STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175294	A. BUILDING _____ B. WING _____	C 09/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICALODGES GODDARD	**501 EASY STREET GODDARD, KS 67052**

(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 A Targeted Infection Control Survey/COVID-19 Focused Survey was conducted on 09/15/20 to 09/17/20. The facility was found to be in compliance with CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID 19. A complaint survey for KS00155779 was conducted by the Kansas Department of Aging and Disability Services (KDADS), on behalf of the Centers for Medicare and Medicaid Services (CMS) on 09/15/20, 09/16/20, and 09/17/20. On 09/16/20 at 04:50 PM, Administrative Nurse A and Administrative Staff N were provided with the IJ template and notified that the facility failed to provide appropriate supervision to cognitively impaired R1 (without shoes or his walker), identified by the facility as at risk for wandering and who exhibited exit seeking behaviors, to prevent an elopement of 1 hour and 16 minutes, when staff did not check the alarm door and silenced it without checking for eloped residents which constituted immediate jeopardy at F689. The immediate jeopardy at F689 also constituted Substandard Quality of Care at 42 CFR 483.12. The immediate jeopardy was determined to first exist on 09/04/20 at 01:35 PM, when R1 eloped out of the DON doors. The facility identified and corrected the deficient practice on 09/04/20 by 11:59 PM when the facility implemented the following: 1. 1:1 sitter initiated for R1 2. Mandatory elopement drills performed on all shifts. 3. All staff reviewed the elopement policy and	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 09/28/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175294	A. BUILDING _____ B. WING _____	C 09/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 000	Continued From page 1 procedure. 4. Maintenance verified door functioning, company notified to repair door and door was locked and not used until fixed on 09/10/20. 5. QAPI to monitor the on-going effectiveness of the corrective action plan. Due to the facilities actions to identify and correct the deficient practice on 09/04/20, it was deemed past non-compliance at a scope and severity of "J". The facility failed to provide sufficient supervision to cognitively impaired R1 who eloped from the facility for 1 hour and 16 minutes without staff knowledge within a block of a busy four-lane highway. These failures placed R1 in immediate jeopardy. The 2567 was electronically sent on 09/28/20.	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 census totaled 44 residents, with three sampled for wandering behaviors. Based on observation, interview, and record review the facility failed to provide sufficient supervision to cognitively impaired Resident (R) 1, identified by the facility as an elopement risk with known	F 689	Past noncompliance: no plan of correction required.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175294	A. BUILDING _____ B. WING _____	C 09/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 689	Continued From page 2	F 689		

wandering/exit seeking behaviors, to prevent an elopement. On 09/04/20 R1 exited the facility via a malfunctioning door staff exited prior which failed to alarm for five to six minutes after R1 left the facility through the same door. A facility staff member silenced the alarm to the door without checking for eloped residents and no facility staff knew R1 eloped without his walker and shoes for 1 hour and 16 minutes, when the local police department called to ask if the facility if R1 was a resident. The emergency responders found the resident within a block of a busy four-lane highway with speed limits of 60 miles per hour (mph), during a high traffic time, after a neighbor reported to emergency services a man yelling for help in a backyard. These failures placed R1 in immediate jeopardy.

Findings included:

- Review of R1's pertinent diagnoses from the "Physician's Order's" in the electronic medical record (EMR) dated 09/10/20 revealed: anemia (a condition without enough healthy red blood cells to carry adequate oxygen to body tissues), diabetes (a disease in which the body's ability to produce or respond to the hormone insulin is impaired, resulting in abnormal metabolism of carbohydrates and elevated levels of glucose in the blood and urine), Parkinson's (slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity and weakness), dementia with Lewy Bodies (a type of progressive neurodegenerative dementia closely associated with Parkinson's disease primarily affecting older adults; the primary feature is cognitive decline, which can lead to hallucinations, as well as varied attention and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175294	A. BUILDING _____ B. WING _____	C 09/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICALODGES GODDARD	**501 EASY STREET GODDARD, KS 67052**

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F 689	Continued From page 3	F 689		

alertness), pacemaker (an implanted device to regulate the beating of the heart), and artificial right knee joint.

