

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E356	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/11/2024
NAME OF PROVIDER OR SUPPLIER Satanta District Hospital Ltcu		STREET ADDRESS, CITY, STATE, ZIP CODE 401 S Cheyenne Street Satanta, KS 67870	

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 14 residents with one resident 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, interview, and record review, 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)1, who the facility identified as an elopement risk. On 06/04/24 at 07:41 PM, R1 exited the facility in his wheelchair through the unlocked exit door to the garden area, without staff knowledge. At 07:42 PM R1 then went out of the garden exit gate and down the sidewalk. At 07:45 PM, a community member saw R1 laying in the parking lot in front of the neighboring care facility, with his wheelchair tipped over on its side and R1 was bleeding from his elbow. The community members assisted R1 into his wheelchair and inside the neighboring care facility. Meanwhile, staff inside R1's facility looked for R1 as he was not in his usual spots and the staff could not find him. R1 remained in the neighboring facility, until he exited it unsupervised at 08:03 PM. At 08:04 PM a facility Certified Nurse Aide (CNA) observed R1 outside of the neighboring facility, 22 minutes after he exited the facility without staff knowledge. This deficient practice placed R1 in immediate jeopardy.</p> <p>Findings included:</p> <ul style="list-style-type: none"> - The Diagnosis and Problem tab included diagnoses for R1 of dementia (progressive mental disorder characterized by failing memory, confusion), generalized anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), and Huntington's disease (rare abnormal hereditary condition characterized by progressive mental deterioration, a disabling central nervous system movement disorder). <p>The Annual Minimum Data Set (MDS) dated [DATE], assessed R1 with a Brief Interview of Mental Status (BIMS) score of 10, indicating moderate cognitive impairment. The MDS documented R1 exhibited no wandering during the lookback period. R1 was independent with transfers and moving himself in a manual wheelchair.</p> <p>The Cognitive Loss Care Area Assessment [CAA] dated 12/05/23, revealed R1 had a diagnosis of dementia and required assistance with making daily decisions most of the time and was at risk for injury and decline in cognition.</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 Activities of Daily Living [ADL] Functional/Rehabilitation Potential CAA dated 12/05/23, revealed R1 had a diagnosis of Huntington's disease that resulted in the need for assistance with ADLs due to his flailing movements. R1 could propel his wheelchair without assistance.</p> <p>The Quarterly MDS dated [DATE] assessed R1 with a BIMS score of eight, indicating moderate cognitive impairment and documented no wandering exhibited by R1. R1 required partial/moderate assistance for transfers and setup assistance for wheeling himself in a manual wheelchair.</p> <p>The Care Plan dated 05/13/24, revealed on 05/26/24, the facility reinstated the problem of R1 being at risk for elopement. The staff were to closely monitor R1 when the weather was nice or if he was close to the doors, as he was not easily redirected when he wanted to go outside. The staff were to accompany R1 and supervise him while he was outside, and if unavailable to assist him outside when he became persistent, a time would be agreed upon when staff was available to go with him. The staff were to attempt to distract him with activities, food, one-to-one visits, television, or activities of his choice. R 1 could propel himself in the wheelchair around the facility and transferred himself often without staff assistance.</p> <p>The Elopement Risk assessment dated [DATE] revealed R1 had a history of resistance to redirection, had no recent wandering from the residence, had no verbalizations of intentions to elope, was not highly delusional (untrue persistent belief or perception held by a person although evidence shows it was untrue)/psychotic (gross impairment in reality perception) and mobile, and not attempted to leave unit, resulting in one yes answer to the questions. The assessment revealed if yes to any two, the facility was to place the resident on precautions.</p> <p>The Nurse's Notes dated 05/26/24 at 11:54 AM, revealed R1 attempted to open a gate and leave during an outside activity. After the activity, staff brought R1 in for lunch without issue, but then R1 immediately attempted to elope from the garden entrance. R1 pushed on the doors so hard they came off the track and he attempted to leave through the broken doors, which required staff to be posted by the doors and keep constant supervision (of R1). Addendum to note revealed on 05/27/24 at 09:50 AM, the facility placed R1 on every 30-minute checks and updated his care plan.</p> <p>The Nurse's Notes dated 05/29/24 at 12:26 PM revealed R1 had not attempted to exit the courtyard or attempt to go through the garden entrance doors unsupervised since 05/26/24, his behaviors had improved, every 30-minute checks discontinued, and the staff were to continue close supervision.