STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175114	A. Building B. Wing	09/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Diversicare of Hutchinson	1202 E 23rd Avenue Hutchinson, KS 67502

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 to resident health or safety 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** 46960 The facility identified a census of 64 residents, which included one resident reviewed for accidents and identified 12 residents that were confused and independently mobile. Based on observation, interview, and record review the facility failed to ensure cognitively impaired Resident (R)1 remained free from accident hazards when on 07/15/24 at approximately 10:15 AM, R1 left the facility through an unsecured gate in the west courtyard. R1 remained unsupervised until Law Enforcement Officers (LEO) contacted R1 outside of a local business, located approximately 2.8 miles away from the facility, at 11:10 AM (55 minutes after R1 left the facility unsupervised and without staff knowledge). R1 did not return to the facility until approximately 11:25 AM (one hour and 10 minutes after R1 left the facility). This deficient practice had the potential to lead to serious bodily harm to R1 and placed R1 in immediate jeopardy. Findings included: - The Electronic Health Record (EHR) for R1 included the following diagnoses: unspecified psychosis (any major mental disorder characterized by a gross impairment in reality perception), history of traumatic brain injury (TBI - an injury to the brain caused by external forces), schizophrenia (a mental disorder characterized by gross distortion of reality, disturbances of language and communication and fragmentation of thought), falls, cognitive communication deficits, and other symptoms involving cognitive functions and awareness. The Admission Minimum Data Set (MDS) dated [DATE] documented a staff assessment of R1's cognition as severely impaired. The assessment documented R1 had other behaviors not directed at others, which occurred 1-3 days during the seven-day look-back period, these behaviors interfered with the resident care, the resident's social activities, social interactions, and intruded on the privacy of others. The assessment documented that R1 had no wandering behaviors, he required extensive assistance with toileting, and limited assistance with dressing and personal hygiene, but was otherwise independent with his cares. R1 was frequently incontinent of bowel and bladder, had no history of falls, received an antipsychotic medication (a class of medications used to treat major mental conditions which cause a break from reality) daily during the seven-day look-back period. The assessment documented that R1 did not wear a wandering or elopement alarm. The Cognitive Loss / Dementia Care Area Assessment (CAA) dated 08/01/23 documented R1 had a BIMS score of 00, which indicated severely impaired cognition. (continued on next page)

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

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Communication CAA, dated 08/01/23 documented R1 had an impaired ability to understand others through verbal communication. The Behavioral CAA, dated 08/01/24 documented R1 had behavioral symptoms present. The Care Plan in place on 07/15/24 documented on 07/31/23 R1 was at risk for elopement related to previous attempts to elope and history of wandering and provided the following interventions: On 07/31/23, staff were to educate family and/or responsible party to talk positively about resident's placement at the facility. On 07/31/23, staff were to encourage family to bring in personal possessions. On 07/31/23, staff were to evaluate the effect of cognitive impairment upon R1's ability to understand changes in the environment. On 07/31/23, staff were to introduce R1 to his peers. On 07/31/23, staff were to involve R1 in activities of his choosing. On 07/31/23, staff were to redirect R1 away from exit doors due to R1's risk for elopement. On 07/31/23, staff were to obtain a photograph of R1 for identification and place the photograph in the elopement book. The Care Plan interventions added on 07/17/24 (after R1 left the building without staff knowledge and unsupervised) included reinforcing staff to redirect R1 away from exit doors and the utilization of a WanderGuard (bracelet that sets off an alarm when residents wearing one attempt to exit the building without an escort) with instructions for staff to assess placement and function each shift. The facility's investigation of the elopement revealed the following information: On 07/15/24 at approximately 10:10 AM, an Administrative Nurse witnessed R1 ambulating in the courtyard window (as he was care planned to do). On 07/15/24 at approximately 10:15 AM, an independent lawn care