

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/24/2019  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>175386</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>05/14/2019</b>
NAME OF PROVIDER OR SUPPLIER  <b>SCHOWALTER VILLA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>200 W CEDAR PO BOX 5000</b> <b>HESSTON, KS 67062</b>		
(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	
F 000	INITIAL COMMENTS  The following citations represent the findings of a partial extended survey for complaint investigation # KS 00140792.  This 2567 was electronically sent to the facility on 5/15/19.  A revision of this 2567 was electronically sent to the facility on 5/24/19.	F 000			
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)  §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 90 residents with 3 residents selected for sample review of elopement. Based on observation, interview, and record review, the facility failed to ensure one of the 3 residents reviewed, (#1) received adequate supervision to prevent the resident from exiting the facility courtyard, passing through the attached assisted living facility and then crossing a water spillway and pond, a residential street leading to an outdoor, non-supervised walking path through an Arboretum (a large garden of winding paths with flowers, trees and bushes), approximately a 10 to 15 minute walk away from the resident's place of residence, and without the staffs' knowledge. This deficient practice placed	F 689			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

05/15/2019

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.

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F 689	<p>Continued From page 1 the resident in Immediate Jeopardy.</p> <p>Findings included:</p> <ul style="list-style-type: none"> <li>- Resident #1's ECR (electronic clinical record) included an alert "flag" indicating the resident as an elopement risk and included a diagnosis of dementia (progressive mental disorder characterized by failing memory, and confusion).</li> </ul> <p>The admission MDS (minimum data set), dated 12/21/18, included a BIMS (brief interview of mental status) score of 10, indicating moderately impaired cognition. The assessment further identified the resident wandered and required supervision for walking and locomotion on and off the unit and ambulated without the use of any assistive devices (such as a walker, cane or wheelchair). (The resident previously resided on and admitted from the AL side of the facility.)</p> <p>A quarterly MDS, dated 3/11/19, identified a decline in the resident's cognition from 10 to 5, which identified severe cognitive impairment, however, lacked evidence of wandering. The resident's mobility status lacked change.</p> <p>Elopement risk assessments, dated 12/27/18 and 3/21/19, respectively. scored the resident at 15 and 10. The assessment identified scores 7 and greater identified a risk for elopement.</p> <p>A 4/9/19 care plan directed staff in the following care needs for the resident:</p> <ol style="list-style-type: none"> <li>1) Complete Wandering/Elopement Risk Assessments on admission, quarterly and with any significant change in condition or the development of increased exit seeking behaviors.</li> </ol>	F 689			

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F 689	<p>Continued From page 2</p> <p>2) Code alert tag (a small watch-type unit, used to alert staff to the resident's whereabouts) to the resident's right wrist.</p> <p>3) Re-direct the resident away from exits and provide distractions such as snacks, engaging in an activity or having a 1:1 interaction with the resident.</p> <p>4) Anticipate the resident's needs, at all times.</p> <p>5) The resident continued to make poor safety choices, as evidenced by removing code alert tag 2 times, this month. Staff are to visualize the tag on my wrist, every day.</p> <p>6) Complete 15-minute checks to ensure the resident's safety.</p> <p>7) Staff to walk with the resident, when going outside for walks and remain with him/her. Staff added this on 4/25/19, following the elopement.</p> <p>The care plan failed to direct, prior to 4/25/19, the staff in whether to remain with the confused and wandering resident or provide the 15-minute checks when the resident was in the courtyard.</p> <p>Review of the Potential Wanderers List, last updated on 4/19/19, included this resident and 15 others identified at risk for elopement.</p> <p>Review of nursing notes relative to the elopement included: On 3/5/19 at 11:50 AM, staff notified the resident's family that he/she removed the code alert tag, at some point. The staff removed scissors, a pocket knife and matches from the</p>	F 689			

