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	09/28/2022

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 - Some	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 94 residents. The sample included six with three residents reviewed for neglect. Based on observation, interview, and record review the facility failed to ensure the safety of Resident (R1), who admitted to the facility with a self-care deficit, signed himself out of the facility on 09/11/22 at 01:30 PM, and failed to document an anticipated return time. R1 did not return to the facility on [DATE] and the facility staff did not begin to search for R1 until around 09:45 PM, eight hours and 15 minutes later. Administrative Nurse D did not notify law enforcement until 09/12/22 at 11:34 AM (22 hours and four minutes after R1 signed out), to file a missing person report. R1 was to be supervised while outside of the facility, if leaving the facility, and was known to sign himself out prior, with staff knowledge of R1 obtaining/consuming alcohol, against physician's orders. On 09/12/22 at approximately 03:00 PM (25 and a half hours after signing out), Licensed Nurse (LN) G observed R1 seated in his nonfunctioning motorized wheelchair, due to a depleted battery, on the sidewalk with wheels wedged between the edge of the sidewalk and the grass. The resident was located near a four lane, heavily trafficked area of Meridian and Kellogg, approximately 2.5 miles from the facility, with speed limits of 40-60 miles per hour, respectively. Staff observed R1 with noted odor, as he had defecated/urinated in his pants, which were lowered down on his body. The staff member notified the facility she located R1 and she called 911 to have R1 transported to the Emergency Department (ED) for evaluation and treatment by Emergency Medical Services (EMS). These cumulative failures placed R1 in immediate jeopardy. Findings included: - R1's 08/02/22 signed Physician Order Sheet (POS), documented the facility admitted the resident on 02/18/22, with the following diagnoses: spinal stenosis (degenerative condition of the spine that could cause weakness and loss of use of extremities), cervical region (pertaining to the neck), chronic pain (persistent or intermittent pain), muscle weakness (lack of muscle strength), difficulty in walking (difficulty with balance and unsteady), insomnia (inability to sleep), major depressive disorder (major mood disorder), history of tobacco (smoking), and alcohol abuse. The 02/25/22 Admission Minimum Data Set (MDS) documented the resident had a Brief Interview for Mental Status (BIMS) score of four, which indicated severely impaired cognition. He required two-person extensive assistance with transfers and one-person supervision with locomotion on and off of the unit. The resident was not steady and was only able to stabilize with staff assistance. The resident used a motorized wheelchair for mobility. (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

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The 02/28/22 Cognitive Loss/Dementia Care Area Assessment (CAA) documented the resident had short/long-term memory loss. The resident had pain related to spinal stenosis and was at risk for isolation, depression, and further cognitive decline. The resident required assistance from staff to make safe, rational decisions. The 02/28/22 Urinary Incontinence and Indwelling Catheter CAA documented the resident required total assistance with toileting needs and was frequently incontinent. The 02/28/22 Falls CAA revealed R1required one to two-person assistance with transfers, was only able to stabilize with staff assistance, and had weakness and pain in the back and lower extremities. The 07/04/22 Quarterly MDS documented the resident had a BIMS score of 13, which indicated intact cognition. The resident required supervision with transfers and toilet use, ambulation, and locomotion. The resident was not steady, but able to stabilize without staff assistance. R1 utilized a motorized wheelchair and was continent of bowel and bladder. The resident's Wish to Return to Community or Rescue Mission Care Plan, dated 07/01/22, included interventions that the resident was his own person and could make his own decisions. R1 could sign himself out of the facility and was required to have supervision and someone to assist with making safe decisions. Revision on 09/21/22, instructed staff that the resident could sign himself out of the facility in his motorized wheelchair with someone who was cognitively able to keep him away from hazardous conditions in the community. The resident's Fall Care Plan, dated 02/28/22, instructed staff to assess the resident's clothing for proper fit, to not leave the resident in the bathroom unattended, ensure the resident's personal items were within reach, and that R1 wore gripper socks. Revision on 03/09/22, reminded staff to ensure R1's call light was in reach and encourage him to use the call light for assistant as needed. The care plan further instructed staff to not leave the resident alone in his room in the wheelchair, offer to bring him to the nurse's station or transfer to his bed, and ensure the resident wore appropriate footwear such as non-skid socks or shoes when ambulating or mobilizing in wheelchair. The resident's Activities of Daily Living Care Performance Deficit Care Plan dated 05/02/22, included the resident could reposition himself in his bed and wheelchair. The resident required one-staff assistance with toileting. The Physician Order dated 08/02/22, instructed staff that the resident may not have alcohol, may not go out on Leave of Absence (LOA). The Health Status Note dated 09/11/22 at 01:30 PM revealed R1 signed out of the facility. The Behavior Note dated 09/11/22 at 10:30 PM, LN H documented that R1 left the facility before the 02:00 PM to 10:00 PM shift started, and R1 had not returned to the facility at this time. At approximately 09:45 PM, Certified Nurse Aide (CNA) N and CNA O drove to the near-by places R1 may have gone, to search for him. The staff members were unable to locate the resident. At 10:10 PM another group of staff went looking for R1. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the Health Status Note on 09/12/22 at 11:34 AM, revealed Administrative Nurse D documented the resident signed himself out of the building on 09/11/22 in the afternoon. The resident did not return at 10:00 PM. The staff were at break and looked for the resident at his usual places and he was not seen. The jail and hospitals were called, and the nurse was advised the resident was not at either of the facilities. The Medical Director and APRN were notified and they would watch for the resident at hospitals. The nurse writer called Law Enforcement and filed a missing person report. Review of a Social Services Note dated 09/12/22 at 03:49 PM, documented off-duty Licensed Nurse (LN) G called the facility to advise staff she was pulling up to her house when she saw the resident outside her window. The nurse then called the facility and informed them the resident was seen and needed assistance. EMS subsequently called the facility to report the resident was in their care. The Director of Nursing (DON) advised and recommended sending the patient to the Emergency Department (ED) for evaluation as he had been signed out of the facility for over 24 hours. Review of Health Status Note on 09/13/22 at 08:55 AM LN I documented the resident returned from acute hospital. The resident was educated that he would not be able to check himself out. The resident agreed and stated he would not try and leave. Review of the Health Status Note on 09/14/22 at 12:51 PM Administrative Nurse D and Social Services (SS) X presented to the resident's room to inquire about his wishes as a resident here. The resident was asked if he would like to stay here as a resident or find a safe place to discharge to. Resident replied, it's cold outside and my body will shut down. When asked if he wanted to stay here, he replied with I guess, for now. Administrative Nurse D advised resident that he would not be able to sign out on his own recognizance and if he wished to do this without a safe discharge plan, he would be discharged AMA. The resident voiced understanding and agreed to the terms. Administrative Nurse D and SS X left room without incident. Observation on 09/21/22 at 09:11 AM revealed the resident appropriately and safely utilized his motorized wheelchair in the hallways, stopping to visit with staff members. On 09/21/22 at 10:48 AM Administrative Nurse D reported she did not know what date R1 was able to sign himself out without supervision. She stated R1 signed himself out on 09/11/22 at 01:30 PM and the records did not reflect when he would return. Administrative Nurse D revealed on 09/12/22, she saw a text from Administrative Nurse E, which read R1 signed himself out around 02:00 PM and was still not back at the facility. Administrative Nurse D expressed concern that on 09/11/22 during 02:00 to 10:00 PM shift, the staff failed to contact her and Administrative Staff A by phone due to the incident. She reported upon arrival to work at 06:30 AM she emailed (the company office) of the situation, called the jail and ED's of area Hospitals, and was unable to find R1. On 09/13/22 at 11:34 AM, she reported the local Law Enforcement Agency was notified to complete a missing person report. Administrative Nurse D stated she received a phone call from off duty LN G on 09/12/22 at 02:49 PM who revealed R1 was near Meridian St. and Kellogg (54 and 400 highways) in his wheelchair between the sidewalk and the grass. Administrative Nurse D advised LN G called 911 to have Emergency Medical Service (EMS) transport R1 to the Hospital for an evaluation. She further stated R1 did have a cell phone, however she was unsure if staff attempted to call his cell phone. Administrative Nurse D reported she received a return call from the Corporate Office due to R1 being his own person and with a BIMS of 13 and was told the facility could not force the resident to stay in the facility. If he became agitated and wanted the motorized wheelchair outside, per therapy, R1 was to have supervision while in the motorized wheelchair. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 09/21/22 at 11:24 AM LN G reported she was near Meridian St. and Kellogg driving in her personal vehicle. She reported she observed R1 in his motorized wheelchair on the sidewalk with the wheels stuck between the sidewalk and the grass. LN G stated she notified Administrative Nurse D and was instructed to call 911 for EMS to transport the resident to the hospital. LN G revealed R1 had his pants down to his mid-thigh and had soiled himself. She revealed R1 stated he had fallen out of his wheelchair, but did not indicate how he was able to get back in. LN G stated the wheelchair and the resident's personal cell phone was covered in feces. LN G reported she stayed with R1 until EMS arrived and R1 was transported to the hospital. LN G reported R1 was the approximately 2.5 miles from the facility. On 09/21/22 at 11:47 AM R1 reported that he signed himself out around 1:30-2:00 PM and drove his motorized wheelchair to the convenient store that was four blocks from the facility. He further reported it was a nice day, so he continued to drive around. R1 reported as it began to become dark, he hit a crevasse and he was ejected from his motorized wheelchair. R1 reported two people were jogging and helped him back in his motorized wheelchair. R1 revealed he had a bowel movement in his pants, was embarrassed, and did not want to be around anyone. On 09/21/22 at 01:35 