

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  175334	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/28/2024
NAME OF PROVIDER OR SUPPLIER  Good Samaritan Society - Liberal		STREET ADDRESS, CITY, STATE, ZIP CODE  2160 Zinnia Lane Liberal, KS 67901	

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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41121</b></p> <p>The facility reported a census of 40 residents, with four residents sampled, including three residents reviewed for risk of elopement (an incident in which a cognitively impaired resident with poor or impaired decision-making ability/safety awareness leaves the facility without the knowledge of staff). Based on observation, record review, and interview, the facility failed to provide adequate supervision and a safe environment, as free of accident hazards as possible, to prevent the elopement of cognitively impaired and independently mobile Resident (R)2. The facility staff knew R2 was an elopement risk and R2 had been upset and voiced she wanted to go home. The facility staff then left R 2 unsupervised near the front entrance. The facility staff had knowledge the front doors had malfunctioned and did not require a code to be entered to open the door, however, reported the WanderGuard (bracelet that sets off an alarm when residents wearing one attempt to exit the building without an escort) still functioned. On 03/19/24 at 07:10 PM, R2 exited the facility via the front doors without staff awareness and the WanderGuard system failed to alarm. Facility staff did not know R2 eloped until a neighbor brought her to the front entrance at 07:24 PM, fourteen minutes later. This deficient practice placed R2 in immediate jeopardy.</p> <p>Findings included:</p> <ul style="list-style-type: none"> <li>- The Medical Diagnosis tab in the electronic medical record (EMR) for R2 included diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), altered mental status, restlessness and agitation, and dementia (progressive mental disorder characterized by failing memory, confusion).</li> </ul> <p>The Quarterly Minimum Data Set (MDS) dated [DATE], assessed R2 with a short-term and long-term memory loss and impaired decision making.</p> <p>The Significant Change MDS dated [DATE] assessed R2 with a Brief Interview of Mental Status (BIMS) score of zero, indicating severe cognitive impairment. R2 used a wheelchair for mobility.</p> <p>The Cognitive Loss/Dementia Care Area assessment dated [DATE] revealed R2 had a diagnosis of Alzheimer's disease and required staff to give one command at a time, cue to task at hand, speak in simple direct sentences, and repeat as needed.</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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  175334	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/28/2024
NAME OF PROVIDER OR SUPPLIER  Good Samaritan Society - Liberal		STREET ADDRESS, CITY, STATE, ZIP CODE  2160 Zinnia Lane Liberal, KS 67901	
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>The Care Plan dated 03/07/24, revealed R2 was at risk for elopement related to increased wandering and a WanderGuard used to alert staff to movement when close to the exit doors. The staff were to check the WanderGuard daily to ensure it was in place. The care plan indicated R2 had a behavior symptom related to her dementia as evidenced by wandering. Staff were to minimize R2's potential for wandering behaviors by offering toileting, snacks, and interaction which may divert attention or prevent wandering behavior.</p> <p>The Elopement Risk assessment dated [DATE] assessed R2 as an elopement risk.</p> <p>The Physician Order tab included an order dated 04/14/22 for R2 to have a WanderGuard in place and to check for placement every day.</p> <p>The Work History Report dated 12/02/23 through 03/31/24 revealed the magnetic exit locks, doors, locks, and gates (elopement) testing and inspection (receivers) task completed by Maintenance Staff U on 03/13/24. The report lacked an area to document if there were any issues.</p> <p>The Progress Note dated 03/19/24 at 07:38 PM, revealed R2 had been hanging around the front lobby and crying, demanding that she goes home. R2 was able to get out of the front door because of the broken lock, and a visitor brought her back into the building.</p> <p>The Progress Note dated 03/20/24 at 01:22 AM, revealed R2 eloped from the building during shift change, the door lock was broke, and entry/exit was possible with no staff mediation. R2 had been crying in the lobby area demanding she go home. The WanderGuard system did not sound, however, R2 had a WanderGuard in place and returned to the facility uninjured, accompanied by a person from a nearby residence. R2 had told the neighbor she was from the facility. R2 was in her wheelchair with her orthopedic boot (device used to protect broken bones and other injuries of the lower leg, ankle, or foot) on her right lower extremity. Licensed Nurse (LN) G assessed R2 for injuries and R2 returned to her room.</p> <p>The Progress Note dated 03/20/24 at 10:39 AM revealed R2 eloped at approximately 07:10 PM last evening.</p> <p>On 03/27/24 at 01:37 PM, observation of the area R2 traversed after she exited the facility revealed a sidewalk in front of the facility that went around to the south side, an area of the sidewalk on the south side had an uneven surface approximately two inches all the way across, and an area of dirt/grass around a tree for approximately 25 feet from the facility sidewalk before reaching a paved area in front of the neighbor's residence. R2 traveled approximately 140 feet from the front entrance to the neighbor's residence without staff knowledge.</p> <p>On 03/27/24 at 01:44 PM, observation revealed R2 resting in her bed with a WanderGuard bracelet in place to her left ankle.</p> <p>On 03/27/24 at 01:45 PM, when R2 asked if she had gone outside after supper last week, she stated no it was cold, cold, cold.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  175334	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/28/2024
