STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175172	A. Building B. Wing	07/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Excel Healthcare and Rehab Topeka	2515 SW Wanamaker Road Topeka, KS 66614

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** 22686 The facility reported a census of 102 residents. The sample included four residents identified at risk for elopement (when a resident leaves the premises or safe area without staff knowledge). Based on record review, observation, and interview, the facility failed to provide adequate supervision to prevent an elopement for Resident (R) 1, who was independent with ambulation, at risk for elopement, and had impaired cognition. The facility reported a census of 102 residents. The sample included four residents identified at risk for elopement (when a resident leaves the premises or safe area without staff knowledge). Based on record review, observation, and interview, the facility failed to provide adequate supervision to prevent an elopement for Resident (R) 1, who was independent with ambulation, at risk for elopement, and had impaired cognition. On 07/12/22 at approximately 10:10 AM Certified Nurse Aid M let R1 outside into the enclosed courtyard. R1 proceeded to walk towards the back area of the courtyard, out of the line of sight of CNA M. CNA M then escorted another resident back into the building. When CNA M went back to look for R1, R1 was gone. CNA M then alerted other facility staff and staff began to search inside the facility but were unable to locate the resident. Staff began to search the surrounding area outside the facility. Approximately one hour and five minutes later, CNA N located R1 by a food establishment more than 0.5 miles from the facility. CNA M returned R1 to the facility. The facility staff failed to provide adequate supervision and allowed R1 to wander outside of visualization resulting in R1 climbed over the fence in the courtyard and left the facility without staff knowledge or supervision. This deficient practice placed R1 in Immediate Jeopardy. Findings included: - R1's Electronic Medical Record (EMR), under the Diagnosis tab, listed diagnoses of dementia (a mental disorder in which a person loses the ability to think, remember, learn, make decisions, and solve problems); encephalopathy, (a broad term for any brain disease that alters brain function or structure); late onset Alzheimer's disease, (a progressive memory decline occurring after age 65); amnesia, (an inability to remember events for a period of time); speech and language deficit and hearing loss following a cerebral vascular accident, (difficulty with hearing and/or articulating words following an interruption of blood flow to the brain). (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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(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 Admission Minimum Data Set (MDS) dated [DATE] recorded R1 had a Brief Interview for Mental Status score of nine, which indicated R1's cognition was moderately impaired. R1 had wandering behavior daily during the assessment period. The MDS recorded R1 as independent with most activities of daily living (ADL's) including transfers, dressing, and toileting, and R1 ambulated without use of assistive devices. The Behaviors Care Area Assessment (CAA) dated 05/05/22 recorded R1 wandered about the facility and wore an alarming bracelet (Wanderguard- bracelet that sets off an alarm when residents wearing one attempt to exit the building without an escort) to indicate when R1 neared a facility entry and/or exit. An admission Elopement Risk assessment dated [DATE] recorded a score of 14, which placed the resident at high risk for elopement. Follow-up Elopement Risk Assessments dated 06/01/22 recorded R1 was at greater risk for elopement with a score of 26. R1's initial Care Plan dated 03/12/22 documented the resident was at risk for elopement and directed staff to distract the resident by offering pleasant diversions, attempt to identify any pattern to target interventions, initiate psychiatric services evaluation if needed, and check placement of a left ankle personal alarm (Wanderguard), every shift. A Social Service Progress Note dated 05/11/22 timed 12:19 PM. documented R1 stated he was leaving the facility, and R1 removed the left ankle alarm bracelet. The note documented staff redirected R1. A Social Service Progress Note dated 07/12/22 at 08:56 AM (94 minutes before the elopement) recorded R1 was agitated, wanted to leave the facility unaccompanied, and wanted to take the bus to his fiance's house. Social Services X explained to R1 he would need to have an escort due to his cognition and memory issues. R1 became agitated, but accepted