contractor entered the west courtyard and left the north gate in the west courtyard unlocked and unsecured. On 07/15/24 at approximately 10:20 AM, another resident alerted staff she was concerned that the lawn care contractor left the courtyard gate open and R1 could no longer be seen from the window in her room. Staff then alerted leadership and initiated elopement protocol with an overhead announcement of Code [NAME]. On 07/15/24 from approximately 10:25 AM to 10:38 AM, the facility initiated a room-to-room search and noted R1 to be missing. Staff expanded their search to the courtyards where the lawn care contractor identified R1 as having left the courtyard and headed to the south. Staff re-secured the previously unlocked gate. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 07/15/24 at 10:38 AM, local law enforcement was notified R1 was missing, and the leadership team went out in vehicles to search for R1. On 07/15/24 at 10:40 AM, R1's guardian, family, and PCP were notified. On 07/15/24 at 10:41 AM, law enforcement arrived to the building and Administrative Staff A provided them with a statement and recent photo of R1. On 07/15/24 at 11:01 AM, law enforcement received a report that a person matching R1's description was located at a nearby business (approximately 1.2 miles away) walking south. On 07/15/24 at 11:10 AM, law enforcement made contact with R1 at a local business (approximately 2.8 miles away) and ensured R1's safety awaiting facility staff to come get R1. On 07/15/24 at 11:15 AM, Administrative Staff A arrived to the local business with law enforcement and made contact with R1. On 07/15/24 at approximately 11:19 AM, Administrative Staff A had R1 in her vehicle, where he reported he went through the gate that the guy left open. R1 reported no injuries. On 07/15/24 at approximately 11:25 AM, R1 and Administrative Staff A returned to the facility. R1 was assessed for injuries, and none were discovered. R1 was provided with water and a shower. Facility staff initiated one-on-one supervision for R1. Review of historical meteorological data from the National Weather Service (www.weather.gov) on 07/15/24 at 10:00 AM documented ambient temperature of 90 degrees Fahrenheit (?) with heat index of 93?, at 11 am, 95? with heat index of 98?, and at noon, 98? with heat index of 99?. There was clear sky with wind 17 miles per hour (mph) out of the southwest. On 09/05/24 at 12:14 PM, R1 observed wandering in hallway, through dining area and back into the hallway. On 09/15/24 at 12:32 PM, Certified Nurse Aide (CNA) C stated if staff discovered a resident missing, they would immediately tell the nurse, then follow whatever instructions were provided. CNA C confirmed since the incident with [NAME] 07/15/24, the facility provided training and frequent elopement drills had occurred. On 09/15/24 at 01:25 PM, CNA D stated if a resident was suspected to be missing, they were to immediately tell the nurse, then follow the instructions provided. CNA D confirmed that since the incident with R1 on 07/15/24 the facility provided training and frequent elopement drills had occurred. On 09/15/24 at 01:28 PM, Licensed Nurse (LN) E stated that if a resident was suspected or confirmed missing that nursing staff would announce a Code [NAME] over the overhead speakers and administration would get involved. Staff would be directed to monitor each exit, initiate a headcount, and if a resident was discovered missing after a headcount, law enforcement would be notified, and the staff would follow the instructions of law enforcement and administration. LN E confirmed since the incident with R1 on 07/15/24 the facility provided extensive education and elopement drills frequently occurred. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 09/05/24 at 01:30 PM, Maintenance Director F stated that in the event of a suspected or confirmed elopement that he would follow the instructions given by administration. He confirmed that since the incident on 07/15/24 that corrective measures were initiated and that he was responsible to check the locks on the gates at the start of every day and delegated this task to other maintenance personnel when he was not working so that the checks were performed every day. Maintenance Director F further stated that he performed checks on the exterior doors three times weekly to ensure that the magnetic locks were functioning properly and that the WanderGuard system was operational. Maintenance Director F confirmed the facility provided training since the incident with R1 on 07/15/24 and that he regularly participated in elopement drills. On 09/05/24 at 01:33 PM, Activities Director (AD) G stated that in the event of a suspected or confirmed elopement staff were to tell the nurse then follow whatever instructions were provided. AD G confirmed