| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175171 | A. Building<br>B. Wing | 01/29/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| McCrite Plaza Health Center | 1610 SW 37th Street<br>Topeka, KS 66611 |

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) |
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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47834<br><br>The facility identified a census of 64 residents. The sample included three residents. Based on observation, record review, and interview, the facility failed to provide adequate supervision for cognately impaired Resident (R)1, a resident with a risk for elopement and falls, to prevent an elopement. On 01/26/25, R1 self-propelled in his wheelchair down a hallway to a locked door with a keypad. The door was not latched and R1 left the unit and proceeded out a set of double doors that exited the building. When R1 opened the double doors, an alarm sounded at the nurse ' s station, but the staff turned the alarm off without checking the door. Per interview and investigation, R1 exited the facility building at 05:58 AM and entered the Assisted Living (AL) building at 07:02 AM. The weather ranged from 22 degrees Fahrenheit (F) to 23 degrees F. AL staff contacted the nursing staff in R1 ' s building and nurses from R1s unit came to get him. The lack of supervision and response to the door alarms placed R1 in immediate jeopardy.<br><br>Findings Included:<br><br>- R1 ' s Electronic Medical Record (EMR) documented diagnoses of cerebral infarction (stroke - sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain), need for assistance with personal care, Alzheimer ' s disease (progressive mental deterioration characterized by confusion and memory failure), and vascular dementia (a progressive mental disorder characterized by failing memory and confusion caused by a decreased blood flow to the brain).<br><br>The Significant Change Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of three, which indicated severe cognitive impairment. The MDS documented R1 used a wheelchair and was independently mobile. The MDS further documented R1 required partial to moderate assistance for bathing, upper body dressing, personal hygiene, ability to move from a seated position to standing, and transfers. The MDS documented no wandering behavior.<br><br>The Falls Care Area Assessment (CAA), dated 10/14/24, documented R1 had a risk for falls related to impaired balance, taking scheduled antidepressant medication, high fall risk score, and decreased cognition. The CAA further documented staff assisted the resident with functional abilities and transfers as indicated.<br><br>The Cognitive Loss/Dementia CAA dated 10/14/24, documented R1 had a BIMS score of three, diagnosis of Alzheimer's disease, and vascular dementia.<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | R1's Care Plan with an initiated date of 10/03/23 documented R1 required limited to extensive assistance. R1 ' s Care Plan with an initiated date of 10/03/23 documented R1 had a fall and safety risk related to cognition, impulsiveness, decreased safety awareness, impaired balance, impaired mobility, and weakness. R1 ' s Care Plan with an initiated date of 02/22/24 documented R1 was an elopement risk related to a high-risk score on an elopement assessment and unpredictable behaviors. An intervention with an initiated date of 10/15/24 documented R1 ' s elopement risk as high.<br><br>Review of the Elopement Assessment 2013 dated 01/10/25 documented R1 had a moderate risk for elopement.<br><br>R1 ' s Health Status note dated 01/26/25 documented Certified Medication Aide (CMA) R reported R1 was at the facility ' s [assisted living] apartments at 07:11 AM, unassisted, per phone a call received by an apartment Certified Nurse Aide (CNA). The note further documented Licensed Nurse (LN) G and LN H went to assist R1 back to the facility. The note documented R1 wore a short-sleeved T-shirt, sweatpants, socks, and shoes. The note recorded R1 was a poor historian, unable to recall where he was going, and was cold to the touch.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | The Facility Incident Report with a signed date of 01/28/25, documented on the morning of 01/26/25, staff reported seeing R1 in the facility hallways at approximately 06:00 AM to 06:15 AM. The investigation documented that at approximately 07:11 AM CMA R received a phone call from AL staff informing them R1 was in the dining room of the AL building. The investigation further recorded CMA R and LN G went to the AL to get R1 and brought R1 back to the Health Center where he resided. The investigation notes documented that upon review of the camera system, R1 was observed going out of the northwest therapy door of the Health Center at 05:58 AM. R1 was in his wheelchair with sweatpants, a t-shirt, and tennis shoes on. The investigation note documented there was no exterior footage of the building, and there was a path through the snow to the AL building across the parking lot. Upon review of the camera system in the AL, R1 was observed at the south door of the AL building at 07:02 AM and entered the AL facility at 07:04 AM into their dining room. The note further recorded Dietary BB was in the AL dining room and turned to see R1 behind her, and per Dietary BB ' s report, R1 asked where he could sit to eat. Dietary BB told R1 he could sit anywhere and then realized R1 did not look familiar. Dietary BB stayed with R1 and contacted nursing staff via the facility communication system. Dietary staff noted R1 ' s hands to be red and cold. The investigation note further documented CMA R and LN G arrived at the AL at approximately 07:11 AM to get R1. LN H and LN J met CMA R and LN G in route to return R1 to the building via wheelchair and LN J assumed resident care. The investigation