NAME OF PROVIDER OR SUPPLIER  Good Samaritan Society - Liberal		STREET ADDRESS, CITY, STATE, ZIP CODE  2160 Zinnia Lane Liberal, KS 67901	
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>On 03/27/24 at 01:29 PM, Maintenance Staff U stated he checked the doors every week or two, whenever it came due in the electronic system, and did not recall any door malfunctions with his last door check completed prior to R2's elopement on 03/19/24. Maintenance Staff U stated he checks each WanderGuard used, weekly. Maintenance Staff U stated the WanderGuard system works fine and when checked the day after the elopement, the system was fine and so was R2's WanderGuard device.</p> <p>On 03/27/24 at 02:00 PM, Certified Medication Aide (CMA) R stated on 03/19/24 she worked 04:00 PM to 10:00 PM and R2 had been upset all day, had been asking staff to take her out, and she last saw R2 around 06:20 PM or 06:30 PM and R2 was crying. CMA R stated she provided R2 reassurance and that was the last time she had seen R2. CMA R stated there was a meeting at 07:00 PM for CMAs and Certified Nurse Aides (CNA) on 03/19/24, which she said she was approximately 10 minutes late getting to, and she never heard an alarm sound around the time R2 eloped.</p> <p>On 03/27/24 at 02:53 PM, CNA M stated she was on duty on 03/19/24 when R2 eloped. CNA M last saw R2 around 06:50 PM to 07:00 PM at the nurse's station talking to LN G and the resident was crying and saying she wanted to go home. CNA M stated R2 started crying after supper, and she observed her starting to walk and reminded she was not supposed to be up walking and needed to sit down (due to recent foot surgery). CNA M stated at one-point R2 was just past the fishpond headed to the front door and she moved R2. R2 had tried to call a friend or family and when they did not answer, it made R2 cry more and she kept saying she wanted to go home. CNA M stated after assisting other residents to lay down, she and CNA N sat in a chair at the fishpond area to chart and a guy had entered the facility and had R2 outside. They brought R2 inside and took to her to the nurse's station.</p> <p>On 03/27/24 at 03:07 PM, CNA N stated she was on duty on 03/19/24 when R2 eloped. CNA N stated R2 had been upset off and on and was talking about going home. CNA N stated she attempted to keep an eye on her and around 07:00 PM, she observed R2 in the hallway and entering her room. CNA N assisted another resident, then helped another staff member with cares, and did not have a chance to see if R2 was still in her room. CNA N stated after that she was in the fishpond area and a young man came in the facility and appeared to be looking for someone, she stood up to hear him better and observed R2 outside with the young man's mother, who said R2 told them she came from here. CNA N stated she brought R2 inside and then to the nurse and informed the nurse of the elopement. CNA N stated she did not hear the WanderGuard system sound when R2 eloped, which was usually a loud sound able to be heard down the hall when in a room. CNA N stated she knew the door was not locking and did not require a code to open since the previous week and as far as she knew it had been fixed.</p> <p>On 03/27/24 at 03:18 PM, Maintenance Staff V stated the magnetic lock was shut off to the door because the circuit board in the keypad was bad, which did not affect the Wanderguard system as it required to be shut off with a switch at a different location.</p> <p>On 03/27/24 at 03:50 PM, Administrative Nurse D stated she expected the staff to do one-to-one with R2 when she was upset that evening, on 03/19/24, and saying she wanted to go home.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  175334	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/28/2024
NAME OF PROVIDER OR SUPPLIER  Good Samaritan Society - Liberal		STREET ADDRESS, CITY, STATE, ZIP CODE  2160 Zinnia Lane Liberal, KS 67901	
