STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175522	A. Building B. Wing	04/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medicalodges Great Bend	1401 Cherry Lane Great Bend, KS 67530

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 - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43204 The facility identified a census of 38 residents, with four residents reviewed for elopements (when a resident leaves the premises or a specific safe area without authorization and/or necessary supervision). Based on record review, observation, and interview, the facility failed to provide adequate supervision to prevent an elopement for cognitively impaired Resident (R) 1, who the facility identified as a high risk for elopement. On 04/05/24 at approximately 04:18 PM, R1 exited the facility's 200 hall through an unlocked door, which did not alarm. R1 walked approximately the length of a football field over cracked sidewalks, uneven grassy areas, a parking lot full of large potholes, and over several curbs before falling, between two apartment buildings, behind the facility. A community member living in the apartment building called 911 and reported R1 lying on the apartment complex lawn. At 04:45 PM, Certified Medication Aide (CMA) R saw an ambulance behind the facility and identified R1 on the ambulance stretcher. Emergency Medical Services (EMS) transported R1 to the local hospital for evaluation. The facility's failure to ensure R1 received adequate supervision to prevent an elopement which resulted in a fall outside of the facility, and the failure to ensure functioning door alarms and locks placed R1 in immediate jeopardy. Findings included: - R1's Electronic Medical Record (EMR) documented R1 had diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), dementia (progressive mental disorder characterized by failing memory, confusion), anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), unsteadiness on her feet, abnormalities of gait (manner or style of walk), and muscle weakness. The Significant Change Minimum Data Set (MDS), dated [DATE], documented R1 had a Brief Interview for Mental Status (BIMS) score of zero, which indicated severely impaired cognition. The MDS documented R1 had physical and verbal behaviors directed towards others during the look-back period. The MDS documented R1 had episodes of wandering during the look-back period, and the wandering episodes placed R1 at significant risk of getting to a potentially dangerous place. The MDS documented R1 was dependent on staff for toileting, bathing, and personal hygiene; and required substantial staff assistance with dressing and donning and doffing footwear. The MDS documented R1 required supervision or touching assistance with transfers, ambulation, and bed mobility. The MDS documented R1 had one non-injury fall and one minor injury fall during the look-back period. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Cognitive Loss/Dementia Care Area Assessment (CAA), dated 01/31/25, documented R1 had diagnoses of Alzheimer's disease, dementia, irritability, anger, and altered mental status. The CAA documented R1 displayed physical and verbal outbursts and wandering, and staff would redirect R1 as needed. The Falls CAA, dated 01/31/25, documented R1 had poor safety awareness and had fallen during the look-back period. The CAA directed staff to monitor R1 closely. R1's Care Plan documented R1 was independent most of the time with transfers, ambulation, and locomotion, but needed assistance at times when her gait was unsteady. The care plan documented R1 was at risk for falls and needed appropriate footwear. The plan directed staff to have R1's call light within reach. The plan directed staff to keep pathways in R1's room clear and unobstructed and when R1 had increased wandering, offer her activities to redirect her (12/13/22). The care plan documented R1 had cognitive deficits that affected her memory (02/15/24). The care plan directed staff to consider R1's physical needs when R1 was wandering (09/22/23). The Facility Incident Report, dated 04/07/25, documented on 04/05/25 at approximately 04:00 PM, CMA R reported she saw R1 at the front nurse's station. At 04:15 PM, video camera footage showed R1 pushing on the far-left side of the exit door on 200 hall. R1 pushed on the right side of the 200 hall exit door, and the door opened. R1 quickly exited the building and turned to shut the door. CMA R passed medication on the 400 hall at the back of the facility when she observed an ambulance behind the facility with someone on the stretcher with a purple jacket on. CMA R asked another CNA what color R1's jacket was, and the aide said purple. At that point, EMS turned the stretcher, and staff saw it was R1. CMA R ran down the hall, alerted LN G, ran back to the parking lot, and spoke to EMS personnel. At 04:47 PM, the ambulance pulled up in front of the facility to get a copy of R1's face sheet and told staff they were transporting R1 to the local hospital for testing and possible treatment. The emergency room Dismissal Instructions, dated 