| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | B023025 | A. BUILDING: _____ B. WING _____ | 07/28/2022 |

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| ELTERN'S HOUSE | 1701 RESEARCH PARK DRIVE BLDG 4 LAWRENCE, KS 66047 |

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| S 000 | INITIAL COMMENTS<br><br>The following citations represent the findings of an Initial Survey with an investigation for complaint #173301 for the above named Home Plus Facility conducted on 07/27/22 and 07/28/22. | S 000 | | |
| S5026 SS=J | 26-42-101 (f) (1) Staff Treatment of residents ANE<br><br>(f)The administrator or operator shall ensure that all of the following requirements are met:<br>(1) No resident shall be subjected to any of the following:<br>(A) Verbal, mental, sexual, or physical abuse, including corporal punishment and involuntary seclusion;<br>(B) neglect; or<br>(C) exploitation.<br><br>This REQUIREMENT is not met as evidenced by:<br>KAR 26-42-101(f)(1)(B)<br><br>The facility reported a census of 11 residents. The sampled included three residents. Administrative Licensed Nurse B reported facility identified one resident at risk for elopement. Based on observation, interview and record review the Administrator failed to ensure Resident (R) 727 was not subjected to neglect, by the failure to provide adequate supervision and ensure that all outside gates were locked and properly secured. This resulted in cognitively impaired R727 exiting the facility, walking to a busy four lane street with speed limits of 40 miles per hours, and being unaccounted for by staff for 2.5 hours. The failure of staff to provide | S5026 | | |

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

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| S5026 | Continued From page 1 | S5026 | | |

adequate supervision and to ensure all outside gates were properly locked and secured, placed R727 in immediate jeopardy.
Findings included:

- Review of R727's medical record revealed the resident moved into the facility on 07/11/22 with diagnoses of cognitive impairment, macular degeneration, and seizure disorder

R727's "Functional Capacity Screen" (FCS) dated 04/01/22, from a prior sister facility, revealed the resident was independent with transfers and mobility, had a cognitive score of two related to long term memory deficit and impaired decision making. He also had a risk of falls and impaired vision and hearing.

R727's current FCS dated 07/27/22 revealed no changes except the resident had a cognitive score of four, indicating a decline in cognitive impairment and had wandering behaviors.

R727's "Negotiated Service Agreement" revealed staff would provide services as appropriate, for walking, transfers, and behaviors and would involve the resident in individual and group activities.

An interview on 07/27/22 at 11:31 AM with "Licensed Nurse" (LN) C reported the facility did not do elopement risk assessments, but just kept an eye on the residents who liked to wander.

The resident's record lacked a current care plan. His record included an undated prior care plan from the sister facility which identified the resident had the following behaviors: anxious/agitated, angry, combative, hallucinations/delusions, and wanders/elopes. The care plan lacked specific

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| S5026 | Continued From page 2 | S5026 | | |

interventions related to elopement/wandering or the other behaviors listed above.

Review of the resident's "Nurse's Notes" included notes from the prior sister facility as well as this facility. They included the following:

07/10/22 at 11:19 AM - Resident went with family yesterday afternoon and tried to leave the house when another resident's family left.

07/11/22 at 06:11 PM - Resident transferred to a sister house and not wanting to stay in house.

07/15/22 at 07:29 AM - Resident had a fall out of bed and staff were instructed to place resident on 15-minute checks.

07/17/17 at 12:30 AM - Around 10:15 PM on 07/16/22 staff called this LN and reported the resident was missing and they started a search for the resident. Staff were instructed to get flashlights, check outside again, check all houses, and rooms. Staff notified LN C who notified LN B who notified authorities.

07/17/22 at 12:45 AM- Administrative LN B arrived at the facility and checked for the resident in all houses and in each resident room. Outside parameters were searched as well. Staff notified the Administrator, and she came to the facility. Once the Administrator arrived the resident's legal representative was notified as well as local police. Local police found the resident 0.7 miles from the facility and brought the resident back to the facility. LN assessed the resident who had no signs of injury. Resident cognition was at resident's baseline. Staff instructed to provide 15-minute visual checks.

