he wondered about the documentation. Staff was to chart bathing in the tablet, but LN D thinks a lot of agency aides do not do that, so it looks like the resident was not getting bathed. LN D agreed the resident needed attention to his facial hair and nails. R25 was scheduled to take a bath on 05/12/22.

During an interview on 05/12/22 at 01:30 PM, Administrative Nurse B reported she did not think the residents were not getting baths. The residents had clean clothes and their hair was not greasy. She believed it was a problem with documentation and that several agency aides could probably be taught about nail care and shaving and documenting what they are doing.

A policy for bathing was requested on 05/12/22 at 11:00 AM though no policy was provided.

The facility failed to provide bathing and grooming for R25, as evidenced by lack of documentation on the bath record, long facial hair and dirty and long fingernails.

- R26's signed physician orders dated 05/02/22

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revealed the following diagnoses: Hypertension (elevated blood pressure), constipation Difficulty passing hard stool), pain, Posttraumatic stress disorder (PTSD; psychiatric disorder characterized by an acute emotional response to a traumatic event or situation involving severe environmental stress, such as natural disaster, military combat, serious automobile accident, airplane crash or physical torture), major depression (major mood disorder), and delusional disorder (untrue persistent belief or perception held by a person although evidence shows it was untrue).

The 02/03/22 "Quarterly Minimum Data Set" (MDS) revealed a "Brief Interview for Mental Status" (BIMS) score of 99 indicating resident did not participate in the assessment. The resident required extensive assistance of two staff for dressing, toileting and personal hygiene. No documentation for bathing during the seven-day observation period. Medications included antipsychotic, antidepressant and anticoagulant medications 7 days of the seven-day observation period.

The 03/24/22 "Significant Change in Status MDS" revealed a BIMS of 99 unable to complete the BIMS. The resident had no behaviors documented. The resident required limited assistance with dressing and extensive assist of two with toileting. The resident required limited assistance of one staff with bathing. Medications included antipsychotic, antidepressant and anticoagulant medications seven days of the seven-day observation period.

The 03/24/22 "Dementia Care Area Assessment" (CAA) revealed per the BIMS, resident had a

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score of 99. He displayed memory impairment, and moderately impaired daily decision-making skills. He could identify season, location of room, staff names/faces, and that he was in a nursing home. Per staff interviews, resident displayed constant inattention and disorganized thinking. This was typical of resident's baseline.

The 03/24/22 "Psychosocial CAA" documented that R26 had a BIMS score of 99. Per the plan of care, the resident required staff assistance with bed mobility, transfers, locomotion, dressing, eating, toileting, personal hygiene, and bathing during his look back period.

The 03/31/22 "Care Plan" revealed a self-care deficit due to changing cognitive status, behavioral signs, mood decline, and psychotropic med use.
The resident required extensive assistance of one staff for showers and limited assistance of one for bed mobility, dressing, personal hygiene and toileting.

The 01/09/22 through 05/11/22 "Nurse's Progress Notes" laced documentation the resident refused his bath.

The "CNA Task Documentation" reviewed on 05/10/22 revealed the resident was scheduled for a bath on Wednesdays and Saturdays. The resident received one bath in April of 2022, on 04/27/22. In May of 2022, the facility lacked documentation that R26 received a bath.

An observation on 05/09/22 01:58 PM revealed the resident had nails long and dirty debris under nails.

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An observation on 05/10/22 11:10 AM revealed the resident was lying on his bed sleeping. The resident had a soda on the bedside table with a cup containing fluid and a straw in the cup. The resident was calm and sleeping quietly. The resident had clean clothes on with long facial hair. Unable to visualize fingers under the blanket.

An observation on 05/11/22 at 11:50 AM revealed the resident wheeled himself to the dining room for the noon meal. The resident spoke to no one and only took a few bites of his meal before he wheeled himself back to his room. His room was dark and quiet. The resident laid on the bed and turned towards the wall. No interaction with staff. The resident was unshaven.

An observation on 05/12/22 at 08:40 AM revealed the resident wheeled himself out of the dining room towards his room. The resident went into his room and shut the door. The resident would not answer questions or greeting. The resident had facial hair unshaved.

