

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175359	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/16/2024
NAME OF PROVIDER OR SUPPLIER Good Samaritan Society - Valley Vista		STREET ADDRESS, CITY, STATE, ZIP CODE 2011 Grandview Drive Wamego, KS 66547	

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** 43204</p> <p>The facility identified a census of 39 residents with three residents reviewed for elopement. Based on record review, observation, and interview, the facility failed to ensure staff provided adequate supervision to cognitively impaired Resident (R) 1, who had a history of wandering and elopement, to prevent R1 from exiting the facility unsupervised through an unlocked kitchen area and door. On 05/04/24 at approximately 05:58 PM R1 sat in the dining room finishing his supper. The only Certified Nurse Aide (CNA) in the dining room assisted another resident out of the dining room. R1 then got up from his table and, with his walker, walked to the dishwasher room. R1 attempted to open the door but it was locked. R1 left his walker at that doorway and walked back towards the front of the dining room. R1 walked to the next doorway, which was open and permitted R1 to enter the kitchen. R1 walked through the facility kitchen and went out the back door of the kitchen at 06:02 PM. The regular alarm sounded and Licensed Nurse (LN) G checked the alarm system that was going off. The alarm system indicated the interior kitchen door and another outside door by the dietary manager's office were triggered. LN G looked towards the dining room and Dietary Staff BB, who was coming down the hall, stated the cook went out for a break and must have set off the alarm. LN G shut off the alarm. Dietary Staff BB walked outside four minutes later and discovered R1 outside by the dumpsters. Dietary Staff BB asked R1 he was doing and R1 said, Enjoying the weather. R1 was eating ice cream at the time. CNA M came outside with the trash and both aides redirected R1 back into the facility without incident. R1 was outside on the property unattended for 4 minutes. The facility failed to ensure R1 received adequate supervision to prevent him from entering the kitchen unattended and exiting the facility unsupervised and unbeknownst to staff. This failure placed R1 in immediate jeopardy.</p> <p>Findings included:</p> <p>- R1's Electronic Medical Record (EMR) documented R1 had diagnoses of cognitive communication deficit, weakness, disorientation, a history of falls, and difficulty walking.</p> <p>The Quarterly Minimum Data Set (MDS), dated [DATE], documented R1 had a Brief Interview for Mental Status (BIMS) score of five, which indicated severe cognitive impairment. The MDS documented R1 required moderate assistance from staff for toileting hygiene, bathing, and lower body dressing. The MDS documented R1 required supervision for ambulation. The MDS documented R1 had a history of delusions and wandering. The MDS documented R1 had two or more non-injury falls and one fall with a minor injury during the observation period.</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>The Cognitive Loss/Dementia Care Area Assessment (CAA), dated 11/17/23, documented R1 had increased confusion and disorientation.</p> <p>The Functional Abilities CAA, dated 11/17/23, documented R1 was independent with most of his activities of daily living (ADL) with general oversight and limited assistance with bathing. The CAA documented R1 was able to move about the facility independently with a front-wheeled walker.</p> <p>The Behavioral Symptoms CAA, dated 11/17/23, documented R1 had a history of wandering and had attempted to exit the building without assistance. The CAA documented R1 utilized a WanderGuard (a bracelet that helps monitor residents who are at risk of wandering) that alerted staff with a separate alarm when opening an exit door.</p> <p>R1's Care Plan documented R1 would not leave the facility unattended (01/05/24). Staff were directed to offer to take R1 for walks outdoors if weather permitted (12/06/23). Staff were directed to ensure R1's WanderGuard was in place and functioning properly (01/26/24). R1's family would be educated to use the sign-in/sign-out sheet at the nurse's station (01/23/23). Staff were directed to ensure exit door alarms were in working order (01/23/23).</p> <p>R1's Elopement Risk Assessment, dated 04/10/24, documented R1 as at risk for elopement. The assessment documented R1 had a history of leaving the building, a history of wandering, increased confusion, and forgetfulness, had wandered in the last 60 days, had elopement attempts in the past, had packed his belongings in the past, had repeatedly opened doors/set off secure door alarms, verbalized statements about leaving, and wandered with no rational purpose and attempted to open doors.</p> <p>The Mood/Behavior Note, dated 03/27/24 documented R1 continually wandered around his room and into the hallway without his walker. The staff had to continually remind R1 to use his walker, however R1 was unable to remember sixty seconds after being reminded. R1 did not feel like he lived here and wanted to go home.</p> <p>The Mood/Behavior Note, dated 04/10/24, documented R1 had increased agitation due to his belief that another female resident was his wife. R1 attempted to go into the female resident's room at which time the female resident told R1 to get out. Staff stepped in, closed the door, and tried to redirect R1. R1 became angry and stated he was going to hit someone if they did not let him be.</p> <p>The Mood/Behavior Note, dated 04/24/24, documented R1 was showing an increased risk for elopement. R1 had been going to exits and stated he wanted to find his car. R1 was opening and closing doors in the facility looking for an exit. R1 stood at one exit, and he read, door will open in 15 seconds then asked the nurse if they should go for it. The staff redirected R1 to his room to watch a movie. R1 sat in his recliner with his eyes closed.