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F 689	<p>Continued From page 3 resident's room.</p> <p>On 3/11/19 at 11:26 AM, the resident removed the code alert tag on 3/10/19, because he/she did not like the way it looked. Staff noted the tag failed to trigger a code alert. Staff removed pocket knife, scissors, nail clippers and mail cutters from the resident's room.</p> <p>On 3/17/19 at 4:33 PM staff documented at 2:45 PM, the resident walked down to West (hall) with a staff member. The resident pushed the correct code to open the door without assistance and then passed into the courtyard. The code alert activated the sensor, at that time. The resident indicated the desire to stay in the courtyard for a bit. The staff member had to take another resident back to the North (hall), but returned after being gone for approximately 3 minutes. Upon return to the courtyard, the staff did not see the resident in the courtyard, however, none of the code alerts signaled to alert the resident returned into the facility. The staff searched and found the resident on the 150 hall (an assisted living hall), talking to an AL (assisted living) resident. The resident pushed the correct code to open the door into AL. At that time, the resident stated he/she did not plan to leave but wanted to walk around by him/her self. Staff placed the resident on 15-minute checks for closer monitoring and updated the care plan. The facility failed to implement changes to the code alerts, at that time, to prevent the resident from exiting the facility, without the staff's knowledge.</p> <p>On 4/9/19 at 1:55 PM, staff documented on 3/21/19 staff held a care plan meeting with the resident and his/her family members, who provided input into the care plan. A discussion of</p>	F 689			

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F 689	<p>Continued From page 4</p> <p>the resident's decline in cognition was held and staff noted the resident made 2 attempts to exit the building and cut off his/her code alert tag on 2 occasions. Staff updated the Elopement Risk Assessment and the level of care assessment.</p> <p>On 4/25/19 at 8:08 PM, staff documented the resident walked to the Arboretum, unsupervised. The resident exited the building at 2:20 PM. The resident was found on the ground near the Arboretum building and was assisted by arboretum staff into a wheelchair. Staff returned the resident from the Arboretum to the health care facility at 3:05 PM (45 minutes after he/she exited). An assessment by nursing staff identified the resident as alert, with eyes responsive to light, neurological assessment within normal limits, vitals assessed, charted and were noted as stable, and the resident denied pain. The staff noted the resident with several skin issues located to the resident's left shoulder, left wrist, and left knee. The resident exhibited good range of motion to the left wrist, with swelling noted. Good range of motion to all extremities was present and the resident followed commands without difficulty. The resident indicated he/she wished to go for a walk, as the reason for leaving the facility. Notifications were made to the family and PCP (primary care physician) who examined the resident in his/her office at 4:15 PM. The resident returned with a splint located to left hand due to left 5th digit fracture and instructions to keep the splint on and dry until a follow-up appointment on 5/3/19 at 10:30 AM. Staff updated the care plan.</p> <p>Review of the facility provided investigation, evidenced the resident, on 4/25/19 at 2:22 PM, exited through the unlocked courtyard door. The</p>	F 689			

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F 689	Continued From page 5 code alert notified staff of the resident exiting through the door. Direct care staff member D responded to the notification and seeing the resident in the courtyard, inquired of the resident what he/she was doing. The resident responded he/she wanted to walk around the courtyard a bit. Staff D returned to the north hall and reported to Nurse B and C the resident remained in the courtyard and inquired if the resident should be left alone. (Staff D failed to use his/her walkie talkie in her possession to ask licensed staff, but instead left the resident unsupervised.) Licensed nurse C returned to the courtyard, as both nurse B and C did not believe the resident should be left alone. When arriving at the courtyard nurse C did not see the resident, walked through the courtyard and returned inside the building and inquired of other staff in the vicinity if they saw the resident. Staff C requested the staff begin looking in the halls/rooms for the resident, while staff C continued to another hall to look. After checking the hall and returning to the courtyard and checking one more time, and not finding the resident, nurse C returned to the north hall and nurses C and B initiated a Code Green (a procedure implemented whenever a resident was missing, to aid in finding a resident). Multiple staff responded, and alerts went out to other staff members throughout the health care facility. Staff began a search outside of the building and without any sign of the resident, notification to 911 was made. At that time, a more extensive search of the outside of the building began. A report, from an AL resident, of the resident possibly being seen heading towards the Arboretum was followed up on and staff located the resident at the Arboretum building seated in a wheelchair with a staff member of and volunteer of the Arboretum. Direct care staff E and F	F 689			