Review of the 05/21/20 "Annual Minimum Data Set" (MDS) revealed the staff assessment of R1's mental status indicated modified independence with some difficulty in new situations only. The MDS noted R1 with fluctuating inattention, disorganized thinking, and altered level of consciousness. R1 exhibited wandering behaviors for one to three days of the seven-day review period that indicated the resident's wandering placed him at risk of getting into a potentially dangerous place. The resident required supervision of one staff with walking/locomotion off the unit, had impairment to his bilateral (both) lower extremities, and used a walker for mobility. R1 experienced one non-injury fall since prior assessment and used a wandering/elopement alarm daily.

Review of the 08/20/20 "Quarterly MDS" revealed a brief interview for mental status (BIMS) score of 13, indicating intact cognition. R1 exhibited no wandering behavior during the seven-day review period. The resident required supervision of one staff with walking, limited one-person assistance for locomotion off the unit, had bilateral lower extremities impairment, and used a walker for mobility. R1 experienced two or more non-injury falls and used a wander/elopement alarm daily.

Review of the 05/21/20 "Cognitive Loss Care Area Assessment" (CAA) revealed R1scored 99 due to confusion and inability to progress with assessment. R1 displayed short-term memory loss and modified independence with daily decision-making skills.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175294	A. BUILDING _____ B. WING _____	C 09/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICALODGES GODDARD	**501 EASY STREET GODDARD, KS 67052**

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F 689	Continued From page 4	F 689		

Review of the 05/21/20 "Activities of Daily Living (ADL) CAA" revealed R1 required staff assistance with walking and was unsteady while moving from a sitting to a standing position and walking/turning but could rebalance without staff assistance.

Review of the 05/21/20 "Behavioral CAA" revealed the resident had multiple episodes of wandering during his look back period, which was an increase in behaviors over the last quarter. The CAA noted the wandering placed R1 at risk for elopement, and the behavior was not redirectable and could be disruptive.

Review of the 05/21/20 "Falls CAA" revealed R1 exhibited multiple episodes of wandering during his look back period. R1 had one non-injury fall on 05/19/20, and risk factors for falls included anemia, Parkinson's disease, delirium (a sudden severe confusion, disorientation and restlessness), agitated behavior, and cognitive impairment.

Review of the 09/17/18 "Care Plan" identified R1 as an elopement risk due to door watching and intermittent confusion. A revision dated 02/12/20 revealed R1 with a Wander Guard (technology with the express purpose of keeping "wanderers" safe, preventing them from straying too far) on his right ankle in which the staff checked every shift for placement and effectiveness. The care plan noted if an elopement occurred, the staff followed the facility protocol. The staff were to provide frequent checks when R1 was close to the front door or any exit door and to divert him away from the door if able.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175294	A. BUILDING _____ B. WING _____	C 09/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICALODGES GODDARD	**501 EASY STREET GODDARD, KS 67052**

(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 5	F 689		

Review of 09/17/18 "Care Plan" revealed R1 had an Activities of Daily Living (ADL) deficit related to delirium, change in cognitive status, behavior symptoms, communication problems, mood decline, medication use, weakness and poor balance. A revision dated 08/27/20 revealed R1 required supervision of one with use of a walker and noted his tendency to often walk away from his walker.

Review of 09/17/18 "Care Plan" revealed R1's BIMS score of 14, but due to his poor decisions, the staff needed to monitor him for safety. A revision dated 01/31/20 revealed R1 wore a Wander Guard due to poor decision-making skills. Due to these poor decisions, he would choose to go outside not dressed appropriately for the weather or at an inappropriate time of day, therefore staff may need to monitor R1 for safety.

Review of 02/05/20, 05/13/20, 07/29/20, 08/12/20 and 09/04/20 "Clinical Health Reviews" for elopement risk identified R1 as a high risk for elopement.

Review of 07/22/20 at 03:55 PM "Behavior Note" revealed R1 continued to wander and noted him as increasingly difficult to redirect. The staff re-directed but noted the redirection as ineffective and it held the resident's attention for just minutes before he needed additional redirection.

