STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E210	A. BUILDING _____ B. WING _____	03/09/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
FRANKLIN HEALTHCARE OF PEABODY LLC	500 PEABODY PEABODY, KS 66866

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 36 residents, with three selected for review for elopement (run off secretively). Based on record review, observation, and interview, the facility failed to provide adequate supervision for one Resident (R) 1, of the three selected, to prevent elopement. Staff failed to monitor the resident as care planned with one to one supervision, when on an outing from the facility. The staff left the resident unattended in the facility van and the resident eloped near a highway that was heavily traveled . The speed limit was 55 miles per hour. Findings included: - The signed physician order [REDACTED]. The annual Minimum Data Set (MDS), dated [DATE], revealed the resident had a Brief Interview for Mental Status (BIMS) score of 99, indicating impaired cognition. She had delusions and verbal behavioral symptoms directed at others that significantly interfered with the resident's participation in activities or social interactions. It was very important for her to go outside to get fresh air when the weather was good. She was independent with her activities of daily living (ADL's) and did not require mobility devices. She received routine antipsychotic (medication used to treat [MEDICAL CONDITION]) and antianxiety medications (medication used to treat anxiety). The resident did not have alarms. The Cognitive Loss/ Dementia Care Area Assessment (CAA), dated 03/14/19, documented the resident had a long-standing history of mental health disorders. She had poor memory and spoke in a child-like voice. The resident heard voices no one else could hear, and she would speak to those voices. She required antipsychotic medications. The quarterly MDS, dated [DATE], documented the resident had a BIMS score of nine, indicating moderately impaired cognition. She hallucinated (an experience in which you see, hear, feel, or smell something that does not exist) and had delusions (fixed, false conviction in something that is not real or shared by other people). She had verbal behavioral symptoms directed towards others and behavioral symptoms not directed toward others. She received antipsychotic medications, antianxiety medications, and antidepressant medications. The resident required a wander/elopement alarm daily. The care plan, dated 12/11/19 , identified the resident was at risk for elopement due to poor decision making, auditory hallucinations, and a history of unauthorized leaving of the facility. Her goal was that she would not leave the building without staff presence. The resident required a WanderGuard (a wearable device to alert staff she was nearing a facility exit door). Staff should consider patterns of exit seeking need or behavior to alter the resident's schedules, treatment, medications or environment to manage behavior and ensure the resident's safety . Staff should complete an elopement assessment quarterly and as needed. Staff should encourage activity participation. Staff to re-direct the resident when she made attempts to leave the facility. In addition, staff should provide one to one supervision with the resident on outings or physician appointments. Staff should accompany the resident for occasional walks around the facility. The Wander Data Collections Tool, located in the resident's clinical records, revealed on 12/11/19 and on 03/06/2020, a score of three. A score of three or more documented a Definite Risk for Elopement. The summary on both assessments documented the resident was a definite risk for elopement, due to her ambulation, and her [DIAGNOSES REDACTED]. The nurse's notes, on 03/04/2020, documented the Resident returned from an outing this afternoon from Dollar General. Staff completed a skin assessment, blood pressure, pulse and respirations monitored, however, the resident's temperature was not obtained. Staff notified the physician of the Incident that happened on the resident's outing today. The records lacked documentation that the resident eloped when she was on an outing. The investigation report, reported 03/09/2020, documented staff took the resident, along with other residents, on a shopping trip, accompanied by activities staff Z and social services staff X. Activities staff Z was in the van with the residents, including the resident, when another resident, who was in the store with social service staff X, became dizzy. Social service staff X requested assistance with the resident in the store. Activity Staff Z left the van and six other residents, unattended, to assist with Social service staff X inside the store. After both staff returned to the van, a roll call determined the resident had left the van, unattended. Staff drove the van in attempts to locate the resident, however, was unsuccessful. Staff returned to the facility, called the local police department at approximately 01:47 PM, and was informed by the police department there was a call with the description of a female that matched the resident's description. Staff returned towards the store, located her, and brought the resident back into the facility at 01:52 PM. According to www.Wunderground.com, on 03/04/2020 at 12:53 PM, the outside temperature was 54-degree Fahrenheit. At 01:53 PM, the temperature was 58-degree Fahrenheit , with five miles per hour wind from the North East, cloudy, and no rain. On 03/09/2020 at 08:20 AM, the resident ambulated by herself with a swift, steady gait. The resident wore a sweatshirt with matching slacks. On 03/09/2020 at 11:40 AM, the resident ambulated with a swift, steady gait. She carried a plastic bag that contained clothing, shoes, and a stuffed animal. On 03/09/2020 at 01:05 PM, the resident was in her bed, with night clothing on. She was awake and spoke to herself. On 03/09/2020 at 04:40 PM, the resident stood in the hallway, faced toward the wall, and had a conversation with herself. On 03/09/2020 at 08:11 AM, Licensed Nurse (LN) G, reported the resident was an elopement risk. She had left the building unattended before. The resident enjoyed walking and was ambulatory ad lib. If the resident was On a mission, she could walk quick. LN G was unaware of what time staff transported the residents to the outing. She became aware the resident eloped when staff returned to the facility, without the resident. Social services staff notified the local police department, and the Police Chief reported the resident had been located, so both Social Service staff X and Activity Staff Z left the facility to transport the resident back to the facility. When staff returned with the resident, the resident walked into the facility and went to bed. The resident wore appropriate clothing for the weather, because she always wore a sweatshirt, and long pants. The