STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175291	A. Building B. Wing	06/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Azria Health Great Bend	1560 K 96 Hwy Great Bend, KS 67530

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** 43204 The facility identified a census of 58 residents with three residents reviewed for elopement and wandering. Based on record review, observation, and interview, the facility failed to ensure staff provided adequate supervision to prevent cognitively impaired Resident (R)1 from exiting the facility without staff knowledge and supervision. On 06/13/24 at approximately 07:55 AM R1, who was at risk for elopement, propelled his wheelchair from the dining room to the smoker's room on the south hall. R1 went into the smoker's room and said that it was his home. Housekeeping Staff U removed R1 from the smoker's room and told Certified Nurse Aide (CNA) N what R1 was doing. R1 reentered the smoker's room and CNA N went in and tried to convince R1 to leave but R1 again stated it was his home. Since R1 was not attempting to exit, CNA N left him to go answer call lights. Both CNA N and CNA M began assisting other residents. At 08:20 AM, Administrative Staff A entered the parking lot and headed to the door of the facility. She heard someone say, Good Morning. When she looked back to the east, she saw R1 in the parking lot, sitting in his wheelchair. Administrative Staff A approached R1 and asked what he was doing outside, and he said, I am going home to see my wife and brother. Administrative Staff A called Administrative Nurse D and she came to assist R1 back into the facility. The investigation revealed the door alarm to the smoker's room sounded, but staff could not hear it. The facility's failure to provide adequate supervision to prevent R1 from eloping placed R1 in immediate jeopardy. Findings included: - R1's Electronic Medical Record (EMR) documented diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), muscle weakness, history of falling, difficulty in walking, and hypertension (high blood pressure). The Quarterly Minimum Data Set (MDS), dated [DATE], documented R1 had a Brief Interview for Mental Status (BIMS) score of seven which indicated severe cognitive impairment. The MDS documented R1 used a wheelchair for locomotion and required moderate to maximum assistance from one staff for toileting, dressing, bed mobility, and bathing. R1 was able to use his wheelchair to move from one place to another without assistance. The MDS documented R1 had no behaviors. The Functional Abilities Care Area Assessment (CAA), dated 11/29/23, documented R1 required assistance with bed mobility, transfers, dressing, bathing, and personal hygiene tasks. The CAA documented R1 was able to eat independently with set-up assistance as needed. The CAA documented R1 was able to self-propel independently for short distances. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175291	A. Building B. Wing	06/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Azria Health Great Bend	1560 K 96 Hwy Great Bend, KS 67530

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	The Fall CAA, dated 11/29/23, documented R1 was at risk for falls due to generalized weakness, unsteadiness, decreased safety awareness, and actual falls. R1's Care Plan documented R1 was an elopement risk/wanderer, and his safety would be maintained (06/11/24). R1's information was added to the elopement risk binder. The care plan directed staff to identify a pattern of wandering and intervene as appropriate and provide R1 with structured activities like toileting, walking inside and outside, and reorientation strategies. The care plan directed staff when R1 wanted to go home or stated that he needed to go home, to use redirection and remove R1 away from the door. The Elopement Risk Evaluation, dated 06/10/24, documented R1 had a score of three which indicated R1 was at risk for elopement. The Fall Risk Evaluation, dated 06/10/24, documented R1 had a score of twenty which indicated he was at risk for falls. The Facility Incident Report, dated 06/13/24, documented at approximately 07:55 AM on 06/13/24, R1 was seen in the facility's smoking room by CNA N. CNA N stated R1 was not exit seeking so she left him in the smoking room and went to answer call lights. At 08:20 AM, Administrative Staff A observed R1 sitting in the parking lot in his wheelchair. R1 told Administrative Staff D he was waiting for his family. R1 was easily redirected. R1 had on a sweatshirt, pants, socks, and shoes. The temperature outside was 71 degrees, sunny, with a light breeze. R1 was taken back into the facility and a head count of all residents was performed. A head-to-toe assessment of R1 revealed no injuries. R1 went outside through the smoke room door. The door alarm was alarming, but the staff did not respond to the door alarm because they could not hear the alarm where they were. Staff were in residents' rooms and two CNAs were in the dining room. Interventions included R1 was one-to-one with staff until it was determined he was not exiting seeking. All the door alarms were checked and functioning properly. Education was performed with all staff to respond to door alarms. Maintenance is looking for ways the smoking-room door alarm can be made louder. CNA M's Witness Statement, dated 06/13/24, documented CNA M had just finished giving another resident a shower and walked the resident out of the shower room and to their room. CNA M saw R1 heading from the dining room onto the south hall at 07:50 AM. Housekeeping Staff U's Witness Statement, dated 06/13/24, documented at around 07:55 AM Housekeeping Staff U saw R1 in the smoke room. R1 stated he was going home. Housekeeping Staff U removed R1 from the smoke room and R1 said the smoke room was his home. A couple of minutes later, R1 went back into the smoke room and Housekeeping Staff U notified CNA N of R1's location. CNA N's Witness Statement, dated 06/13/24, was documented at around 07:55 AM Housekeeping Staff U informed CNA N R1 was in the smoke room, and she attempted to keep R1 out of the room, but he had gone in again stating the room was his home. CNA N attempted to remove R1 from the smoke room but R1 refused to come out. R1 was just sitting in the room and not attempting to leave. CNA N stated she made sure R1 was just sitting there and left to go answer call lights. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175291	A. Building B. Wing	06/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Azria Health Great Bend	1560 K 96 Hwy Great Bend, KS 67530

