STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175304	A. Building B. Wing	08/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Emporia Presbyterian Manor	2300 Industrial Road Emporia, KS 66801

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40689 The facility reported a census of 41 residents, with one resident reviewed for elopement. The facility failed to ensure staff provided appropriate supervision for cognitively impaired Resident (R1), who resided in a locked memory care unit, when staff accompanied the resident to the Chapel in the Independent Living Facility area for podiatry services, then left the resident with the contract service staff. On 08/24/23 at 10:10 AM, R1 exited the chapel, ambulated with his walker approximately 100 feet to the unlocked facility exit door, and exited the facility door. R1 then turned right, walked around the front of the building, approximately 400 feet, and sat on the bench under the canopy outside of the entrance door to the facility. On 08/24/23 at 10:25 AM, Certified Nurse Aide (CNA) M observed R1 seated on the front bench, outside of the facility, and notified Administrative Nurse A by phone. CNA M reported she sat outside with R1 for approximately five minutes after notifying Administrative Nurse A, but then left R1 unattended outside of the facility as she left the parking area. R1 remained unattended outside for approximately 15 minutes, per interview and review of camera footage. This deficient practice placed the resident in immediate jeopardy. Findings included: - R1's unsigned Physician Order Sheet (POS), documented the facility admitted the resident on 11/13/22 with diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure) and dementia (progressive mental disorder characterized by failing memory, confusion). The Quarterly Minimum Data Set (MDS), dated [DATE], documented the resident with a Brief Interview of Mental Status (BIMS) of five, which indicated the resident had severely impaired cognition. He was independent with bed mobility, transfer, toileting, and ambulation. He required a walker for mobility. R1's Care Plan, dated 07/22/23, documented staff placed a photo of R1 on his bedroom door to assist him with finding the location of his room. The resident resided on the locked memory care unit. The resident was able to ambulate independently with a four-wheel walker. The Elopement Risk Screen, dated 07/16/23, documented a score of 12, with a score of 10 or greater indicating the resident had a high risk for elopement. Documentation of the elopement screen risk revealed the resident was in a secured area. (continued on next page)

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

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of R1's Electronic Health Records (EHR), on 08/24/23, lacked documentation of R1's elopement (an incident in which a cognitively impaired resident with poor or impaired decision-making ability/safety awareness leaves the facility without the knowledge of staff). Review of R1's Electronic Health Records (EHR), on 08/25/23, the Incident Note, documented Licensed Nurse (LN) G accompanied R1 to the Chapel, for podiatry services. When podiatry completed the resident's podiatry visit, podiatry staff advised LN G that R1 was told he could go back to his room. On 08/24/23 at 10:25 AM, the resident was outside of the facility and sat himself on a bench outside of the facility entrance. Activity Staff Z assisted the resident with his walker into the facility and ambulated with him back into the locked memory care unit. Administrative Nurse D assessed the resident after he was brought back inside the facility. Administrative Nurse D reviewed arial cameras and determined the resident ambulated with his walker approximately 100'from the chapel to the exit door. The resident exited the facility, turned right, then ambulated with his walker to the front of the facility, approximately 400 feet, and sat down on a bench near the front facility entrance. The resident had an unwitnessed exit. According to information found at the website Underground (wunderground.com), on 08/24/23 at 09:53 AM for the local area, the temperature was 93 degrees Fahrenheit, with wind speeds of nine miles per hour. On 08/29/23 at 09:33 AM, Administrative Nurse D confirmed the resident exited the facility by the Chapel located in the Independent Living area, walked around the facility to the front door. She reported she viewed the video footage and R1 exited the building on 08/24/23 at 10:10 AM. She reported CNA M notified her by phone that the resident was outside by himself. LN G reported Activity Staff Z brought the resident inside the facility and ambulated with him to the secured memory care unit. She reported the resident was outside without staff, according to the video, for approximately 15 minutes, and staff brought him back into the facility at 10:25 AM. After he was brought inside and returned to the locked memory care unit, she began staff education at 11:00 AM related to the need for staff members to remain present with residents from the locked unit, at all times. On 08/29/23 at 11:16 AM, Licensed Nurse (LN) G reported on 08/24/23 at approximately 10:00 AM, she assisted R1 from the locked unit to the chapel for podiatry services. She left the chapel to take another resident back to the locked unit, and when she returned, R1 was not in the Chapel area. Contract Podiatry Staff reported R1's services were completed, and the contracted Podiatry Staff member told R1 he could go back to his room. She reported when she stepped out into the hallway to look for the resident and report him missing from the chapel, she saw someone (staff) ambulating with him back towards the locked unit. On 08/29/23 at 11:30 AM, Certified Nurse Aide (CNA) M reported on 08/24/23 at 10:25 AM, she observed R1 sitting on the bench at the front entrance of the facility, without staff accompaniment. She reported she recognized R1 from the locked memory care unit and notified Administrative Nurse D via telephone. CNA M reported she waited approximately five minutes and staff members did not come to assist the resident back into the facility. She was running behind taking another resident to an appointment and she left the resident unattended on the bench as she left the facility parking lot. CNA M verified she should have waited until facility staff arrived to assist R1 into the facility before she drove away. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility Hazardous Wandering and Elopement (Unwitnessed Exit) Policy, dated 10/12/22, documented that the community would exercise reasonable care to prevent injuries and ensure a secure environment for residents. When staff fail to follow the unwitnessed exit policy, the staff would be counseled, re-educated, and disciplined accordingly. The facility failed to ensure staff provided appropriate supervision for cognitively impaired Resident (R1), who resided in a locked memory care unit, when staff accompanied the resident to the Chapel in the Independent Living Facility area for podiatry services, then left the resident with the contract service staff. The resident left the Chapel, went out the door, walked around to the front of the facility, and sat down, unaccompanied by staff and without staff knowledge. On 08/29/23 at 02:46 PM, Administrative Staff A was provided a copy of the IJ template and notified the facility failure to prevent neglect with the failure to ensure staff provided appropriate supervision to cognitively impaired Resident (R)1, when staff left him unattended while podiatry services performed in the Chapel, at the Independent Living area. When contracted podiatry services completed, R1 left the Chapel, went out the door, walked to the front of the facility to the entrance door, and sat down. CMA M observed the resident outside by himself, notified Administrative Nurse D by phone, waited approximately five minutes, and then left the facility, drove away, and the resident remained outside, without staff. The facility identified and implemented the following corrective action completed on 08/25/23 at 11:00 AM. 1. On 08/24/23 at 11:00 AM, immediate verbal re-education to the on-duty staff regarding that no memory care resident would leave the memory care without staff accompanying them off the unit and the necessity of staying with the residents. 2. On 8/24/23 at 04:00 PM, The Director of Nursing verbally informed the charge nurse, to ensure communication continued for the night shift. The Medical director was also notified. 3. On 08/25/23 at 11:00 AM, The Quality Assurance Nurse had a written Teachable Moment for staff to read, sign. This was completed at approximately 11:25 AM. 4. As needed staff (PRN) and any staff member that was not educated due to not working would be educated regarding elopement prior to being allowed on work. 5. The facility will bring this to the next Quality Assurance and Performance Improvement (QAPI) meeting. The surveyor verified the implemented corrective actions while onsite 08/29/23 at 03:30 PM.