

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E026	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/13/2024
NAME OF PROVIDER OR SUPPLIER Meade District Hosp Ltcu Dba Lone Tree Retirement		STREET ADDRESS, CITY, STATE, ZIP CODE 801 E Grant Meade, KS 67864	

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** 41121</p> <p>The facility reported a census of 32 residents, with three 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 the knowledge of staff). Based on observation, record review, and interview, 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)2, who the facility identified as an elopement risk. On 05/25/24 R2 displayed an increase in his wandering/exit seeking behavior which included statements he was going to leave, and he attempted to push open the front. On 05/26/24 R2 pushed on the doors leading to the apartments, displayed agitation, and thought the facility was a jail. On 05/27/24 at 10:38 AM, R2 attempted to exit the front entrance without success. On 05/27/24 at 10:40 AM, visitors entered the building and held the door open for R2 and he exited the front entrance without staff knowledge. R2 remained outside, unsupervised by staff until 10:43 AM, when Certified Nurse Aide (CNA) LL noticed R2 sitting outside unattended. The failure to provide adequate supervision and effective intervention to address the exit seeking behaviors, placed R2 in immediate jeopardy.</p> <p>Findings included:</p> <ul style="list-style-type: none"> - The Medical Diagnosis tab for R2 included diagnoses of vascular dementia (a progressive mental disorder characterized by failing memory and confusion caused by a decreased blood flow to the brain) with agitation, anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear) disorder, and altered mental status. <p>The Admission Minimum Data Set, dated dated dated [DATE] assessed R2 with a Brief Interview of Mental Status score of three, indicating severe cognitive impairment. R2 wandered one to three days of the assessment period, did not require the use of mobility devices, and was independent with walking and transfers.</p> <p>The Cognitive Loss/Dementia Care Area Assessment (CAA) dated 04/30/24 revealed R2 was at risk for impaired cognitive function or thought process related to anxiety, forgetfulness, and confusion.</p> <p>The Behavioral Symptoms CAA dated 04/30/24 revealed R2 was at risk for physical and verbal unusual behaviors directed towards others, related to complications from loss of independence and anxiety. The CAA lacked information about R2's wandering.</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 Care Plan dated 05/06/24 for R2 included a goal of R2 not having any episodes of wandering or elopement through the next review period. The care plan revealed R2 may have wandered one to three days and the staff were to perform a Wandering Risk scale quarterly and as needed. The staff were to keep the medical provider informed of changes in behavior, and to watch for and report to the nurse of any signs and symptoms of wandering. The care plan lacked additional interventions related to wandering/exit seeking until 05/27/24 when the facility added new interventions to include a Wander Guard (bracelet that sets off an alarm when residents wearing one attempt to exit the building without an escort) to his right ankle and if R2 verbalized thought of wanting to leave the facility, the staff were to stay with him and have someone notify the nurse. Additionally, on 05/27/24, the facility posted signage at the front door for visitors to not let residents out of the facility.</p> <p>The Wandering Risk Scale dated 05/18/24, scored R2 at a nine, which indicated R2 was at risk to wander.</p> <p>The Census tab for R2 revealed a room change to a different hallway on 05/22/24.</p> <p>The Progress Note dated 05/19/24 at 08:04 PM, revealed R2 wandered down the hall and walked into two other resident rooms.</p> <p>The Progress Note dated 05/23/24 at 03:59 AM, revealed R2 had been wandering the hallway he resided on throughout the night, had gone in another resident room, and hollered out where is everyone at?</p> <p>The Progress Note dated 05/23/24 at 06:29 AM, revealed R2 had walked up and down his hallway and another hallway in the facility all day yesterday after R2 was moved into another room.</p> <p>The Progress Note dated 05/24/24, revealed R2 walked up and down the halls most of the shift. R2 went on a facility bus ride and at supper time asked if staff had seen his brother. R2 did not sit in chairs for very long before he got right back up and started walking again.</p> <p>The Progress Note dated 05/25/24 at 02:20 AM, revealed R2 had recent medication changes and continued to have difficulty sleeping. R2 was wandering around the hallways at night and noted R2 wandered to the front door, at times.</p> <p>The Progress Note dated 05/25/24 at 05:41 PM, revealed R2 constantly stated he was going to leave.</p> <p>The Progress Note dated 05/25/24 at 06:00 PM, revealed R2 went to the front door and attempted to push it open.</p> <p>The Progress Note dated 05/26/24 at 04:50 PM, revealed R2 went up front and to the double doors leading to the apartments and was pushing on the doors. R2 thought the facility (staff) was keeping him from his house.</p> <p>The Progress Note dated 05/26/24 at 05:08 PM, revealed R2 thought the facility was a jail and displayed agitation.</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>The Progress Note dated 05/26/24 at 05:52 PM, revealed Licensed Nurse (LN) G received a phone call from R2's family. LN G informed family R2 had been restless and wanting to go to the farm and the house, more agitated and trying to open doors, and the facility (staff) possibly would put a Wander Guard on him.</p> <p>The Progress Note dated 05/26/24 at 06:58 PM, revealed R2 had confusion to place, time, and situation, ambulated independently with a front wheeled walker, and had six episodes of wandering in the last week.</p> <p>The Progress Note dated 05/27/24 at 10:54 AM, revealed LN H notified Administrative Nurse D regarding R2 seated on the outdoor bench at the entrance of the building.</p> <p>The Progress Note dated 05/27/24 at 11:12 AM, revealed R2 sat at the front door in a chair after elopement, upset and stated, this is jail and they are all liars! and refused to move. R2 had a Wander Guard placed to his right ankle. Administrative Nurse D reviewed the facility camera which revealed at 10:38 AM, R2 walked to the front door and attempted to enter a door code, then turned towards a chair. At 10:40 AM, visitors opened the front door and left it open for R2 to exit. R2 then turned and sat on the bench outside the front doors, and when a truck was outside, he became upset and wanted to leave in the truck.</p> <p>On 06/12/24 at 12:02 PM, observation of facility video footage from 05/27/24 revealed at 10:39 AM, R2 was at the front entrance and could not get out. He sat down in a chair at 10:40 AM until three visitors came in the front doors and held the door open for him. R2 then went outside and sat on a bench next to the front doors. At 10:43 AM, two staff exited the front of the building to bring R2 back inside.</p> <p>On 06/12/24 at 12:09 PM, observation revealed R2 sat in the dining room eating his lunch with his walker beside him. R2 then exited the dining room with the walker. Right before he made it to his room CNA O approached his side and offered the restroom, which R2 declined. R2 sat in his recliner and had a Wander Guard in place to his right ankle.</p> <p>On 06/12/24 at 12:52 PM, CNA LL stated on 05/27/24 she was propelling a resident down [specified hall] and happened to glance to the left and observed R2 outside on the bench by the front doors, through a resident room window. CNA LL then got on the walkie talkie and asked if anyone was out with R2 or had let him out and received a response back no. CNA LL stated then we all started to head to the front door. CNA LL did not know if his family was there with him or if R2 was just sitting there. CNA LL stated when staff tried to get him in, he became agitated, but were able to get him in and then applied a Wander Guard.</p> <p>On 06/12/24 at 02:10 PM, CNA M stated R2 wandered on the evening shift and R2 wandered more since he moved to another room. CNA M stated before the room change, he would come out of his room and go back in and now he goes to all areas of the facility and other resident rooms. CNA M stated before R2 eloped, he would try to open the doors on the halls, resident room doors and say he wanted to go to another city and CNA M saw him try to push doors open. CNA M stated she made the charge nurse aware when R2 did that.</p> <p>(continued on next page)</p>		

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