STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175274	A. Building B. Wing	09/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meridian Rehabilitation and Health Care Center	1555 N Meridian Street Wichita, KS 67203

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 41120 The facility census totaled 83 residents (R) with three residents sampled for showers/bathing. Based on observation, interview, and record review the facility failed to provide showers per resident preference/schedule and failed to document showers/bathing for R2 and R4. Findings included: - R2's pertinent diagnoses from the Physician's Order in the electronic medical record (EMR) dated 07/19/21 revealed morbid (severe) obesity, Diabetes Mellitus (DM, 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), muscle weakness, and heart failure (HF, a condition with low heart output). The 10/30/20 Admission Minimum Data Set (MDS) revealed a staff interview for mental status indicated the resident was independent with decision making. The resident preferences for bathing were not noted, and he was totally dependent on two staff to assist with bathing. The 10/30/20 Activities of Daily Living (ADL) Care Area Assessment (CAA) revealed R2 was morbidly obese, alert, and able to make his needs known. The 06/29/21 Quarterly MDS revealed a BIMS of 11, indicating moderately impaired cognition. The resident was totally dependent on one staff with bathing. The 10/13/20 ADLs Care Plan revealed a revision dated 08/18/21 which indicated R2 required one staff assistance for bathing. The care plan lacked resident preference for bathing frequency or scheduled days. The undated Shower List for Station 1 and 2 revealed bathing was scheduled by resident room number on specific days, indicating R2's room number was scheduled for bathing on Mondays, Wednesdays, and Saturdays. The 08/24/21 to 09/21/21 Certified Nurse Aide (CNA) tasks ADL- bathing for Monday/Wednesday/Friday revealed shower documentation completed on 09/06/21, 09/15/21, 09/17/21 and 09/20/21. Missing documentation noted for 8 out of 12 baths reviewed from 08/24/21 to 09/21/21. (continued on next page)

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175274	A. Building B. Wing	09/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meridian Rehabilitation and Health Care Center	1555 N Meridian Street Wichita, KS 67203

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 08/19/21 to 09/20/21 Shower/Bath sheets revealed bathing documentation completed on 08/20/21, 09/06/21 and 09/15/21. Missing documentation for 10 out of the 13 baths reviewed, received 3 baths during the review period. Observation of R2 on 09/20/21 at 03:39 PM revealed the resident in his room seated in his wheelchair and his hair appeared disheveled. Interview with R2 on 09/20/21 at 03:41 PM revealed he should get his showers every Monday, Wednesday and Friday because he preferred that, and stated he was not getting them as scheduled. He stated, the other day he got a bed bath, but before that, it has been about four weeks since he had a shower. Interview with CNA D on 09/20/21 at 03:57 PM revealed R2's showers were scheduled for Monday, Wednesday, and Friday. The CNAs filled out the shower sheets for refusals and bath completion for documentation. Interview with CNA H on 09/20/21 at 04:05 PM revealed R2's shower days were Monday, Wednesday, and Friday. CNA H stated R2 liked to get in the shower but did not like bed baths. Interview with CNA I on 09/21/21 at 09:57 AM revealed R2 was scheduled for showers Wednesday and Fridays on second shift. The shower aides and CNAs that completed the resident's showers were supposed to document any baths that occurred or refusals on the shower sheets. Interview with Activity Director J on 09/21/21 at 10:44 AM revealed she did not think anyone went over shower preferences with residents, and said the bathing was scheduled by room number automatically. She did not know who asked and recorded the resident's preference for shower days. Interview with LN F on 09/21/21 at 01:10 PM revealed R2 needed assistance with showers and he was scheduled for showers Monday, Wednesday, and Fridays, and the CNAs documented the bathing. Interview with Administrative Nurse B on 09/22/21 at 11:32 AM revealed the CNAs documented resident refusals of a showers, or completion of the shower, on the shower sheets and in the EMR. The facility failed to provide showers per resident preference/schedule and R2's EMR lacked documentation of bathing/showering/refusals for R2. - R4 pertinent diagnoses from the Physician's Order electronic medical record (EMR) dated 07/14/21 revealed dementia (a progressive mental disorder characterized by failing memory, confusion), chronic kidney disease (CKD, a condition characterized by a gradual loss of kidney function over time), and muscle weakness. The 04/27/21 Annual Minimum Data Set (MDS) revealed a brief interview for mental status (BIMS) of 14, indicating intact cognition. The resident noted that his preferences for bathing were somewhat important and he required physical help from staff for bathing. The 04/27/21 Cognitive Care Area Assessment (CAA) revealed R3 changed from subject to subject when having a conversation. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175274	A. Building B. Wing	09/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meridian Rehabilitation and Health Care Center	1555 N Meridian Street Wichita, KS 67203

