STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175531	A. Building B. Wing	10/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Atchison Senior Village Rehabilitation and Nursing	1419 N 6th Street Atchison, KS 66002

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(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** 39752 The facility identified a census of 41 residents. The sample included three residents reviewed for elopement (when a cognitively impaired resident with little or poor safety awareness exits the facility without staff knowledge). Based on observation, record review, and interview, the facility failed to provide adequate supervision to prevent an elopement for Resident (R) 1, who was cognitively impaired, at high risk for elopement, and had a recent history of exit-seeking. The facility placed a WanderGuard (a bracelet that helps monitor residents who are at risk of wandering) on R1 on 10/04/24 due to R1's exit-seeking behaviors and setting off door alarms. R1 wandered the halls and into other residents' rooms almost daily from 10/06/24 through, and including, 10/11/24. On 10/12/24 R1 ambulated past staff, from the dining room to the great room. Staff observed R1 in the lobby area around the 300 hall after he left the dining room, but did not accompany or redirect him to a safe place. R1 ambulated to the facility's great room, and pushed on the locked door, causing the door to release after 15 seconds. According to staff, the door alarmed, but staff were too far away to hear it. R1 then ambulated unsupervised through the courtyard, opened the gate, and walked around the side of the building on the sidewalk. Staff noted R1 had exited the building unattended when staff observed R1 outside at the front of the facility and at that time staff also acknowledged the sounding door alarm. The lack of supervision and response to a sounding door alarm allowed R1 to exit the facility without staff knowledge or supervision and placed R1 in immediate jeopardy. Findings included: - R1's Electronic Medical Record (EMR), under the Diagnosis tab recorded diagnoses of difficulty in walking, a need for assistance with personal care, dementia (a progressive mental disorder characterized by failing memory and confusion), mild neurocognitive disorder (stage between the expected decline in memory and thinking that happened with age and the more serious decline of dementia) due to known physiological condition with behavioral disturbance, and major depressive disorder (major mood disorder that causes persistent feelings of sadness). The Admission 5-Day Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of one, which indicated severely impaired cognition. R1 required supervision or touching assistance with walking and transfers. R1 required partial to moderate assistance with dressing and toileting. R1 had inattention and disorganized thinking. R1 had physical behavioral symptoms directed toward others and other behavioral symptoms not directed towards others, which occurred one to three days during the look-back period. R1 rejected care one to three days during the look-back period, R1 wandered daily, and significantly intruded on the privacy of activities of others. (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 Care Area Assessment (CAA) dated 10/09/24 documented R1 did not always understand what was being said to him. R1 was disoriented and confused most of the time. R1 wandered aimlessly daily. R1 did exit seek and had a WanderGuard in place for precautionary measures. R1 could be easily triggered for behaviors and had exhibited multiple behaviors since admission related to not cognitively understanding what took place. The Behavioral CAA dated 10/09/24 documented R1 placed himself at greater risk of losing his balance and falling when he lashed out while ambulating. R1 did not sleep well at night and was up most nights. R1 wandered aimlessly and could become behavioral and loud at times disrupting the environment. Staff redirected and attempted to calm R1 to decrease interruptions. Staff continued to intervene and attempted to calm, redirect, resolve, and distract R1 when he had behaviors. R1's Care Plan initiated on 10/04/24 documented R1 could ambulate without assistive devices. Staff were to distract R1 from wandering by offering food, drink, a video of R1 playing in his band, pleasant diversions, structured activities, food, conversations, television, or a book. Staff were directed to document wandering behavior and attempted diversional interventions. R1 was very confused and disoriented and would wander and try doors. R1 was not aware of safety. Staff monitored WanderGuard placement, and staff were to check placement and functioning every shift and as needed. R1's intervention initiated on 10/08/24 documented that R1 wandered daily and was resistant to care and redirection. R1 would hit, slap, yell, cuss, and try the exits. R1 wandered in and out of others' rooms and could be disruptive to the environment with behavioral outbursts. R1's Kardex (a nursing tool that gives a brief overview of the care needs of each resident) informed staff R1 was not aware of his safety, was very confused and disorientated, and would wander and try the doors. It informed staff R1 utilized a WanderGuard and was an elopement risk. R1's Elopement/Wandering Evaluation dated 10/04/24 documented R1's elopement score was 30, which indicated R1 was a high risk of an elopement. R1's Orders dated 10/04/24 ordered staff to monitor the placement and functioning of WanderGuard every shift for monitoring. The Behavior Note dated 10/03/24 at 09:37 PM documented R1 continually wandered the halls since his family left. R1 was very difficult to redirect and at times got very agitated when trying to redirect. The Nursing Note dated 10/04/24 at 07:58 AM documented R1 attempted to exit the door at the end of his hallway and set the door alarm off trying to open the door. R1 was easily redirected back away from the door. The Nursing Note dated 10/04/24 at 08:46 AM documented R1 had a WanderGuard bracelet applied to his right wrist. The Daily Skilled Note dated 10/05/24 at 01:09 PM documented R1 was observed to have wandering behaviors but was easily redirected. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Medication Administration Note dated 10/06/24 at 12:09 AM documented R1 was up and down the halls multiple times, going through drawers, closets, and bins in the hallway. R1 was redirected to the nurses' station and offered snacks, drinks, and distraction with music and television without resolution. R1 received as-needed medication for behaviors. The Daily Skilled Note dated 10/06/24 at 10:26 AM documented R1 was observed to have wandering behaviors. The Nursing Note dated 10/07/24 at 05:38 AM documented R1 was up throughout the night wandering the halls. R1 went in and out of rooms and went through closets at times. R1 was easily redirected. The Behavior Note dated 10/08/24 at 04:07 AM documented R1 wandered the halls all that shift going in and out of other resident rooms. R1 laid down in an empty room and was unable to be redirected back to his room. The Behavior Note dated 10/08/24 at 09:20 PM documented R1 attempted to cut off his WanderGuard. The Daily Skilled Note dated 10/09/24 at 03:50 PM documented R1 rejected care and was wandering. The Behavior Note dated 10/09/24 at 09:47 PM documented R1 continued to wander around the facility and entered other resident rooms. R1 got very agitated and aggressive with staff when staff attempted to redirect R1 out of other resident rooms. R1 was very hard to redirect and attempted to his staff members when staff attempted to redirect R1. The Behavior Note dated 10/11/24 at 10:17 AM documented R1 was undressed from the waist down and staff attempted to assist R1 in putting on clothes, which R1 refused and was hard to redirect. R1 wandered the halls going into other resident rooms. The Daily Skilled Note dated 10/11/24 at 03:22 PM documented R1 wandered around the building and had inappropriate, hard-to-redirect behaviors. R1 would hit staff and was non-compliant when directions were given. The Condition Follow-Up Note dated 10/12/24 at 12:57 PM documented R1 went outside the courtyard door to take a walk at approximately 11:43 AM. The WanderGuard alarm sounded, and staff responded to the alarm in addition to noticing R1 was outside the dining room window. R1 was easily redirected back into the building and assessed. The Facility Investigation dated 10/21/24 documented that at approximately 12:43 PM staff responded to the WanderGuard alarm and noticed R1 was outside the dining room window. R1 went outside the courtyard door to take a walk. Licensed Nurse (LN) H's Notarized Witness Statement dated 10/12/24 documented that Activity Z pointed out the window alerting staff that R1 was outside. LN H went out the dining room door and redirected R1 into the dining room. R1 was easily redirected and sat down to eat at the table. LN H was unable to hear the alarms in the dining room. LN H had last seen R1 seated at the chairs by the little kitchen before LN H started to pass medications and check blood sugars. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Certified Medication Aide (CMA) R's Notarized Witness Statement dated 10/12/24 documented R1 was seen at 12:20 PM on a hall, at which time CMA R encouraged R1 to go to the dining room to eat. R1 reportedly turned and faced the dining room. CMA R reported that R1 was seen coming out of the dining room at approximately 12:30 PM. CMA R again told R1 to go eat lunch. CMA R stated she entered the dining room to see what other medication she needed to pass before she sat down to assist residents with eating. CMA R reportedly sat down to assist residents with eating at approximately 12:40 PM. CMA R reported hearing Activity Z state that R1 was outside at 12:43 PM. That is when LN H and CNA N went out the side door of the dining room and walked R1 back into the dining room. On 10/21/24 at 11:45 AM R1 ambulated from the dining room with CMA R walking with R1. R1 appeared clean, well-groomed, and ambulated independently with no assistive devices. CMA R guided R1 to the recliners to sit and watch television. On 10/21/24 at 12:05 PM the door that R1 was suspected of exiting opened into a courtyard on the side of the building. The door had a sidewalk that wrapped from the doorway around to a gate in the fenced-in area of the courtyard. It was approximately 53 feet from the doorway to the gate. The gate was easily opened, even with a lock on the gate, from the inside of the courtyard. The sidewalk continued around the side of the building to wrap to the front side with the sidewalk ending approximately 43 feet from the gate to the courtyard. The sidewalk had slight variations in level but was relatively smooth. The sidewalk