STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175250	A. BUILDING _____ B. WING _____	**09/24/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WELLSVILLE MANOR	**304 W 7TH ST WELLSVILLE, KS 66092**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0689 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility reported a census of 54 residents, with three identified as an 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) risk and reviewed for elopement. Based on record review, observation, and interview, the facility failed to provide adequate supervision and assistive devices to prevent one of the three residents, Resident (R) 1 from exiting through an unlocked kitchen door, through the kitchen into the back service hallway, through an outside, unsecured exit door, down a cement sidewalk, down 2 cement steps, down a cement curbing, and the resident fell on to the cement parking lot near the facility dumpster, without staff knowledge. The resident experienced a laceration to the head which required a staple in the emergency room to close placing the resident in immediately jeopardy at the time of the incident. Findings included: - The signed Physician order [REDACTED]. The Significant Change Minimum Data Set (MDS), dated [DATE], revealed the resident had a Brief Interview for Mental Status (BIMS) score of 0, which indicated severely impaired cognition. He had delusions (untrue persistent belief or perception held by a person although evidence shows it was untrue) and wandering behaviors in the facility. He required limited assist with activities of daily living (ADLs) and required a mobility device when ambulating. The resident had a history of [REDACTED]. The resident did not have alarms or a previous elopement. The Cognitive Loss/Dementia Care Area Assessment (CAA), dated 09/06/20, revealed the resident had a history of [REDACTED]. He had history of looking out of the facility exit doors. The Quarterly MDS, dated [DATE], revealed the resident had a BIMS score of one, indicating he had severely impaired cognition. The resident required limited assist with ADLs and needed a mobility device for ambulating. The resident had delusions and exhibited wandering behaviors. The resident had history of falls, wandering, and exiting seeking. The resident did not have personal alarms or a previous elopement. The Care Plan dated, 05/18/18, identified the resident was a risk for elopement due to poor decision making, wandering, and had exit seeking behaviors. He had delusions. The resident was a fall risk due to impaired safety awareness, weakness, and lack of coordination. Staff should walk with the resident throughout the facility, one-on-one, and provide validation therapy for redirection when he wandered and was exit seeking. Staff should complete monitoring of his behaviors that included wandering and exiting seeking, or a significant change in his behavior. The Elopement Assessment, dated 08/13/20, revealed the resident experienced hallucinations, cursing, and exit seeking. The Elopement Assessment, dated 08/26/20, revealed the resident exited the building without staff knowledge. Staff found the resident outside on the ground. The summary of both assessments revealed the resident was a Definite Risk for Elopement, due to his ambulation, [DIAGNOSES REDACTED]. Both assessments scored the resident at 24, which was a high risk for elopement. The resident had unsteady gait, altered awareness of his physical environment, impulsive behaviors, and impaired cognition. The facility's Investigative Report, dated 08/26/20 at 04:45 AM, rev sealed Certified Nurse Aide (CNA) N observed the resident without his walker in the hall outside his room prior to the elopement and his fall. CNA N stated she redirected the resident to his chair in his room and placed his walker in front of him. CNA N stated she notified the Licensed Nurse (LN) G and then assisted CNA M with another resident. CNA M and CNA N noticed that R 1 was not in his room, however she was unsure of what time she noticed the opened sliding door into the kitchen. CNA M and CNA N entered the kitchen, down the service hall, through the unsecured exit door to the outside, where staff observed the resident's walker at the top of two stairs. The staff found the resident lying on the concrete at the bottom of two steps and off the curb. CNA M notified LN G. LN G assessed the resident and then transferred him via wheelchair into the facility. After LN G assessed the resident, and the resident transferred to the emergency room for further evaluation . The Nurse's Notes dated, 08/26/20 at 05:33 AM, revealed the resident was found unsupervised outside of the facility. The resident was found lying on the ground with a 2.1 centimeter (cm) laceration to his head and a 0.5 cm abrasion to his right knee. Staff completed a neurological assessment and transported the resident to the emergency room for an evaluation. According to www.Wunderground.com, on 08/26/20 at 04:53 AM, when the resident eloped, the outside temperature was 69 degrees Fahrenheit with calm wind, no precipitation, and 90% humidity. At 5:53 AM, the outside temperature was 68 degrees Fahrenheit with calm wind, no precipitation, and 93% humidity. On 09/23/20 at 03:33 PM, the resident sat at the nurses' nook in a straight back chair, appropriately