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 04/27/21 Activities of Daily Living (ADL) CAA revealed R3 could make his needs/wants known but did not always make safe rational decisions for himself, and staff assisted him. The 07/13/21 Quarterly MDS revealed a BIMS of 14. He required one staff assist for bathing. The 05/23/18 ADL Care Plan revealed he required one staff assist for bathing and staff offered showers twice weekly. The undated Shower List for Station 1 and 2 revealed bathing was scheduled by resident room on specific days, R4 room number was scheduled for bathing on Mondays/Thursdays. The 08/24/21 to 09/21/21 Certified Nurse Aide (CNA) tasks ADL- bathing for Monday/Thursday revealed shower documentation completed on 09/06/21. Missing documentation noted for 8 out of 9 baths reviewed. The 08/19/21 to 09/20/21 Shower/Bath sheets revealed no bathing documentation completed for review period, received 0 baths during review period. Observation of R4 on 09/22/21 at 01:56 PM revealed resident in bed sleeping, noted hair disheveled and appeared oily. Interview with R4 on 09/22/21 at 01:59 PM revealed he has not had a shower in quite a while, staff used to ask him regularly a long while ago; he would like showers one to two times a week. Interview with CNA K on 09/22/21 at 09:42 AM revealed R4 required oversite for bathing. He has scheduled showers, days located in the shower schedule book. The shower aides and CNAs document showers/refusals on the shower sheets and in the EMR. Interview with CNA L on 09/22/21 at 09:55 AM revealed R4s scheduled showers were twice a week, and there were shower sheets to document the resident's refusal or completed shower. Interview with LN M on 09/21/21 at 09:46 AM revealed the CNA's should fill out shower/bath sheets for every bath even if the resident refused. Interview with LN F on 09/21/21 at 01:10 PM revealed he did not know R4s scheduled shower days, but he did not refuse cares. There was a book with the residents scheduled shower days, and the resident's bathing preference should be followed. Interview with Activity Director J on 09/21/21 at 10:44 AM revealed she did not think anyone went over shower preferences with residents, and said the bathing was scheduled by room number automatically. She did not know who asked and recorded the resident's preference for shower days. Interview with Administrative Nurse B on 09/22/21 at 11:32 AM revealed the CNAs documented resident refusals of a showers, or completion of the shower, on the shower sheets and in the EMR. The facility failed to provide showers per resident preference/schedule and R4's EMR lacked documentation of bathing/showering/refusals for R4.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175274	A. Building B. Wing	09/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meridian Rehabilitation and Health Care Center	1555 N Meridian Street Wichita, KS 67203