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F 689	<p>Continued From page 6</p> <p>returned to the facility with the resident at 3:20 PM and the staff called off the Code Green.</p> <p>The facility investigation, dated 5/2/19, identified the resident proceeded through the courtyard and then through the entrance door of the AL facility, where the resident previously resided. The AL entrance door required a code for entrance, but not for exiting. After entering the AL facility (entered the code him/her self) the resident then walked down a hallway and exited through another AL door. The resident proceeded to cross a residential street (with a posted speed limit of 30 MPH) and entered the Arboretum grounds. On the south side of the building on the Arboretum grounds the resident fell, landing on his/her left side. The resident obtained a hematoma and swelling to the left wrist, skin tears and a fracture to the left pinky finger. The resident was seen on the ground by a volunteer who called for an Arboretum employee, who then assisted the resident off the ground and into a wheelchair. The facility staff found the resident in the Arboretum and returned the resident to the facility. The staff lacked knowledge of the resident's whereabouts for 43 minutes, with the resident being out of line of sight for 58 minutes.</p> <p>Observation, on 5/9/19 at 9:50 AM, identified the resident sat on the sofa in his/her room and he/she chatted with a staff member. The resident appeared calm and reported having fallen when out for a walk. The resident raised his/her left arm to reveal a cast present to the lower portion of the arm and extending downward towards the outer aspect of the hand. An ace wrap held the pinky finger to the ring finger on his/her left hand. The resident responded appropriately to questions, indicating by crooking his/her finger on</p>	F 689			

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F 689	<p>Continued From page 7</p> <p>how he/she exited the building when going for the "walk." The resident inquired what day this was and when told the resident got up and walked into his/her bathroom to look at a calendar. The resident exhibited a steady gait. When reviewing the calendar and the dates marked on the calendar the resident became confused and repeatedly inquired as to what day this was.</p> <p>On 5/9/19 at 1:05 PM, observation identified the resident exited the front dining room, unaccompanied by staff. The resident turned and looked briefly into the dining room and then headed down the 100 hall. An unknown staff member observed the resident leaving the dining area and followed the resident.</p> <p>On 5/9/19 at 8:30 AM, administrative staff A provided a requested census roster and reported a lack of other elopements within the past few months. Staff A reported the resident lived at the AL for 4 years, however, when the resident's dementia worsened the family agreed the resident should move to a more secured and supervised area. The staff further clarified being surprised when the resident recalled the entrance code to the AL to allow the resident's elopement from the facility. (The resident entered the AL once before, using the code on 3/17/19.)</p> <p>On 5/9/19 at 10:05 AM, direct care staff G reported the resident routinely walked through the facility and ate in the front dining room for meals. The staff monitored the resident every 15 minutes.</p> <p>On 5/9/18 at 10:57 AM, licensed nursing staff B reported the resident was up and about per his/her normal that day, with wandering, but not</p>	F 689			

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F 689	<p>Continued From page 8</p> <p>exit seeking. The staff reported he/she was in report when the code alert notified the staff the resident was at the courtyard door, around 2:20 PM. The staff continued with report, while instructing aide D, via the walkie talkie to check on the resident. A few minutes later aide D returned to the nursing office to ask the nurse if the resident should be attended in the courtyard. Staff D requested another staff member attend to the resident, if needed, as he/she needed to complete rounds for shift change. The staff believed that direct care staff D should have been aware of the resident's care needs and remained with the resident until another staff could supervise the resident. Additionally, the staff noted the aide had a walkie talkie that he/she could have used to call for assistance or questions. Licensed nurse C immediately left the office to supervise the resident, however, when arriving at the courtyard staff C was unable to locate the resident. At 2:40 PM the staff called the Code Green notifying all staff of a missing resident. The staff reported the resident was found around 3:00 PM, returned for assessment, was sent to the doctor, and diagnosed with a broken finger.</p> <p>On 5/9/19 at 11:27 AM, direct care staff D reported the resident enjoyed visiting with friends throughout the facility and enjoyed eating meals in the main dining room with friends there. The staff indicated the resident often went to the library. The staff indicated that now when the resident wanted to attend activities in the front area of the facility, staff must accompany the resident, because of the elopement. The staff indicated he/she initially checked on the resident on 4/25/19 when the alert was made the resident was at the courtyard door. Because the courtyard</p>	F 689			

