

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175218	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/16/2024
NAME OF PROVIDER OR SUPPLIER Westview of Derby Rehabilitation & Health Care Cen		STREET ADDRESS, CITY, STATE, ZIP CODE 445 N Westview Dr Derby, KS 67037	

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)
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40801</p> <p>The facility reported a census of 65 with three of residents selected for reviewed for accident hazards. Based on observation, interview, and record review, the facility failed to ensure a safe and secure environment to prevent the elopement of cognitively impaired R1, identified at risk for elopement. On 05/07/24 at 09:40 AM a CNA M let R1 out the front doors of the building. CNA M thought R1 had an appointment and was leaving to get on the facility transport vehicle. When R1 went out the doors his WanderGuard caused an alarm to activate, and CNA M did not check which resident caused the alarm. The facility did not know R1 was not in the building until almost 15 minutes later when a staff member driving by the facility saw the resident outside, unsupervised, and notified the facility. Staff found the resident approximately 90 feet from the facility, heading toward a highly trafficked, 4 lane road. These failures placed R1 in immediate jeopardy.</p> <p>Findings included:</p> <ul style="list-style-type: none"> - Review of the resident's Electronic Health Record (EHR) revealed Resident (R)1 had diagnoses which included paraplegia, (paralysis characterized by motor or sensory loss in the lower extremities), cognitive communication deficit (an impairment in organization, sequencing, attention, memory planning, problem-solving, and safety awareness), reduced mobility (difficulty with movement), and chronic pain syndrome (pain that last over three months). <p>Review of R1's Quarterly Minimum Data Set (MDS) dated [DATE], revealed R1 had a Brief Interview for Mental Status score of 10, which indicated moderately impaired cognition. The resident did not wander and had no falls during the look back period. R1 required assistance with bathing, transfers, and dressing.</p> <p>Review of R1's Care Plan dated 05/28/23, with a revision date of 09/13/23, revealed R 1 had an elopement risk, wandered, had attempted to leave the facility, and voiced desire to leave. R1 required frequent monitoring by staff. The care plan stated R1 had impaired cognitive function/dementia or impaired thought process. The care plan further revealed the resident had limited physical mobility and used a wheelchair for locomotion and the resident could go outside with staff supervision only. On 09/23/2023 the care plan informed staff that R1 had attempted to get out of the door in his wheelchair when he sat in front of the door and waited for it to open and occasionally voiced a desire to leave the facility. R1's WanderGuard was replaced on his wheelchair on 02/19/24.</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of the Elopement assessment dated [DATE], identified the resident as cognitively impaired, but not independently mobile.</p> <p>Review of the Nurse's Note dated 05/07/24, revealed at 09:40 AM, Certified Nurse Aide (CNA) M let R1 out the front door (of the facility). At 09:45 AM, Administrative Staff C and Dietary Aide BB reported they saw the resident sitting outside of the front door at a table. At 09:55 AM, an unidentified facility staff member no longer saw the resident sitting at the table. CNA N called the facility and talked to CNA O to let her know the resident was wheeling down the street in front of the facility toward the 4-lane street that runs along the side of the facility. CNA O brought the resident back into the facility.</p> <p>Review of the undated facility Incident and Investigation revealed R1 exited the community and wheeled himself down the sidewalk. A staff member saw him and called another staff member at the facility to go get him. The resident was located at the corner of the facility. The investigation further revealed CNA M let R1 out of the front door of the facility as she thought he was going on the transportation vehicle parked in the front of the building. The investigation verified the resident's WanderGuard sounded when triggered at the door of the facility.</p> <p>Review of the 05/07/24 at 10:00 AM Nurse's Note revealed the facility completed an assessment of the resident with no injuries noted.</p> <p>Observation of the resident on 05/15/24 at 09:00 AM, revealed the resident sat in bed with the head of the bed up and watching TV. No wandering behaviors were observed at that time.</p> <p>Observation of the resident on 05/15/24 at 02:10 PM, revealed the resident continued to lay in bed in his room with no behaviors noted.</p> <p>Observation of the area around the facility where the resident left the facility, unsupervised, revealed the resident mobilized toward a busy 4-lane road with speed limits posted at 30 miles per hour.</p> <p>During an interview with R1 on 05/15/24 at 11:21 AM, the resident stated that when he would get to close to the front door, an alarm would go off. The resident stated he had family that lived in another town and that he planned to move to be closer to family. The resident reported he did not remember the day he left the facility and stated his days run together.</p> <p>During an interview on 05/15/24 at 12:08 PM with CNA O, she reported when the resident was outside of the facility, she was in the shower room with another resident. CNA N called CNA O and reported R1 was on the sidewalk heading toward the 4-lane road on the side of the building. CNA N stated she was on break and was driving so she could not stop to get the resident. CNA O went outside and found R1 about 10 feet away from the crosswalk beside the facility.</p> <p>During an interview on 05/15/24 at 12:17 PM with Administrative Nurse D, revealed her expectation was for the staff to know who the residents were that had a risk for elopement. Administrative Nurse D further expected staff to know which residents had a WanderGuard, the location of the elopement book/policy, and if the alarm went off to look for the resident that caused the alarm to sound.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of the Wunderground.com/accuweather.com report for 05/07/24 at 09:55 AM revealed an outside temperature at the time the resident left the facility and returned to the facility measured 68 degrees Fahrenheit.</p> <p>Review of the 05/23 Elopement Policy revealed it is the policy of the facility that all residents are afforded adequate supervision to provide the safest environment possible. All residents will be assessed for behaviors or conditions that put them at risk for elopement. All residents so identified will have these issues addressed in their individual care plans.</p> <p>The facility failed to ensure a safe and secure environment to prevent the elopement of cognitively impaired R1, identified at risk for elopement, when on 05/07/24 at 09:40 AM, CNA M let R1 out the front doors of the building, unsupervised. The resident remained out of the building without staff knowledge or supervision for approximately 15 minutes and was found headed toward a busy 4-lane road.</p> <p>On 05/15/24 at 03:31 PM, a copy of the immediate jeopardy (IJ) template was provided to Administrative Staff A and Administrative Nurse D and E for the failure to ensure the safety of R1 when he left the facility, unsupervised, and without staff knowledge.</p> <p>The deficient practice was cited as past non-compliance as the facility implemented the following corrective actions beginning on 05/07/24:</p> <ol style="list-style-type: none"> 1. The facility located R1 and brought him back to the building. A skin assessment was performed by the Director of Nursing, with no issues found. A WanderGuard was found in place and functioning at the time of the event. R1's Physician and Durable Power of Attorney were notified of the event. Elopement evaluation completed and care plan reviewed. 2. A headcount of all residents was performed. 3. Community review of all residents at risk for elopement was completed on 05/07/24 by the Director of Nursing and Assistant Director of Nursing. Residents identified as having the potential to be affected were evaluated for elopement risk by the Assistant Director of Nursing. 4. Care plan review of residents identified as having the potential to be affected was completed on 05/07/24 by the Assistant Director of Nursing to verify prevention interventions were in place as indicated. 5. Current associates were re-educated by the Assistant Director of Nursing and/or designee on the community Elopement Policy and the community Elopement Evaluation process on 05/07/24. Associates who had not completed the required education on 05/07/24 were required to complete education prior to working their next scheduled shift. 6. An ADHOC QAPI meeting was completed with the community interdisciplinary team on 05/07/24. 7. The facility Medical Director was notified of elopement on 05/07/24 and further notified of the facility compliance plan. 8. Exit doors were evaluated and noted to be functioning without discrepancy. Front door code changed and communicated to the staff. <p>(continued on next page)</p>		

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