that since the incident with R1 on 07/15/24 the facility provided extensive training and that the facility regularly conducted elopement drills. On 09/05/24 at 09:53 AM, Administrative Staff A stated that in the event of a suspected or confirmed elopement, the staff member would contact the licensed nurse who would initiate the elopement protocol. Administration would be alerted and would direct the search, which included notification of law enforcement if needed. After the resident was returned to the facility, the resident would be assessed for injuries and treated appropriately, if required. The facility would then investigate the root cause of the elopement and develop/implement new interventions or adjust existing interventions to mitigate the risk for additional elopement. Observation of the exterior of the facility revealed a large courtyard on the west side with an 8-foot wrought iron fence that had two gates approximately four feet wide, which were secured with padlocks. The facility's Elopement policy dated 04/2017 documented the facility would have processes in place to mitigate the occurrences of elopements that included assessing residents on admission or when a newly identified elopement risk was identified. The facility would then develop and implement an individualized plan that established interventions to mitigate the risk of elopement. Further, the policy documented steps to follow when an elopement did occur as well as multiple suggestions for staff interventions to address residents at risk for elopement. The facility failed to ensure that R1 remained free from accident hazards when on 07/15/24 at approximately 10:15 AM, cognitively impaired R1 left the facility, without staff knowledge and unsupervised, through an unsecured gate in the west courtyard. R1 remained unsupervised until Law Enforcement Officers (LEO) contacted R1 outside a local business, located approximately 2.8 miles away, at 11:10 AM (55 minutes after R1 left the facility). R1 did not return to the facility until approximately 11:25 AM (one hour and 10 minutes after R1 left the facility). This deficient practice had the potential to lead to serious bodily harm to R1 and placed R1 in immediate jeopardy. On 09/05/24 at 03:20 PM, Administrative Staff A was provided the Immediate Jeopardy (IJ) Template for the failure of the facility to provide an environment free of accident hazards for R1. The facility immediately implemented corrective measures following R1's return to the facility with Administrative Staff A on 07/15/24 at approximately 11:25 AM. The facility's corrective measures included the following which were verified by the surveyor on-site during the investigation: (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	1. The facility initiated 1:1 supervision of R1 and continued until 07/26/24 at 03:40 PM. 2. The facility changed the locks on the gates to require keys that only Administrative Staff A and Maintenance Director F carry completed 07/15/24. 3. The facility informed lawn care contractors that in order to enter or exit the courtyard that staff must be present to allow access and/or egress completed 07/15/24. 4. The facility immediately initiated a facility wide re-education related to elopement of all staff and no staff that were off duty were allowed to return to work without completing the education and was completed on 07/16/24 at approximately 02:00 PM 5. The facility initiated daily lock checks on all locked gates which was an ongoing intervention. 6. The facility performed new admission elopement evaluations on all newly admitted residents, which was an ongoing intervention. 7. The facility initiated weekly elopement drills every shift for one month, then every shift monthly for three months and then reevaluate in with the quality assurance process improvement (QAPI) meetings, which was an ongoing process/intervention. 8. The facility addressed elopement in QAPI and audited/updated elopement evaluations on all existing residents which was completed 07/15/24. 9. The facility assessed and updated R1's care plan to include checking of WanderGuard every shift and updating photo in elopement book and was completed 07/15/24. 10. The facility requested a psychological evaluation to be completed by psych provider to rule out any additional underlying causes for elopement and exit-seeking behavior and was completed on 07/24/24. 11. The facility requested a medication regimen review (MRR) requested from pharmacist and was completed 07/25/24. 12. The elopement policy was reviewed by Administrative Staff A and corporate staff on 07/15/24 to ensure that no updates were required. All corrections were completed prior to the onsite survey, therefore the deficient practice was cited as past noncompliance and remained at a scope and severity of a J.