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>On 03/27/24 at 04:07 PM, LN G stated from the time she arrived for duty on 03/19/24 at 06:00 PM until she went to obtain vital signs at 07:00 PM, R2 was sitting in the nurse's office door. R2 was crying, wanted to call her aunt who did not answer and that caused R2 to start cussing and demanding to be taken home. LN G stated she told R2 this was where she lived, asked her to calm down, and said she could go to her room. LN G stated another CNA (she could not recall which CNA) moved R2 to the fishpond area to see if she would calm down and that was when LN G went down the hall to obtain vital signs. LN G stated around 07:20 PM, she came back to the nurse's desk to document the vital signs and did not know R2 was gone. LN G stated CNA N informed her a man brought R2 back to the facility from his house. LN G stated she assessed R2 for injuries in her room and tried to get her interested in the television. LN G stated she did not hear the WanderGuard system alarm and stated at the time the magnetic locks were broken; however, the WanderGuard system had been functioning because the day before R4 tried to get out and it sounded. LN G stated R2's WanderGuard was in place to her ankle and R2 did not verbalize wanting to go home after she returned to the facility. LN G stated there were not any extra WanderGuards to replace R2's, so she locked the exterior door so nobody could go in or out without her unlocking it. LN G stated the door had been malfunctioning and it allowed anyone to go in or out without entering a code on the keypad.</p> <p>On 03/27/24 at 04:44 PM, observation revealed R2 propelled her wheelchair independently using her left leg. Her right leg had an orthopedic boot in place and her foot rested on the pedal of the wheelchair.</p> <p>On 03/27/24 at 04:45 PM, Administrative Nurse D moved R2 up to the front door, informed R2 there would be a loud noise, and opened the door. When the WanderGuard system sounded, R2 placed her hand up to her ears.</p> <p>On 03/28/24 at 08:42 AM, Maintenance Staff U stated when he checked the WanderGuard devices on 03/13/24, all of the devices worked.</p> <p>On 03/28/24 at 09:25 AM, observation of the facility video footage (lacked audio) dated 03/19/24 at 07:09 PM, revealed R2 propelled herself in the wheelchair from the hall she resided on and went to the front door using both hands to push the door open, and she exited the facility at 07:10 PM. R2 did not cover her ears when she left the facility. There was no further activity at the front door until 07:24 PM, when a male opened the door and came inside and looked around and at 07:25 PM, he exited the door with two staff behind him. One of the staff, CNA N, observed punching a code on the keypad on the exterior prior to exiting.</p> <p>On 03/28/24 at 09:40 AM, Administrative Staff A stated on the video footage from another camera, she could see R2 standing up and pushing her wheelchair to the neighbor's house.</p> <p>The facility policy Elopement dated 07/11/23 revealed measures would be put into place to minimize risk of elopement that were individualized to resident needs and identified on the care plan.</p> <p>The facility failed to provide adequate supervision and a safe environment to cognitively impaired R2, identified as an elopement risk, who was upset and voiced wanting to go home, and eloped from the facility in her wheelchair on 03/19/24 at 07:10 PM for 14 minutes, without staff knowledge.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  175334	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/28/2024
NAME OF PROVIDER OR SUPPLIER  Good Samaritan Society - Liberal		STREET ADDRESS, CITY, STATE, ZIP CODE  2160 Zinnia Lane Liberal, KS 67901	
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>On 03/28/24 at 01:10 PM, Administrative Staff A was provided the Immediate Jeopardy template and notified of the facility's failure to provide adequate supervision when R2 was upset and voiced wanting to go home and eloped from the facility on 03/19/24 at 07:10 PM.</p> <p>The immediate jeopardy was determined to first exist on 03/19/24 at 07:09 PM, and the surveyor verified the facility identified and implemented corrective actions completed on 03/20/24 at 08:30 PM, when the facility completed the following:</p> <ol style="list-style-type: none"> <li>1. The facility locked the front door and checked R2's WanderGuard for functioning and sounding the alarm properly on 03/19/24 at 07:30 PM.</li> <li>2. Nursing conducted a full assessment of R2 on 03/19/24 at 07:35 PM.</li> <li>3. Maintenance checked R2's WanderGuard receiver and tested okay along with checking with resident at front door sounding the WanderGuard system on 03/20/24 at 09:00 AM.</li> <li>4. Nursing completed elopement risk assessments on all residents, checked all care plans of residents at risk for elopement to ensure interventions in place for exit-seeking symptoms, and updated the Treatment Administration Record to check twice daily to ensure the WanderGuard is in place on 03/20/24 at 10:00 AM.</li> <li>5. The Director of Nursing conducted the Preventing Elopement Focus Audit on 03/20/24 at 11:00 AM.</li> <li>6. Maintenance contacted technician to reset the magnetic lock keypads on 03/20/24 at 12:00 PM.</li> <li>7. The facility had a Quality Assurance Performance Improvement meeting on 03/20/24 at 01:00 PM.</li> <li>8. Maintenance replaced circuit board so the magnetic lock would automatically lock and open with a keypad on 03/20/24 at 08:00 PM.</li> <li>9. The facility staff were educated to make a radio communication when a resident was exit seeking and make sure resident was comfortable, needs met, diversional activities offered, and kept in view during this time on 03/20/24 at 08:30 PM.</li> </ol> <p>Due to the corrective actions implemented prior to the onsite visit, the deficient practice was deemed past non-compliance and existed at a J scope and severity.</p>		