STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175124	A. BUILDING _____ B. WING _____	C 04/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEPOINT EL DORADO, LLC	1313 S HIGH STREET EL DORADO, KS 67042

(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 complaint investigations # 169734 and # 170625. This 2567 was electronically sent to the facility on 05/03/22.	F 000		
F 689 SS=E	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 39 residents. The sample include 12 residents and three sampled for elopement. The facility identified seven residents at risk of elopement (incident when a cognitive impaired resident with poor or impaired decision-making ability and safety awareness leaves the facility without the knowledge of staff). Based on observation, interview, and record review, the facility failed to ensure Resident (R)4, identified as a high risk of elopement, received adequate supervision and safety devices to prevent an unaccompanied exit from the building without staff knowledge. The resident exited the facility, without staff knowledge, thru the west exit door of an unsupervised hallway. This unsupervised area in the evening and night hours could affect the seven residents identified at risk for elopement.	F 689		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 689	Continued From page 1	F 689		

Findings included:

- The signed "Physician Order Sheet" (POS), for Resident (R)4, dated 04/01/22, documented the resident admitted to the facility on 03/29/22, with diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion), weakness (loss of muscle strength), disorientation (altered mental state with loss of sense of time, identity, direction and place), and repeated falls (unplanned descent to the floor with or without injury to the patient).

The entry "Minimum Data Set" (MDS), dated 03/29/22, revealed the resident was admitted on 03/29/22 from acute hospital.

The baseline "Care Plan", dated 03/29/22, revealed the resident required setup assist of one staff for ambulating. The resident had a history of falls prior to admission.

According to Weather Under Ground: Wichita, KS Weather History | Weather Underground (wunderground.com), revealed on 03/29/22 at 07:16 PM, the temperature was 72 degrees Fahrenheit, south, southwest wind at 29 miles per hour and no precipitation.

Review of the Comprehensive Nursing Assessment, dated 03/29/22, documented the resident with a "Brief Mental Interview Status" (BIMS) of one, with short-term and long-term memory, indicating severely impaired.

Review of the Wandering/Elopement Risk Assessment, dated 03/29/22, documented the resident was cognitively impaired and ambulated independently. The resident wandered aimlessly

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F 689	Continued From page 2	F 689		

and was at risk of getting into dangerous places.

Review of the Morse Fall Scale (an assessment tool used to assess a resident's likelihood of falls) documented a score of 65. The Morse Fall Risk level of equal or greater than 51 indicated high risk for fall.

On 03/29/22 01:00 PM Clinical Note documented the resident admitted from an acute hospital. The resident was unable to verbalize her needs. The resident required assistance with cares and was resistive to assistance by staff.

On 03/29/22 at 07:30 PM, the "Clinical Note" documented nursing staff became aware that the resident was not in her room. A door alarm sounded on the west side of the building . A staff member located the resident outside by the dumpster approximately 60 feet from the exit door. No apparent injuries resulted in the elopement. . Following the elopement, staff seated the resident in a recliner in the lobby and placed the resident on a one on one. In addition, staff placed a wander guard on the resident.

On 04/25/22 at 2:38 PM observed that dumpster was in the staff parking and staff member identified the parking as the staff parking. The resident was located approximately 60 feet from the exit door.

On 04/25/22 at 02:38 PM Certified Nurse Aide (CNA) M reported on 03/29/22, an exit door alerted staff that someone had exited the facility at the west door. He found the resident standing in the staff parking lot by the dumpster. He redirected the resident into the facility for Licensed Nurse (LN) G to assess the resident.

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F 689	Continued From page 3	F 689		

He reported he was not aware the resident was an elopement risk and required a Wander Guard placement.

On 04/25/22 at 05:36 PM, CNA N, reported she observed the resident was not in her bed on 03/29/22 at approximately 07:25 PM. She reported this to the charge nurse.

On 04/25/22 at 06:11 PM, CNA O reported on 03/29/22, she and CNA N toileted the resident at 07:00 PM prior to her assisting the resident to her bed. She reported she was not aware the resident was assessed as an elopement risk.

On 04/25/22 at 06:45 PM Licensed Nurse (LN) G reported on 03/29/22 (the date of the elopement), the resident sat in a recliner in the common area of four joining halls, and did not display exiting seeking. At 07:25 PM, she reported that she was alerted by the staff the was not in her bed. The alarm to the west exit door was sounding. A staff member exited that door and found the resident to be walking in the staff parking lot, unsupervised. Nurse G reported staff brought the resident back into the facility at 07:26 PM.

On 04/26/22 at 10:48 AM, LN H reported R4 was not exit seeking. The resident asked where she was, and staff "Reminded" the resident she was in the facility. LN H verified she completed a WanderGuard/Elopement Risk Assessment, and verified the resident was at high risk for elopement, a and a Wander Guard should have been placed on the resident at the time of the assessment.

On 04/26/22 at 10:43 AM, Administrative Nurse D reported that R4 had not expressed exiting

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F 689	Continued From page 4	F 689		

seeking since admission, on the same day. The admission nurse failed to place a Wander Guard on the resident upon completion of the WanderGuard/Elopement Risk Assessment which placed the resident at risk for elopement.

On 04/26/22 at 02:32 PM, Administrative Staff A reported the facility policy for residents at risk for elopement is the Wander Guard Placement. Administrative Staff A verified the Wander Guard was not placed on R4 and review of the facility surveillance camera, the resident ambulated through an unsupervised hallway and exited the exit door on the west side of the building at 07:25 PM. The alarm on the exit door alerted staff which exit door opened. At 07:26 PM a staff member assisted the resident into the facility.

The facility's revised "Elopement or Missing Resident Policy", dated 12/19/18, documented the facility should protect cognitively altered residents against actual or potential harm from leaving the community unauthorized and place a Wander Guard bracelet on residents who have been identified as an elopement risk.

The facility failed to ensure a secure environment for this resident identified as a high risk of elopement, when the resident was identified as a high elopement risk when she was admitted on 03/29/22, and eloped that evening when she exited the facility without staff knowledge through the west, exit door of unsupervised hallway. This unsupervised area in the evening and night hours could affect the seven residents identified at risk for elopement.