

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175526	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/30/2024
NAME OF PROVIDER OR SUPPLIER Fowler Residential Care		STREET ADDRESS, CITY, STATE, ZIP CODE 401 E 6th Fowler, KS 67844	

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** 40801</p> <p>The facility reported a census of 16 residents with two residents identified and reviewed for elopement. Based on interview, observation, and record review, the facility failed to provide adequate supervision to prevent one cognitively impaired Resident (R) 1, who was identified with an elopement risk and had a known history of elopement, from leaving the facility unsupervised and without staff knowledge. The facility staff last saw R1 on 04/21/24 sometime between 10:00 PM and 11:00 PM. On 04/22/24 at around 03:00 AM, facility staff were unable to locate R1. After searching and notifying Administrative Staff, Law Enforcement, and R1's family, the facility learned R1 was with his sibling in another state, over five hours away. R1 stated he used a hammer to remove the window braces, crawled out of the window, and walked over 100 feet to the back gate area, where a family member picked him up and drove him out of state. The lack of facility supervision for a resident who displayed verbal expressions of wanting to leave, placed R1 in immediate jeopardy.</p> <p>Finding included:</p> <ul style="list-style-type: none"> - Residents (R) 1's Physician Orders dated 01/20/24, revealed a diagnosis of dementia (progressive mental disorder characterized by failing memory, confusion). <p>The Annual Minimum Data Set (MDS) dated [DATE] indicated a Brief Interview for Mental Status score of 12, which indicated moderate cognitive impairment.</p> <p>The Quarterly MDS dated [DATE], documented a (BIMS) score of 00, indicating R1 refused to participate with the evaluator. R1 had behaviors of delusions (untrue persistent belief or perception held by a person although evidence shows it was untrue). R1 was independent with Activities of Daily Living (ADL).</p> <p>The Care Plan dated 09/26/23 lacked interventions regarding wandering/elopement, supervision, and visual checks for R1.</p> <p>The Care Plan dated 04/23/24, (after the resident left the facility without staff knowledge), identified R1 at risk for wandering/elopement when R1 eloped from the facility on 04/22/24. Staff were to supervise R1 when outside. Staff were to provide visuals check every 30 minutes to identify triggers for wandering/elopement.</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 assessment dated [DATE], documented a score of one, that indicated R1 was at risk for elopement. R1 verbally expressed the desire to go home, packed his belonging to go home or stayed near an exit door.</p> <p>The Elopement assessment dated [DATE], documented score of three, that indicated R1 was at risk. He had a BIMS score of seven, (severe cognitive impairment), and a history of elopement while at his home. R1 verbally expressed the desire to go home, packed belongings to go home, or stayed near an exit door.</p> <p>The Elopement assessment dated [DATE], documented he had a history of elopement while at home and a history of attempting to leave the facility without informing staff. R1 continued to verbally express the desire to go home, packed his belonging to go home, or stayed near an exit door.</p> <p>The Nurses Notes dated 04/22/24, documented the nurse went to R1's room to check his blood sugar at 03:00 AM. The room was dark, and the television was off. Staff were unable to locate R1 in his room. The bottom window nearest R1's bed was partially opened and could be opened easily. Staff notified Administrative Staff A by telephone, and the staff conducted a full search. The staff notified R1's son at 03:20 AM. Law Enforcement arrived at the facility at 03:30 AM. R1 was last seen between 10 PM and 11 PM on 04/21/24</p> <p>The Nurse Note dated 04/22/24 at 12:52 PM, documented law enforcement was able to confirm R1 was with his sibling at his home in another State. The note further revealed R1's son would return R1 to the facility.</p> <p>The Nurse Note dated 04/23/24 at 02:24 PM, documented R1 returned to the facility.</p> <p>According to Google Maps, the distance from the facility to the town where R1 located was approximately 325 miles away, and a non-stop trip would take approximately five and a half hours by vehicle each way (for a total of 11 hours round-trip).