STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175078	A. Building B. Wing	04/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy at College Hill	5005 E 21st Street North Wichita, KS 67208

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** 41121 The facility reported a census of 67 residents, with 11 of those residents identified at risk for 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), and three sampled. Based on observation, record review, and interview, the facility failed to provide adequate supervision to cognitively impaired Resident (R)1, who exited the facility without staff knowledge, on 04/04/23. R1 removed the cardboard staff used to cover the window he broke out on 04/03/23, and exited the facility through the broken window on 04/04/23. R1 exited in an area located one-to-two blocks from a heavily traveled, four lane street, with a speed limit of 40 mile per hour. A community member notified the facility R1 was across the street in a fenced-in yard. This deficient practice placed this resident in immediate jeopardy. Findings included: - The Medical Diagnosis tab for R1 included diagnoses of Alzheimer's Disease (a progressive mental deterioration characterized by confusion and memory failure), dementia (progressive mental disorder characterized by failing memory, confusion), restlessness, and agitation. The 12/09/22 Quarterly Minimum Data Set (MDS) dated [DATE] assessed R1 with short-term and long-term memory problems and moderately impaired decision-making abilities. R1 wandered one-to-three days of the seven-day assessment period, required supervision for walking in and out of his room, was independent in locomotion on and off of the unit, and his balance was not steady during transitions, but he was able to stabilize without staff assistance. R1 did not require a wander/elopement alarm. The Annual MDS dated [DATE] for R1 revealed no changes to his memory or decision making. R1 rejected care one to three days and wandered four to six days of the seven-day assessment period. He required supervision for walking in and out of his room and for locomotion on and off of the unit. R1 had no changes in his balance, continued to not require a mobility device, or a wander/elopement alarm. The Cognitive Loss/Dementia Care Area Assessment (CAA) dated 03/07/23 revealed R1 wandered around the memory care unit frequently and into other resident rooms, at times could be easily redirected, and rejected care at times. (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	The ADL [Activities of Daily Living] Functional/Rehabilitation Potential CAA dated 03/07/23 revealed he required assistance with decision making and increased assistance with cares. R1 wandered around the memory care unit frequently and into other resident rooms. The Care Plan dated 02/08/23 revealed R1 had an alteration in thought process related to his Alzheimer's Disease, was at risk for elopement, and did exit seek. He resided on the locked memory care unit, however, when agitated, he had managed to get the fire door into the building open. Staff were to monitor him when wandering the hallways. The Elopement risk assessment dated [DATE] revealed R1 was at risk for elopement. The Progress Note dated 04/03/23 at 02:30 PM revealed the staff notified Administrative Staff A R1's window in his room was broken and the staff covered the window with cardboard. Administrative Staff A called a window company to repair. The Progress Note dated 04/04/23 at 09:48 PM revealed the staff had safety concerns for R1 who was outside of the facility. The facility staff assisted R1 back into the facility, he resisted at first, but other staff members were able to assist in his return to the facility. R1 transferred to the hospital at 09:15 PM. On 04/06/23 at 01:34 PM Licensed Nurse (LN) G stated she was on duty when R1 eloped from the facility. She said she was not his nurse but received a phone call from a lady who said she saw a person outside and wondered if it was our resident. The lady was on the second balcony of her apartment and saw him at a gate. LN G stated she hung up the phone, ran down out the 300 hall exit door, and saw R1 inside a fenced area next to the apartments. LN G stated he went down where a sign was to the south, approximately a block away, and went through the opening there, which was the only one she could find to get in the fenced area. LN G stated she had a Certified Nurse Aide (CNA) drive her car down the block, into the fenced in yard area, to bring R1 back. LN G stated R1 did not say why he left or what he was doing, and he could walk around on his own, without any assistive devices. On 04/06/23 at 01:40 PM observation revealed a paved parking area approximately 15 feet from R1's bedroom window, and the staff found the resident in a fenced in area across the street. The window had been repaired and a dresser was in place in front of the window. Located approximately one-to-two blocks north from the parking lot by his bedroom window, was a heavily traveled four-lane street with speed limit of 40 miles per hour. R1's bedroom was not in a fenced in area of the facility. On 04/06/23 at 02:38 PM LN H stated she was the charge nurse on duty on 04/03/23 when the R1's window was broken, and on 04/04/23 when R1 eloped. LN H stated on 04/03/23 a housekeeper told her about R1's broken window, and she was in the middle of an admission, so she reported the broken window to Administrative Staff A. Administrative Staff A put cardboard up over the window until someone could replace the window. R1 stayed in the same room while the cardboard was in place. LN H stated R1 was very confused, not able to hold a conversation, and not able to say why he broke out the window. LN H verified the cardboard was still in place the day R1 eloped, and staff informed her he eloped when she came back from break. LN H stated R1 would walk back and forth in the hall and try to open doors. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 04/06/23 at 02:53 PM CNA M stated he was not aware R1's window was broken, and he was exit seeking the day he eloped on 04/04/23. CNA M stated he stayed on the hall when the call came that someone was outside. CNA M stated most of the time when R1 walked or try to get out the door, he tried to get R1's attention from getting out. On 04/06/23 at 03:01 PM CNA N stated she was working on the memory care unit on 04/04/23 when R1 eloped, and it was common for R1 to be at a door trying to get out. CNA N stated she had seen him kick at a door before and he was exit seeking frequently but not every day. CNA N stated she did not know the window in his room had been broken out, until after the call came that he was outside. CNA N stated she watched him walk to his room after dinner, which was around 05:30 PM. CNA N stated R1 could stand up on his own and walk, he would walk to his room, close the door and lay down, and could get up out of bed on his own. She stated there were two aides on the hall at the time the facility received the call and so she left the unit to try and help bring him back in. CNA N stated one of the other CNA's drove her car over to him, he was standing at the fence mumbling, and was resistant at first, then R1 got in the car. On 04/06/23 at 03:12 PM Administrative Staff A stated on 04/03/23 a housekeeper was cleaning and noticed R1's window was broken out. The window was on the outside and a banana peel was outside too. Administrative Staff A stated the glass was cleaned up and cardboard was put up until the facility could get the glass company to repair. Administrative Staff A stated R1 was not in his room when staff found the broken window and thought maybe he broke it trying to throw out the banana peel. Administrative Staff A stated the facility did not move R1 into a different room while awaiting the window repair, and the next day when he eloped, he had removed the cardboard from the window, so she believed he eloped out of the window. On 04/10/23 at 10:18 AM Administrative Staff A stated she observed video camera footage and R1 entered his room at 07:13 PM. Administrative Staff A stated the facility did not implement any new interventions for R1 after the staff placed the cardboard over the broken window. On 04/10/23 at 10:30 AM Administrative Nurse D stated the facility did not implement any new interventions for R1 after the staff placed the cardboard over the broken window. On 04/10/23 at 11:00 AM Administrative Staff A stated the facility received the call that R1 was outside on 04/04/23 at 07:18 PM (five minutes after he had gone to his room) and R1 returned to the facility at 07:30 PM. The facility policy Elopement/Missing Resident dated 01/11/22 revealed upon admission each resident will be assessed for the potential for elopement risk. Consideration will be given to the resident's prior history of wandering, whether the history and assessment indicates impaired decision making and/or impaired cognition and the ability to be mobile by walking or use of wheelchair or similar device. When a resident is identified as having wandering behavior on admission, appropriate interventions will be implemented and documented in the resident's plan of care. Residents who develop wandering or exit-seeking behavior after admission will be reassessed and appropriate interventions will be included in the plan of care at the time of identification of the wandering or exit-seeking behavior(s). (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 04/10/23 at 03:30 PM Administrative Staff A was informed R1 was in immediate jeopardy and provided the Immediate Jeopardy Template for failure to provide adequate supervision for this cognitively impaired, and at risk for elopement resident, R1, after he broke out his window in his bedroom on 04/03/23 and eloped from the facility out of the broken bedroom window on 04/04/23. This placed R1 in immediate jeopardy. The facility completed implementation of the following corrective measure on 04/05/23 at 10:00 PM: 1. Facility implemented one-to-one with R1 upon return until he was sent out to the behavioral unit on 04/04/23. 2. Elopement assessments were completed on all residents residing on the memory care unit on 04/05/23. 3. The facility repaired the window by installation of plexiglass on 04/05/23. 4. The facility will move R1 to a room that is in the locked enclosed courtyard upon return to the facility. 5. The facility educated staff on 04/05/23 on managing difficult behaviors and elopement by 10:00 PM. 6. The facility completed a quality assurance meeting with the medical director on 04/10/23. The deficient practice was deemed past non-compliance due to the implemented corrective actions and existed at a J scope and severity.