04/05/25, documented R1 had a urinary tract infection (UTI - an infection in any part of the urinary system) requiring antibiotics, and abrasions to her face due to a fall. The dismissal instructions directed R1 to take all of her antibiotics and to monitor the wounds on her face; keep the wound clean and dry, and if the wound started to have increased redness, purulent (producing or containing pus) drainage, or swelling, the wounds would need to be re-evaluated for infection. The dismissal instruction directed the facility that if R1 developed a fever, worsening altered mental state, or any other new, concerning symptoms, R1 should return to the emergency room for evaluation. CMA R's Notarized Witness Statement, dated 04/05/25, documented CMA R last saw R1 physically in the facility at 04:00 PM at the front nurse's station. CMA R stated she started her medication pass on the back hall at about 04:15 PM when CMA R started looking on the 400 hall to see if R1 was in one of the rooms. CMA R went into a room and saw an ambulance in the back parking lot, when she looked out the window. CMA R noted she saw EMS placing someone wearing a purple jacket on a stretcher. The statement documented CMA R asked another Certified Nurse Aide (CNA) what color jacket R1 had on, and she said Purple. EMS then turned the stretcher towards the window, and CMA R saw R1 lying on the stretcher. CMA R ran out to the parking lot and spoke with EMS personnel who told CMA R that R1 fell on the sidewalk. R1 was able to tell them her name. The statement recorded the ambulance came around to the front of the facility to get R1's face sheet around 04:47 PM. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Certified Nurse Aide (CNA) M's Notarized Witness Statement, dated 04/05/25, documented CNA M saw R1 with another staff member, and then saw R1 headed around the corner with a nurse. The statement noted that after a while, CNA M asked a co-worker if she had seen R1 and the co-worker said she had not seen R1. CNA M noted she then kept her eye out for R1 and went to check with a co-worker if she had checked R1's room for her. CNA M's co-worker came out of R1's room and said R1 was not there. CNA M searched the front hall but saw no signs of R1, so CNA M went to the back hall to see if anyone had found R1. CNA M noted two aides came out of a room in a hurry, yelling something about R1. CNA M noted the ambulance was outside, and CNA M and another staff member stopped the ambulance, told them R1's name, and then ran back to the facility to report to the nurse. CNA N's Notarized Witness Statement, dated 04/05/25, documented CNA N saw R1 at approximately 04:00 PM, before staff started getting residents up. R1 stood at the end of the 400 hall with another resident. CNA N noted R1 stood at the end of 400 hall and CNA N called for R1 and then assisted R1 into a chair at the back nurse's station. CNA N documented that a co-worker approached her and asked if she had seen R1, so CNA N started looking for R1, but did not see R1. CNA N noted she and another aide went down the 400 hall looking for R1 when they saw an ambulance at the apartments behind the facility. CNA N noted she saw R1 being placed on the stretcher, and immediately notified the nurse. Licensed Nurse (LN) G's Notarized Witness Statement, dated 04/05/25, documented the last time LN G saw R1, R1 was walking down the 200 hall and had stopped around room [ROOM NUMBER], turned around and started walking north. LN G stated after the incident, she went down to the 200 hall exit door and attempted to open the door, but could not open the door using her whole body weight while she pushed the door handle. The Nurse's Note, dated 04/05/25, documented R1 arrived back at the facility via a private vehicle driven by R1's responsible party. A nurse-to-nurse report documented R1 had abrasions to her face and Bacitracin (antibiotic ointment) was applied to the abrasions; all the scans of R1's face and knees came back with no concerns. The note recorded R1 had a severe (UTI - an infection in any part of the urinary system) and received an injection of Rocephin (antibiotic) in the emergency room (ER). The Hospice Note, dated 04/06/25, documented R1 hurt her knee and had a lot of pain in the left knee. The note documented R1 had a hard time putting weight on her knee and used a wheelchair. R1 had a one-to-one CNA sitting with her. The note documented R1 had gotten out of the building and was brought to theER on [DATE]. R1 had abrasions on her forehead, the bridge and tip of her nose, and her inner left eye was bruised. On 04/21/25 at 10:00 AM, observation of the area around the facility in which R1 traversed on 04/05/25, revealed R1 walked approximately the length of a football field around the facility. Observation of the area revealed cracked sidewalks, an uneven grassy lawn to the back parking lot, and the parking lot was cracked and uneven, with several very large potholes. On 04/21/25 at 10:30 AM, observation revealed R1 sat in a wheelchair watching an activity where other residents were playing a game. R1 had a