redirection. R1's clinical record lacked any documentation regarding the circumstances surrounding the elopement, or a descriptive narrative and/or timeline of R1'elopement from the facility. A Social Service Progress Note dated 07/12/22 at 11:49 AM (after the elopement) recorded Social Services X, Administrative Nurse F, and the Consultant GG met with R1 to evaluate R1's wellbeing. R1 was agitated and confused. R1 was calmed, redirected, and R1's responsible party was contacted and verbalized understanding of the situation. The facility's Investigation recorded on 07/12/22 a staff member took R1 outside to the South patio smoking area for fresh air and left the resident alone. It was speculated that the resident exited through a gate that had a broken lock. At 10:30 AM staff noted R1 was missing and performed a room sweep, and outside sweep to look for R1. Staff drove around the area and looked for R1. The investigation documented at 11:15 AM R1 returned to the facility on his own and walked in the front door. Consultant GG was in the facility and assessed the resident. Consultant GG gave an order for Ativan (an antianxiety medication) and sent the resident to the hospital for evaluation. The investigation noted the resident was dressed in overalls, a long-sleeved shirt, and an undershirt. (continued on next page)

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(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	A Witness Statement from Agency Certified Nurse Assistant (CNA) M documented she took a female resident outside in the courtyard for a late smoke break. R1 knocked on the window to come outside. R1 walked the sidewalks and walked to the west side of the courtyard towards the back area, where he was no longer visible. The other resident was done smoking shortly after R1 went out of sight. Agency CNA M documented she assisted the female resident back inside and then went to look for R1. R1 was no longer in the courtyard. Agency CNA M checked the locks and the door in that corner and everything on that side was secure. Agency CNA M went inside to see if anyone saw R1 come inside and was told no one saw R1. Staff checked R1's room and R1 was not present. Agency CNA M was told R1 went over the fence and to see a sibling and was found near local fast-food restaurants. A Witness Statement from Agency Licensed Nurse (LN) H documented after a code grey (missing resident) was called, Agency LN H searched for R1 in a private vehicle. Agency LN H located R1 approximately one mile from the facility, walking toward the facility. Agency LN H circled back, and R1 stated to LN H that R1 was headed to his family home nearby. R1 was reluctant at first, but eventually agreed to enter the vehicle and return to the facility with Agency LN H. Upon return, R1 exited the vehicle and walked through the facility front door to his assigned room. According to Wunderground.com on 10/13/22 at 10:53 AM the temperature was 86 degrees Fahrenheit with variable winds and fair skies. Observation on 07/14/22 At 10:00 AM revealed R1 walked about the facility easily, accompanied by a private duty caregiver. R1 wore a personal alarm bracelet on R1's left ankle. On 07/14/22 at 11:00 AM observation of the area where R1 exited the facility with Administrative Staff A revealed an alarming maglock key coded door to the facility courtyard. The door was not equipped with a Wanderguard alarm system. The courtyard itself revealed an approximately 6-foot-high wooden fence, the south end of which was obscured from the entrance door to the courtyard. On 07/14/22 at 11:30 AM observation of the area where R1 was found revealed an [NAME] area along a heavily trafficked road with four lanes of traffic. The posted speed along that stretch of the road was 35 miles per hour. R1 had to cross a busy intersection with four lanes of traffic moving north/south and east/west to reach the location where he was found, approximately 0.7 miles from the facility. On 07/14/22 at 10:00 AM R1 remembered exiting the facility on 07/13/22. R1 stated he was going to visit a friend in the hospital. R1 then stated he was going to visit his sister. R1 displayed the personal alarm, which he referred to as the tracking device on his ankle, and stated the alarms were easily removed with a pair of fingernail trimmers. R1 stated he exited the facility by climbing the brick encased standards between the wooden fence slats. R1 demonstrated his agility by standing next to a door in the dining room and stretched a leg to near the top of the door; R1 stated it's easy for a tall guy. On 07/14/22 at 11:46 AM Agency LN G stated the only preventative measures known for R1 wandering was the Wanderguard. Agency LN G stated that the morning of the elopement, R1 verbalized that he wanted to go home so all staff watched R1 at intervals. (continued on next page)