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** 41120 The facility census totaled 83 residents, with three sampled for elopement risk and six residents at risk for elopement. Based on observation, interview, and record review the facility failed to provide sufficient supervision to Resident (R) 1 to prevent an elopement. On 09/16/21 between 08:30 PM and 10:00PM R1 exited the facility via an unalarmed exit door and walked approximately a mile to a convenience store. He was outside the facility for approximately one and a half hours when the staff noticed the resident was not in the building. He was outside of the facility for a total of approximately five and a half hours. The resident walked past several residential blocks and down a busy, highly traveled 4 lane road with speeds of 30 to 40 miles per hour (mph), and across major intersections, within 0.2 miles of a railroad track and construction zone, and within a mile a major waterway. These failures placed R1 in immediate jeopardy. Findings included: - Resident (R) 1's pertinent diagnosis from the Physician's Orders in the electronic medical record (EMR) dated 09/09/21 revealed schizophrenia (a psychotic disorder characterized by gross distortion of reality, disturbances of language and communication and fragmentation of thought). The 09/16/21 Admission Minimum Data Set (MDS) revealed a brief interview for mental status (BIMS) of 14, indicating intact cognition. He exhibited delusions (an untrue persistent belief or perception held by a person although evidence shows it was untrue), wandering noted one to three days of review period which placed him at significant risk of getting into a potentially dangerous place. He was independent with transfers/walking and his gait (manner or style of walking) was steady at all times. The 09/16/21 Cognitive Care Area Assessment (CAA) revealed R1 exhibited a short attention span and focused on one thing such as smoking. R1 was a new admit and wandered one time in the last seven days. He was easily redirected and needed a lot of cueing and reminders. The 09/16/21 Activities of Daily Living (ADL) CAA revealed the resident ambulated independently and required assistance in making safe rational decisions in Long-Term Care. The 09/16/21 Behavioral CAA revealed R1 wandered one day in the review period and had behaviors of getting fixated on one thing, repeating the same question or questions, such as with smoking. The 09/16/21 Falls CAA revealed he ambulated independently on smooth and uneven surfaces, able to step up and off curbs, and climb stairs. The 09/11/21 Comprehensive Care Plan revealed the resident was independent with his ADLs. He exhibited poor impulse control and moods problems due to his schizophrenia diagnosis. A revision dated 09/17/21 revealed R1 was an elopement risk/wanderer as evidenced by the fact he left the building unsupervised. Staff were to distract the resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, or a book. He exhibited poor impulse control and poor decision making. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175274	A. Building B. Wing	09/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meridian Rehabilitation and Health Care Center	1555 N Meridian Street Wichita, KS 67203

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	The 09/10/21 Physician Orders revealed R1 may go on leave of absence (LOA) from the facility with an escort. The 09/09/21 Nursing Admission/Readmission Data Collection revealed the resident came from the Mental Health Association for LTC care due to schizophrenia. The resident was independent with ADLs, had no skin issues, and was alert with clear speech. Elopement Assessments completed on 09/09/21 determined the resident was not at risk. An assessment on 09/17/21 described wandering activity, mental illness, anger related to placement, appearance of a t visitor which placed the resident at risk for elopement. Intervention of frequent visual monitoring placed. The 09/13/21 at 08:14 PM Orders/Administration Note revealed R1 appeared more agitated, antsy, spoke loudly at times, and was disruptive of others. The 09/15/21 at 02:06 PM Orders/Administration Note revealed R1 repeatedly exited the isolation area, repeatedly asked staff about cigarettes several times within a 15-minute period. The 09/17/21 at 01:38 AM Alert Note revealed the resident left the facility and during shift change Certified Nurse Aide (CNA) N noticed the resident was missing from the unit. Staff searched the entire building, building perimeter, and surrounding streets immediately, but was unable to locate the resident. Staff notified administration, the physician, and completed a head count of the facility residents. Staff called 911 at 11:45 PM and the police arrived at 12:40 AM to complete a report to attempt to locate the resident. The 09/17/21 at 03:03 AM Alert Note revealed at 02:09 AM, the police brought R1 back to the facility. The police found R1 at a convenience store. Licensed Nurse (LN) F completed a skin and injury assessment with no injuries found, completed vital signs, noted a blood pressure of 109/78 millimeters of mercury (mmHg), a pulse of 112 beats per minute, a respiratory rate of 16 breaths per minute (bpm), a temperature 97.1 degrees Fahrenheit, and an oxygen saturation of 94% on room air. Staff completed an elopement investigation report. An undated Elopement Investigation Worksheet revealed R1 had no history of elopement attempts since admission on 09/09/21 and was not a risk for elopement. He had a diagnosis of schizophrenia and ambulated independently. He eloped on 09/16/21 from his room and was missing during rounds at 10:00 PM. He was last seen at 08:30 PM by CNA D. R1 exited out of the 200-hall through an alarmed exit door that had been unalarmed/unlocked intentionally. Staff completed a resident count and search. LN F notified the police. The 09/17/21 Notarized Statement from CNA H and CNA O revealed they last saw R1 at 03:55 PM on 09/16/21 when he asked to smoke and at 04:30 PM on 09/16/21 when he went to smoke. The 09/17/21 Notarized Statement from CNA D revealed that at approximately 10:00 PM, CNA N indicated R1 was missing to CNA D, who last saw the resident at 08:30 PM smoking by the exit door at the end of the 200-hall. CNA N reported this to LN F, and staff searched for the resident. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175274	A. Building B. Wing	09/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meridian Rehabilitation and Health Care Center	1555 N Meridian Street Wichita, KS 67203