Review of 07/24/20 at 09:31 PM "Behavior Note" revealed R1 exhibited increased anxiety and wandering. The resident attempted to break down the front doors and leave the facility. He also attempted to leave by other doors in the facility. When staff intervened, he became hostile, though he was redirectable.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175294	A. BUILDING _____ B. WING _____	C 09/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICALODGES GODDARD	**501 EASY STREET GODDARD, KS 67052**

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F 689	Continued From page 6	F 689		

Review of 09/04/20 at 03:55 PM "Nurse's Note Late Entry" revealed the police department contacted the facility to inform them of R1's location as outside of the facility. The administrator brought the resident back to the facility and assigned him a 1:1 sitter (provided to ensure the safety of residents who may be suffering from cognitive impairment, exhibit challenging behavior, or may be at risk of falls or of causing harm to themselves or others). R1's vital signs were within normal limits, and his skin was diaphoretic (sweaty), pink, and intact. The note mentioned the Wander Guard as present to his left ankle and functional. The note continued and included a review of the security cameras by the administrator. The video revealed at 01:30 PM R1 walked toward the exit door on North hall. He pushed on the North hall door for approximately three minutes without the ability to open it. He then walked away from door and his four-wheeled walker, then headed toward the nurse's station. At the nurse's station, he turned the corner and approached the exit door located in front of the Director of Nursing's (DON) office. At 01:35 PM, he opened the door without difficulty and exited the building walking without an assistive device and wore lightweight sweatpants, short sleeved shirt, and non-skid socks. The temperature at 01:35 PM noted as approximately 90 degrees Fahrenheit (F) and sunny.

Review of 09/15/20 "Facility Investigation" for the 09/04/20 elopement revealed R1 left the facility on 09/04/20 at approximately 01:34 PM until 02:50 PM when the facility received a telephone call informing them police found R1 in the residential area 1-2 blocks from facility, and returned back to the facility at 03:05 PM (1 hour

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175294	A. BUILDING _____ B. WING _____	C 09/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICALODGES GODDARD	**501 EASY STREET GODDARD, KS 67052**

(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 7	F 689		

and 31 minutes out of facility). R1 spent 1 hour and 16 minutes alone outside the facility and walked to a residence one block away from the facility (per google maps, the residence was near highway 54, approximately 1450 feet from facility and approximately 600 to 700 feet from the residence). The high temperature noted as 90 degrees F and R1 wore a white tee shirt, sweats, and gripper socks (no shoes).

Observation of R1 on 09/15/20 at 03:36 PM revealed R1 was in his room, seated in his recliner with a baby doll cradled on his shoulder. R1 had a Wander Guard noted to his left ankle, and his walker was approximately three to four feet away from the resident in his recliner. R1 made no attempts to get up from his recliner or to wander.

Observation on 09/16/20 at 02:25 PM of the area outside the DON doors and into the residential area in which the police located R1 on 09/04/20 included a steep hill with a concrete drainage area near the residential area When standing in front of the residential area in which the police found R1 revealed the four-lane highway was easily visible.

Interview with R1 on 09/15/20 at 03:36 PM revealed he did not know if he went somewhere on 09/04/20. He indicated that his Wander Guard ensured "he did not get a speeding ticket." Pleasantly confused, he stated the month and day currently as December of 2018, and stated he was in the Army and the facility was not his home.

Interview with Activity Aide M on 09/16/20 at 09:33 AM revealed when a door alarm sounded,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175294	A. BUILDING _____ B. WING _____	C 09/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICALODGES GODDARD	**501 EASY STREET GODDARD, KS 67052**

(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 8	F 689		

the staff go out the alarming door and look around the perimeter for any eloped residents. She indicated the facility staff were on especially high alert because of the most recent elopement on 09/04/20.

