STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E034	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROTECTION VALLEY MANOR	600 S BROADWAY , PROTECTION, Kansas, 67127

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS An abbreviated survey for KS00195813 was conducted by the Kansas Department for Aging and Disability Services (KDADS), on behalf of the Centers for Medicare and Medicaid Services (CMS) on 07/01/25. The facility was found not to be in substantial compliance with 42 CFR 483 subpart B. On 07/01/25 at 02:30 pm, Administrative Staff A and Administrative Nurse D received a copy of the "Immediate Jeopardy [IJ] Template" and were informed of the IJ for Resident (R)1. On 06/04/25 at 07:29 PM, R1 exited the facility without staff knowledge or supervision through an unlocked front door. The door was typically locked but the door lock override was implemented, leaving the door unsecured and the alarm disabled. Staff received a call from an off-duty staff member who observed R1 walking outside, approximately two blocks away from the facility. Staff assisted R1 into the staff member's car and returned the resident to the facility at 07:42 PM. R1 was uninjured. The facility's failure to ensure door locks and alarms were implemented and failure to provide adequate supervision to prevent R1 from eloping through an unlocked door placed R1 in immediate jeopardy. The facility's corrective measures were fully completed on 06/10/25, which were verified by the surveyor on-site during the investigation. All corrections were completed prior to the onsite survey; therefore, the deficient practice was cited as past noncompliance at a scope and severity of "J." The 2567 was sent electronically on 07/15/25	F0000		
F0689 SS = SQC-J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)	F0689	"Past Noncompliance - no plan of correction required"	

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 reverse for further 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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F0689 SS = SQC-J	Continued from page 1 §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: The facility reported a census of 41 residents with one resident sampled for accident hazards. Based on observation, interview, and record review, the facility failed to ensure operational door locks, alarms, and supervision for cognitively impaired Resident (R) 1, a resident at high risk for elopement (when a cognitively impaired resident leaves the facility without the knowledge or supervision of staff) to prevent an elopement. On 06/04/25 at 07:29 PM, R1 exited the facility without staff knowledge or supervision through an unlocked front door. The door was typically locked but the door lock override was implemented, leaving the door unsecured and the alarm disabled. An off-duty staff member observed R1 walking outside, approximately two blocks away from the facility. Staff assisted R1 into the staff member's car and returned the resident to the facility at 07:42 PM. R1 was uninjured. The facility's failure to ensure door locks and alarms were implemented and failure to provide supervision to prevent R1 from eloping through an unlocked door, placed R1 in immediate jeopardy. Findings included: - A review of the Electronic Health Record (EHR) documented R1 had diagnoses that included dementia (a progressive mental disorder characterized by failing memory and confusion) with psychotic (a gross impairment perception) disturbance. R1's 06/03/25 "Entry Minimum Data Set" (MDS) documented R1 admitted to the facility from her home on 06/03/25. R1's 06/09/25 "Admission" MDS documented a Brief Interview for Mental Status (BIMS) score of six, which	F0689		

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F0689 SS = SQC-J	Continued from page 2 indicated severely impaired cognition. The assessment documented R1 had hallucinations (sensing things while awake that appear to be real, but the mind created) and delusions (untrue persistent belief or perception held by a person although evidence shows it was untrue) with wandering behavior one-to-three days during the seven-day observation period. The MDS documented R1 was independent with locomotion and was not at risk for falls. The 06/09/25 "Behavioral Symptoms Care Area Assessment" (CAA) documented R1 was at high risk for elopement and would often have her belongings packed. R1's paper "Elopement Risk Assessment" dated 06/03/25 at 03:00 PM recorded a score of 22 which indicated R1 was at high risk for elopement. R1's initial "Care Plan" lacked interventions related to her high risk for elopement on 06/04/25. On 06/05/25 (after the incident) R1's "Care Plan" was updated to reflect R1's elopement risk related to impaired safety awareness. The following interventions were initiated on 06/05/25 and revised on 06/06/25: Staff would assess R1 for fall risk. Staff would distract R1 from wandering by offering pleasant diversions, structured activities, food, conversation, television, and books. Staff would identify patterns of R1's wandering and intervene as appropriate. Staff would monitor R1 for fatigue and weakness. Staff would monitor R1's location with visual checks every 30 minutes and document wandering and attempted diversions in the behavior log. Staff would provide structured activities such as toileting, walking inside and outside, utilize orientation strategies such as signs, pictures, and	F0689		