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	Administrative Staff A's Witness Statement, dated 06/13/24, documented she pulled into the facility parking lot around 08:20 AM. Administrative Staff A stated she walked to the front door of the facility when she heard someone say, Good morning. Administrative Staff A looked to her right and saw R1 sitting in his wheelchair in the middle of the parking lot. Administrative Staff A asked R1 where he was going and R1 said to see his wife and his brother. Administrative Staff A asked R1 how he got outside and R1 said the back door. Administrative Staff A called Administrative Nurse D at 08:23 AM and informed her of the situation. Administrative Staff A then moved R1 out of the parking lot and onto the sidewalk. Administrative Nurse D arrived to assist R1 back into the facility. On 06/17/24 at 09:15 AM, observation revealed a sidewalk leading out to the parking lot which was full of cars. There was multiple car-stops. The pavement in the parking lot had cracks and weeds growing up in the cracks. On 06/17/24 at 09:30 AM, observation revealed R1 sat up in his bed drinking water. R1 was very pleasant and friendly. R1 was not oriented to time or place. A CNA sat outside of R1's room providing one-on-one supervision. On 06/17/24 at 09:15 AM, CNA O stated R1 could not walk and used a wheelchair for locomotion but R1 had poor safety awareness and had falls where he had tried to stand up and walk. On 06/17/24 at 10:30 AM, CNA M stated she was working the day R1 eloped, and she did not hear the door alarm sound when she was in another resident's room. CNA M stated she thought R1 would be safe in the smoke room, or she would not have left him there. On 06/17/24 at 11:30 AM, Administrative Nurse D stated when she was outside with R1 she could hear the alarm sounding outside, but as soon as she came into the building, the alarm was not sounding at the alarm panel to alert staff. Maintenance fixed the alarm so it was sounding at the alarm panel and staff could hear the alarm throughout the building. Administrative Nurse D stated she expected all staff to respond to door alarms and provided education to all the staff regarding elopements and conducted elopement drills twice a day to ensure everyone knew what to do. The facility Wandering and Elopement Policy, dated 07/01/24, documented the purpose of the policy is to provide a system of identification of residents at risk for unsafe wandering and elopement, provide a program of supervision and interventions to minimize the risk of resident elopements, improve resident safety through timely investigations of elopements and elopement attempts, and provide staff education in effective wandering/elopement management through in-services and elopement drills. On 06/17/24 at 01:06 PM Administrative Staff A received a copy of the Immediate Jeopardy [IJ] Template and was informed that the facility's failure to provide adequate supervision to prevent R1 from eloping placed R1 in immediate jeopardy. The facility identified and implemented immediate corrective actions, which were completed on 06/13/24 and included: All nursing staff were re-educated on wandering/elopement. R1 is one-on-one with staff until it is determined he is not exiting seeking. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175291	A. Building B. Wing	06/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Azria Health Great Bend	1560 K 96 Hwy Great Bend, KS 67530

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	Maintenance fixed the smoke room door alarm, so it would alarm not only in the room and outside but at the alarm panel to alert staff. Maintenance staff and the manager on duty on the weekends are checking all door alarms twice a day. Care plans of residents at risk for elopement were reviewed and new elopement risk evaluations were completed on all residents. Due to the corrective action completed before the onsite survey, the citation was deemed past noncompliance at a J scope and severity.