An attempt was made to interview the resident on 05/09/22 01:58 PM. The resident refused the interview.

On 05/10/22 at 02:30 PM, Certified Nursing Assistant (CNA) E reported the resident was a very grumpy man. Staff go in to assist the resident but if he starts yelling and cussing, staff leave just stepping out of the room then reenter and he will usually calm down. He has a specific place in the DR and if any other resident sits in his place the resident has a fit. He yells and carries on until the other resident leaves. He stays by himself most of the time in his room. The

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resident is scheduled for two baths a week but refuses care from staff. The staff were to report to the nurse if he refused and chart that he refused.

On 05/12/22 at10:00 AM, CNA F reported she would try to bathe the resident every time she worked that hall. The resident most often refused. If pushed to take a shower R26 would get agitated and start cussing and yelling for staff to leave his room. Staff are supposed to chart our baths but often forget to go back and chart the refusals.

During an interview on 05/12/22 at 09:30 AM, Licensed Nurse D reported the resident took psych meds to control his behavior, but it was day by day. He would be cooperative one minute and volatile the next. His behaviors were verbal outbursts of cussing, name calling and isolating in his room. When he had behaviors, staff was to monitor those in the nurse notes with a behavior note.

During an interview on 05/12/22 at 01:30 PM, Administrative Nurse B reported she did not think the residents were not getting baths. The residents had clean clothes and their hair was not greasy. She believed it was a problem with documentation and that several agency aides could probably be taught about nail care and shaving and documenting what they are doing.

A policy for bathing was requested on 05/12/22 at 11:00 AM though no policy was provided.

The facility failed to provide bathing and grooming for R26 as evidenced by lack of documentation on the bath record, long facial hair and dirty and long fingernails.

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Resident (R) 26's 04/30/22 "Physician Orders" revealed the diagnosis of acute osteomyelitis left ankle and foot (an infection in the bone) and type two diabetes (a disease in which the body's ability to produce or respond to the hormone insulin is impaired, resulting in abnormal metabolism of carbohydrates and elevated levels of glucose in the blood and urine).

The 04/06/22 "Admission Minimum Data Set" (MDS) documented a "Brief Interview for Mental Status" (BIMS) score of 15 indicating intact cognition. R26 received supervision with set up help only with the "Activities of Daily Living" (ADL's).

The 04/06/22 "Activities of Daily Living Care Area Assessment " (CAA) documented R26 required staff assistance, during the look back period, with bathing due to unsteadiness with sitting to standing, walking/turning, getting off or on the toilet, and/or any surface to surface transfers. R26 was able to rebalance without staff assistance.

The 04/30/22 "Baseline Care Plan" documented R26 required staff assistance with ADL's related to a history of fall, a recent hospitalization, poor balance and limited range of motion to the left foot. Bathing required extensive assist of one staff member and R26 preferred to shower.

The 04/01/22 to 05/10/22 "Bathing Record

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F 677	Continued From page 16 Sheets" documented R26 received one bath. Interview with R26 on 05/11/22 at 10:36AM regarding the bath schedule stated the only bath he received was about two weeks ago. Interview with Certified Nurse Aide (CNA) J on 05/11/22 at 1:35 PM revealed staff received the bathing schedule. The facility had a lot of agency staff working, so the residents did not always receive their baths. Interview with Licensed Nurse C LN on 05/12/22 at 1:16 PM revealed R26 left the building frequently for either appointments or family outings, which made it difficult to complete his treatments and baths on time. Interview with Administrative Nurse B on 05/12/22 at 03:15 PM revealed the agency staff did not know the appropriate way to chart the baths given. The facility failed to provide a policy regarding Activities of Daily Living as requested on 5/12/22 at 11:00 AM. The facility failed to provide R26 with the necessary services (bathing) to maintain good grooming and good personal hygiene.	F 677		
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	F 689		

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§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 census totaled 49 residents, with three residents reviewed for elopement (an incident in which a cognitively impaired resident with poor or impaired decision-making ability/safety awareness leaves the facility without the knowledge of staff). Based on observation, interview, and record review the facility failed to ensure a safe/secure environment for cognitively impaired, independently mobile Resident (R) 1, with a known history of exit seeking, to prevent him from leaving the facility on 05/20/22 at around 08:00 PM. The facility failed to ensure all staff working were trained in elopement procedures, failed to have an effective system in checking the wandering alarm system for functionality at the exit door, and did not provide adequate supervision for R1. The resident remained outside of the facility for 17 minutes and staff found R1 walking west on the southside a four-lane divided highway, with speeds of 60 miles per hour. These failures placed R1 and one other resident with a WanderGuard and at risk for elopement, in immediate jeopardy.