PM Hospital Emergency Department Licensed Nurse (EDLN) LL reported the resident was granted permission to leave the facility. R1 was with friends, it became dark, and he could not find his way back to the facility. EDLN LL called the Administrative Nurse D, who notified the ED and asked the ED to hold R1 until SS X could talk to him regarding the Sign Out Policy. and stated the facility refused to take him back, because he left Against Medical Advice (AMA). EDLN LL expressed her concerns with Administrative Nurse D and noted that R1 did not leave AMA, he wanted to return to the facility. EDLN LL expressed concerns with dumping the resident at the hospital, and said Administrative Nurse D hung up on her. R1 stayed in the ED until the facility decided to allow R1 to return to the facility on [DATE]. On 09/21/22 at 02:25 PM Certified Nurse Aide (CNA) M reported R1 did not know the code to exit the building and said R1 could not leave the facility without staff supervision. He required one-person assistance with most of his Activities of Daily Living (ADLs) and utilized a motorized wheelchair. On 09/21/22 at 05:11 PM the surveyor traveled distances from the facility to the location in which staff found the resident and it measured 3.0 miles. 0n 09/21/22 at 07:15 PM Consultant MM explained that R1 arrived at the ED by EMS on 09/12/22 at 02:00 PM and he was covered in feces, with minor skin breakdown on the right hip due to the feces. The facility refused to readmit R1 until SS X talked with the resident, and he agreed to not leave the facility again. When Consultant MM came to work on 09/13/22, R1 was still in the ED at 07:30 AM. On 09/22/22 at 08:58 AM Administrative Staff B reported they followed the facility's Sign Out and Sign In Policy, however it was not clear what needed to be done if the resident did not return. She revealed if R1 wanted to sign out and leave the facility grounds to go to the store, she would direct him to Administrative Staff A. She revealed on 09/11/22 R1 signed out of the facility at 01:30 PM and did not enter a time he planned to return to the facility. Administrative Staff B reported on 09/11/22 two staff members attempted to locate R1 but did not notify her to report if they had found him or not. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The facility Sign In Sign Out Policy, Revised 01/2017, documented it was the policy that all residents and visitors would use the Sign Out Sign In Log when leaving the facility. The log included: resident's name, person name accompanying the resident if the resident was not taking self out, date and time leaving, and the date and time of anticipated return. The policy documented if the resident left unaccompanied, and did not return at the anticipated return time, the facility would follow process until the resident returned. The policy noted the staff would notify the Administrator, DON, resident representative, health care provider, local ER, and local law enforcement. The policy did not address staff processes in instances when a resident did not leave an anticipated return time. The facility failed to ensure the safety of Resident (R1), who admitted to the facility with a self-care deficit, signed himself out of the facility on 09/11/22 at 01:30 PM, and failed to document an anticipated return time. R1 did not return to the facility on [DATE] and the facility staff did not begin to search for R1 until around 09:45 PM, eight -hours and 15 minutes later. Administrative Nurse D did not notify law enforcement until 09/12/22 at 11:34 AM (22 hours and four minutes after R1 signed out), to file a missing person report. R1 was to be supervised while outside of the facility, if leaving the facility, and was known to sign himself out prior, with staff knowledge of R1 obtaining/consuming alcohol, against physician's orders. On 09/12/22 at approximately 03:00 PM (25 and a half hours after signing out), Licensed Nurse (LN) G observed R1 seated in his nonfunctioning motorized wheelchair, due to a depleted battery, on the sidewalk with wheels wedged between the edge of the sidewalk and the grass. The resident was located near a four lane, heavily trafficked area of Meridian and Kellogg, approximately 2.5 miles from the facility, with speed limits of 40-60 miles per hour, respectively. Staff observed R1 with noted odor, as he had defecated/urinated in his pants, which were lowered down on his body. The staff member notified the facility she located R1 and she called 911 to have R1 transported to the Emergency Department (ED) for evaluation and treatment by Emergency Medical Services (EMS). These cumulative failures placed R1 in immediate jeopardy. The facility provided an acceptable plan of removal of the immediately jeopardy on 09/26/22 at 02:00 PM. The plan included the following: 1. On 09/26/22 at 11:25 AM the facility began educating staff on the revised Sign In Sign Out policy, and education continued with staff through 02:00 PM. All staff would be educated on the updated policy prior to working. 2. The revised facility Sign In Sign Out policy, included if there was inclement weather (rain, snow, and extreme weather), the facility staff would educate the resident on the risk of exposure and encourage the resident to wait until the weather was favorable. If no anticipated returned date and time is documented on the log, after four hours, the facility would initiate notifying the Administrator and Director of Nursing, contact the location the resident was going, contact resident's representative, notify the health care provider, contact local emergency departments, and notify local law enforcement within one hour. The survey team verified onsite the facility implemented the IJ removal plan on 09/28/22 at 12:48 PM, therefore at that time, the IJ was lowered to a scope/severity level of G.