

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175245	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/29/2025
NAME OF PROVIDER OR SUPPLIER Edwardsville Care and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 751 Blake Street Edwardsville, KS 66111	

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** 22686</p> <p>The facility reported a census of 96 residents, with 31 residents assessed at risk for elopement (when a resident leaves the premises or safe area without staff knowledge), and five residents sampled. Based on record review, observation, and interview, the facility failed to ensure staff provided adequate supervision and appropriate interventions to prevent the elopement of cognitively impaired R1, who had poor safety awareness. On 01/23/25 at approximately 04:58 PM, R1 exited the facility, unimpeded and without staff knowledge, and R1 remained out of the facility without staff knowledge for approximately 45 minutes, with outdoor temperatures between 16 and 18 degrees Fahrenheit (F). Local law enforcement located R1 approximately 43 minutes later at 05:45 PM, and returned R1 to the facility. This deficient practice placed R1 in immediate jeopardy at risk for life-threatening physical injury or harm.</p> <p>Findings included:</p> <ul style="list-style-type: none"> - The Electronic Medical Record (EMR) documented R1 was admitted to the facility on [DATE] and had diagnoses of: schizoaffective disorder bipolar type (a mental health condition marked by a mix of symptoms, such as hallucinations, delusions, and mood disorder symptoms, such as depression, and mania), diabetes mellitus without complications (a disorder characterized by the body's inability to metabolize sugar), and dysphagia, oropharyngeal phase (a disorder or impairment on the inability to swallow). <p>The Significant Change Minimum Data Set (MDS) assessment dated [DATE] documented the resident had a Brief Interview for Mental Status (BIMS) score of 12, which indicated intact cognition. The MDS documented R1 had inattention and disorganized thinking, which was continuously present and did not fluctuate. The MDS documented R1 experienced delusions, hallucinations, rejection of care, and episodic wandering for one to three days during the seven-day assessment period. R1 ambulated with the use of a rolling walker.</p> <p>The 12/11/24 Cognitive Loss/Dementia Care Area Assessment (CAA) identified R1 at risk for decreased activity involvement due to refusal to engage in assessments, frequent visual and auditory hallucinations, fluctuating mood cycles, and medication refusals. This same assessment recorded a Care Plan would be developed to address the resident's at-risk status.</p> <p>R1's recent Quarterly Elopement Risk assessment dated [DATE] recorded R1 was not at risk for elopement with a score of zero.</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>R1's Care Plan initiated on 05/04/21, and last reviewed on 12/26/24, recorded R1 as at risk for elopement related to making statements she was leaving or moving. The care plan directed staff to assess for risk of elopement per facility policy, redirect residents from doors, and the placement of a WanderGuard (a bracelet-worn signaling device when a resident nears an exit) located on R1's left wrist. The staff were to check the WanderGuard every shift to ensure function. The facility would replace the resident's WanderGuard every 90 days or as needed.</p> <p>R1's Care Plan recorded she had behaviors such as delusional thinking, paranoia, hallucinations, repetitive movements, pacing, wandering, and others related to R1's diagnoses. The Care Plan directed staff to allow R1 to voice her needs and concerns, provide distraction, as needed, and monitor R1 for possible changes in mental status, agitation, confusion, and restlessness.</p> <p>The Care Plan lacked documentation of any new interventions implemented after R1's elopement on 01/23/25.</p> <p>A Nurses Progress Note dated 01/23/25 at 06:10 PM recorded R1 eloped from the facility to the street, where city police found the resident. The police contacted the facility, brought R1 back to the facility, and staff received R1 at the facility entrance. R1 was assessed with no new skin issues noted.</p> <p>The Nurse Notes lacked any health assessment of the resident such as R1's vital signs, and physical, emotional, and/or cognitive/mental state upon return to the facility after the elopement.</p> <p>The Facility Investigation documented review of video surveillance cameras recorded: On 01/23/25 at 04:58 PM R1 looked at the exit sign at the end of A Hall, pushed the doors open, and exited the door. The investigation also noted Police contacted R1 at 05:27 PM approximately 500 feet from the building, and R1 offered an [NAME] (different name). R1 had a cell phone and where Police saw the facility's address and surmised R1 was a resident of the facility. Law Enforcement returned R1 to the facility at 05:43 PM.