Findings included:

- R1's diagnoses from the 02/24/22 "Physician's Orders" in the "Electronic Medical Record (EMR)" revealed dementia (progressive mental disorder characterized by failing memory, confusion) with behaviors and delusional disorder (untrue persistent belief or perception held by a person although evidence shows it was untrue).

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The 10/07/21 "Admission Minimum Data Set" (MDS) revealed a brief interview for mental status (BIMS) score of 12, indicating moderate cognitive impairment. The resident was independent with ambulation and the MDS indicated R1 did not wander during the seven-day look back period.

The 10/07/21 "Cognitive and Behavioral Care Area Assessment" (CAA) documented that R1 demonstrated fluctuating disorganized thinking during his look back period.

The 04/21/22 "Quarterly MDS" revealed a BIMS of five, indicating severe cognitive impairment. The resident was independent with ambulation and the MDS indicated R1 did not wander during the seven-day look back period.

The 10/25/21 "Elopement Risk Scale" assessment documented R1 was a high risk for elopement, due to wandering, verbal threats of elopement, packing his belongings, exit seeking, and his ability to open doors independently. The assessment documented R1 wore a WanderGuard (bracelet that sets off an alarm when residents wearing one attempt to exit the building without an escort) on his ankle.

The 01/27/22 "Care Plan" documented R1 ambulated independently and had a history of removing his WanderGuard. Staff were to check for WanderGuard placement each shift and to follow the facility protocol if he eloped. Staff were to complete frequent visual checks if R1 was near the exit doors.

The "Care Plan" lacked updated elopement interventions after 01/27/22, as of review on 05/25/22.

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The "Behaviors Notes" written by staff between 02/12/22 and 02/17/22 documented R1 opened the front exit door on four occasions and walked out of the facility once. The front door alarm sounded on one of the four occasions, and the WanderGuard alarm system sounded on two of the four occasions.

The 02/26/22 "Behavior Note" documented R1 walked out the front door of the facility and down the sidewalk toward the street. The note lacked documentation if any alarms triggered or sounded.

The 03/09/22 "Physician Orders" documented the staff were to check for placement of the WanderGuard each shift.

The 03/17/22 "Behavior Note" documented that R1 opened the front door to the facility and walked outside, set off the door alarm, but not the WanderGuard alarm system.

The 04/16/22 "Nurse's Note" documented R1 exhibited exit seeking behaviors throughout the shift, with attempts to exit the facility.

The 05/20/22 "Nurse's Note" documented staff heard the door alarm sound around 08:00 PM, assessed the area, and noted no one present. The note documented R1 was the highest risk for elopement and staff initiated the facility's elopement protocol. Administrative Staff A found R1 outside of the facility and returned R1 to the facility at 08:17 PM, unharmed.

Review of the surveillance video of the elopement involving R1 from 05/20/22 (no audio available)

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revealed R1 walked to the front lobby, pushed the front left door open (without difficulty) and exited the facility at 08:00 PM, per the time stamp. Both Administrative Staff A and Administrative Nurse B confirmed the door alarm sounded throughout the facility. The video review revealed the staff in the area at the time were walking or standing in the halls, but did not have a reaction to the audible door alarm, with staff observed walking in the opposite direction of the lobby and the front door. At 08:03 PM, Licensed Nurse (LN) P walked to the nurse's station, checked the "alarm box" for the exit door, then walked to the front door. LN P shut off the alarm via the code box at the front door and walked outside. LN P went back into the facility after a few seconds and walked to the nurse's station. Both Administrative Staff A and Administrative Nurse B confirmed that LN P initiated the facility's elopement procedure. Administrative Staff A left the facility at 08:08 PM, while staff walked throughout the facility, checking rooms and opening doors. At 08:17 PM, Administrative Staff A walked up to the front door with R1.