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| S5026 | Continued From page 3<br>According to "Wunderground.com" the temperature outside between 08:21 PM and 10:55 PM ranged from 81 to 86 degrees Fahrenheit.<br><br>Review of the "Facility Investigation" included the following witness statements:<br><br>CNA H's undated witness statement revealed she came to work at 08:00 PM on 07/16/22 and did not see R727. At 10:00 PM CNA I arrived and said that R727 was missing. Staff looked for the resident and could not find him.<br><br>CNA J's undated "Witness Statement" revealed she last saw the resident at 08:00 PM out in the courtyard.<br><br>Observations of the resident during the survey revealed the following:<br><br>07/27/22 at 01:37 PM -"Certified Medication Aide" (CMA) E took resident outside and sat out on the patio and came back in at 1:45 PM.<br><br>07/27/22 at 02:43 PM, R727 went over to the front door and tried to open it and then went around the corner to another short hall. Then very fast, almost at a run, the resident went over to the front door again as someone came in the front door. The surveyor got up to look out the door and observed the resident outside of the facility walking down the sidewalk fast with Dietary Staff F with him and they went into one of the other sister houses.<br><br>07/27/22 at 02:56 PM The resident was back inside the facility and walking around in front living area, the kitchen staff and CMA E told other staff to not let him out of their sight.. | S5026 | | |

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| S5026 | Continued From page 4<br><br>07/28/22 at 08:58 AM R727 went throughout different areas of the facility and to the patio door.<br><br>On 07/27/22 Administrative LN B and CMA E acknowledged the resident would not be aware of his own safety needs when crossing a street.<br><br>On 07/17/22 Dietary Staff F acknowledged that he just happened to be outside when the resident went out the front door otherwise, he did not know how far the resident would have gotten.<br><br>On 07/28/22 at 09:34 AM "Certified Nurse Assistant" (CNA) G acknowledged the resident was at risk for elopement. She stated the staff were to keep him occupied, watch the doors, and check the patio door if it alarms. R727 could go outside now since all gates were locked and they were to check on the resident every 15 minutes.<br><br>On 07/28/22 at 09:45 AM CMA E stated, if a resident had a risk for elopement, we would do 15-minute checks and keep our eyes on him. If he was exit seeking, then we tried to hang out with him for awhile until he calmed down. CMA E confirmed that the 15-minute checks included checking on the resident every 15 minutes when he goes outside<br><br>On 07/27/22 at 02:21 PM Administrative staff A and Administrative LN B acknowledged that staff failed to complete the 15-minute checks when the resident was out in the courtyard and acknowledged that the patio gate was not locked at the time the resident eloped.<br><br>The Administrator failed to ensure Resident (R) 727 was not subjected to neglect, by the failure to provide adequate supervision and ensure that all | S5026 | | |

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| S5026 | Continued From page 5<br>outside gates were locked and properly secured. This resulted in cognitively impaired R727 exiting the facility, walking to a busy four lane street with speed limits of 40 miles per hours, and being unaccounted for by staff for 2.5 hours. The failure of staff to provide adequate supervision and to ensure all outside gates were properly locked and secured, placed R727 in immediate jeopardy.<br><br>The immediate jeopardy was removed on 07/27/22 at 04:26 PM when Administrative Staff A provided a plan for the prevention of recurrence of elopement for this resident, or any other resident identified at risk or elopement. The plan included the following:<br><br>Root cause review:<br>1. Management identified the gate on the southwest corner of the house was ajar and concluded the gate was not latched allowing the resident to elope. Latch was immediately latched.<br><br>2. Staff failed to follow 15-minute checks throughout the evening hours.<br><br>3. Management staff failed to fully educate staff on R727's elopement risk and did not address all potential issues in the prior policy.<br>Corrective actions:<br><br>1. Policy has been changed as of 07/27/22.<br><br>2. Management carried out in-person education of new policy with house #4 staff.<br><br>3. Sign with R727's picture placed in staff communication book and signs indicating elopement risk at front and side door. The door | S5026 | | |