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(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	On 07/14/22 at 11:48 AM Agency LN H confirmed finding R1 about a mile south of the facility, by a fast food restaurant. R1 was walking back toward the facility when he was found. Agency LN H stated she pulled alongside R1 and R1 said he was not coming back. Agency LN H stated she asked R1 if he would like to get some fresh air in the car and R1 said yes and got in the car. Interviewed on 07/14/22 at 10:00 AM Social Services Y stated he assisted in the search for R1and stated all staff assisted as well. Social Services YY said R1 was at a stage in his dementia where R1 did not think he should be in a facility but did not know where he should be. On 07/13/22 At 12:15 PM Consultant GG stated R1 was sent to the hospital for evaluation and treatment and was diagnosed with a urinary tract infection. R1 was placed on antibiotic therapy and returned to the facility. On 07/14/22 at 01:00 PM Administrative Nurse F acknowledged staff allowing R1 to be unsupervised in the courtyard did not follow the facility's policies and procedures. On 07/14/22 at 11:00 AM Administrative Staff A acknowledged residents should not be left outside unattended. Administrative Staff A provided documentation of immediate staff education conducted after the incident. The facility's policy titled Missing Resident/Elopement revised 01/20/20 provided for identification, information activation, and search procedures after a resident eloped from the facility. The policy however, lacked documentation to address any measures to prevent the elopement of at-risk residents. The facility failed to provide adequate supervision to prevent an elopement for R1 who was independent with ambulation, at risk for elopement, and had impaired cognition when facility staff allowed R1 to wander outside of visualization resulting in R1 climbed over the fence in the courtyard and left the facility without staff knowledge or supervision. This deficient practice placed R1 in Immediate Jeopardy. The deficient practice was determined past noncompliance when the facility completed the following corrective actions on 07/12/22 prior to the survey event: R1 was evaluated at a local Hospital and returned to the facility. R1 was placed on 1:1 supervision when he returned to the facility on . Psychiatric services were scheduled for R1. An updated elopement risk assessment was completed and R1's Care Plan and Kardex were reviewed and revised with elopement interventions. Staff were re-educated on elopement prevention, safety, and supervision of residents at all times when a resident was outside. All residents in the facility were reviewed for Elopement Risk Assessments. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Facility Staff were in-serviced on Elopement Prevention, Safety, and line-of-sight Supervision of residents when outside. The scope and severity remained at a J Findings included: - R1's Electronic Medical Record (EMR), under the Diagnosis tab, listed diagnoses of dementia (a mental disorder in which a person loses the ability to think, remember, learn, make decisions, and solve problems); encephalopathy, (a broad term for any brain disease that alters brain function or structure); late onset Alzheimer's disease, (a progressive memory decline occurring after age 65); amnesia, (an inability to remember events for a period of time); speech and language deficit and hearing loss following a cerebral vascular accident, (difficulty with hearing and/or articulating words following an interruption of blood flow to the brain). The Admission Minimum Data Set (MDS) dated [DATE] recorded R1 had a Brief Interview for Mental Status score of nine, which indicated R1's cognition was moderately impaired. R1 had wandering behavior daily during the assessment period. The MDS recorded R1 as independent with most activities of daily living (ADL's) including transfers, dressing, and toileting, and R1 ambulated without use of assistive devices. The Behaviors Care Area Assessment (CAA) dated 05/05/22 recorded R1 wandered about the facility and wore an alarming bracelet (Wanderguard- bracelet that sets off an alarm when residents wearing one attempt to exit the building without an escort) to indicate when R1 neared a facility entry and/or exit. An admission Elopement Risk assessment dated [DATE] recorded a score of 14, which placed the resident at high risk for elopement. Follow-up Elopement Risk Assessments dated 06/01/22 recorded R1 was at greater risk for elopement with a score of 26. R1's initial Care Plan dated 03/12/22 documented the resident was at risk for elopement