</p> <p>An outside observation on 04/22/24 at 01:30 PM revealed R1's room window braces had been removed. Further outside observation revealed train tracks approximately two blocks from the facility and a major highway approximately one quarter of a mile from the facility speed limits of 65 miles per hour.</p> <p>During an interview on 04/29/24 at 12:40 PM, R1 stated he removed the window braces and the screen from the window and crawled out of the window. He reported he did not want his sibling to be in trouble, and he reported he hitchhiked to a neighboring state.</p> <p>During an interview on 04/29/24 at 01:45 PM, Administrative Nurse D reported the facility expected the staff to know the whereabouts of the two elopement risk residents and provide those two residents hourly checks. Administrative Nurse D stated staff did not follow the elopement policy because the staff should have checked on R1 every hour. Administrative Nurse D reported the facility did not do any training regarding elopement after the incident.</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>During an interview on 04/29/24 at 01:50 PM, Administrative Staff A revealed R1 had removed the braces on the window in his room and crawled out the window. Administrative Staff A said R1 walked approximately 100 feet to the back gate of the facility and used his cell phone to call his sibling to pick him up.</p> <p>The facility's Elopement Policy dated 02/02/17, revealed the facility wished to ensure the safety of those elders identified as being at risk for elopement. It was the policy of the facility to identify those elders at risk for elopement and take precautions to ensure their safety and well-being. The facility provided special secure living areas and additional security including a Wander Guard door locking system. This policy applied to all residents residing in any licensed area.</p> <p>The facility failed to provide adequate supervision to prevent the elopement of cognitively impaired Resident (R) 1, identified as an elopement risk and with a known history of elopement. On 04/22/24 R1 left the facility without staff knowledge and the staff did not know R1 was missing until they checked on him around 03:00 AM, which was 4 to 5 hours since staff last saw R1. The resident was located in another State, approximately five and a half hours from the facility.</p> <p>On 04/09/24 at 05:27 PM Administrative Staff A and Administrative Nurse D were provided the Immediate Jeopardy template and notified of the facility's failure to provide adequate supervision to prevent cognitively impaired Resident (R) 1, who was identified with an elopement risk and had a known history of elopement, from leaving the facility unsupervised and without staff knowledge.</p> <p>The immediate jeopardy was determined to first exist on 04/21/24 at 11:00 PM, approximately one hour since staff last saw R1 and around the one hourly check time, due to staff failure to supervise the resident's whereabouts.</p> <p>The facility identified and implemented the following corrective action on 04/30/24 which included:</p> <ol style="list-style-type: none"> 1. Mandatory all staff review of elopement policy and online education prior to shift work confirmed by sign-in sheet and verification on online education program. Started 04/29/24 at 06:45 PM and will finish on 04/30/24 by 05:00 PM sign in and completion rosters included. 2. Counseling along with disciplinary action on staff involvement with the follow up with the Director of Nursing (DON) to assure compliance. Completed 04/30/24 at 07:50 AM. 3. Room was searched and R1's belonging searched R1 for any additional tools on 04/22/24 at approximately 05:00 AM and when the R1 returned to the facility on [DATE] at 09:20 PM. 4. The window cranks in areas where R1 spends time were replaced and window braces were repaired and secured by maintenance staff. Staff education regarding window repairs, cranks, and tool removal, completed on 04/30/24 at 04:09 PM. 5. Resident on visual checks every 15 minutes upon returning to the facility on [DATE] until reassessment on 04/29/24 by Director of Nursing. R1 will have visual checks every 30 minutes until the next mental health visit (May 14, 2024) which will result in an evaluation of frequency of visual checks. Visual checks will be monitored on the facility electronic charting, via tasks, program. 6. Licensed Nurse meeting held on 04/23/24 at 04:00 PM to discuss elopement assessment values. <p>(continued on next page)</p>		

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