</p> <p>The Nurse's Notes dated 06/04/24 at 10:00 PM, revealed R1 exited the building unattended at approximately 07:46 PM and staff located him on facility property in front of a neighboring care facility. R1 had been gone for approximately 20 minutes and the weather was around 80 degrees Fahrenheit (F). Certified Nurse Aide (CNA) M brought R1 back to the facility at approximately 08:07 PM in his wheelchair. R1 had two skin tears to his left forearm, reddened/scraped areas to his left forehead and right knee in two small spots, areas treated, and 15-minute checks started. An addendum to the note, dated 06/05/24 at 08:16 AM, revealed per staff, R1 stated he wished to go to [specified city] to see his son. The oncoming and outgoing staff were to check all doors for security at shift change, 15-minute checks were to continue until further notice, and if R1 sat close to an exit, staff were to divert his attention with an activity, one-to-one, or snacks in an attempt to relocate him away from the door. The staff were to close the double doors entering the activity room when the last activity completed for the day. At shift change, staff were to ensure all exits were securely locked.</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 undated typed statement, signed by CNA N, revealed on 06/04/24 at 07:45 PM she received a call from her relative informing her there was a man who had fallen out of his wheelchair, outside of a neighboring care facility, who was out of breath and his elbow was pretty skinned up and bleeding. Two high school students happened to drive by at the time and helped R1 into his wheelchair and into the neighboring care facility. CNA N stated she called the facility at 07:46 PM and spoke with LN G to inform of the information she had received, and LN G said to call 911 to make sure he did not have any broken bones or anything else wrong with him. At 07:57 PM, CNA N received a call from LN G asking if the person who had fallen was male or female. CNA N informed LN G the person was male. LN G then informed her it was a resident from the facility that had gotten out and an aide was on her way to get him.</p> <p>On 06/10/24 at 03:05 PM, tour with Administrative Staff A of where R1 exited revealed he left the facility through the activity room exit door that led to the garden entrance. Administrative Staff A stated the door was not magnetized and did not lock. Administrative Staff A stated when reviewing video footage, R1 went to the garden exit gate (located approximately 10 feet from the exit door) and unlatched the gate and wheeled himself down the sidewalk. Administrative Staff A stated the video footage did not show the exact location where R1 fell, as R1 could not be seen because the cameras did not work in front of the neighboring facility. Administrative Staff A said they were informed R1 fell in front of the neighboring care facility (approximately 256 feet from the garden exit gate). Administrative Staff A stated the cameras inside the neighboring facility noted R1 wheeled inside around 08:07 PM about the same time CNA M was coming up the ramp that adjoins the two facilities.</p> <p>On 06/10/24 at 03:30 PM, Maintenance Staff U stated the doors were checked monthly for proper function and the checks were not logged anywhere. Maintenance Staff U could not recall the date when the doors were last checked.</p> <p>On 06/10/24 at 04:40 PM, observation revealed R1 sat in his wheelchair in the dining room eating supper. R1 exhibited choreiform movements (involuntary, rapid, irregular and unpredictable movements) of his arms and legs.</p> <p>On 06/10/24 at 05:05 PM, observation revealed R1 propelled his wheelchair independently down the hallway, past the nurse's station, and down the hallway he resided on. CNA O and CNA P approached him right before he arrived at his room, provided ADL assistance, and exited the room after assisting R1 to his room recliner.</p> <p>During an interview on 06/10/24 at 08:50 PM, CNA M stated the day before she redirected R1 away from the door in the activity room that led to the garden area. CNA M stated on 06/04/24 around 07:30 PM she observed R1 in his room in bed, but not under the covers. CNA M stated she assisted his roommate and when she exited the room, R1 was headed down the hall. CNA M stated she was always on the lookout for him. CNA M stated she went to the waiting area by the garden sliding exit doors and he was not there. She said she checked the door in the activity room which exited to garden area, and he was not there. She said she then checked the bathroom in the hallway by the activity room and he was not there. CNA M stated she let the nurse know, who informed her the gate was wide open, so CNA M checked there two to three times and the other aides checked the halls. CNA M stated she located R1 outside the neighboring facility on the sidewalk. She said she saw R1 on the porch, so she ran through the door, and he was going down the ramp to the right side of the neighboring facility. CNA M stated she had no problems bringing him back (to the facility). CNA M said the nurse assessed R1 and started 15-minute checks, and R1 still wanted to go outside and leave.</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 06/10/24 at 09:07 PM, Licensed Nurse (LN) G, who started duty at 06:00 PM on 06/04/24, stated she saw R1 in his room at the beginning of her shift while she was passing medications. At approximately 07:45 PM she realized R1 was not in the facility. LN G stated she received a call from an off-duty CNA N who reported a relative saw somebody out by the neighboring care facility. LN G turned and saw the garden gate open but did not think it was R1 because CNA N said it was a female. LN G stated she had everyone look and then called CNA N back, who said she was not sure if it was a male or female and would call her relative and find out. LN G told CNA N to call 911 if it was a resident from the neighboring facility, and then CNA N stated the person was male. LN G stated at that time she had one staff in a vehicle looking and three others staff outside looking and checking the doors. LN G stated CNA N told her that her relative said two high school students helped R1 and he had blood from somewhere. LN G stated she assessed R1 when he was brought back in, which revealed two skin tears on his left forearm, a scrape on his left forehead, and tiny scrapes like rug burn on his knee. LN G stated CNA M brought R1 back around 08:07 PM. LN G stated she started 15-minute checks on R1 after completing her assessment.