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F0689 SS = SQC-J	Continued from page 3 memory boxes. R1 had a WanderGuard (a bracelet that helps monitor residents who are at risk of wandering) placed on her right ankle (revised 06/09/25). R1's EHR documented under the "Progress Note" tab documented the following: On 06/05/25 at 11:52 AM, Administrative Nurse D documented a late entry for 06/03/25 at 03:15 PM, which recorded staff placed a WanderGuard on R1's right wrist as she declined to have the device placed around her ankle. On 06/03/25 at 03:26 PM, Administrative Nurse D documented R1 was admitted to the facility from a private residence where she had lived for the last five years. R1 was accompanied by family and her family reported R1 had been leaving her apartment to go looking for jobs, find family members, and purchase items but R1 had difficulty remembering where businesses were and would ask for directions from other local businesses. On 06/03/25 at 09:10 PM, Licensed Nurse (LN) H documented R1 had not exhibited exit-seeking behaviors. On 06/04/25 at 10:00 PM, LN H documented that on 06/04/25 at approximately 07:45 PM, an (unnamed) off-duty staff member called the facility to report R1 was walking down the road. The note documented the staff member returned R1 to the facility. LN H assessed R1 who was without injury; R1 was not wearing a WanderGuard. The note documented LN H placed a new WanderGuard on R1's ankle and initiated 30-minute visual checks. LN H's "Witness Statement" dated 06/06/25 documented on 06/04/25 at approximately 07:45 PM, an (unnamed) off-duty staff member called the facility to report a resident was walking along the road to the west of the facility. The staff member brought R1 back to the facility and R1 was not wearing the WanderGuard. R1 was dressed appropriately for the weather. R1 was without injury and a new WanderGuard was secured to R1's ankle.	F0689		

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F0689 SS = SQC-J	Continued from page 4 Certified Nurse Aide (CNA) M's "Witness Statement" dated 06/06/25 documented LN G came back with an (unnamed) resident at approximately 06:45 PM and the front door alarm sounded. LN H went to the front door and shut off the door alarm. CNA M noted she set up her snack cart for the evening snack rounds and offered R1 a snack between 07:15 PM and 07:20 PM. CNA M documented she finished snack rounds at approximately 07:45 PM and was in the office when the phone rang and then LN H asked CNA M to go check on R1. R1 was not located in her room or bathroom and CNA M alerted LN H. CNA M noted she then went and checked the front door, and the keypad light was green (which indicated the door was unlocked and unsecured). CNA M noted she entered the override code to lock the door, and the keypad light turned red (which indicated the door was locked and secured) and sometime after that, a staff member brought R1 back to the facility. Dietary BB's "Witness Statement" dated 06/06/25 documented on 06/04/25 at 07:42 PM she was driving in the community with her children and noticed someone walking along the road who looked like a resident in the facility. Dietary BB documented the individual was wearing a red long-sleeve shirt with jeans. Dietary BB was able to positively identify the individual as R1 and initiated contact with the resident. R1 told Dietary BB that she was unsure how she left the facility other than she just walked out. Dietary BB asked R1 to accompany her back to the facility and Dietary BB drove R1 back to the facility in her private vehicle. R1 and Dietary BB were greeted by the facility staff at approximately 07:50 PM. During an observation on 07/01/25 at 08:15 AM, R1 sat in a recliner in her room and appeared to be reading a book. Further observation revealed a WanderGuard on R1's right ankle. During an observation on 07/01/25 at 11:35 AM, R1 walked independently in the hallway. She wore a WanderGuard on her right ankle. On 07/01/25 at 09:33 AM, Administrative Nurse F said that upon admission, the facility initiates the care plan but does not use the baseline care plan template. Administrative Nurse F said the full care plan was initiated within the first 48 hours and included the required basic items; the full care plan was completed	F0689		

