STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175100	A. BUILDING _____ B. WING _____	**08/13/2020**

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

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 -** Minimal harm or potential for actual harm **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 had a census of 86 residents. The sample included four residents with three reviewed for elopement. Based on observation, record review, and interview, the facility failed to provide Resident (R) 1 adequate supervision when R1 exited the building without staff knowledge. Findings included: - R1's Electronic Medical Record (EMR) documented the facility admitted R1 on 03/13/2019. The EMR documented a [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set (MDS), dated [DATE], documented the resident had a Brief Interview for Mental Status score of four, indicating severely impaired cognition. The MDS documented the resident independent with walking, balance steady at all times, used a walker for mobility, and did not wander. The Elopement Risk Screening Evaluation, dated 02/05/20, recorded R1 at risk for elopement and wandered. The Elopement Risk Screening Evaluation, dated 08/05/20, recorded R1 at risk for elopement. The Safety Care Plan, dated 07/07/20, recorded R1 at risk for altered mood and elopement. The care plan directed staff to follow the community's elopement evaluation and monitoring process, identify the resident's current mood, behavioral expression, and monitor for changes. The care plan recorded staff placed a wander guard (electronic device which activates doors to lock when approached) on R1 on 08/04/20. The Social Services Care Plan Note, dated 07/26/20, recorded R1 demonstrated altered level of cognitive function due to dementia, walked around and forgot how to return to her court, and staff redirected R1 back to her unit. Review of the facility's surveillance camera footage from 08/4/20 at 06:07 PM, recorded R1 exited the facility through the C Court exit door after she pushed on the door for 15 seconds. At 06:11 PM, Licensed Nurse (LN) G walked past R1 on the sidewalk, waved at her, and kept walking toward the parking lot. At 06:14 PM, LN H exited the main door, observed R1, and went back into the building. At 06:15 PM, LN H exited the main door and talked with R1. At 06:16 PM, LN H assisted R1 back into the building. LN G's Witness Statement, signed 08/11/20, documented on 08/04/20 around 06:15 PM, LN G left the facility, on her way out (of the building) LN G saw R1 outside with her walker and thought R1 was going back in the building. On 08/11/20 at 01:23 PM, LN H stated on 08/04/20 at 06:15 PM, she clocked out from her shift and left the building. LN H stated she observed R1 outside walking on the sidewalk, so LN H went back into the building to call other staff to come help get R1 back into the building. LN H stated she could see R1 standing on the sidewalk while she made the call, then went back outside, and talked R1 into returning to her room. On 08/13/20 at 12:58 PM, Administrative Nurse D stated he expected staff to follow the facility's Elopement Response policy. The facility's Elopement Response policy, dated December 2019, documented associates shall promptly report any resident who tries to leave the premises or is suspected of being missing to the Charge Nurse. If an associate observes a resident leaving the premises, he/she should attempt to prevent the departure in a courteous manner; get help from other associate members in the immediate vicinity, and instruct another associate member to inform the Charge Nurse or Director of Nursing Services a resident has left the premises. The facility failed to adequately supervise confused, ambulatory R1 to prevent her from eloping, placing the resident at risk for injury.

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.