

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: B089093	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 05/10/2022
NAME OF PROVIDER OR SUPPLIER OUR HOME SENIOR CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 5745 ROSEHILL RD SHAWNEE, KS 66216		
(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
S 000	INITIAL COMMENTS The following citations represent the findings of the licensure resurvey with attached complaint #KS00171412 for the above named facility conducted on 05/09/22 to 05/10/22.	S 000		
S5026 SS=J	26-42-101 (f) (1) Staff Treatment of residents ANE (f)The administrator or operator shall ensure that all of the following requirements are met: (1) No resident shall be subjected to any of the following: (A) Verbal, mental, sexual, or physical abuse, including corporal punishment and involuntary seclusion; (B) neglect; or (C) exploitation. This REQUIREMENT is not met as evidenced by: KAR 26-42-101(f)(1)(B) The facility reported a census of seven residents, three residents were included in the sample. The operator failed to protect five out of seven residents from neglect by failing to provide goods and services which were reasonably necessary to ensure safety and well-being and to avoid physical or mental harm or illness. This failure placed the resident's in immediate jeopardy by the following: the operator reported the facility had two wandering, cognitively impaired, independently mobile residents. Resident (R) 510 left the interior of the building on 04/29/22 at 09:01 PM without facility staff knowledge, per camera footage confirmed by the operator. Facility staff reported the resident as missing	S5026		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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S5026	Continued From page 1 from the interior of the facility at 02:02 AM (5 hours later on 04/30/22). The facility further reported three residents who required two-person assistance for toileting, transfers, and mobility and only scheduled one staff in the facility after 11:00 PM. Findings included: - Record review for Resident (R) 510 revealed an admission date of 04/18/22 with the following diagnoses: anxiety, depression, dementia unspecified with behavioral disturbance, and hypertension. The 04/18/22 Admission "Functional Capacity Screen" (FCS) documented R510 required staff supervision with walking and mobility, redirect as needed for cognition, supervise and redirect for impaired decision making and wandering. The 04/18/22 "Negotiated Service Agreement" (NSA) documented R510 had a "history of staying up at night with frequent naps during the day. . . becomes disoriented/confused often, will wonder (sic) into uncommon areas." Review of nursing progress notes for dates 04/20/22 through 05/09/22 revealed lack of entry documenting elopement on 04/29/22. The "Investigation Report" provided by Administrative Staff A dated 04/29/22 revealed the following information: 2:02 AM CMA B called the Administrative Staff A to report R115 missing. Administrative Staff A stayed on the phone with CMA B as she walked through the entire facility looking for R510. CMA B then looked outside the	S5026		

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S5026	Continued From page 2 front entry door and found R510. The signed and notarized witness statement dated 05/09/22 by Administrative Staff A revealed the following events: 04/29/22 at 02:02 AM Administrative Staff A received a call on from CMA B to notify her R510 was missing. Administrative Staff A believed the resident had just exited the facility. CMA told her at that time she found R510 outside the front door in the parking lot. Administrative Staff A instructed CMA B to take R510 inside, check her for any injuries and keep her in eye sight the rest of the night. 04/29/22 at 09:00 AM Administrative Staff A watched the video footage and found the initial incident details reported to her were not accurate. She found R510 had exited the building on 04/28/22 around 09:00 PM while one staff was outside on break and the other staff was in the south hall with a resident. 04/29/22 at 09:00 AM Administrative Staff A watched the video footage and discovered the initial incident details reported to her were not accurate. 04/29/22 around 02:00 PM, Administrative Staff A notified CMA B she was terminated due to her failure to check on all residents between 04/28/22 at 10:38 PM and 04/29/22 at 02:00 AM. Administrative Staff A provided CNA C with education to check on residents prior to clocking out at the end of her shift at 11:00 PM. Observation on 05/09/22 at 11:48 AM revealed the south hall back door had a cardboard box	S5026		