documented R1 was assessed with no injury noted, R1 was reported as alert and oriented to self and situation and reported being hungry. R1 ' s cognition was recorded as being at baseline and skin was cool to touch. Vital signs upon reentry to the facility at approximately 07:15 AM were temperature (T) 94.1F taken via ear thermometer, pulse (P) 59 beats per minute (BPM), blood pressure was 99 millimeters of mercury (mmHg) over 48 mmHg, and respirations 16 breaths per minute. The investigation documented staff applied a jacket and warm blankets to R1 and placed him on one-to-one supervision. At approximately 07:40 AM vitals were T 95.8F per ear thermometer, P 67 BPM, blood pressure 146/69 mmHg. At approximately 09:00 AM vitals included R1 ' s temperature was 96.1 degrees F via ear thermometer, pulse was 66 BPM, respirations were 16 breaths per minute, and blood pressure was 146/68 mmHg. The investigation recorded R1 ' s family and provider were notified, and no new orders were received. The investigation documented per guidelines a normal temperature via ear thermometer was 96.4 degrees F to 100.2 degrees F and cold skin could have a direct effect on the accuracy of the thermometer. R1 did not present with signs or symptoms to suspect hypothermia (medical emergency that occurs when the body's core temperature drops below 95 F). The investigation documented R1 was alert and oriented to self and occasionally situation. R1 is a one-to-one transfer and used a wheelchair for mobility. R1 was able to propel himself in his wheelchair, was a high elopement risk, and was care planned as such. The investigation further documented elopement fliers were at the nurse ' s stations with R1 ' s photo. The investigation further documented per the camera system, R1 exited the north hall by therapy by pushing the door to the therapy hallway open; the door had not properly latched when last used and did not require the key code to be pushed open due to not being latched completely. R1 then pushed open the exterior door, which sounded an alarm at the north nurses ' station. When the alarm sounded at 05:58 AM, per camera time, LN I deactivated this alarm from the nurses ' station without going to check on the location of the alarm. Per the investigation note, the entrance R1 exited the facility from was an entrance that staff used, and LN I thought it was staff entering and exiting the building as residents should not be able to access the door in the therapy hall.<br><br>According to Wunderground.com the temperature at 06:00 AM on 01/26/25 was 23 degrees F and the temperatures dropped to 22 degrees F at 07:00 AM.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Dietary BB ' s Notarized Witness Statement, dated 01/28/25, documented at approximately 07:05 AM, R1 appeared behind Dietary BB in the dining room. R1 was in a wheelchair and asked where he could sit for a meal. Per the witness statement, R1 told Dietary BB he was locked out and had been outside for quite a while. R1 was able to tell Dietary BB where his room was. Dietary BB contacted the nurses in R1 ' s building and the nurses came to get R1. Dietary BB ' s witness statement documented R1 looked very cold, especially his hands.<br><br>CMA R ' s Witness Statement, dated 01/26/25, documented CMA R received a phone call at 07:11 AM from AL staff and was asked if CMA R knew R1. CMA R went to the south hall to ask if staff had seen R1 and to check his room. The witness statement document R1 was not in his room. LN G and CMA R went to the AL dining room where R1 sat, and CMA R and LN G brought R1 back to the Health Center.<br><br>LN G ' s Witness Statement, dated 01/26/25, documented during report a CMA received a call from AL staff that R1 was in their dining room. LN G and CMA R went to get R1 per the witness statement. Witness statement documented that R1 was cold to the touch and hungry. The statement documented two other nurses met LN G on the way back to the Health Center and assumed care for R1. The witness statement further documented LN G contacted Administrative Staff A, another nurse contacted Administrative Nurse D, and other staff performed room checks to ensure other residents were present.<br><br>A document titled Written Warning #1 with a signed date of 01/26/25, documented an audible alert went off at the nurses ' station at 05:57 AM on 01/26/24 and LN I did not immediately go to the door indicated on the annunciator system (provides an indication of the location and type of alarm that has been activated). The document recorded LN I did not check both inside and outside the door to determine who or why the door alarm sounded. LN I turned the alarm off and proceeded with his tasks. The document further recorded that under no circumstances should a door alarm be deactivated until the source of the activation was determined. Moving forward, LN I was to check both inside and outside the door to determine who or why the door alarm sounded.<br><br>On 01/29/25 at 01:38 PM, an observation made outside where R1 exited the facility revealed R1 exited through the double doors to a sidewalk with three paths. The path leading southwest curves around and is attached to a facility road and parking area. The road and parking area continued south and eventually led to a pond on facility property. The sidewalk also connected to a main road that traveled east and [NAME] on the South side of the facility. The posted speed for the main road was 35 miles per hour (mph). The second path from the exit doors went down concrete stairs and connected to the same parking lot and facility roadway as the Southwest path. The third path went North alone the building then turned East. The sidewalk had a rail that traveled along the edge. There was some snow left on the sidewalk and a thin trail was noted in the snow that appeared to be