</p> <p>The Communication with Physician Note, dated 05/04/24 documented staff informed LN I and LN G that R1 was found outside by the dumpster. Upon arriving on scene, R1 was with CNA M and Dietary Staff BB. The staff assisted R1 back into the facility by wheelchair and obtained R1's vital signs. The staff completed R1's skin assessment with no skin abnormalities noted. The staff notified R1's primary care physician and responsible person of the situation. The staff notified maintenance staff of the WanderGuard system not activating and had staff watch the door until fixed.</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>The undated Facility Incident Report revealed on 05/04/24 at approximately 05:58 PM R1 sat in the dining room finishing his supper. There was one aide in the dining room at the assisted table. The aide got up and assisted another resident out of the dining room. R1 then got up from his table with his walker and walked to the dishwasher room. The door was closed. R1 attempted to open the door but it was keypad locked. R1 left his walker at the doorway turned around and walked back towards the front of the dining room. R1 walked to the next doorway and found entry into the kitchen. The kitchen door was open (if closed would have required a keypad lock). R1 walked through the kitchen and went out the back door of the kitchen at 06:02 PM. The regular alarm sounded (that door did not have a WanderGuard alarm). LN G was seen checking the alarm system that was going off. The alarm system indicated the interior kitchen door and another outside door by the dietary manager's office. LN G looked towards the dining room and Dietary Staff BB came up the hall and stated the cook was in her car and must have set off the alarm when going out for a break. LN G shut off the alarm. Dietary Staff BB walked outside four minutes later and discovered R1 outside by the dumpsters. Dietary Staff BB asked what R1 was doing and R1 said, Enjoying the weather. CNA M went outside with the trash and both aides redirected R1 back into the facility without incident. R1 was outside on the property unattended for four minutes. LN G escorted R1 to his room, vitals were taken and were within normal limits, and a skin assessment was completed (no abnormalities found).</p> <p>CNA M's Witness Statement, dated 05/04/24, documented CNA M was taking out the trash and saw R1, called R1's name, and went to R1. CNA M called LN G to inform her of what happened.</p> <p>Dietary Staff BB's Witness Statement, dated 05/04/24, documented Dietary Staff BB saw LN H turn off the alarm as he was walking by. Dietary Staff BB went out back to let the cook know about another resident and saw R1 outside without his walker. Dietary Staff BB asked R1 what he was doing out there and R1 said, Just enjoying the weather. CNA M came out with the trash and the staff called both nurses, who came out and redirected R1 back into the facility.</p> <p>LN G's Witness Statement, dated 05/04/24, documented CNA M called her personal cell phone and informed LN G R1 was outside of the building by the dumpster trash can. R1 was fully clothed and had on a jacket and a ball cap. R1 had on his shoes. The sky was clear, still daylight, and the air was warm on the skin. CNA M and Dietary Staff BB were with R1, each had a hold of one of R1's arms and stood by R1. R1 walked back into the facility with CNA M and LN I. LN I assisted LN G with R1. R1 did not have his walker with him. R1 had no obvious injury, had a strong gait, and no shortness of air was noted.</p> <p>On 05/16/24 at 09:45 AM R1 sat in the day room drinking coffee and watching people. R1 had a WanderGuard to his right wrist. His walker was at his side.</p> <p>On 05/16/24 at 10:15 AM, observation revealed the path R1 took through the kitchen had pots and pans, drawers with knives and utensils, cleaning products, and a hot grill. Observation of the outside area revealed a concrete parking lot with cracks in the concrete, an air conditioning unit, two large dumpsters, and a street with a posted speed limit of thirty miles an hour.</p> <p>On 05/16/24 at 10:00 AM, Administrative Nurse D stated if the kitchen staff had closed the door to the kitchen, then R1 would not have been able to run the keypad lock to the door and would not have gotten out of the building. Administrative Nurse D stated she immediately put an intervention in place the kitchen door must always remain closed.</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 05/16/24 at 10:30 AM, Administrative Staff A stated that a CNA did come to the kitchen door to check the alarm but did not see anything. Administrative Staff A stated the cook was on break out in the parking lot and if she had been parked different direction, she would have seen R1 come out of the building.</p> <p>The Elopement Policy, dated 07/11/23, documented the SNF location will be responsible for maintaining a system that clearly defines the mechanisms and procedures for monitoring residents/clients at risk for elopement. These include identifying, evaluating, and analyzing environmental hazards and risks and implementing monitoring and modifying interventions as needed.</p> <p>On 05/16/24 at 03:10 PM Administrative Staff A received a copy of the Immediate Jeopardy [IJ] Template which noted the facility's failure to ensure R1 received adequate supervision to prevent him from entering the kitchen unattended and exiting the facility unsupervised and unbeknownst to staff, placed R1 in immediate jeopardy.</p> <p>All corrective actions were completed on 05/14/24 and included: R1's WanderGuard was checked and was working properly. Immediate education for all staff and kitchen staff to keep the kitchen door closed when the kitchen is not occupied. The facility immediately checked all residents who had WanderGuards to make sure the WanderGuards were functioning properly. The facility also checked all of the WanderGuards on the doors to make sure they were functioning as well. All residents with WanderGuard were assessed and their elopement assessment was updated if needed to make sure it was up to date. The facility would also use walkie-talkies to communicate when exit-seeking behaviors were seen with any resident. R1's Care Plan was updated by adding a nursing order for the nurse to sign off and write progress notes if he was exit seeking and added it to the care plan for the aides to document.</p> <p>Since all corrections were completed before the onsite survey, the citation was deemed past noncompliance.</p>		