STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175480	A. Building B. Wing	07/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Logan Manor Community Health Services	108 S Adams Street Logan, KS 67646

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. The facility identified a census of 35 residents, with three reviewed for elopement. Based on record review, observation, and interview, the facility failed to provide sufficient supervision for Resident (R) 1 to prevent R1 from exiting the building. This deficient practice placed R1 at risk for elopement, falls, and injury. Findings included: - R1's Electronic Medical Record (EMR) documented R1 had diagnoses of nontraumatic brain dysfunction (brain damage that occurs form internal factors), dementia (progressive mental disorder characterized by failing memory, confusion), anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), and psychotic disorder (any major mental disorder characterized by a gross impairment in reality perception). The admission Minimum Data Set (MDS), dated 05/11/25, documented R1 had a Brief Interview for Mental Status score of 15, which indicated intact cognition. The MDS documented R1 required moderate staff assistance for bathing, upper body dressing, personal hygiene, transfer, bed mobility, and ambulation. The MDS documented R1 was dependent on staff for lower body dressing and donning/doffing footwear. The MDS documented R1 was independent with locomotion in his wheelchair. The MDS documented R1 had delusions. The Cognitive Loss/Dementia Care Area Assessment (CAA), dated 05/11/25, documented R1 was alert and oriented but had impaired decision-making skills and confusion. R1's Care Plan lacked any interventions for wandering/elopement prior to the incident. R1's care plan documented he required one staff assistance for most activities of daily living (ADLs) (05/12/25). The care plan directed staff R1 was a fall risk and required a chair and bed alarm to alert staff when R1 got up by himself (05/12/25). The care plan directed staff to call R1's wife when he hallucinated (05/12/25). (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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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Health Status Note, dated 05/28/25, documented R1 sat in his wheelchair in the community room watching Maintenance Person U unwrap a new refrigerator. Maintenance Person U left the community room to go get a knife. When Maintenance Person U returned, he saw R1 outside in his wheelchair on the sidewalk by the generator. R1 left through the double door. As Maintenance Person U headed outside to bring R1 back in, he saw Licensed Nurse (LN) G, and they both went out to get R1 and assisted R1 back into the facility. R1 was asked where he was going, and he said, I was just looking around. A head-to-toe assessment was completed with no abnormal findings. R1's primary care physician and the responsible party were notified. A Wanderguard was applied to R1's wheelchair. The Notarized Witness Statement, dated 05/28/25, documented Maintenance Person U unpackaged some equipment which had just come in. The double doors to the community room were open. As Maintenance Person U worked on unpackaging the boxes, R1 came up behind and visited with Maintenance Person U as he worked. Maintenance Person U went back to his office to grab a knife to keep unpackaging boxes, and came right back. Maintenance Person U saw R1 was no longer by the equipment, and looked outside and saw R1 outside a set of unlocked doors in his wheelchair on the sidewalk. Maintenance Person U saw LN G in the main hallway and called for her to come help bring R1 back inside. LN G and Maintenance Person U brought R1 back into the facility. LN G's Notarized Witness Statement, dated 05/28/25, documented LN G was walking down the main hallway when Maintenance Person U caught her and asked if she could come with him as R1 got out. We arrived at the west exit doors just south of the double doors that lead to our facility. LN G stated she could see R1 in his wheelchair pedaling slowly along the sidewalk. R1 was looking all around and was calm. R1 was about sixty feet away from the building. R1 apparently exited the building through the west exit doors, which do not lock from the inside, only from the outside. LN G walked up behind R1 and asked R1 what he was doing and startling R1. LN G told R1 we needed to get him inside out of the rain. LN G pushed R1 to the west facility exit, and once inside R1 continued to pedal himself to his household. The Health Status Note, dated 05/31/25, documented R1 was found sitting outside in his wheelchair on the grass looking at the generator out the west door. R1's Wanderguard did not activate. R1 was assisted back into the building. A head-to-toe assessment was completed with no abnormalities noted. R1 stated he was trying to figure out what the generator was and was impressed with its size. R1's primary care physician and responsible party were notified. Certified Nurse's Aide (CNA) M's Notarized Witness Statement, dated 05/31/25, documented CNA M took out trash to the dumpster and saw R1 in his wheelchair on the grass between pod 3 and the building to the south. R1 stated he got out the southwest door of pod 3. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Facility Incident Report, dated 06/01/25, documented on 05/28/25, R1 was seen on camera exiting the building at 03:37:49 PM. R1 had sat in the hallway of the community room and watched Maintenance Person U open a new freezer and refrigerator. Maintenance Person U went to get a knife from his office. R1 then proceeded to exit the building. At 03:59:37 PM, Maintenance Person U and LN G exit the same door to get R1, and at 04:00:36 PM, LN G and R1 entered the west door of the facility. A head-to-toe assessment was done upon return to the facility, with no abnormalities noted. The outside temperature was 59 degrees, and it was sprinkling. Immediate intervention: a wanderguard was placed underneath R1's wheelchair. On 05/31/25 at 04:39 PM, CNA M went to take the trash out when she saw R1 sat in his wheelchair on the grass looking at the generator. Upon review of the camera footage, R1 kicked the west door open to exit the building at 04:23:31 PM. R1 and staff returned to the building at 04:46:05 PM. The outside temperature was 86 degrees and sunny. It was noted the wanderguard did not activate. A new wanderguard was placed an in working order. On 07/02/25 at 10:30 AM, observation revealed R1 self-propelled in his wheelchair around the household where he lived. A wanderguard was placed underneath R1's wheelchair. On 07/02/25 at 11:00 AM, observation revealed the door out of the community room led to a smooth, brand-new sidewalk with very nice grassy areas on each side. There were several air conditioning units in the grassy areas to the left side of the sidewalk, and then farther down was a very large generator (12 feet tall by 6 feet wide) for both the school and the facility. Out the west door was more sidewalk that led around the corner to the south (left) to the above area just described. In front of the west door was car parking on a gravel road with a baseball field that was fenced in behind the parking. To the north of the door (right) was more sidewalk leading to the north side of the building. The sidewalk had grassy areas on both sides and ran along the gravel parking area. On 07/02/25 at 11:30 AM, CNA M stated R1 waited until she was getting residents up for supper, and then he disappeared, and for whatever reason, she went to take the trash out the back (west) door and went around to the south side of the building and found R1. R1 had rolled his w/c into the grass and was watching the generator. On 07/02/25 at 12:30 PM, Administrative Nurse D stated R1 has been a farmer his whole life and just wanted to be outside. Administrative Nurse D stated R1 is a younger man who went in to have neck surgery, and the anesthesia messed with his head, and he has not been the same since. R1 is alert and oriented during the day, but as it gets closer to evening, his behavior worsens. After the initial exit, the new wanderguard was placed on R1, and they must not have programmed it wrong because initially it alarmed at the doors, but then when R1 went out the west door, it did not alarm. The video showed R1 kicking the door open and broke the door. Administrative Nurse D stated that all education on elopement and elopement drills on every shift had been completed. The facility's Elopement Policy, dated 08/23/24, documented the facility wished to ensure the safety of those residents who had been identified as being at risk for elopement. It is the policy of this facility to identify those residents at risk for elopement and take precautions to ensure their safety and well-being. Special secure living units are provided by the facility, and additional securing, including a Wanderguard door locking system, is provided.