a track from R1 ' s wheelchair. The sidewalk turned North and connected to a crosswalk that joined to the entrance of the AL building. The area of the sidewalk that connects to the crosswalk was covered with snow. There was a grass area that continued East from this sidewalk and eventually joined at another sidewalk with a ramp that connected to the same facility road with the crosswalk. There was snow in the grass and another thin line that appeared to be a track from R1 ' s wheelchair. From the second sidewalk exit ramp, R1 could have used this to cross the road and enter the front door of the AL building. This was the path Administrative Staff A stated he believed R1 took to get to the AL. The facility roads connected to other roads off the facility property to the East and [NAME] sides of the facility. The facility was surrounded to the North, East, and [NAME] by residential housing, and to the South a main road with small businesses across that street and some residential housing and small apartment buildings.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | On 01/29/25 at 05:11 PM, R1 sat in the dining room in his wheelchair. R1 fed himself at the table with staff seated nearby. R1 did not appear to be in any distress.<br><br>On 01/29/25 at 05:47 PM, LN I was unavailable for Interview.<br><br>On 01/29/25 at 12:12 PM, Dietary BB stated she was in the AL dining room and turned around to see R1 in a wheelchair behind her. Dietary BB stated she didn ' t know where R1 came from and thought R1 may have been a new resident to the AL. Dietary BB stated R1 wheeled himself to a table and stated the room he stayed in and further said that he had been locked outside for a while. Dietary BB asked where he was, and she stated R1 pointed across the road. Dietary BB stated she called the nursing staff, and they came over to get him. Dietary BB stated R1 ' s hands were red, and believed R1 may have been outside quite a while. Dietary BB stated she didn ' t touch R1s hands but stated that just looking at him she could tell R1 was cold. Dietary BB stated R1 had on a t-shirt, sweatpants, socks, and shoes. She further stated R1 did not have a coat, gloves, or hat on.<br><br>On 01/29/25 at 01:50 PM, Administrative Staff A stated residents were not supposed to able to get back to the therapy hall and believed the door that led to the therapy hall, did not latch properly when it was last closed and that allowed R1 to get through the door without using the keypad. Administrative Staff A stated the nurse on duty turned off the alarm at the nurses ' station when the alarm sounded without checking the source. Administrative Staff A further stated the facility had a company coming out to see about eliminating the ability for staff to turn off the alarms at the desk. Administrative Staff A stated staff were educated on elopement, what to do, the policy, and door alarms. Administrative Staff A stated all but a few staff were educated and those left would be educated before they could work their next shift. Administrative Staff A stated signs have been posted to remind staff they were not allowed to turn off alarms without checking the source. Administrative Staff A stated maintenance was notified about the door and came in to inspect and make adjustments. Administrative Staff A stated they had no further issues with the door since maintenance inspected it.<br><br>On 01/29/25 at 02:02 PM, CMA R stated she was working the med cart when she received a call from the AL. CMA R stated she was asked if R1 was their resident. CMA R stated she notified LN G and looked on the unit for R1 before going to the AL with LN G to bring him back. CMA R stated R1 was really cold, she stated they put his foot pedals on his wheelchair and brought him back to the building and the nurses that worked on his hall took over care. CMA R stated she felt R1 ' s skin and he felt cold, and he looked white. She stated staff put blankets on R1 they took from the dryer to help warm him. CMA R stated she believed R1 was normally confused and was an elopement risk prior to him exiting the facility.<br><br>On 01/29/25 at 02:09 PM, LN G stated CMA R told her R1 was in the AL and they both went to the AL to bring him back. LN G stated R1 was at a dining room table in the AL, he responded to his name, and he said he was cold and hungry. LN G stated that R1 was cold to touch. LN G further stated LN H and LN J took over his care as she and CMA R brought R1 back. LN G stated she contacted Administrative Staff A to inform him of the situation. LN G stated R1 was red and looked cold. She stated dietary staff in the AL told her R1 had knocked on the door and told them he was locked out. LN G stated when Administrative Staff A arrived, they performed a head check for all residents, information and education packets were handed out to staff and an in-service was done the following day. LN G stated they went over education for an elopement, the facility policy, and door alarms. She stated signs have been put in place reminding staff they must physically check every door when alarms go off. LN G stated staff were always expected to check door alarms when they went off.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | On 01/29/25 at 02:23 PM, LN H stated she went with LN J to get R1 and met LN G and CMA R as they were bringing him back. LN H stated she got him some blankets and some hot chocolate in the dining room. She stated she did rounds to check other residents to ensure they were all accounted for. LN H stated R1 looked nervous, felt cold, and was shivering. She stated when she saw him his hands were cold and looked purple. LN H stated that R1 had on a short-sleeved shirt, pants, socks, and shoes. LN H stated R1 appeared to be at his baseline. LN H stated the facility had three types of thermometers, one for oral, one that could be used in the ear, and one to scan a resident ' s forehead. LN H stated LN J used the ear thermometer on R1 and she didn ' t believe it would have been an accurate reading as his skin was a cold. LN H stated R1 was placed on a one-to-one observation after the incident and was unsure when the facility would discontinue it. LN H stated the facility provided elopement education, went over the policy with staff, and provided education on door alarms. LN H stated signs were put up to remind staff not to shut off alarms without checking to see what caused it first.