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F0689 SS = SQC-J	Continued from page 5 within 14 days of when the admission MDS was completed. Administrative Nurse F confirmed R1's "Care Plan" lacked interventions related to elopement risk until 06/05/25. Administrative Nurse F confirmed that on 06/03/25 at approximately 03:00 PM, staff completed an elopement risk assessment on R1, who scored 22, which indicated a high elopement risk. Administrative Nurse F stated the facility's elopement book at the nursing station was updated at that time and Administrative Nurse D put a WanderGuard on R1's right wrist. Administrative Nurse F said somehow R1 was able to remove the WanderGuard from her wrist and staff later discovered it under R1's bed. On 07/01/25 at 11:32 AM, CNA M confirmed the information documented in her "Witness Statement" and stated on 06/04/25 at approximately 07:45 PM she checked the front door, and the keypad light was green (which indicated the door was unlocked and unsecured). CNA M noted she entered the override code to lock the door, and the keypad light turned red (which indicated the door was locked and secured) and sometime after that, a staff member brought R1 back to the facility. CNA M said that prior to R1's elopement on 06/04/25, she was unaware of the facility processes in place to check for WanderGuard placement. CNA M confirmed since R1's elopement on 06/04/25, education has been provided related to elopement prevention and revealed staff visually check on R1 every 30 minutes which included visually checking the placement of the WanderGuard on R1's ankle and documenting in the log. On 07/01/25 at 11:37 AM, Certified Medication Aide (CMA) S revealed she was working on 06/04/25, the day that R1 eloped, but she was not in the building at the time of the elopement because the incident occurred after her shift had ended. CMA S said that she was unaware of any facility processes in place to check for WanderGuard placement, prior to the elopement. CMA S confirmed since the incident, staff visually checked the resident's location every 30 minutes, checked the placement of the WanderGuard on R1's ankle and documented it in the log. During an interview on 07/01/25 at 11:45 AM, Dietary BB said she had nothing to add to the "Witness Statement" and confirmed since R1's elopement on 06/04/25, education was provided related to elopement prevention and steps to follow in the event of an elopement.	F0689		

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F0689 SS = SQC-J	Continued from page 6 On 07/01/25 at 11:57 AM, Administrative Nurse D revealed she placed a WanderGuard on R1's wrist on 06/03/25 at approximately 03:15 PM but it was not tight enough on her wrist as she was able to remove it sometime during the day on 06/04/25. R1 was the first resident in a long time to have an elopement risk high enough to warrant WanderGuard placement/use. Administrative Nurse D revealed prior to the elopement on 06/04/25 Administrative Nurse D or Administrative Nurse E checked the placement and function of the WanderGuard system on the doors once per month. Administrative Nurse D or Administrative Nurse E checked the function of the WanderGuard device worn by the resident(s) every morning, and this process was performed by the day shift charge nurse on the weekends or whenever administrative nurses were not in the facility. Administrative Nurse D said on the morning of 06/04/25, she checked the placement and function of R1's WanderGuard and it was in place and functioning appropriately. Administrative Nurse D stated the biggest factor that allowed R1's elopement to occur was the door override code (to disable the door locks) was known by all staff, and a staff member had inadvertently left the front doors unlocked and unsecured. On 07/01/25 at 12:00 PM, Administrative Staff A stated the facility's investigation revealed one of the contributing factors that allowed R1 to elope on 06/04/25 was that a staff member had entered the door override code and did not reset the lock before leaving the area. This allowed R1 to leave the building without the permission, knowledge, or supervision of staff. Administrative Staff A said this was an unacceptable risk, and the door override code had been changed and provided only to Administrative Staff A, Administrative Nurse D, and Maintenance W. The facility's "Elopement Risk Policy" policy, dated 04/06/17 documented the facility would provide a safe environment for residents at risk for wandering. Every newly admitted resident would be assessed by a licensed nurse to determine the risk for wandering. Residents identified at risk for wandering/elopement must have an individualized plan of care. The policy documented alarmed doors would not be disengaged except for repair or emergency evacuation and required continual and constant observation by a staff member. On 07/01/25 at 02:30 pm, Administrative Staff A and Administrative Nurse D received a copy of the	F0689		

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F0689 SS = SQC-J	Continued from page 7 "Immediate Jeopardy [IJ] Template" and were informed of the IJ for R1. The facility's corrective measures, fully completed on 06/10/25, included the following, which were verified by the surveyor on-site during the investigation. 1. On 06/05/25 at approximately 07:45 PM, a WanderGuard was placed on R1's right ankle and staff implemented visual checks of R1 and R1's WanderGuard every 30 minutes and documented checks in a log. 2. On 06/04/25 at 08:00 PM, a new override code procedure was implemented, and the override code was changed, the only staff who know the override code are Administrative Staff A, Administrative Nurse D, and Maintenance W. The new override code was placed in a sealed bright pink envelope with the emergency evacuation log in the nurses' station. 3. On 06/04/25 at an unknown time, all facility staff were educated related to elopement prevention and procedures to follow in the event of an elopement, completed on 06/10/25. 4. On 06/06/25 an ad hoc Quality Assurance Process Improvement meeting was held. 5. On 06/06/25 the "Wander Guard System" and "Elopement Risk ..." policies were updated All corrections were completed prior to the onsite survey; therefore, the deficient practice was cited as past noncompliance at a scope and severity of "J".	F0689		