Observation on 05/25/22 at 10:00 AM revealed the only facility door to have the WanderGuard alarm system was the front door. Administrative Staff A checked the WanderGuard for functionality and used a hand-held (unnamed) device which scanned the tag that displayed "tag ok," indicating the WanderGuard tag was functioning properly. Administrative Staff A then took the WanderGuard tag to the front lobby, which set off the alarm system and created a loud alarm sound. Administrative Staff A walked to the front door and turned off the alarm.

On 05/25/22 at 10:10 AM, R1 ambulated

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throughout the halls independently and wore a WanderGuard on his right wrist. Resident was steady on his feet with a normal gait and wore appropriate clothing and shoes.

On 05/25/22 at 03:51 PM, LN Q used the hand-held device to check R1's WanderGuard for functionality. After confirming the WanderGuard was on R1's right wrist LN Q scanned the WanderGuard tag with the device, receiving the "tag ok" message. Staff did not check the WanderGuard with the WanderGuard system alarm in the lobby area.

On 05/26/22 at 02:50 PM, Certified Nurse Aide (CNA) S stated R1 went out the facility door on 05/20/22. CNA S confirmed R1 wore a WanderGuard, but that it did not work, allowing R1 to walk out the front door. The evening of 05/20/22, the front door did not latch and R1 pushed it open easily. When R1 exited the facility, staff told CNA S to check every room and open every door to look for R1, but she could not find him. CNA S stated other staff found R1 and brought him back to the facility unharmed. The facility gave R1 a new WanderGuard tag when he returned to the facility. CNA S stated she did not have any training on elopement protocol.

Interview on 05/25/22 at 03:52 PM with LN Q revealed staff checked the placement of the WanderGuard each shift for R1 with the hand-held device to ensure the WanderGuard tag worked properly. When the device displayed "tag ok," it meant that the WanderGuard tag functioned properly and will set off the WanderGuard alarm system if R1 walked too close to the front door. LN Q did not know what the hand-held device would show if the

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WanderGuard tag was not functioning properly, because "it had never happened before." LN Q stated staff also checked the placement of R1's WanderGuard to ensure it was still on him. She stated that the WanderGuard tag was not checked with the WanderGuard alarm system regularly, only when the WanderGuard was first put on the resident. LN Q stated R1 set off the WanderGuard alarm system almost daily when he walked into the lobby and attempted to open the front door. LN Q said Maintenance Staff R was responsible for checking the doors and would sometimes set off the alarm, but LN Q did not know how he completed the task.

Interview on 05/26/22 at 11:27 AM with LN P revealed on 05/20/22 he heard the door alarm sound when he passed medications and he went to investigate. He turned off the door alarm and walked outside to see who set off the alarm, but he could not find anyone. LN P stated he did not hear the WanderGuard alarm system sound at any time. He then walked back inside to look for R1 because R1 was a high elopement risk resident, but he could not find R1. LN P initiated the search for R1 with the other staff and notified Administrative Staff A of the elopement, who left the facility to go look for R1. LN P and the other staff continued to look for R1 in all rooms, opening doors and calling R1's name. Administrative Staff A called LN P stating staff found R1. LN P stated R1 was missing for approximately 15 minutes, and the staff assessed R1 when he returned to the facility unharmed with normal vital signs.. R1 told LN P he left the facility because he wanted to visit his wife. LN P stated he cut off the WanderGuard tag on R1's ankle and checked it with the WanderGuard alarm system, but the alarm did not trigger. LN P put a

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new WanderGuard tag on R1, but it too did not trigger the alarm. LN P stated the facility notified the WanderGuard company to fix the issue. Once fixed, both the old WanderGuard tag and the new WanderGuard tag triggered the WanderGuard alarm system. LN P confirmed the WanderGuard tags were checked daily with the hand-held device that displayed "tag ok" when it was working, but he did not know what was displayed when the tag did not work. LN P stated he remembered hearing the WanderGuard alarm system being triggered sometime earlier in the week, but did not know when it stopped working. R1 was a high elopement risk and LN P tried to keep track of him as often as he could, to monitor for attempted elopements. LN P stated R1 frequently spoke of wanting to leave to see his wife, but R1 never eloped prior to 05/20/22. LN P stated the management team was responsible for checking the WanderGuard alarm system.