<br><br>On 01/29/25 at 02:45 PM, Administrative Nurse D stated she and Administrative Staff A did the investigation; however, she was the one who typed up the investigation documents that were provided. Administrative Nurse D stated LN I shut off the door alarm from the desk. Administrative Nurse D stated the first door R1 went through to get into the therapy hall was supposed to be secure. She stated it ' s supposed to lock so residents cannot access that area without staff. Administrative Nurse D stated the double doors R1 exited the facility through are used by staff, so it didn ' t alert LN I to check that door when the alarm went off. Administrative Nurse D stated maintenance came in to fix the door R1 was able to get through, but that did not latch properly. Administrative Nurse D stated maintenance normally does monthly checks on the doors; however, since the incident maintenance has been checking them daily, three times per day, each shift, and will continue that for two weeks. She stated if there are no further issues with the doors after two weeks, they will return to monthly checks. Administrative Nurse D stated that R1 may possibly be moved to memory care; however, until that happens, he would remain on one-to-one observation until the two-week door inspections were completed, and no issues were found. Administrative Nurse D stated there were no poor outcomes for R1 after the incident. Administrative Nurse D stated the facility ordered a rectal thermometer in case a situation like this occurred in the future so staff could obtain a more accurate temperature and an ear temperature would not have been as accurate in this situation. Administrative Nurse D stated Administrative Staff A provided immediate education for all staff related to elopement, the policy, and door alarms. Administrative Nurse D stated the few staff that had not completed the education were set to receive it before working their next shift and that the majority of staff had already completed the education.<br><br>On 01/29/25 at 03:13 PM, Maintenance U stated from his understanding, the door R1 went through did not latch properly and that allowed him to get through the door. Maintenance U stated he came in that morning and inspected the door and did not find anything wrong with it; however, he made some adjustments to it. Maintenance U stated he checked the doors three times per day once for each shift and would continue that for two weeks. He stated he had never had any issue with the door prior to this incident. He further stated the facility was working on making changes to the alarm system to prevent staff from being able to turn off alarms at the nurses ' station.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | The facility ' s undated Missing Resident policy documented it is the policy of this facility to protect the safety of our residents through early assessment of their risk for exit-seeking behaviors. Once identified we take steps to mitigate that risk through an individualized care plan and good communication between staff, visitors, and families regarding supervision needs. All residents at risk for elopement will be identified through assessment. All staff members should be aware of those residents at risk for elopement and this procedure. All exit doors are alarmed with audible alerts, in the care of a door alarm sounding, staff will immediately go to the door indicated on the enunciator system and check both inside and outside the door to determine who/why the door alarm sounded. Under no circumstances will a door alarm be deactivated until the source of the activation has been determined.<br><br>On 01/29/25 at 06:04 PM, Administrative Staff A and Administrative Nurse D received the Immediate Jeopardy (IJ) Template and was informed that the facility failed to respond to door alarms in order to prevent cognitively impaired R1 from exiting the facility without staff supervision or knowledge and entering an unsafe location placed R1 in IJ.<br><br>The facility identified and completed the following corrective actions:<br><br>A new elopement risk assessment was completed for the resident on 01/26/25<br><br>The nurse involved received corrective actions for not following elopement procedures and received education on 01/26/25.<br><br>Maintenance assessed and adjusted the door and checked door alarms on 01/26/25.<br><br>Staff education on policy, elopements, and door alarm response was completed on 01/26/25.<br><br>A QAPI meeting related to elopements was completed on 01/27/25.<br><br>Signs posted on door alarm mechanism at each nursing station to ensure all alarms are on and reminder that under no circumstances will an alarm be turned off until the source of the activation has been determined completed by 01/27/25.<br><br>An all-staff in-service completed 01/27/25.<br><br>Reviewed elopement risk posters to ensure all were up to date and completed by 01/27/25.<br><br>The resident ' s care plan was updated to include interventions and monitoring of wandering completed on 01/28/25.<br><br>The surveyor verified the above corrective actions were completed prior to the onsite survey on 01/29/25, therefore the deficient practice was cited as past noncompliance and existed at a scope and severity of J. |