STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175380	A. BUILDING _____ B. WING _____	C 04/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CEDARS	1021 CEDARS DRIVE MCPHERSON, KS 67460

(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 investigation KS00170866. The 2567 was sent electronically on 04/22/22.	F 000		
F 689 SS=D	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 had a census of 51 residents with three reviewed for elopement. Based on observation, record review, and interview, the facility failed to educate staff regarding the door locks and wander guards (a bracelet designed to help protect memory care residents against elopement) deactivated during a fire alarm which led to the elopement (when a cognitively impaired resident leaves the facility without staff knowledge or supervision) of Resident (R) 1 and placed R1 at risk for injuries or accidents related to elopement. Findings included: - R1's Electronic Medical Record (EMR) documented R1 had diagnoses of psychiatric disorder (any major mental disorder characterized by a gross impairment in reality testing) with hallucinations (sensing things while awake that	F 689		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 04/22/2022

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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appear to be real, but the mind created), dementia (progressive mental disorder characterized by failing memory, confusion), and anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear).

R1's "Quarterly Minimum Data Set (MDS)" dated 01/11/22 documented R1 had a Brief Interview for Mental Status (BIMS) score of 99 which indicated severe cognitive impairment. The MDS further documented R1 had short and long-term memory loss, inattention, and disorganized thinking. The MDS documented R1 required extensive assistance of two staff for bed mobility, dressing, toileting, personal hygiene, and transfer. The MDS documented R1 required limited assistance of one staff for walking in her room and walking in the corridor.

R1's "Dementia Care Area Assessment (CAA)," dated 04/12/21, directed staff to ensure optimal participation in daily decision making.

R1's "Activities of Daily Living CAA," dated 04/12/21, directed staff to proceed to care plan the level of assistance R1 needed to ensure her needs were being met.

R1's "Risk for Elopement Care Plan," dated 01/12/21, directed staff to monitor the wander guard placement to her right ankle, and observe R1 for wandering patterns and emotional status. It directed staff to provide consistent routine in daily needs and use validation techniques to discuss emotion behind wanting to leave the facility. The care plan further informed staff R1 had a history of wandering, had impaired cognition, had impaired decision-making abilities,

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and was able to mobilize independently when she chose to.

The "Risk Meeting Note," dated 04/07/22 documented R1 had behaviors of wandering throughout the facility, decreased desire to eat, and restlessness. Interventions for staff included: one to one interaction, reassurance, assess for medical/physical needs, leave in a safe environment, and to re-direct.

The "Interdisciplinary Note," dated 04/08/22, documented R1 was found wandering outside by facility maintenance staff. The incident leading up to the elopement was due to the fire alarm being triggered in house 807 and affected house 805. The fire alarm de-activated the locks on the doors in houses 805 and 807 (the house where R1 was living). The fire department arrived at the facility at 06:16 PM. In reviewing the camera footage, R1 exited the facility at 06:24 PM. R1 had on a short-sleeved night gown and tennis shoes with her purse in hand. The temperature outside at the time was 57 degrees Fahrenheit (F). R1 was brought back into the building at 06:28 PM by facility staff. The nurse assessed R1. R1's vital signs were normal. A fire watch was implemented at 06:30 PM. Staff were educated regarding checking all residents and doors hourly until the wander guard system was functional again.

On 04/13/22 at 12:00 PM, observation revealed R1 ate her lunch in a recliner. She had a wander guard bracelet on her right ankle.

On 04/13/12 at 10:00 AM, Administrative Staff A stated R1 was seen on camera getting out of her chair with her purse and walking outside. The fire fighters were looking at her and then

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maintenance man was walking up the side walk and went in and told the nurse and CNA that she was outside. She stated they have completed some of the staff education regarding the wander guards and they will be having a mandatory staff meeting on 04/19/22, 04/20/22, and 04/21/22 and will completely cover during fire alarms, all of the doors, and wander guards de-activate so every staff will have that knowledge to ensure the safety of the residents in all of the houses.

On 04/13/22 at 10:30 AM, Maintenance Staff U stated the fire alarms went off on 04/08/22 due to a pin hole leak in the fire pumps that triggered the fire alarm to go off and then the fire dept had been dispatched to the 807 house at the facility. Maintenance Staff U stated when the fire alarms go off and the fire dept is dispatched the door locks disengage and the wander guards disengage. Maintenance Staff U stated the door locks and wander guards will not reengage until the fire system is reset. That day it probably took about 30 minutes for the fire department to clear the building and find out what the problem was and clear the fire panel, but the fire alarms, doors, and wander guards could not be reset until the problem was taken care of so a fire watch was initiated for houses 805 and 807 until 04/11/22 at 11:00 AM when the pin hole leak could be repaired. Maintenance Staff U stated the facility does fire drills once per shift per quarter and the door locks and the wander guards are down for approximately 10 minutes. Maintenance Staff U stated that all staff in the houses should be aware that when the fire alarm sound that the door locks stop working and the wander guards stop working.

On 04/13/22 at 12:00 PM, CMA R stated that she

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worked at the facility for 14 years and she was unaware that the wander guards stopped working when the fire alarms went off until the incident on 04/08/22. CMA R stated she was not been trained regarding the wander guards disengaging when the fire alarms went off unless it had been when she very first started.

On 04/13/22 at 12:10 PM Administrative Nurse D stated that the facility did not do any training regarding the door locks and the wander guards disengaging when a fire alarm goes off because it just doesn't happen very often. Administrative Staff D stated that she would expect staff to keep a close watch on elopement risk residents during a fire alarm.

On 04/13/22 at 12:30 PM CMA S stated that the she was unaware of the wander guards not working when the fire alarms went off and did not know anything about it until after the incident.

The facility "Elopement" policy, revised February 2021, documented it is the facility's responsibility to prevent an incident of elopement of the residents. Elopement is defined as leaving the facility without the knowledge of staff of a resident who has impaired decision-making ability, is unaware of own safety needs, or is at risk for injury outside the confines of the facility. Elopement occurs when a resident leaves the premises or a safe area without authorization and/or any necessary supervision to do so.

The facility failed to ensure adequate supervision to prevent elopement by R1 on 04/08/22. This placed R1 at risk for accidents and/or injuries related to elopement.