Interview on 05/25/22 at 05:07 PM with Maintenance Staff R revealed he checked the code to the front door weekly to ensure it still worked and he changed the code each month. Maintenance Staff R stated the nursing staff were responsible for checking the WanderGuard code daily, but Maintenance Staff R stated he would check that it worked each week. Maintenance Staff R stated that the front door was stuck and would not latch properly at one point, so he had the company go out to the facility to fix it. He checked the door alarm by opening the front door and holding it open until the alarm sounded. Maintenance Staff R stated that staff would sometimes respond to the door alarm, but they had a monitor at the nurse's station and could see him, so they would not always respond. Maintenance Staff R stated he did not check the

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WanderGuard tags against the doors and that the nursing staff would check them daily.

Interview on 05/25/22 at 09:15 AM with Administrative Nurse B revealed all facility doors had an alarm that would sound if left open for five to eight seconds. All residents with a WanderGuard were checked each shift for placement and functionality, with the hand-held device.

Interview on 05/25/22 at 10:00 AM with Administrative Staff A revealed a resident's family arrived at the facility at 07:45 PM and entered through the front door. Administrative Staff A reviewed the surveillance footage with Administrative Nurse B and noted R1 pushed the front door open at 08:00 PM. Administrative Staff A stated he assumed the door was not latched all the way closed or that the door was malfunctioning because R1 should not have been able to open the door. He confirmed that door alarm triggered and sounded throughout the facility, but the WanderGuard alarm system did not trigger or sound. When R1 exited the facility, the WanderGuard was on his left ankle, covered by socks and pants and Administrative Staff A thought that the layers could have interfered with the WanderGuard tag triggering the system. Because of this, staff moved R1's WanderGuard to his right wrist after the elopement. Administrative Staff A stated R1 removed the WanderGuard from his wrist in the past, so it was moved to his left ankle. When R1 was found by Administrative Staff A on 05/20/22, the WanderGuard was on R1's left ankle. Administrative Staff A stated he saw R1 walking at 08:10 PM, and got in his car to pick up R1. At 08:13 PM, R1 was found walking on a [major

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four-lane] US Highway, at mile marker 202, walking west on the south side of the highway. Administrative Staff A stated R1 got in the car and told him "I know you. I am going to visit my wife." At 08:13 PM, Administrative Staff A called LN P at the facility, to notify staff they found R1 unharmed. R1 returned to the facility by car with Administrative Staff A, at approximately 08:15 PM. Administrative Staff A stated the weather was warm and in the 70s, and R1 wore appropriate clothing and shoes. He stated R1 had many elopement attempts, but was never successful until 05/20/22.

Interview on 05/25/22 at 01:15 PM with Administrative Nurse B revealed R1 was last seen walking down the south hall toward his room at 07:50 PM by LN P. R1 then turned around and walked up the hall toward LN P and the front door. Administrative Nurse B stated R1 was a known elopement risk and she continued to educate staff on monitoring R1 for exit seeking behavior. The only documentation used for monitoring R1 was the WanderGuard placement checks.

On 05/25/22 at 04:30 PM, Administrative Staff A and Administrative Nurse B revealed the WanderGuard tags could be used until the expiration date listed on the tag, and stated changing of the batteries was not necessary. When the WanderGuard tag stopped working or met the expiration date, staff disposed of the expired WanderGuard tag and placed a new WanderGuard tag on the resident. Staff checked the WanderGuard tag against the front doors when first placed on a resident. They stated R1 would set off the WanderGuard alarm system all the time, so the WanderGuard alarm system did

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not need to be checked. When R1 got too close to the lobby, the WanderGuard tag would sound and would turn off when R1 backed out of the area. If R1 opened the front door, both the door alarm and the WanderGuard alarm system would be triggered and sound off.

