STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175335	A. BUILDING _____ B. WING _____	**07/20/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CHERRYVALE NURSING AND REHABILITATION CENTER	**1001 W MAIN STREET, PO BOX 366 CHERRYVALE, KS 67335**

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 reported a census of 38 residents. The sample of five residents included three reviewed for elopement. Based on observation, interview and record review, the facility failed to provide adequate supervision and/or assistive device to prevent one Resident (R1) of the three sampled residents, from exiting the facility without staff knowledge. The resident went out the facility front door and the alarm failed to sound. The facility video recorded the resident exiting the front door on 07/14/2020 at 10:43.03 and a staff member noted and went out after the resident at 10:44.11 AM, a minute later. The resident fell under the covered patio area and sustained a superficial scraped knee before being returned into the facility. Findings included: - The medical record evidenced the facility readmitted R1 on 09/10/19. The readmission notes included the primary care physician identified [DIAGNOSES REDACTED]. The 04/25/20, annual Minimum Data Set (MDS) assessment documented the resident with a Brief Interview for Mental Status (BIMS) score of 09/15, indicating moderate cognitive impairment. The assessment documented no active wandering behavior. The resident required limited staff assistance with transfers and walking on and off the unit. The 05/07/19 Care Area Assessment, for cognition included, the resident had cognitive loss related to [DIAGNOSES REDACTED]. She was able to hold a conversation and currently had no noted behaviors. The assessment for activities of daily living documented, R1 ambulated with a walker but required stand by assistance and a gait belt. She was at high risk for falls with a fall risk assessment score of 14. The 11/15/19 Plan of Care included, resident with limited physical mobility related to weakness. She was able to ambulate throughout the facility using a front wheeled walker (FWW) and stand by assist (SBA). She was unaware of safety needs and was at risk for falls. (R1 was not identified as an elopement risk prior to this incident.) The 4/11/20 Wander Assessment scored the resident at low risk for elopement with score of 4.0. The facility investigation for the elopement incident on 07/14/20 at 10:43 AM, revealed the resident got up from her recliner in the TV area (lobby) and began to walk towards the front door. She pushed open the front door then went outside the door standing on the covered patio for a few seconds then started to walk off the patio. Certified Nurse Aide (CNA) D noted the resident outside. She exited the front door and called the residents name. The resident turned toward the aide, lost her balance and fell . She told staff, I am Fine. Staff D assisted the resident back into the facility. Licensed Nurse (LN) C assessed the resident's right knee as a superficial abrasion. The Administrative Licensed Nurse B also reviewed the facility video and determined the resident was out of the facility from 10:43.03 AM to 10:44.11 AM, without staff present. On 07/20/20 at 10:00 AM, Administrative Licensed Staff B explained the facility 10/14/2020 investigation, determined that on 07/14/2020 approximately two and a half hours prior to the resident elopement, staff shut off the front entrance door alarm and failed to turn it back on. At approximately 08:00 AM, that morning another resident left the facility through the front door on a gurney with EMS (emergency medical services). Observations, on 07/20/20 from 09:00 AM through 05:00 PM, revealed the resident preferred to set in a recliner in the TV area with her feet elevated all day long. She wore oxygen per nasal cannual. She exited the recliner with assistance and walked to and from the bathroom and the dining room with her FWW, gait belt on and stand by assistance of one staff. The facility's undated Elopement Policy, included the staff should identify residents who, due to his/her cognitive impairment, may be at risk for wandering from the facility unattended without knowledge of facility staff. All staff were responsible for the residents' safety. The facility failed to ensure adequate supervision and/or assistive devices to prevent R1 from exiting the facility without staff knowledge, and then fell sustaining a scraped knee.

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.