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| S5026 | Continued From page 6<br>code is changed, and family will ring bell for entry.<br><br>4. Gates around the house will be checked and signed off on each shift rather than by one individual. House manager to check log weekly to ensure gates are being checked.<br><br>5. Education over internal communications to all staff who occasionally work in Eltern's House will be completed by 07/29/22. | S5026 | | |
| S5028 SS=D | 26-42-101 (f) (3) Staff Treatment of Residents Reporting<br><br>(f) (3) Each allegation of abuse, neglect, or exploitation shall be reported to the administrator or operator of the home as soon as staff is aware of the allegation and to the department within 24 hours. The administrator or operator shall ensure that all of the following requirements are met:<br>(A) An investigation shall be started when the administrator or operator, or the designee, receives notification of an alleged violation.<br>(B) Immediate measures shall be taken to prevent further potential abuse, neglect, or exploitation while the investigation is in progress.<br>(C) Each alleged violation shall be thoroughly investigated within five working days of the initial report. Results of the investigation shall be reported to the administrator or operator.<br>(D) Appropriate corrective action shall be taken if the alleged violation is verified.<br>(E) The department ' s complaint investigation report shall be completed and submitted to the department within five working days of the initial report.<br>(F) A written record shall be maintained of each investigation of reported abuse, neglect, or exploitation. | S5028 | | |

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| S5028 | Continued From page 7<br><br>This REQUIREMENT is not met as evidenced by:<br>KAR 26-42-101(f)(3)<br><br>The facility reported a census of 11 residents. The sample included three residents. Based on interview and record review the facility failed to report an allegation of abuse, neglect, or exploitation to the state agency within 24 hours for Resident (R) 727 was cognitively impaired and exited the facility, walking to a busy four lane street with speed limits of 40 miles per hours, and being unaccounted for by staff for 2.5 hours<br><br>Findings included:<br><br>- Review of R727's medical record revealed the resident moved into the the facility on 07/11/22 with a diagnoses of cognitive impairment, macular degeneration, and seizure disorder. Prior to moving into the Eltern's House he lived in one of the other houses on campus which shares an outside gated area.<br><br>R727's prior "Functional Capacity Screen" (FCS) dated 04/01/22, from when he lived in a sister facility, revealed the resident was independent with transfers and mobility, had a cognitive score of 2 related to long term memory deficit and impaired decision making. He also had a risk of falls and impaired vision and hearing.<br><br>R727's current FCS dated 07/27/22 included the same assessment results except the resident had a cognitive score of 4 indicating a decline in cognitive impairment and had wandering | S5028 | | |

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| S5028 | Continued From page 8<br>behaviors.<br><br>R727's "Negotiated Service Agreement" dated 07/11/22 had marked that staff would provide services as appropriate for walking, transfers, and behaviors and involve resident in individual and group activities.<br><br>The resident's Care plan had not been revised for when he moved from the sister facility to this facility.<br><br>On 07/27/22 at 10:45 AM Administrative staff A acknowledged the resident eloped from the facility on 07/16/22 and the department was notified by staff on 07/19/22.<br><br>The facility failed to report an allegation of abuse, neglect, or exploitation to the state agency within 24 hours for R727 who eloped from the facility on 07/16/22. | S5028 | | |
| S5080 SS=E | 26-42-201 (a) (b) Functional Capacity Screen on Admission<br><br>(a) On or before each individual ' s admission to a home plus, a licensed nurse, a licensed social worker, or the administrator or operator shall conduct a screening to determine the individual ' s functional capacity and shall record all findings on a screening form specified by the department. The administrator or operator may integrate the department ' s screening form into a form developed by the home, which shall include each element and definition specified by the department.<br>(b) A licensed nurse shall assess any resident whose functional capacity screening indicates the need for health care services. | S5080 | | |

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| S5080 | Continued From page 9 | S5080 | | |

This REQUIREMENT is not met as evidenced by:
KAR 26-42-201(a)

The facility reported a census of 11 residents. The sample included three residents. Based on interview and record review the operator failed to ensure the admission screening for determination of functional capacity for two residents, Resident (R) 727 and R728, of three had a Functional Capacity Screen completed on or before admission to the facility.