Interview on 05/26/22 at 09:16 AM with Administrative Nurse B revealed on the evening of 05/20/22, at the time of the elopement, four of the six staff working were agency staff. She stated the agency staff going to the facility to work did not have elopement training, but she expected them to use the "agency book" [a book for agency staff, filled with facility policies and procedures and emergency phone numbers] located at the nurse's station. Administrative Nurse B expected all staff in the facility, including agency staff, to respond immediately to any alarm, find out what the alarm was, where it was coming from, and the act accordingly.

The 12/2019 "Resident Elopement Policy and Procedure" documented interventions were to be documented in the care plan for residents at risk for elopement. The policy lacked clear directions for testing the functionality for the WanderGuard system when worn by a resident.

The facility failed to ensure a safe/secure environment for cognitively impaired, independently mobile Resident (R) 1, to prevent him from leaving the facility on 05/20/22 at around 08:00 PM without staff knowledge. The facility staff working did not respond appropriately to the door alarm (the wandering resident alarm system did not activate) per video review and four of the six staff working, at the time of the incident, did not have facility elopement training. The

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	175294	A. BUILDING _____ B. WING _____	05/26/2022

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resident was outside of the facility for 17 minutes and found walking west on the southside a four-lane divided highway, with speeds of 60 miles per hour. The facility staff did not have an effective system in checking the wandering alarm system for functionality at the exit door. The facility did not provide adequate supervision for R1, identified by the facility as a high risk for elopement and who exited the facility on three separate occasions prior to the 05/20/22 incident, to prevent the elopement. These failures placed R1 and one other resident with WanderGuard in immediate jeopardy.

On 05/27/22 at 12:41 PM, the facility provided an acceptable plan for removal of the immediate jeopardy, when the facility implemented the following:

1. The facility checked all exit doors to ensure all alarmed doors were in proper working order on 05/20/22.
2. All residents at risk for elopement were reevaluated and assessments and care plans were updated on 05/21/22.
3. The facility will review elopement risk residents weekly at the risk meeting.
4. The facility identified the need for staff education on the elopement policy, drills and plan of action and completed an in-service on 05/21/22 with all facility and agency staff. All staff members not in attendance must complete training prior to working the floor.
5. Elopement drills were completed each shift on 05/21/22 and will continue monthly.
6. The elopement book was reviewed to ensure accuracy on 05/21/22.
7. Weekly door checks will be completed by maintenance staff documented in tracking

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F 689	Continued From page 28 system, to include taking a WanderGuard bracelet to the door, for verification of alarm functionality (implemented on 05/27/22). 8. A Quality Assurance and Performance Improvement (QAPI) meeting was held on 05/20/22 with Administrative Staff A, Administrative Nurse B and Physician O.	F 689		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: The facility reported a census of 46 residents with 12 included in the sample. Based on observation, interview, and record review the facility failed to ensure they had a system in place to change oxygen tubing, nebulizer tubing and cleaning of respiratory equipment in a timely manner for Residents (R) 20 and R92. Findings included: - R20's 05/02/22 "Signed Physician Orders" documented the following diagnoses: dementia (progressive mental disorder characterized by failing memory, confusion), diabetes mellitus (when the body cannot use glucose, not enough insulin is made or the body cannot respond to the insulin), depression (abnormal emotional state	F 695		

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characterized by exaggerated feelings of sadness, worthlessness and emptiness), and peripheral vascular disease (abnormal condition affecting the blood vessels).

The 03/10/22 "Significant Change in Status Minimum Data Set" (MDS) documented a "Brief Interview for Mental Status" (BIMS) score of 10, indicating moderate cognitive impairment. R20 required extensive assistance of two staff for daily care. R20 received oxygen therapy (O2).

The 03/10/22 "Care Area Assessment" (CAA) did not address the use of oxygen therapy.

The 03/22/22 "Care Plan" did not address the use of oxygen as ordered by the physician on 03/03/22.

