STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175323	A. Building B. Wing	07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Anew Healthcare	412 E Walnut St Nortonville, KS 66060

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 - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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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(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 - Minimal harm or potential for actual harm Residents Affected - Few	The facility identified a census of 33 residents. The sample included three residents. Based on observation, record review, and interview, the facility failed to provide adequate supervision to prevent an elopement for Resident (R) 1, who was independently mobile, at risk for falls, and had impaired cognition. On 07/28/25 at approximately 06:45 AM, Certified Nurse Aide (CNA) N let R1 out of the facility doors after R1 had requested to go outside. Staff reported they were unable to locate R1 in the facility and began searching for him at approximately 08:20 AM. Consultant HH thought R1 may have tried to return to his apartment at the Assisted Living (AL), across the street, and went to look for him. R1 was found in his electric wheelchair, sitting under a gazebo, in front of his previous apartment building. R1 drove his electric wheelchair several blocks down the road, into the surrounding neighborhood, after he was asked to return to the facility by staff. Staff followed R1 and got him to return to the facility. The facility's documentation recorded R1 was let out of the facility at approximately 6:45 AM and was returned to the facility at approximately 08:50 AM. This deficient practice placed R1 at risk for avoidable injuries.Findings Included:- 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), hemiplegia affecting right dominant side (paralysis of one side of the body), chronic obstructive pulmonary disease (COPD- progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), respiratory failure (inadequate gas exchange by the respiratory system resulting in not enough oxygen or too much carbon dioxide in your body), need for assistance with personal care, and unsteadiness of feet. R1's Entry Minimum Data Set (MDS) dated 07/19/25 documented when R1 was admitted to the facility. R1's admission MDS dated 07/25/25, had a status of in progress. An Assessment Outcomes document with a description of Brief Interview for Mental Status (BIMS) dated 07/22/25, documented R1 had a BIMS score of seven, which indicated severe cognitive impairment.R1's Care Plan with an initiated date of 09/22/19, documented R1 was at risk for falls. R1's Care Plan with an initiated date of 07/19/25, documented R1 had an altered respiratory status or difficulty breathing related to respiratory failure. An intervention, with an initiated date of 07/19/25, directed staff to monitor for signs and symptoms of respiratory distress and monitor, document, and report abnormal breath patterns. R1's Care Plan with an initiated date of 09/22/29 documented R1 had limited physical mobility related to stroke with right-sided hemiplegia.R1's Care Plan lacked evidence of elopement concerns or interventions prior to 07/28/25.R1's EMR under the Assessment tab recorded two Elopement Evaluation assessments, both dated 07/28/25. One elopement assessment was listed as type admission with a score of seven, and one was listed as type other with a score of four.An Elopement Risk Screen dated 07/28/25 at 09:16 AM, and a score of seven, recorded R1 had a history of elopement while at home, and a history of elopement or attempted leaving the facility without informing staff. The assessment further recorded R1 had verbally expressed the desire to go home, exhibited wandering behavior, and the wandering was a pattern or goal directed. The assessment further recorded R1's wandering behavior was likely to affect the safety or well-being of himself or others. R1 had been recently admitted and was not accepting the situation.An Elopement Risk Screen dated 07/28/25 at 11:29 AM documented a score of four, and R1 did not have a history of elopement or attempted elopement while at home. The assessment recorded R1 had a history of elopement or attempted leaving the facility without informing staff. The assessment further recorded R1 had verbally expressed the desire to go home and had wandering behavior. The assessment recorded R1's wandering behavior was not a pattern and not goal directed. The assessment recorded R1's wandering behavior was not likely to affect the safety of himself or others. The assessment recorded R1 had been recently admitted and was not accepting the situation.R1's EMR lacked evidence of other elopement evaluation assessments completed prior to 07/28/25. An Assessment Outcomes dated 07/21/25 document with a description of Fall Risk Evaluation recorded R1 had a fall score of 20 and was at risk for falls.A Fall Risk Evaluation dated 07/21/25, documented R1 had three or more falls in the past three months, had a change in condition in the last 14 days, and had a recent hospitalization in the last 30 days.The untitled and undated investigation documents, provided by the facility, recorded R1 had been in the facility for nine days, and R1 had left the facility to go across the street to the AL where he came from. The documents recorded the root cause as R1 wanted to return to his apartment. The documents recorded CNA N as the staff member involved in the incident. The documents recorded, under the conclusion section, the incident was substantiated, the facility did not follow policies and