Findings included:

- Review of R727's medical record revealed the resident moved into the the facility on 07/11/22 with a diagnoses of cognitive impairment, macular degeneration, and seizure disorder. Prior to admission he resided at a sister facioity on campus which shares an outside gated area.

R727's prior "Functional Capacity Screen" (FCS) dated 04/01/22, from the sister facility, revealed the resident was independent with transfers and mobility, had a cognitive score of two related to long term memory deficit and impaired decision making. He also had a risk of falls, impaired vision and impaired hearing.

On 07/27/22 at 12:03 PM Administrative Licensed Nurse B acknowledged she did not complete a new FCS when the resident moved from the sister facility to this facility.

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| S5080 | Continued From page 10<br><br>The administrator failed to ensure designated staff completed a FCS on or before admission to the facility.<br><br>- Review of R728's medical record revealed the resident moved into the facility on 06/22/22 with diagnoses of dementia with aphasia, depression and anxiety.<br><br>R728's "Functional Capacity Screen" (FCS) dated 07/20/22, 28 days after moving in, identified the resident needed physical assistance with bathing, dressing, and toileting, and had impaired cognition.<br><br>On 07/28/22 at 11:56 AM Administrative Licensed Nurse B acknowledged she did not complete a FCS on or before the resident moved into the facility.<br><br>The administrator failed to ensure designated staff completed a FCS on or before admission to the facility. | S5080 | | |
| S5156 SS=E | 26-42-204 (b) Health Care Services<br><br>(b) If the functional capacity screening indicates that a resident is in need of health care services, a licensed nurse, in collaboration with the resident, the resident ' s legal representative, the case manager, and, if agreed to by the resident or resident ' s legal representative, the resident ' s family, shall develop a health care service plan to be included as part of the negotiated service agreement.<br><br>This REQUIREMENT is not met as evidenced | S5156 | | |

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| S5156 | Continued From page 11<br>by:<br>KAR 26-42-204(b)<br><br>The facility reported a census of 11 residents. The sample included three residents. Based on interview and record review the administrator failed to ensure designated staff completed a health care service plan (HCSP) for two, Resident (R) 727 and R728 of three sampled residents who required health care services to meet the residents' needs.<br><br>Findings included:<br><br>- Review of R727's medical record revealed the resident moved into the facility on 07/11/22 with a diagnoses of cognitive impairment, macular degeneration, and seizure disorder. Prior to moving into the facility he lived in one of the sister houses on campus which shares an outside gated area.<br><br>R727's prior "Functional Capacity Screen" (FCS) dated 04/01/22, from the sister facility, revealed the resident was independent with transfers and mobility, had a cognitive score of two related to long term memory deficit, impaired decision making a risk of falls and impaired vision and hearing.<br><br>R727's Negotiated Service Agreement dated 07/11/22 indicated the facility would provide appropriate services for activities of daily living and would provide supervised nursing services 24 hours/day for health care services.<br><br>R727's "Health Care Service Plan" on record was from the prior sister facility where the resident had lived. The record lacked a current HCSP. | S5156 | | |