Observation on 05/10/22 at 11:30 AM revealed Certified Nursing Aide (CNA) G and CNA I in the room to get R20 up for the noon meal. The O2 tubing was rolled up in a bag on the concentrator. The humidifier bottle was empty. No date noted on the tubing or bottle. The concentrator continued to run after the resident was taken out of the room.

On 05/10/22 at 2:35 PM, CNA E stated R20 had O2 on at all times. It was the night nurse who changed the tubing. He was not sure who was to make sure there was water in the bottle, but he would fill it since it was empty.

On 05/12/22 at 10:00 AM, CNA F stated it was everyone's job to keep water in the O2 bottles and to keep an eye on when the small tank needed to be replaced.

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On 05/11/22 at 02:00 PM, Licensed Nurse D reported R20 used O2 continuously. It was the night nurse who changed the bottle and the tubing weekly. The night nurse was supposed to date the tubing and bottle, but often did not. It was not charted on the electronic record.

On 05/12/22 at 1:30 PM, Administrative Nurse B reported the night shift nurse was to change the tubing and bottle every Sunday night. It was her expectation the tubing and bottle were dated.

A policy for Oxygen use was requested on 05/12/22 at 11:00 AM. No policy was received.

The facility failed to ensure they had a system in place to change oxygen tubing, and cleaning of respiratory equipment in a timely manner

- Review of Resident (R) 92's 04/24/22 "Electronic Health Record" (EHR) documented the following diagnosis: Methicillin-resistant Staphylococcus aureus (MRSA; a type of bacteria resistant to many antibiotics) of tracheostomy (opening though the neck into the trachea through which an indwelling tube may be inserted) stoma (surgically created opening of an internal organ on the surface of the body).

The 04/29/22 "Admission Minimum Data Sheet (MDS) documented the assessment was in progress.

The "Care Area Assessment" (CAA) due on 05/04/22 had not been completed for R92.

The 04/25/22 "Care Plan" documented R92 had a tracheotomy and needed to use oxygen to assist with breathing.

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An observation on 05/09/22 04:54 PM revealed the resident in his bed sleeping. R92's O2 mask was on the floor with the O2 still running. No date on the bottle or tubing noted.

An observation on 05/10/22 at 11:20 AM revealed R92 laid in his bed on his back with the head of the bed elevated and his breathing was unlabored. No date on O2 tubing noted.

On 05/12/21 at 12:35 PM Administrative Nurse B confirmed the O2 tubing and nebulizer tubing should be dated.

The "Electronic Health Record" lacked instructions to change tubing on a weekly basis.

A policy for Oxygen use was requested on 05/12/22 at 11:00 AM. No policy received.

The facility failed to ensure they had a system in place to change oxygen tubing, and cleaning of respiratory equipment in a timely manner

The facility reported a census of 46 residents with 12 included in the sample. Based on observation, interview, and record review the facility failed to ensure they had a system in place to change oxygen tubing, nebulizer tubing and cleaning of respiratory equipment in a timely manner for Residents (R) 20 and R92.

Findings included:

- R20's 05/02/22 "Signed Physician Orders" documented the following diagnoses: dementia (progressive mental disorder characterized by

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failing memory, confusion), diabetes mellitus (when the body cannot use glucose, not enough insulin is made or the body cannot respond to the insulin), depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness), and peripheral vascular disease (abnormal condition affecting the blood vessels).

The 03/10/22 "Significant Change in Status Minimum Data Set" (MDS) documented a "Brief Interview for Mental Status" (BIMS) score of 10, indicating moderate cognitive impairment. R20 required extensive assistance of two staff for daily care. R20 received oxygen therapy (O2).

The 03/10/22 "Care Area Assessment" (CAA) did not address the use of oxygen therapy.

The 03/22/22 "Care Plan" did not address the use of oxygen as ordered by the physician on 03/03/22.

Observation on 05/10/22 at 11:30 AM revealed Certified Nursing Aide (CNA) G and CNA I in the room to get R20 up for the noon meal. The O2 tubing was rolled up in a bag on the concentrator. The humidifier bottle was empty. No date noted on the tubing or bottle. The concentrator continued to run after the resident was taken out of the room.