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	The 09/16/21 Notarized Statement from CNA N revealed she clocked in for work at 09:49 PM and went on rounds, but she did not see R1 in his room. She reported this to LN F. She then searched the 100-hall and 300-hall while the nurse notified administration and police. R1 returned to the facility with the police at 02:11 AM. Observation of R1 on 09/21/21 at 11:12 AM revealed the resident seated in his room located within the COVID/isolation area hall, dressed appropriately with shoes on, and packed travel bags were on the floor beside him. He fidgeted with the bags and repositioned himself in the chair frequently. There were no staff in the isolation area and the isolation entrance doors obscured a visual of the resident from nurses' station. Interview with R1 on 09/21/21 at 11:15 AM revealed his bags were packed because he was moving to another room today but did not know when he would move. He left the faciity on either Wednesday or Thursday of last week at 04:30PM/05:00PM. His room on the 200-hall was for isolation since he was a newer resident. He was let out the 200-hall exit door by a staff member at approximately 04:30 PM/05:00PM. He did not know her name. He was outside for a while and then noticed the staff member leave for the day. He then stated, he could not get back in the facility without knocking on the door, and since he ran out of cigarettes, he decided to go to a convenience store to get a drink and to buy some cigarettes. He had problems walking, and his feet hurt, so he sat down to rest for a few hours at the table and chairs in front of the convenience store because he did not know what to do or who to call. He wore long pants, tennis shoes, and a short sleeve shirt. After a few hours, police walked up to him and asked if he was R1 and told him the facility was looking for him. No staff at the facility told him he could not leave, and he did not know that he had to sign out of the facility when leaving or let someone know where he was going. After the incident, staff told him he had to sign out, but have not allowed him to sign out since the incident. His diagnosis included schizophrenia and he took his medications when they were given to him, but he had not received his schizophrenia medications for a few days after his admission to the facility on [DATE]. He also stated, he was from this city, not this area, and he knew there would be a convenience store around the facility somewhere. He did not have any falls or injuries and used the sidewalks and crossings. Interview with CNA D on 09/21/21 at 12:30 PM revealed the incident happened last Thursday. He worked from 06:00 AM to 10:00 PM that day on R1's hall. He last saw R1 at 08:30 PM out by the COVID/isolation hall exit door, a staff member was with him, but he was unsure who, and the exit door was left open. He went to lunch after that and 30 minutes later he came back to the floor and checked the residents in the 100-hall and helped CNA H on the 300-hall with resident cares and gathering trash. Then at approximately 10:00 PM, CNA N arrived for work in the isolation unit and asked LN F and CNA D where R1 was located. CNA D told her R1 was in his room and what hall, to which she responded that he could not be found there. CNA D and N went to R1's room, then searched all the resident rooms, and notified LN F that R1 could not be found. Staff then went outside the facility, walked the perimeter and drove nearby streets, but could not find him, and reported to LN F. LN F made notifications. We check on him often to make sure this does not occur again. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175274	A. Building B. Wing	09/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meridian Rehabilitation and Health Care Center	1555 N Meridian Street Wichita, KS 67203