Interview with Certified Nurse Aide (CNA) D on 09/16/20 at 07:32 AM revealed she had taken the laundry downstairs and come back down the hallway toward the DON's office and the DON door alarm was going off, but the door was locked, so she turned off the alarm. She did not think any resident went out of the building because when she pushed on the door it was latched. She indicated that if staff heard a door alarm, the staff should go outside to look around the area and see if we could locate a resident. She also indicated that people had been going in and out that door that morning for COVID testing, so she thought one of them set it off. She indicated that now, if a door alarmed, staff alert other staff and do a perimeter check because that was what staff were supposed to do when that situation happens. R1 wandered and stood by the exit doors often before he eloped on 09/04/20. R1 would say things like "I have to feed the cows" or "I have to get this lawn mower on the back of my truck" because he would get confused.

Interview with CNA E on 09/16/20 at 07:44 AM revealed R1 liked to get up and wander the halls, sometimes he would go without his walker and staff would retrieve it for him. Staff were pretty busy, on the go all the time caring for other residents. Staff do one-on-one time with R1, but she could not verbalize any other interventions for his wandering, other than keeping a closer eye on him.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175294	A. BUILDING _____ B. WING _____	C 09/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICALODGES GODDARD	**501 EASY STREET GODDARD, KS 67052**

(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 9	F 689		

Interview with CNA F on 09/16/20 at 07:51 AM revealed he worked the day R1 eloped, but left at 01:15 PM. R1's behaviors included walking around the facility often, he had Lewy body dementia and had a mindset that he worked on the farm with his cattle. R1 could be easily redirected some days and others his agitation and confusion were high. When R1 tried to get out of a door, staff asked him what he was doing, CNA F indicated he reached his arm around R1 and talked with him, explained that it was not safe to go outside because of coronavirus, and R1 laughed and talked on the way back to the resident's room. There were safety concerns with R1's cognition and unsteady gait since he fell in the facility before. CNA F indicated he had not read R1's kardex (care planned interventions) in the last couple days and was unsure about what other interventions for elopement/wandering for R1.

Interview with CNA G on 09/16/20 at 08:35 AM revealed R1 sat himself in the recliner at the nurse's station on 09/04/20 at approximately 01:25 PM. He then decided to stand and walked toward the North exit door. CNA G brought his walker to him at that time because of R1's unsteady gait while walking. She then went to assist other residents and indicated that the door alarm never went off at all that day. R1 wandered, looked outside, and asked staff to open the doors, so she re-directed him by bringing R1 back to the nurse's station or to his room, the bathroom, get him a snack if he wanted, and try anything to see if she could change his mind. R1 stated he was looking for his truck or something.

Interview with CNA B on 09/16/20 at 01:22 PM revealed she left the building after her shift right

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175294	A. BUILDING _____ B. WING _____	C 09/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICALODGES GODDARD	**501 EASY STREET GODDARD, KS 67052**

(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 10	F 689		

before R1 eloped on 09/04/20 at 01:30 PM. She indicated that the DON door "clicked" so she knew it was closed. R1 had been a farmer and stated often that he needed to milk the cows, get the tractor, and looked for exits, trying to leave the facility. R1 used a walker most of the time, but he stated that "he did not need it." R1's Wander Guard was on his left ankle. When an elopement occurred, staff looked outside for a resident, and if no resident visualized, staff followed procedure. If a resident made it outside or was missing, staff notified the DON and charge nurse. Staff answered door alarms quickly, any resident that eloped could be found quickly. CNA B indicated that she did not know how R1 got through the locked DON doors.

Interview with LN I on 09/16/20 at 08:09 AM revealed R1 wandered all the time in the facility. He ambulated to the North/South hall doors frequently and staff re-directed/reminded him to use his walker. He fell prior to his elopement because he forgot his walker, and he had an unsteady gait at times. No staff notified her about his walker being at the end of North hall or that he was missing on the 09/04/20 shift. She did not recall hearing the alarm go off that day. R1's cognition varied, some days he understood nothing, and other days he experienced lucid cognition (expressed clearly; easy to understand).