resident refused to have her temperature monitored, because she did not like thermometers in her mouth. LN G reported facility staff should walk with her when she was out of the building, unless it was in the enclosed fenced area in the patio. On 03/09/2020 at 08:45 AM, Administrative Staff A, reported the facility system failure occurred when staff left the resident unattended, while out of the facility. Staff should have followed the resident's care plan. On 03/09/2020 at 10:50 AM, Social Services staff X, reported while on the outing, she assisted a Slow walking resident while in the store and they were the last ones to leave the store. The other residents were outside of the store, when Social Services Staff X motioned for Activity Staff Z to assist with the other resident. Social Services Staff X reported she paid for the merchandise as Activity Staff Z ambulated with the other resident to the van. After the residents were in the van, it was determined that R1 was not in the van. Social Services Staff X searched the inside and the outside parameter of the store, and the resident was not located. After staff searched for the resident, and was unable to find her, staff returned to the facility without the resident. The staff notified the local Police by phone. The local police informed the staff that there was a female located that fit the resident's description, and both staff drove to the area, located the resident across the street, and transported the resident back to the facility. The resident would have disappeared when both staff were in the store and left the resident unattended. She was aware the resident required one to one while on outings. On 03/09/2020 at 10:09 AM, Activity Staff Z,

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) reported she was with the resident in the store, however, left the resident unattended while she returned to the store. She reported she May have forgotten to close the van door. It was determined the resident was gone when staff completed a roll call, and the resident was not in the van. Social Services staff searched inside and outside the store, and was unable to locate the resident, so staff drove around, looking for her. After the other residents returned back to the facility, the police informed staff there was a female that matched the resident's description, in the approximate location of the store. Staff located the resident on the opposite side of the street, from the store. She was standing in the grass, and had grass on her head, so she may have laid down in the grass, in the ditch. She verified a high traffic highway was close to the location the resident disappeared. Activity Staff Z verified she was aware the resident required one to one while on outings but reported I dropped the ball when another resident Had health issues. On 03/09/2020 at 11:53 AM, Outside Resource Staff KK, identified as the Chief of Police, reported he received a call two minutes prior to the facility calling in the report of the missing resident. The call came from a Citizens report of a female walking East on Highway 50. He gave the description of the female, and it matched the lost resident. The police did not go to that location, because he was on a previous call. He verified he did not make out a police report. On 03/09/2020 at 01:39 PM, Administrative Staff A, reported staff were aware the resident required one- to-one supervision on outings. Staff should follow the resident's care plan. The resident had a history of [REDACTED]. The resident is required to wear a WanderGuard, because she is at risk for elopement. On 03/09/2020 at 01:51 PM, Certified Medication Aide (CMA) R, reported staff should provide one to one supervision with the resident when on outings. On 03/09/2020 at 02:05 PM, R1 reported she remembered she left the van because she was Possessed and pushed to leave the van. She walked to the highway, but Didn't get hurt. On 03/09/2020 at 02:04 PM, Administrative Nurse D, reported staff failed to provide a one on one outing with the resident, and the resident eloped from the van, while both staff were inside the store. Staff should have provided one on one supervision with the resident, and Their eyes should not have been off her. On 03/09/2020 at 02:14 PM, reported the resident required one on one supervision with staff if she was out of the building on an outing. She can walk outside in the fenced patio by herself. On 03/09/2020 at 02:37 PM, Physician GG, reported he was aware the resident eloped. The resident was out on a supervised outing, and someone had a problem in the store. Staff got pre-occupied with another resident, turned their back on the resident, she took advantage of the situation, and left. On 03/09/2020 at 10:10 AM, R 2 reported he was on the outing when the resident Took off. Staff and residents rode in the van but were not able to locate her. When they (staff) could not locate her, they brought the residents back to the facility. On 03/09/20 at 10:14 AM, R 3 reported he was on the outing when the resident disappeared from staff. He reported he was outside, behind the van, smoking. Staff called out her name in the roll call, and she was not on the van. Staff searched for her, but was not able to locate her, so staff returned the residents back to the facility. On 03/09/2020 at 02:25 PM, R4 reported she was on the outing when the resident disappeared. Staff searched for her but was unable to locate her. The facility's policy for Wandering, Unsafe Resident, F 689, dated 11/2017, documented the resident's care plan would indicate the resident at risk for elopement and interventions to try to maintain safety would be included in the resident's care plan. Staff would institute a detained monitoring plan, as indicate for residents assessed to have a high risk of elopement or other unsafe behavior. The facility failed to adequately monitor this cognitively impaired, independent resident that required one to one supervision when on an outing from the facility, as care planned. The staff left the resident unattended in the facility van and the resident left unattended and walked near a highway that was heavily traveled , with a speed limit of 55 miles per hour, and was left unattended for a minimum of five minutes. The deficient practice cited as past non-compliance on 03/05/2020 at 03:40 AM, when the facility completed the following: 1. All staff education, started on 03/04/2020 and completed on 03/05/2020 at 03:40 AM. This education included unsafe resident wandering, elopement, safety and supervision of residents, abuse prevention training, and following the resident's individualized care plan . 2. Staff involved in the failure to follow the resident's care plan for one on one supervision were given a written disciplinary action. 3. The facility notified the medical director and conducted an immediate quality assurance/ performance improvement (QAPI) plan on 03/04/2020.