

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  175387	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/09/2024
NAME OF PROVIDER OR SUPPLIER  Parkside Homes		STREET ADDRESS, CITY, STATE, ZIP CODE  200 Willow Rd Hillsboro, KS 67063	

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 38 residents with two 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 knowledge of staff). Based on observation, interview, and record review, 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)1. On 03/31/24 at approximately 11:30 AM, R1 attempted to exit the front door of the house she resided in without success, and then exited the house into the gated courtyard, followed by staff. R1 was agitated and voiced she wanted to leave. After sitting outside for approximately 45 to 60 minutes with staff, the staff accompanied R1 inside the main building. On 03/31/24 at 03:00 PM, the staff attempted to take R1 back to the house without success. On 03/31/24 at 04:49 PM, R1 exited the front entrance of the building when she was let out by a visitor. The staff was not aware R1 eloped until 05:00 PM when a Certified Nurse Aide (CNA) looked out a window and saw R1 outside in the parking lot area in front of the house, by herself, 11 minutes later. This deficient practice placed R1 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 R1 included diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion) and amnesia (loss of memory caused by brain damage or severe emotional trauma).</li> </ul> <p>The Admission Minimum Data Set (MDS) dated [DATE], assessed R1 with a Brief Interview of Mental Status (BIMS) score of three, indicating severe cognitive impairment, and was independent with transfers. R1 did not require any mobility devices and could walk 150 feet in corridor independently.</p> <p>The Cognitive Loss/Dementia Care Area assessment dated [DATE], revealed R1 had dementia and short-term and long-term memory loss.</p> <p>The Quarterly MDS dated [DATE], assessed R1 with a BIMS score of three, did not require any mobility devices, and did not wander.</p> <p>The Care Plan dated 02/22/24, revealed R1 had impaired cognitive function related to dementia and was unable to find her room or go to meals without reminders, cues, or assistance from staff.</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 Elopement Evaluation dated 02/21/24, revealed R1 wandered, making her score a one, that indicated she was a risk for elopement.</p> <p>The Progress Note dated 03/31/24 at 11:49 AM, revealed R1 became agitated and left the house she resided in and went to the main building. R1 refused to return to her house.</p> <p>The Progress Note dated 03/31/24 at 12:37 PM, revealed R1 continued to refuse to return to her house and remained in the main building.</p> <p>The Progress Note dated 03/31/24 at 12:42 PM, revealed R1 told Licensed Nurse (LN) H and Certified Nurse Aide (CNA) M she did not know what was going on and was leaving. R1 tried to leave by the front door, then went to patio door, and went to the main building followed by a CNA. (This note was a follow-up note to 03/31/24 at 11:49 AM).</p> <p>The Progress Note dated 03/31/24 at 02:58 PM, revealed at approximately 11:30 AM, a Certified Medication Aide (CMA) from R1's house alerted LN G that R1 was out in the courtyard trying to leave. LN G went outside and R1 told LN G everyone was trying to make her do things she did not want to do, like go back over there and pointed to her house. LN G tried to get R1 to go inside the main building to have lunch and R1 said she was not going to go anywhere but right here, and pointed to the chair she sat in. While outside, R1 talked on the phone for approximately 30 minutes with a family member, sat outside a while longer, then agreed to go with LN G inside the main building for lunch. After lunch and after she watched some television, LN G walked with R1 back to her house at 03:00 PM. R1 did not want to stay there and agreed to go back to the main building. R1 returned to the main building and sat by the nurse's station as she watched television.</p> <p>The Progress Note dated 03/31/24 at 06:30 PM, revealed at approximately 04:42 PM, LN G observed R1 in a recliner by the nurse's station watching television. At approximately 05:00 PM, a staff member called from R1's house reporting R1 was seen outside in the parking lot in front of the house she resided in. LN G then immediately ran out of the door to look for R1 and when approaching R1's house she saw R1 walking on the street towards the house, carrying her phone. LN G asked R1 where she was going and R1 responded I don't know, but not back there, and pointed to the house she resided in. When asked if she wanted to go back to the main building, R1 responded Sure and grabbed LN G's hand.</p> <p>On 04/08/24 at 11:30 AM, observation with Administrative Staff A of the area R1 traversed after she exited the facility revealed a downhill paved driveway to the street. The area lacked a sidewalk from the main building to the side of the house where she was found in the parking lot in front of. The parking lot was approximately 360 feet from the front entrance when walking from the entrance, down the paved driveway, along the street, and to the paved parking lot area where she was found.