Interview with LN C on 09/16/20 at 08:02 AM revealed R1 exhibited "sundowners" (a neurological phenomenon associated with increased confusion and restlessness in patients with delirium or some form of dementia) and wore a Wander Guard on his left ankle. He indicated to staff he needed to leave the facility to "milk the cows or feed them," he would go to the doors

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175294	A. BUILDING _____ B. WING _____	C 09/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICALODGES GODDARD	**501 EASY STREET GODDARD, KS 67052**

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F 689	Continued From page 11	F 689		

and pushed on them, and also looked for "hidden" keys. The staff ensured his walker was near him, but he left it and walked alone. She indicated that R1's fell while in the facility. When the facility received the call R1 was found out of the facility, staff completed an elopement drill. LN C indicated she looked on North hall and found R1's walker then, no staff alerted her to his walker being in the hall prior to this. She indicated that R1 walked pretty well, but he was unstable enough to need his walker. His cognition s varied, and he could be clear sometimes and confused at other times. When R1 arrived back to the facility, she completed a full skin assessment and he had a shower. R1 had no scratches, no open areas, his vital signs were good, with no adverse consequences of his elopement.

Interview with Activity Staff H on 09/16/20 at 08:22 AM revealed she opened the DON door after a family member delivered an item before R1 eloped. When she pulled the DON door shut, it latched with no alarming. R1 always tried to get out of the North hallway door like he did in the video on 09/04/20, but he then walked down the North hallway without his walker and exited the building through the DON doors. The door alarm never triggered the whole time, from when she closed the door until the facility got the call R1 was found outside of the facility. She indicated that R1's cognition at times was "very good" and other times "very bad." He exhibited "sundowners" and wanted to milk the cows and get the truck/trailer every afternoon. His unsteady gait presented problems for him, and staff reminded him to use his walker.

Interview with Maintenance Staff J on 09/16/20 at 08:50 AM revealed the other maintenance staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175294	A. BUILDING _____ B. WING _____	C 09/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICALODGES GODDARD	**501 EASY STREET GODDARD, KS 67052**

(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 12	F 689		

indicated to her that the pin mechanism fell out of the DON door or malfunctioned, and the door latched incorrectly when staff had last closed the door. R1 walked out of the DON doors and then approximately six minutes later, staff finally turned off the door alarm, but did not go outside and look to ensure a resident had not eloped. The staff should have taken that alarm seriously and started looking for the resident.

Interview with Administrative Nurse A on 09/15/20 at 01:34 PM revealed R1 did not have any elopements in last six months. She indicated the reason the staff member did not look outside or follow elopement policy was because the DON door was not open, it appeared to be closed and she assumed the door alarming was an error." The DON door alarmed simply because the doors did not close all the way or stayed open too long.

Interview with Administrative Nurse A on 09/15/20 at 04:07 PM revealed a police officer contacted the facility on 09/04/20 at 02:50 PM and asked if R1 was a resident at this facility. She then told staff and started the elopement drill. She indicated that the video revealed R1 had been exit seeking at the North hall door and then ambulated without his walker to the nurse's station, then went to the DON door next to the DON's office and walked right through the door at approximately 01:35 PM and no alarm sounded. The alarm for the door did not sound until approximately 01:40 PM when CNA D turned it off. The door alarm should signal within 30 seconds of being opened, but it did not go off for approximately five minutes. Maintenance checked the door alarms monthly, the last time door alarms were checked, the DON door worked correctly. The locking mechanism on the DON

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	175294	A. BUILDING _____ B. WING _____	C 09/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICALODGES GODDARD	**501 EASY STREET GODDARD, KS 67052**

(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 13	F 689		

doors malfunctioned, the mechanism prevented the door from latching appropriately. She indicated that R1's had a high elopement risk and staff were aware. He exhibited exit seeking one to three times a week since January 2020 and his elopement on 09/04/20. In the elopement video on 09/04/20, R1 slept in the recliner at the nurse's station, and then got up and walked down the North hallway without his walker. A staff member brought him his walker, and when the staff walked away, R1 then left his walker in the hallway, and he walked to the DON doors and eloped. She indicated R1 was "pretty steady" on his feet, even without his walker, ambulatory, and moved without assistance, even though he should be assisted. His cognition varied on the time of day; some days he woke lucid, other days he knew nothing. R1 requested help when ambulating with his walker, but he forgot most of the time. The DON doors functioned correctly before 09/04/20. She indicated that the she initiated elopement training as soon as the facility knew of the elopement and was completed prior to midnight of that day.