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F 689	<p>Continued From page 9</p> <p>was "secured" when checking on him/her it was felt the resident could be outside alone. When I checked on the resident he/she indicated the plan to walk a while in the courtyard and staff D returned to let the nurse know about the resident then returned to complete end of shift rounds with the on-coming shift. Before leaving for the day the staff learned the resident exited the courtyard and was missing.</p> <p>On 5/9/19 at 11:55 AM, licensed nursing staff C reported that during the between shift report, around 2-2:15 PM, the alert notified the staff of the resident being at the courtyard door. It was announced on the walkie talkie for a staff member to check on the resident. The alert was cleared, and then direct care staff D returned and indicated the resident was outside in the courtyard unattended. Staff C immediately went to the courtyard to remain with the resident while outside and was unable to locate the resident. Doing a quick search of the courtyard, then 100 hall, the main dining area, back out into the courtyard and not finding the resident, staff C returned to the north hall, and nurses B and C determined to conduct a Code Green. Staff C reported while awaiting the police arrival to provide pictures of the resident to the police. A call over the walkie talkies alerted everyone that the resident was found and being returned to the facility.</p> <p>The facility failed to ensure a secure and safe environment for this resident. This resident eloped from the facility when the staff failed to change the access codes into the unsecured assisted living home, which the resident entered and then exited through those unlocked/alarmed doors.</p>	F 689			

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F 689	<p>Continued From page 10</p> <p>An interview on 5/10/19 at 12:45 PM, with administrative staff A, provided notification to the facility of the elopement and the failure to maintain a secure environment for the confused and mobile resident placed the resident in Immediate Jeopardy.</p> <p>The facility removed the immediate jeopardy on 5/13/19 at 2:43 PM, when facility staff completed the following:</p> <ol style="list-style-type: none"> <li>1) On 4/25/19 at 4:00 PM, until the code alert company could update the interior entry door from the courtyard into AL (assisted living), staff locked the outer door into the AL to prevent entry from the secured courtyard into assisted living.</li> <li>2) On 5/3/19 at 11:30 AM staff changed the code access to the doors in the north hall, where the majority of the ER (elopement risk) residents reside. These 2 exit doors were changed to emergency exits only and without access codes posted and posted for emergency use only, not for general entry and exiting of the facility.</li> <li>3) On 5/3/19 at 4:00 PM installation of a code alert antenna and door function update at the courtyard and AL entrance completed. The door access from the courtyard into AL was unlocked (see #1).</li> <li>4) On 5/9/19 by 4:30 PM maintenance staff changed all exit doors with code access required from the former code, to prevent any resident identified as ER from recalling the formerly used code to access and/or exit the facility/AL. Staff re-posted new access codes, in a less prominent location.</li> </ol>	F 689			

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NAME OF PROVIDER OR SUPPLIER  <b>SCHOWALTER VILLA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>200 W CEDAR PO BOX 5000</b> <b>HESSTON, KS 67062</b>		
(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	
F 689	Continued From page 11  5) On 5/10/19 at 4:00 PM a policy change to the Elopement policy, required annually changing of the access code. The code can be changed more frequently, as requested by the Director of Nursing or the Executive Director. The facility assigned the policy review as part of the all staff required education completed by 5/13/19.  6) On 5/13/19 at 2:34 PM the majority of the staff received the Relias training on elopement and the change in policy. The remaining staff are flagged to complete the training before their next scheduled shift.  The immediate jeopardy abated to a G level deficiency.	F 689			