</p> <p>During observation of the video footage with Administrative Staff A on 06/11/24 at 08:16 AM, revealed on 06/04/24 at 07:40 PM, R1 entered the activity room in his wheelchair and went to the garden exit door. Administrative Staff A stated R1 was familiar with the exit. The video footage revealed R1 opened the door, with some difficulty managing the door, while moving his wheelchair through the doorway, and exited into the garden entrance at 07:41 PM. At 07:42 PM, R1 opened the latch to the garden gate and exited, going down the sidewalk towards the neighboring care facility. The video footage revealed between 07:47 PM through 08:04 PM multiple times staff looked for R1 and had gone outside several times. Then at 08:04 PM, CNA M exited the double doors that led to the adjoining neighboring care facility. At 08:07 PM, CNA M brought R1 back inside the facility. (The video footage did not include footage of the area in which R1 fell).</p> <p>On 06/11/24 at 08:44 AM, observation of video footage from the neighboring care facility with Administrative Staff A revealed at 07:27 PM, R1 entered the neighboring care facility and at 08:03 PM, R1 headed towards the front entrance doors. At 08:03:47 PM, video footage revealed CNA M walking from the facility adjoining hallway and at 08:04 PM, she quickly headed towards the front entrance doors of the neighboring care facility.</p> <p>On 06/11/24 at 10:50 AM, CNA N stated she was off duty at the time of the elopement, however had received a phone call from her relative who reported she saw a male in the parking lot, by the flagpole, on the ground with a wheelchair on its side, as they turned on the road from across the street. CNA N stated there were two high school students there and CNA N's family member suggested they get him in the wheelchair and noticed R1's elbow was skinned and bleeding. CNA N stated her relative did not see him fall, just saw R1 lying on the ground with the wheelchair tipped over on its side. CNA N stated her relative said the two students took the mal into the neighboring care facility.</p> <p>On 06/18/24 at 09:57 AM Administrative Staff A stated the reason R1 was up at that time on 06/04/24 was due to the staff going above and beyond inviting him to have ice cream outside, and the team noticed within a few minutes he was gone and started searching right away. Administrative Staff A stated the staff would have found R1 earlier if he had not been taken into the neighboring care facility by a good-hearted community member.</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 facility policy Elopement and Elopement Prevention dated 03/22/23, revealed the purpose was to maintain a system which protects residents/patients not capable of protecting themselves. Equipment in the policy included a security system with locked doors at all times.</p> <p>The facility failed to provide effective supervision and failed to ensure the facility doors were in proper working order, which resulted in the failure of one of the exit doors locking, to prevent the elopement of R1 who exited the facility without staff knowledge and supervision. R1 was outside for 22 minutes unsupervised by staff and received minor skin injuries that required treatment by the facility licensed nurse upon his return.</p> <p>On 06/11/24 at 02:12 PM, Administrative Nurse D was provided the Immediate Jeopardy template in person via email, while Administrative Staff A was on speakerphone, and notified the facility's failure to provide adequate supervision to prevent R1's elopement when R1 exited the facility without staff knowledge on 06/04/24 at 07:42 PM, placed the resident in immediate jeopardy.</p> <p>The immediate jeopardy was determined to first exist on 06/04/24 at 07:42 PM, and the surveyor verified the facility identified and implemented corrective actions completed on 06/06/24 at 09:40 AM when the facility completed the following:</p> <ol style="list-style-type: none"> 1. R1 placed on every 15-minute checks along with neurological checks on 06/04/24 at 08:10 PM. R1 to remain on 15-minute checks until reassessed on 06/10/24. 2. On 06/04/24 several GroupMe messages sent out to staff regarding monitoring of entrances, ensuring doors were closed, and making sure residents did not follow them. Elopement policy reviewed with night shift and sent to night shift via Administrative Nurse E to make sure safety measures were in place. 3. On 06/04/24 at 08:30 PM, family made aware of situation and encouraged to visit. Nurses to chart on resident every shift for the next two weeks. 4. On 06/04/24 Elopement risk assessments to be done once a shift for four weeks. 5. R1's care plan updated with five interventions and information passed on to the staff on 06/04/24 at 09:57 PM via GroupMe messaging system. 6. Maintenance ticket put in to check the activity door on 06/04/24 at 10:00 PM. Maintenance adjusted the locking system, but the door is bent (probably due to wind) and will need replaced. 7. On 06/05/24 at 06:00 AM, the CNAs started to check all doors to ensure they are secure and then sign off when completed. The charge nurse is to verify the doors have been checked and signed off by floor staff. 8. A huddles with facility staff done for dayshift with Administrative Nurse D educating watching the doors, every 15-minute checks, monitor residents' behaviors, watching doors and making sure they shut behind them and visitors and had the Elopement policy out for staff to read on 06/05/24 at 08:00 AM. <p>(continued on next page)</p>		

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