Interview with Administrative Nurse A on 09/16/20 at 07:18 AM revealed R1 eloped out of the hospitality room door in January 2020, and it appeared from the video that he punched in the code, walked out, and then came right back in when staff re-directed him. He has a Wander Guard, and his care plan indicated that he did not make good decisions. The nurses charted these behaviors frequently on the report sheets. R1 exhibited exit seeking behavior approximately five minutes before he actually eloped at the DON door near the nurse's station, a double door, on 09/04/20. One door had shut, which did not allow the other door to latch correctly, but did not set off

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F 689	Continued From page 14	F 689		

the door alarm. A staff member opened the door to exchange items with family of a resident, and the door did not latch when it closed. R1 opened it without difficulty when he eloped. The door itself had pins at the top that come down when the door closed, but the feature malfunctioned. From the bottom of the door, it appeared closed, and when staff recreated the situation it took a few minutes for the door alarm to go off. The door alarmed that day and indicated the door had been open too long, and CNA D turned the alarm off without looking further to figure out why the DON door alarmed.

Interview with police officer K on 09/16/20 at 11:52 AM revealed he dispatched for a welfare check because a residential neighbor behind the facility called 911 because he thought his neighbor yelled "help", but it was R1 who stood in his backyard. When officer K arrived on the scene, R1 wore sweatpants, shirt and socks (no shoes), and the officer thought that R1 may be a "silver alert" (a missing senior citizen). He checked R1's name for warrants and called a family member who recognized R1 as a resident of the facility. Officer K then notified the facility, and Emergency Medical Services (EMS)/Paramedics checked R1 out for injuries with none noted. R1 gave officer K his personal address before living at the facility. Officer K indicated that R1 was very coherent at that point, with some confusion. R1 did not know who to call to come get him, but he talked to the other first responders, and offered water.

Interview with Dietary staff L on 09/16/20 at 11:03 AM revealed officer K realized R1 was a resident of the facility and called saying that a homeowner over near the facility heard R1 yelling for help

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F 689	Continued From page 15	F 689		

because he "got himself in a pickle and stuck in a bush" and called 911.

Review of the revised 12/2019 "Resident Elopement Policy and Procedure" policy revealed the elopement drills were to be completed a minimum of quarterly on each shift. Staff were educated that when a resident was missing from the facility, staff are to immediately report to the charge nurse or the Director of Nursing. The charge nurses initiate a search inside the facility, on the premises, and account for other residents within the facility.

On 09/16/20 at 04:50 PM, Administrative Nurse A and Administrative Staff N were provided with the IJ template and notified that the facility failed to provide appropriate supervision to cognitively impaired R1 (without shoes or his walker), identified by the facility as at risk for wandering and who exhibited exit seeking behaviors, to prevent an elopement of 1 hour and 16 minutes, when staff did not check the alarm door and silenced it without checking for eloped residents which constituted immediate jeopardy at F689. The immediate jeopardy at F689 also constituted Substandard Quality of Care at 42 CFR 483.12. The immediate jeopardy was determined to first exist on 09/04/20 at 01:35 PM, when R1 eloped out of the DON doors.

The facility identified and corrected the deficient practice on 09/04/20 by 11:59 PM when the facility implemented the following:
1. 1:1 sitter initiated for R1
2. Mandatory elopement drills performed on all shifts.
3. All staff reviewed the elopement policy and procedure.

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F 689	Continued From page 16 4. Maintenance verified door functioning, door company notified to repair door and door was locked and not used until fixed on 09/10/20. 5. QAPI to monitor the on-going effectiveness of the corrective action plan. Due to the facilities actions to identify and correct the deficient practice on 09/04/20, it was deemed past non-compliance at a scope and severity of "J". The facility failed to provide sufficient supervision to cognitively impaired R1 who eloped from the facility for 1 hour and 16 minutes without staff knowledge within a block of a busy four-lane highway. These failures placed R1 in immediate jeopardy.	F 689		