dressed. The resident's walker sat in front of him. On 09/23/20 at 03:49 PM, the resident remained in the straight back chair at the nurses' desk, with three staff members present. The resident's front wheel walker satin locked position, within reach of the resident. On 09/23/20 at 05:21 PM, the resident sat on the side on his bed eating dinner on a bedside table. His front wheeled walker was in a locked position within reach and the call light was securely attached to the grab bar on the resident's bed. On 09/24/20 at 02:19 PM, The resident sat in a straight back chair across from the nurse's nook. The resident was wearing blue jeans, red long sleeve button shirt, and rubber soled laced shoes. The resident's front wheel walker was in locked position in front of him. The resident was alert, people watching . On 09/23/20 at 05:36 PM, CNA M stated she and CNA N assisted (R6) another resident, both staff heard the resident's door open. She observed the resident was not in his room and the sliding door to the kitchen was unsecured and open. CNA M stated she entered the kitchen, through the service hall, through the exit door of the building, and observed the resident lying on the concrete by the dumpster. She then advised LN G the resident was outside of the facility without supervision. On 09/24/20 at 12:47 PM, CNA O stated the resident recently had a doctor's appointment outside of the facility prior to the elopement and the resident's exit seeking behaviors increased. The resident slept during the night prior to the incident. He wandered to the nurses' nook looking for his wife and car during the day. The CNA O stated that she was the Certified Medication Aide (CMA) passing medications the evening of 8/25/20 and secured the sliding kitchen door at 09:00 PM. On 09/24/20 at 01:01 PM, CNA P stated the resident had exiting seeking behaviors. The resident's exiting seeking was not daily. The resident does not wear a wanderguard and ambulated well with staff supervision, with a front wheel walker. On 09/24/20 at 01:08 PM, CNA Q stated the resident had been exiting seeking on 08/25/20 (the day prior to the elopement) during the day. He was alert with confusion. His care plan included one on one with his exiting seeking behaviors. On 09/23/20 at 03:21 PM, LN G stated that CNA M and CNA N advised her the resident entered the unsecured, sliding door of the kitchen, entered the service hall, exited the building through the unsecured locked door, and staff found him lying on the ground outside of the facility. LN G stated that she was sitting at the nurses' nook and did not see the resident ambulating in the hall prior to exiting through the unsecured kitchen door, however, LN G stated she did not recall CNA M and CNA N advised her the resident entered the hall prior to the incident. After the resident fell , staff transferred him into the facility via a wheelchair. She stated the resident always wore jeans, long-sleeves, and rubber soled, laced shoes. The resident should be supervised with wandering/exiting seeking behaviors. The resident received a laceration to the right side of his head and an abrasion to his right knee. Staff sent the resident to the emergency room for evaluation. The resident did have a history of four falls in the previous three

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0689 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 1) months. On 09/23/20 at 02:38 PM, Administrative Staff A stated the facility system failure occurred when the staff failed to secure the sliding door to the kitchen, failed to have a secure lock on the exit door of the service hall, and failed to have a functioning camera in the dining room to view the unsecured, sliding door in the kitchen. The resident had a history of [REDACTED]. She stated the resident had a history of [REDACTED]. She stated when reviewing the facility cameras, the resident exited the unlocked exit door of the building at 05:03 AM and the visibility was still dark. The facility's undated Elopement Policy, lacked guidance of regarding supervision of residents that wander and secured exit doors, for the safety of the residents of the facility . The facility failed to provide adequate supervision and assistive device to prevent R1 from exiting the unsecured facility exit door. The resident experienced a laceration to the head which required a staple in the emergency room to close and placed the resident in immediate jeopardy. This deficient practice was cited as past non-compliance when the facility completed the following on 08/27/20 at 08:00 PM; 1. The door entering the kitchen was shut and locked by LN G on 08/26/20 at 5:15 AM. 2. The facility staff provided one-on-one with R1 until he was transported to the local emergency room by staff. 3. The facility installed a secure lock with a code on the unsecured exit door of the service hall, on 08/26/20 at 4:00 PM. 4. All staff were reeducated starting on 08/26/20 and completed on 08/27/20 at 08:00 PM. This education included elopement, elopement risks, report and investigate missing residents of unauthorized leave, assessment of resident upon return to the facility, and new security locks and codes to the facility. 5. The facility notified the medical director and conducted a quality assurance/performance improvement (QAPI) plan.