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	Interview with CMA E on 09/21/21 at 02:06 PM revealed he worked his first shift at the facility on 09/16/21 from 02:00 PM to 10:00 PM on R1's hall. When he arrived at 02:00 PM for his shift, he saw a resident outside by the isolation unit exit door standing outside with the door wide open, but he did not see a staff member with the resident. He saw R1 outside of the open isolation unit exit door again without a staff member at an unknown time. The nurses sit at the nurse's station but could not see R1 in the hallway due to the isolation doors were shut to the hallway. R1 walked out of the COVID/isolation hall doors into the common area and walked toward the dining hall common area. CMA E did not see R1 after that, and around 10:00 PM staff were saying he was missing. Interview with LN F on 09/21/21 at 01:10 PM revealed he worked a shift at the facility from 04:00 PM on 09/16/21 until 09/17/21 at 07:00 AM. When he arrived, he checked on the residents in the isolation unit at approximately 04:20 PM and R1 was in his room. At approximately 07:00 PM, LN F allowed R1 to smoke in the smoking area, and he returned to his room at approximately 07:05 PM. That was the last time he saw R1 that night. Then, at approximately 10:30 PM, CNA N notified him that R1 was missing. Staff immediately searched all the hallways, the perimeter of the facility, and one staff member drove the nearby streets looking for R1. He then notified administration, the on-call staff, physician and the police at approximately 11:00 PM. Staff continued the search until the police brought R1 back to the facility at approximately 02:00 AM. LN F assessed R1, he had no injuries, his vital signs were within normal limits, and documented the incident. He stated, R1 wore pants, a shirt, a jacket, and running/tennis shoes. The incident happened in the evening, so the temperature outside was 70 degrees or so. Interview with Administrative Staff C on 09/21/12 at 11:34 PM revealed R1 was not safe to sign himself out of the facility to go to a convenience store. Interview with Social Services Director G on 09/21/21 at 12:16 PM revealed she completed R1's admission to the facility on [DATE] and did not educate R1 on the process to sign himself out and leave the facility because with COVID regulations the facility had not allowed any resident to sign out unless necessary for an appointment. She stated, the facility had a sign out book, but it was not in use currently. Interview with Administrative Nurse B on 09/21/21 at 11:36 AM revealed R1 arrived at the facility on 09/09/21, and staff completed the elopement assessment and determined he was not at risk for elopement. R1 was responsible for himself and could sign himself out of the facility. He was not told about the sign out process at the time of admission. Staff made notifications and contacted the police around 11:45 PM. R1 was out of the building for approximately 4 to 5 hours until the police found him at the convenience store approximately a mile from the facility. LN F assessed the resident and found no injuries, vital signs within normal limits, his demeanor was appropriate. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175274	A. Building B. Wing	09/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meridian Rehabilitation and Health Care Center	1555 N Meridian Street Wichita, KS 67203

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	Interview with Administrative Staff A on 09/21/21 at 11:36 AM revealed the facility assessed the resident's cognition when deciding if the resident was able to sign themselves out of the facility. Any self-responsible, cognitively intact resident could sign themselves out and into the facility. The COVID/isolation hall doors were closed and the exit door to the outside was intentionally unalarmed/unlocked so staff could get in to work the unit. On 09/16/21 in the late evening, CNA D reported he last saw the resident around 08:30 PM. R1 told Administrative Staff A that between approximately 08:30 PM and 10:00 PM he went outside to get fresh air because he had seen staff members leave through this door at the north end of the hallway, and then decided to go to the convenience store. Shift change at 10:00 PM was when staff were alerted to R1's absence and noticed R1 was not in his room. Staff searched the facility, the facility perimeter, drove around the surrounding area, but were unable to locate him. The temperature outside at the approximate time he left the facility was approximately 76 degrees Fahrenheit and upon return at approximately 02:00 AM was 73 degrees Fahrenheit. Administrative Staff A stated, the root causes of the incident as of right now were that the COVID/isolation hall alarmed exit door was left intentionally unalarmed/unlocked for staff entrance, R1 was not educated on the sign-out processes, and staff monitoring for residents in this hallway. Review of 01/2017 Elopement Policy revealed all residents are afforded adequate supervision to provide the safest environment possible. All residents will be assessed for behaviors or conditions that put them at risk for elopement. For the purpose of this policy, missing resident shall be defined to mean a resident who has left the facility grounds without signing him/herself out of the facility. At no time shall a door alarm be turned off without the continual supervision of the exit. The facility failed to provide sufficient supervision for R1 to prevent an elopement on 09/16/21 when R1 exited the facility via an un-alarmed exit door and walked approximately a mile to a convenience store. He was outside the facility for approximately one and a half hours, when the staff noticed the resident was not in the building. He was outside of the facility for a total of approximately five and a half hours. The resident walked past several residential blocks and down a busy, highly traveled 4 lane road with speeds of 30 to 40 mph, and across major intersections, within 0.2 miles of a railroad track and construction zone, and within a mile a major waterway. These failures placed R1 in immediate jeopardy. The facility identified and corrected the deficient practice on 09/17/20 when the facility implemented the following: 1. Maintenance re-alarmed the exit door on 09/17/21 and completed a check for functionality on 09/17/21 and 09/20/21. 2. The facility educated staff on elopement and completed training on 09/17/21. Due to the facility's actions to identify and correct the deficient practice on 09/17/21, it was deemed past non-compliance at a scope and severity of J.