that led into the front parking lot had a wheelchair ramp going down to the asphalt and then ended. The sidewalk had an inch to an inch and a half step down to the grass along the sides of the sidewalk. The sidewalk did not start back up until roughly 15 feet away from the wheelchair ramp, which then started at the front door and then wrapped down in front of the dining room windows. On 10/21/24 at 11:55 AM Licensed Nurse (LN) G stated that R1 frequently ambulated down the hall he lived on and triggered the door alarm. LN G stated that staff were good at redirecting R1 when the alarm sounded and having R1 turn away from the door. On 10/21/24 at 12:01 PM, CMA R stated that she had been rounding up residents to eat lunch off a hallway. CMA R stated that R1 ambulated in the hallway and at approximately 12:20 PM CMA R encouraged R1 to go to the dining room for lunch. CMA R stated R1 followed her to the dining room. CMA R revealed that at that time she went to administer medications to residents that were not in the dining room, upon returning to the dining room at approximately 12:30 PM CMA R observed R1 leaving the dining room. Again, CMA R encouraged R1 to go back into the dining room to eat, but R1 continued to ambulate away from the dining room. At approximately 12:43 PM Activity Z asked if that was R1 outside the building. CMA R stated staff responded to R1 out in the parking lot brought R1 back into the building and placed R1 on one-on-one supervision. On 10/21/24 at 02:00 PM, Certified Nurse Aide (CNA) M stated that she was getting residents to the dining room. CNA M revealed that she passed R1 in the hallway and asked if R1 was going to eat lunch. R1 reportedly told CNA M that he was not hungry. CNA M revealed that the dining room was loud, and she could not hear any alarm going off at all. CNA M further stated that it was not until Activity Z stated that R1 was out in the parking lot that staff were aware that R1 had left the building. CNA M stated that R1 usually triggered the door alarms and that staff attempted to redirect him to be able to silence the door alarms. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 10/21/24 at 02:05 PM Administrative Nurse D stated that the alarm was sounding when R1 exited the building. On 10/21/24 at 02:20 PM Administrative Staff A stated that the WanderGuard alarmed on the walkies that were carried by staff and that staff needed to make sure that they had a walkie on. Administrative Staff A also stated that she could not even hear the door alarm from her office, so the facility would need to do something different. On 10/21/24 at 04:09 PM, LN H stated she was in the dining room passing medications when Activity Z said she thought that was R1 outside the building. LN H stated she ran out to him through the door in the dining room and brought him back into the dining room. LN H stated that she could not hear any alarms sounding when she was in the dining room. LN H revealed that when she exited the dining room back towards the nurse's station, she could not hear any alarms going off until she passed the fish tank which was approximately ten feet from the dining room doors. LN H revealed that she was unsure which door R1 had exited but when she went out into the courtyard the gate to the fenced-in area was opened. R1 had his WanderGuard on when he was brought back into the building. On 10/21/24 at 04:54 PM Administrative Nurse D stated that R1 was found on the sidewalk outside the dining room, not the parking lot. On 10/22/24 at 12:01 PM, LN H emailed that Activity Z pointed to the row of windows in the dining room and stated, Isn't that R1 outside? LN H looked up and observed R1 standing next to the window outside. LN H and CNA N ran outside from the dining room door to intercept R1. R1 wore tennis shoes, sweats, and a t-shirt with his WanderGuard visible on his ankle. LN H stated the door alarm was heard after leaving the dining room. The door alarm that was triggered was the great room door. On 10/22/24 at 01:39 PM, Activity Z emailed that while she was in the dining room delivering a plate of food to a resident R1 was seen out the window walking across the parking lot. Activity Z stated she calmly stated R1 was outside. Activity Z stated normally she could hear the door alarm whenever it went off, but on that day she did not. Activity Z stated that after R1 was back in the building staff went to figure out how R1 got out. Activity Z revealed R1 went out the side door by the great room and out the fence. The facility's policy Quality of Care revised October 2024 documented it was the policy of the facility to provide a safe environment, as free of accidents, as possible, for all residents through appropriate assessment, interventions, and adequate supervision to prevent accidents related to unsafe wandering or elopement while maintaining the least restrictive manner for those at risk for elopement. The resident's care plan would be updated to include interventions to address the possible need for an increased level of supervision. On 10/21/24 at 04:58 PM Administrative Staff A received a copy of the Immediate Jeopardy [IJ] Template and informed that the facility's failure to ensure R1 received adequate supervision to prevent an elopement placed R1 in IJ. The facility completed the following corrective actions by 10/16/24: (continued on next page)

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