</p> <p>The facility report documented R1 wore a black jacket, long pants, gloves, and closed-toed shoes.</p> <p>The facility's investigation lacked witness statements regarding R1's elopement from the facility.</p> <p>According to Weather Underground, (www.wunderground.com), on 01/23/25 at 04:53 PM, the temperature was 18 degrees F, with a west-northwest wind at eight miles per hour (mph). At 05:53 PM the temperature dropped to 16 degrees F and wind speed decreased to 3 mph.</p> <p>The facility investigation documented a detailed explanation of loose wiring caused a power interruption and the door's malfunction. This power source (located externally on the wall above the door), also prevented the alarm from sounding to alert staff of R1's exit. The exit door was not equipped with a WanderGuard (wall unit) alert system.</p> <p>On 01/29/25 at 11:00 AM, R1 slept in a chair, in the facility's common area. At 12:49 PM R1 rested in her room.</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>On 01/29/25 at 12:49 PM, R1 reported she was doing ok, but people kept making her fall. R1 said others try to make her fall flat on her face. R1 stated she goes out but does not smoke anymore. R1 would not respond to any questions about being outside the facility and/or leaving the facility grounds. R1 ended the conversation by stating, I'm done talking to you, I'm not going to repeat myself.</p> <p>On 01/29/25 at 03:00 PM, Administrative Nurse D acknowledged R1 had a noninjury fall on 01/21/25, was assessed, and doing ok. Administrative Nurse D acknowledged that R1 had poor safety awareness.</p> <p>On 01/29/25 at 03:00 PM, Administrative Staff A stated the facility WanderGuards (wall unit) were located on the two front doors and a back door, but not the door R1 exited the building from. Administrative Staff A stated the doors were checked daily for function, but maintenance failed to routinely check the wiring and/or power source at the door. Administrative Staff A did not know why the resident was not seen exiting due to the door's location being within sight of the nurse station.</p> <p>A review of the facility's F689 Accidents -Elopement policy revised August 2024 recorded a definition of elopement as follows: A situation in which a resident leaves the premises or a safe area without the facility's knowledge or supervision if necessary and this situation represents a risk to the resident's health and safety and places the resident at risk of heat or cold exposure, dehydration and/or other medical complications, drowning or being struck by a motor vehicle. The policy recorded all residents would be assessed for elopement risk status and at-risk residents, would be care planned with interventions to address wandering and/or exit-seeking behaviors. This policy noted that at-risk residents would be monitored by staff supervision. This policy further recorded a resident with decision-making capacity, leaving the facility intentionally is considered an elopement if the facility is unaware of the resident's departure and/or whereabouts. The policy further recorded that new wandering behavior or attempted elopement would be documented in the nurses' notes and the resident's care plan would be updated to include increased monitoring.</p> <p>The facility failed to provide adequate supervision and appropriate interventions to prevent R1, who was diagnosed with psychiatric illness and identified, as at risk for elopement, from exiting the facility without staff awareness. For approximately 45 minutes facility staff did not know R1 was missing in freezing weather until law enforcement returned R1 to the facility. This deficient practice placed R1 in immediate jeopardy for potentially life-threatening injury.</p> <p>On 01/29/25 at 03:21 PM, Administrative Staff A was provided a copy of the Immediate Jeopardy Template and informed of the facility's failure to provide adequate supervision and appropriate interventions to prevent R1 from elopement, placed R1 in immediate jeopardy.</p> <p>The facility completed the following corrective actions to remove the immediacy for R1:</p> <p>Staff conducted a headcount ensuring the safety of all residents in the facility.</p> <p>Camera footage was reviewed, identified the malfunction, and effected immediate repairs on the faulty exit door.</p> <p>Audited all doors and windows to ensure no similar situations existed. Reported the issue to the stated agency, physician et al.</p> <p>(continued on next page)</p>		

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