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| S5156 | Continued From page 12<br><br>On 07/27/22 at 12:03 PM Administrative Licensed Nurse B acknowledged she did not complete a new FCS or HCSP when the resident moved from the sister facility to this facility.<br><br>The administrator failed to ensure designated staff completed a HCSP on or before admission to the facility.<br><br>- Review of R728's medical record revealed the resident moved into the facility on 06/22/22 with diagnoses of dementia with aphasia, depression and anxiety.<br><br>R728's "Functional Capacity Screen" (FCS) dated 07/20/22, 28 days after moving in, identified the resident needed physical assistance with bathing, dressing, and toileting, and had impaired cognition.<br><br>R728's Negotiated Service Agreement dated 07/2/22 identified staff would provide appropriate services for all activities of daily living and would provide health care services supervised by nursing 24 hours/day.<br><br>The undated "Health Care Service Plan" (HCSP) from a sister facility failed to identify the resident used an assistive device attached to the bed for mobility. The record lacked a HCSP for this facility.<br><br>On 07/28/22 at 11:56 AM Administrative Licensed Nurse B acknowledged she did not complete a FCS or a HCSP on or before the resident moved into this facility.<br><br>The administrator failed to ensure designated staff completed a HCSP on or before admission to the facility. | S5156 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | B023025 | A. BUILDING: _____ B. WING _____ | 07/28/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ELTERN'S HOUSE | 1701 RESEARCH PARK DRIVE BLDG 4 LAWRENCE, KS 66047 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| S5171 SS=E | 26-42-204 (i) Health Care Services Standards of Practice<br><br>(i) All health care services shall be provided to residents by qualified staff in accordance with acceptable standards of practice.<br><br>This REQUIREMENT is not met as evidenced by:<br>KAR 26-42-204 (i)<br><br>The facility reported a census of 11 residents. The sample included 3 residents with a total of 7 residents identified who used some type of bed rail/assistive device attached to the bed. Based on observation, interview and record review the operator failed to ensure all health care services were provided according to acceptable standards of practice for one sampled Resident (R) 728, and 4 other residents who used upside-down "U" shaped bed cane/bed assistive devices.<br><br>Findings included:<br><br>- Review of R728's medical record revealed the resident moved into the facility on 06/22/22 with diagnoses of dementia with aphasia, depression and anxiety.<br><br>R728's "Functional Capacity Screen" (FCS) dated 07/20/22, 28 days after moving in, identified the resident needed physical assistance with bathing, dressing, and toileting, was independent with transfers, and had impaired cognition.<br><br>R728's "Negotiated Service Agreement" (NSA) dated 07/2/22 identified staff would provide appropriate services for all activities of daily living and would provide health care services | S5171 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| S5171 | Continued From page 14 | S5171 | | |

supervised by nursing 24 hours/day. The NSA failed to identify that the resident used an assistive device attached to the bed for mobility assistance.

The undated "Health Care Service Plan" (HCSP) from a sister facility failed to identify the resident used an assistive device attached to the bed for mobility. The record lacked a HCSP for this facility.

The residents record included a "Side Rail Utilization Assessment" dated 05/01/22, prior to admission to the facility, which failed to assess for gap safety in order to prevent entrapment.

Observation on 07/27/22 at 03:25 PM the resident had a bed cane attached to the side of the bed with the gap between the rails within the assistive device measuring 11.5 inches and another area within the device measuring 5.5 inches.

Observations during initial tour on 07/27/22 revealed four other residents had upside-down "U" shaped assistive devices attached to their beds and the gap between the rails within each device measured greater than 11 inches.

On 07/27/22 at 4:05 PM "Administrative Licensed Nursing" staff B reported the hand canes checked when put on the beds and monthly for functionality . Upon assessment of the bed canes, Administrative LN B acknowledged the gaps were potential entrapment risks.

The FDA (food and drug administration) Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment dated 03/10/06, listed 4 zones of greatest concern with specific

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|---|---|---|---|
| | B023025 | A. BUILDING: _____ B. WING _____ | 07/28/2022 |

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| S5171 | Continued From page 15<br>measurements to reduce the risk of entrapment as follows:<br><br>Zone 1 within the rail should measure less than 4 and 3/4 inches<br><br>Zone 2 under the rail, between the rail supports or next to a single rail support should measure less than 4 and ¾ inches<br><br>Zone 3 between the rail and the mattress should measure less than 4 and 3/4 inches<br><br>Zone 4 under the rail at the ends of the rail should measure less than 2 and 3/8 inches.<br><br>The operator failed to ensure all health care services were provided according to acceptable standards of practice for one sampled Resident (R) 728, and 4 other residents who used upside-down "U" shaped bed cane/bed assistive devices when the devices did not meet the safety standards to reduce entrapment. | S5171 | | |