and directed staff to distract the resident by offering pleasant diversions, attempt to identify any pattern to target interventions, initiate psychiatric services evaluation if needed, and check placement of a left ankle personal alarm (Wanderguard), every shift. A Social Service Progress Note dated 05/11/22 timed 12:19 PM. documented R1 stated he was leaving the facility, and R1 removed the left ankle alarm bracelet. The note documented staff redirected R1. A Social Service Progress Note dated 07/12/22 at 08:56 AM (94 minutes before the elopement) recorded R1 was agitated, wanted to leave the facility unaccompanied, and wanted to take the bus to his fiance's house. Social Services X explained to R1 he would need to have an escort due to his cognition and memory issues. R1 became agitated, but accepted redirection. R1's clinical record lacked any documentation regarding the circumstances surrounding the elopement, or a descriptive narrative and/or timeline of R1'elopement from the facility. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 07/14/22 at 10:00 AM R1 remembered exiting the facility on 07/13/22. R1 stated he was going to visit a friend in the hospital. R1 then stated he was going to visit his sister. R1 displayed the personal alarm, which he referred to as the tracking device on his ankle, and stated the alarms were easily removed with a pair of fingernail trimmers. R1 stated he exited the facility by climbing the brick encased standards between the wooden fence slats. R1 demonstrated his agility by standing next to a door in the dining room and stretched a leg to near the top of the door; R1 stated it's easy for a tall guy. On 07/14/22 at 11:46 AM Agency LN G stated the only preventative measures known for R1 wandering was the Wanderguard. Agency LN G stated that the morning of the elopement, R1 verbalized that he wanted to go home so all staff watched R1 at intervals. On 07/14/22 at 11:48 AM Agency LN H confirmed finding R1 about a mile south of the facility, by a fast food restaurant. R1 was walking back toward the facility when he was found. Agency LN H stated she pulled alongside R1 and R1 said he was not coming back. Agency LN H stated she asked R1 if he would like to get some fresh air in the car and R1 said yes and got in the car. Interviewed on 07/14/22 at 10:00 AM Social Services Y stated he assisted in the search for R1and stated all staff assisted as well. Social Services YY said R1 was at a stage in his dementia where R1 did not think he should be in a facility but did not know where he should be. On 07/13/22 At 12:15 PM Consultant GG stated R1 was sent to the hospital for evaluation and treatment and was diagnosed with a urinary tract infection. R1 was placed on antibiotic therapy and returned to the facility. On 07/14/22 at 01:00 PM Administrative Nurse F acknowledged staff allowing R1 to be unsupervised in the courtyard did not follow the facility's policies and procedures. On 07/14/22 at 11:00 AM Administrative Staff A acknowledged residents should not be left outside unattended. Administrative Staff A provided documentation of immediate staff education conducted after the incident. The facility's policy titled Missing Resident/Elopement revised 01/20/20 provided for identification, information activation, and search procedures after a resident eloped from the facility. The policy however, lacked documentation to address any measures to prevent the elopement of at-risk residents. The facility failed to provide adequate supervision to prevent an elopement for R1 who was independent with ambulation, at risk for elopement, and had impaired cognition when facility staff allowed R1 to wander outside of visualization resulting in R1 climbed over the fence in the courtyard and left the facility without staff knowledge or supervision. This deficient practice placed R1 in Immediate Jeopardy. The deficient practice was determined past noncompliance when the facility completed the following corrective actions on 07/12/22 prior to the survey event: R1 was evaluated at a local Hospital and returned to the facility. R1 was placed on 1:1 supervision when he returned to the facility on . (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Psychiatric services were scheduled for R1. An updated elopement risk assessment was completed and R1's Care Plan and Kardex were reviewed and revised with elopement interventions. Staff were re-educated on elopement prevention, safety, and supervision of residents at all times when a resident was outside. All residents in the facility were reviewed for Elopement Risk Assessments. Facility Staff were in-serviced on Elopement Prevention, Safety, and line-of-sight Supervision of residents when outside. The scope and severity remained at a J