large yellow/green bruise on the entire left side of her face with two abrasions to her nose. When asked if her face hurt, R1 said, Well, what's wrong with my face? (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 04/21/25 at 11:00 AM, CMA R stated she last saw R1 around 04:15 PM, and then when she went to look for R1, she could not find her so she asked other CNAs if they knew where R1 was but no one knew, so they started searching rooms. CMA R stated she was in a resident's room and saw an ambulance out back loading someone in the ambulance, so CMA R asked another staff member what color R1's jacket was, and they said purple. CMA R said that EMS swung the cot around at that point, and CMA R saw R1. CMA R stated she ran out to the EMS and told them R1's name, and they said they were going to pull around and get a face sheet at the front of the building. CMA R stated she had received training regarding elopement. On 04/21/25 at 09:30 AM, Administrative Staff A stated they thought contractors working in the facility had unhooked the door alarm sensors, and then, when they went out the door, they did not shut it tight, so the mag-lock did not engage. Administrative Staff A stated that 1200-pound mag-locks had been installed on all doors on 04/16/25, and the 1200-pound mag-locks would pull the doors shut if they were within two inches of shutting. Administrative Staff A stated the door at the end of 200 hall was immediately secured and the mag-lock was functioning; the alarm was rewired and was now in working order. Administrative Staff A said all staff were re-educated on the facility's elopement policy, stop signs were placed on each exit door, and the signs also requested contractors to alert staff before using the exit doors so staff could stay at the exit doors until the contractors were done. Administrative Staff A stated the facility's elopement book was reviewed for accuracy, R1 was put on one-to-one over the weekend, and the findings of the incident were taken to an emergency Quality Assurance and Performance Improvement (QAPI) meeting. Administrative Staff A verified that all the door alarms and mag-locks were checked for functionality on 04/01/25. On 04/21/25 at 10:00 AM, Administrative Nurse D stated she thought contractors working on the back rooms down 200 hall had unhooked the door alarm from the censors, but the facility could not prove that. Administrative Nurse D verified the door alarm was not hooked up on 04/05/25. Administrative Nurse D showed the path staff thought R1 took when she exited the 200 hall. Administrative Nurse D stated R1 was on hospice and her ability to transfer and ambulate fluctuated from day to day; sometimes she was independent and all over the facility, and other days she was in a wheelchair. Administrative Nurse D stated R1 had been on 30-minute location checks because she was a high elopement risk. Administrative Nurse D stated all administrative staff were in the building fifteen to twenty minutes after R1 was seen outside, and all the doors were checked for functioning door alarms and mag locks. Administrative Nurse D stated that education on the Elopement Policy was started that day and that none of the staff could work before completing the education. Administrative Nurse D verified all education was completed on Wednesday, 04/09/25. The facility's Resident Elopement Policy and Procedure, revised December 2022, documented the facility strived to promote a safe and secure environment to help minimize the risk of residents leaving the premises or a safe area without the necessary supervision or authorization to do so. Risk for elopement was to be identified for residents, and an individualized care plan was developed based on risk. Staff are to investigate and report instances of potential elopement. The facility is to have a process to monitor the security of the premises on a routine basis. On 04/21/25 at 01:31 PM, Administrative Staff A was provided the Immediate Jeopardy [IJ] Template and notified the facility's failure to provide adequate supervision to prevent an elopement for R1 placed the resident in immediate jeopardy. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility identified and implemented immediate corrective actions, which were completed on 04/16/25 and included: 1200-pound mag-locks were installed on all doors on 04/16/25. The door at the end of 200 hall was immediately secured, and the mag-lock was functioning. The alarm was rewired and in working order. All staff were re-educated on the facility's elopement policy. Stop signs were placed on each exit door, and the signs also requested contractors to alert staff before using the exit doors so staff could stay at the exit doors until the contractors were done. The facility's Elopement Book was reviewed for accuracy. R1 was put on one-to-one over the weekend. The findings of the incident were taken to an emergency QAPI. Because all corrective actions were completed before the onsite survey, the citation was deemed past noncompliance and existed at a J (isolated, immediate jeopardy) scope and severity.