On 05/10/22 at 2:35 PM, CNA E stated R20 had O2 on at all times. It was the night nurse who changed the tubing. He was not sure who was to make sure there was water in the bottle, but he would fill it since it was empty.

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everyone's job to keep water in the O2 bottles and to keep an eye on when the small tank needed to be replaced.

On 05/11/22 at 02:00 PM, Licensed Nurse D reported R20 used O2 continuously. It was the night nurse who changed the bottle and the tubing weekly. The night nurse was supposed to date the tubing and bottle, but often did not. It was not charted on the electronic record.

On 05/12/22 at 1:30 PM, Administrative Nurse B reported the night shift nurse was to change the tubing and bottle every Sunday night. It was her expectation the tubing and bottle were dated.

A policy for Oxygen use was requested on 05/12/22 at 11:00 AM. No policy was received.

The facility failed to ensure they had a system in place to change oxygen tubing, and cleaning of respiratory equipment in a timely manner

- Review of Resident (R) 92's 04/24/22 "Electronic Health Record" (EHR) documented the following diagnosis: Methicillin-resistant Staphylococcus aureus (MRSA; a type of bacteria resistant to many antibiotics) of tracheostomy (opening though the neck into the trachea through which an indwelling tube may be inserted) stoma (surgically created opening of an internal organ on the surface of the body).

The 04/29/22 "Admission Minimum Data Sheet (MDS) documented the assessment was in progress.

The "Care Area Assessment" (CAA) due on 05/04/22 had not been completed for R92.

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F 695	Continued From page 34 The 04/25/22 "Care Plan" documented R92 had a tracheotomy and needed to use oxygen to assist with breathing. An observation on 05/09/22 04:54 PM revealed the resident in his bed sleeping. R92's O2 mask was on the floor with the O2 still running. No date on the bottle or tubing noted. An observation on 05/10/22 at 11:20 AM revealed R92 laid in his bed on his back with the head of the bed elevated and his breathing was unlabored. No date on O2 tubing noted. On 05/12/21 at 12:35 PM Administrative Nurse B confirmed the O2 tubing and nebulizer tubing should be dated. The "Electronic Health Record" lacked instructions to change tubing on a weekly basis. A policy for Oxygen use was requested on 05/12/22 at 11:00 AM. No policy received. The facility failed to ensure they had a system in place to change oxygen tubing, and cleaning of respiratory equipment in a timely manner	F 695		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.	F 880		

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F 880	Continued From page 35 §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable	F 880		

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disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 46 residents. Based on observation, interview, and record review the facility failed to ensure a safe sanitary environment to prevent infection for Resident (R) 92, by not storing his oxygen mask, nebulizer (device which changes liquid medication into a mist easily inhaled into the lungs) mask, and urinary catheter (insertion of a catheter into the bladder to drain the urine into a collection bag) drainage bag in a sanitary manner.

Findings Included:

- An observation on 05/09/22 at 04:54 PM R92 laid in bed on his back with the head of the bed elevated. R92's oxygen (O2) mask laid on the floor and still had O2 flowing through it. R92's urinary catheter drainage bag also laid on the floor under the bed.

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F 880	Continued From page 37 On 05/10/22 at 01:09 PM R92's O2 mask laid on the mattress next to him with no barrier noted between the mask and the mattress. On 05/11/22 at 09:33 AM R92's O2 mask hung over the back of his wheelchair, with no barrier noted. R92's nebulizer mask sat on the bedside table with no barrier under it and not in a protective covering. On 05/10/22 at 1:30 PM Certified Nurse Aid (CNA) G stated she thought R92 only wore his O2 at night. R92 had a urinary catheter. On 05/11/22 at 09:30 AM Licensed Nurse (LN) D confirmed the oxygen and nebulizer masks should be stored in a clean bag on the resident's oxygen concentrator. LN D confirmed a urinary catheter drainage bag should never be on the floor. The facility failed to provide a policy as requested on 05/12/22 at 11:00 AM. The facility failed to ensure a safe and sanitary environment for R92 to prevent infections, by not storing his oxygen mask, nebulizer mask, and urinary catheter drainage bag in a sanitary manner.	F 880		