</p> <p>On 04/08/24 at 11:35 AM, Administrative Staff A stated she observed the camera footage which showed a visitor let R1 out the front entrance, however the camera did not reveal if she walked through the grass or on the street. Administrative Staff A stated a staff member went in a room of the house and saw R1 walk by, then told the nurse immediately and staff met her out in the parking lot in front of the house.</p> <p>On 04/08/24 at 02:40 PM, observed R1 on her bed in her room of the house with a Wanderguard (bracelet that sets off an alarm when residents wearing one attempt to exit the building without a staff escort) in place to her right ankle.</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 04/08/24 at 02:41 PM R1 stated she would like to go somewhere else but could not state where, could not recall going outside, and stated if she wanted to go outside, she would look both ways and go out. R1 stated she had a bad memory and could not recall everything.</p> <p>On 04/08/24 at 03:55 PM, LN G stated she was on duty when R1 eloped. LN G stated R1 was brought over to the main building around 11:30 AM and was told R1 refused to go back to her house. LN G stated she visited with R1 outside in the courtyard after she talked on the phone with a family member, and R1 did not want to go back to her house because they would not let her do things over there such as go out the front door. LN G stated it was probably 45 minutes before she could persuade R1 to come inside the main building and have lunch. LN G stated she ate with R1 and then took her to the living room area where she sat in a chair and watched television. LN G stated then around 03:00 PM she attempted to take R1 back to her house and R1 wanted nothing to do with the staff there, so she brought R1 back to the main building. LN G stated she last saw R1 at approximately 04:40 PM in the living room area where R1 watched television. LN G stated at 05:00 PM, she received a call that R1 was in the parking lot in the front of R1's house.</p> <p>On 04/08/24 at 04:33 PM, CNA M stated on 03/31/24 she was on duty from 06:00 AM to 06:00 PM and was assigned to the house R1 resided in. CNA M stated in the morning R1 was upset and very agitated and would not calm down, and R1 went to the main building for the day. CNA M stated she was in another resident room in the house R1 resided in and seen R1 through the window walking around outside. CNA M stated she called the nurse because R1 had been acting weird towards her on that day. CNA M stated the day before, R1 packed her belongings, would not give a reason why, and she seemed upset but did not mention leaving.</p> <p>On 04/09/24 at 09:03 AM, CNA N stated the day R1 eloped she was on duty assigned to a different house from where R1 resided. CNA N stated on 03/31/24, she saw R1 in the courtyard with CNA M who attempted to get her to go back inside. CNA N stated R1 had her fist balled up and was saying I need to get out of here. CNA N stated R1 wanted nothing to do with CNA M, so she took over and took R1 to the benches and talked with R1 for a bit. CNA N stated she was able to calm R1 down a little bit and CNA O took over and sat with her. CNA N stated it was around lunch time when that occurred, she would come out and check to make sure all was okay. CNA N stated the staff took R1 inside the main building for lunch. CNA N stated she had not seen R1 try to leave, go out the doors, or wander before.</p> <p>On 04/09/24 at 09:32 AM, CNA O stated she was not on duty when R1 eloped but had worked the shift prior to the incident on 03/31/24. CNA O stated CNA M had her go out to the courtyard to try and get R1 back in the house around lunchtime. CNA O stated she talked to R1 and was with her for about an hour before R1 went inside to eat lunch. CNA O stated she was off duty at 01:00 PM and saw R1 just coming back from lunch and sat in a recliner to watch television. CNA O stated R1's behaviors were a change, and she did not seem to be an elopement risk until that day.</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 04/09/24 at 09:42 AM, LN H stated he was on duty on 03/30/24 and 03/31/24 and the staff did not report to him that R1 packed her belongings. LN H stated on 03/31/24 he sat at a table with CNA M when R1 came out and said she was tired of this, and she was leaving. LN H stated R1 tried to get out the front door and could not, then walked out to the courtyard and told someone staff was trying to kill her. LN H stated CNA M followed her and thought R1 yelled at her to get away from her. LN H stated he had not heard R1 talk about leaving, attempt to leave, or pack her belongings when he was on duty, and she would wander around the house but did not attempt to go outside before this incident. LN H stated he thought R1 needed a Wanderguard on, however, he did not tell anyone that or tell the charge nurse LN G. LN H stated he left at 02:00 PM on 03/31/24 when his shift ended.</p> <p>On 04/09/24 at 01:22 PM, Administrative Nurse D stated residents who wander were reviewed in a weekly meeting and R1 had not displayed any exit seeking behaviors or wandering. Administrative Nurse D stated she expected the staff to follow the policy with R1's exit seeking behaviors and should have placed a Wanderguard on her.</p> <p>On 04/09/24 at 01:47 PM, CNA P stated on 03/31/24 and around 04:30 PM to 04:45 PM, she observed R1 as she sat by the nurse's station watching television. CNA P stated she asked R1 how she was and R1 stated she would be better if she got out of here. CNA P stated she went back to get R1 around 04:55 PM and she was gone, which was the time when everyone was saying she was gone, had eloped, and found her at the other building. CNA P stated R1 had not come to the dining room before she eloped.</p> <p>The Employee Notice of Disciplinary Action dated 04/04/24 revealed proper procedure for elopement risk or someone demonstrating exit seeking behaviors was to apply a Wanderguard bracelet. That information could be found in the elopement policy.</p> <p>The facility's policy Elopement Management dated 06/01/23, revealed for prevention of elopement, staff would be educated on never leaving a resident that is actively seeking elopement from the facility until the resident is no longer exit seeking. Staff would be educated to report unusual behaviors to the supervisor immediately and general interventions to be used with residents seeking to elope from the facility. The policy indicated when a risk of elopement was determined, an interdisciplinary plan of care would be established for the resident and may include door alarms, frequent checks by nursing staff, social work consultation, Wanderguard system in place, and resident-centered life enhancing engagement in activities in attempt to decrease wandering activity.</p> <p>The facility failed to provide adequate supervision and a safe environment to cognitively impaired R1, who had exit seeking behaviors, and/or apply a Wanderguard bracelet to her. R1 eloped from the facility on 03/31/24 at 04:49 PM for 11 minutes without staff knowledge.</p> <p>On 04/09/24 at 02:07 PM, Administrative Staff A was provided the Immediate Jeopardy template and notified of the facility's failure to provide adequate supervision when R1 was upset, attempting to exit the facility, and voiced she wanted to leave, and eloped from the facility on 03/31/24 at 04:49 PM, placed R1 in immediate jeopardy.</p> <p>The immediate jeopardy was determined to first exist on 03/31/24 at 04:49 PM and the surveyor verified the facility identified and implemented corrective actions completed on 04/02/24 at 03:00 PM, when the facility completed the following:</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>	<ol style="list-style-type: none"> <li>1. R1 placed on one-to-one observation following the elopement until she went to bed and LN G educated the visitor about not letting others out without speaking to the nurse first, on 03/31/24.</li> <li>2. An elopement assessment completed, care plan updated, and a Wanderguard bracelet placed on R1 on 04/01/24 at 08:30 AM.</li> <li>3. An elopement action plan completed on 04/01/24 at 08:30 AM.</li> <li>4. A Root Cause completed on 04/01/24 at 08:30 AM for R1 which determined she was on isolation for COVID prior to the day of the incident.</li> <li>5. On 04/01/24 at 09:00 AM the facility medical director, who was also R1's primary care physician, contacted and reviewed the action plan, root cause, policy changes, education plans and advised to place a sign on the exit doors to keep visitors from allowing exit advising them to see the nurse for assistance before opening the door.</li> <li>6. The facility contacted the resident representative to inform about care plan updates with interventions to new elopement risks on 04/01/24 at 09:00 AM.</li> <li>7. A full audit on elopement assessments completed and updated pictures placed at all nurse's stations for all residents with identified elopement risks to educate all staff and all agency staff of residents at risk on 04/01/24 at 09:00 AM.</li> <li>8. All staff provided immediate education on elopement policy update on 04/01/24 at 09:00 AM.</li> <li>9. Signs placed on all exit doors on 04/01/24 at 10:00 AM: Elopement Risk - do not open the door for someone you do not know or allow someone to follow you out the door unless they are with your party. For assistance please call [specified number] and a nurse will come to assist you. Thank you for keeping our resident's safe.</li> <li>10. Elopement Drill completed on 04/02/24 to test staff competency of elopement policy and procedure with an incident after action plan completed. On 04/02/24 at 11:00 AM a new intervention to add sign to the gate exits: Make sure gate is closed behind you, if you find the gate door open notify a nurse immediately.</li> <li>11. All staff educated on non-pharmacological approaches to support individuals living with dementia, maintain isolation precautions, interventions to help prevent behaviors and exit seeking, Abuse, Neglect, and Exploitation policy, and updated policy for resident isolation procedures on 04/02/24 at 03:00 PM.</li> </ol> <p>Due to the corrective action implemented prior to the onsite visit, the deficient practice was deemed past non-compliance and existed at a J scope and severity.</p>		