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S5026	Continued From page 3 with a sign that read "Do not touch" covering the green exit button. On 05/09/22 at 11:48 AM Administrative Staff A stated she covered the green button which read "Push here to exit" with a cardboard box and sign to prevent R510 from pushing the button, exiting the building, and eloping again. Observation on 05/09/22 at 11:50 AM revealed the building had a large foyer/entrance area which led into common areas of the home. Each side of the foyer led to two hallways one to the north and one to the south where the resident's rooms, bathrooms, and shower rooms were located. A back door was located at the end of each hall, which led to the outside. The building was open to all common areas and hallways with no closed doors to prevent residents from wandering from one hall to another. Observation on 05/09/22 at 11:53 AM revealed the north hall back door exit had a green button that read "Push here to exit." A resident was pacing up and down the hallway. Interview on 05/09/22 at 11:53 AM Administrative Staff A stated R511 wanders the hallway and common area about 12 hours a day. Administrative Staff A did not cover the green button because R511 had not pushed the green button to exit the building yet and R10, who had eloped does not come to this side of the building. The door alarm could not be heard on the other side of the building or when providing cares in resident's rooms. Interview on 05/09/22 at 01:15 PM Administrative staff A stated Certified Medication Aide (CMA) B was the only staff in the building from 11:00 PM	S5026		

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S5026	Continued From page 4 04/28/22 until 07:00 AM 04/29/22. The other staff member involved, Certified Nurse Aide (CNA) C, stated upon interview during the facility's investigation she did not know it was her responsibility to check on residents every two hours and before clocking out at the end of her shift at 11:00 PM because CMA B was staying all night. The resident was outside for two hours when CNA C left. CNA C was re-educated to provide two-hour checks and check residents before leaving the building at the end of her shift. Administrative Staff A stated she thought the elopement took place during the night after CNA C clocked out. It was not until the next morning when she arrived to work at 09:00 AM and began looking at the camera footage that she discovered the elopement happened at 09:01 PM while CMA B and CNA C both still in the building. Interview on 05/09/22 at 03:14 PM Administrative Staff A stated all the green buttons in the building were covered with boxes and the newly hired staff member scheduled to start working night shift on 05/13/22 would begin 05/09/22 instead. New keypads for the coded exits will be installed within the next 48 hours and she would send pictures once they were installed. Interview on 05/09/22 at 03:32 PM Administrative Staff A stated staff education was provided through internet training about elopement and she would provide the training materials including the test. Interview on 05/09/22 at 03:52 PM Administrative Staff A stated at the start of employment she provided a walk-through during orientation and educated staff to keep pagers on at all times. Staff signed off they were provided this training on a sign off sheet. She also provided a shift	S5026		

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S5026	Continued From page 5 change checklist for staff to sign at each shift change with the following statement at the top of the page "To ensure shift exchange is done properly, please sign your names for your shift that you provided resident incontinent checks, verified all residents in home, motion sensors on if applied, and cell phone and pagers are on shift." The operator failed to protect R511 from neglect of elopement by not securing exit doors. Findings included: - Review of the resident roster provided by Administrative Staff A on 05/09/22 documented three residents required two-person assistance. Review of the April 2022 facility staffing schedule provided by Administrative Staff A revealed the following; there was only one staff scheduled/working the 11:00 PM to 07:00 AM shift in the facility 29 nights out of 30 total for the month of April and one staff working from 11:00 PM to 03:00 AM On 05/09/22 at 11:33 AM Administrative Staff A stated there was sometimes two staff providing care from 7:00 PM until 11:00 and usually only one staff providing care from 11:00 PM until 07:00 AM the next morning. On 05/10/22 at 02:40 via phone interview Owner D stated "We have always been trying to hire more people." The operator failed to protect three residents who required two-person assistance from neglect by not providing adequate staff to assist with cares and mobility to exit the building in the event of	S5026		

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S5026	Continued From page 6 emergency. The facility's plan of correction included: 1. Staff education which included a training video on resident elopement and a written test started on 05/03/22 and was completed on 05/08/22 by all full-time staff 2. Interview with the facility owner on 5/9/2022 at approximately 03:00PM stated the replacement key pads for the green "Push to exit" buttons just arrived at the facility and would be installed within the next 48 hours. 3. Administrative Staff A provided a staffing schedule showing two staff for the 11:00 PM to 07:00 AM shift starting 5/9/2022. The plan of correction was approved by the department. Both immediate jeopardy findings were abated at 03:42 PM based on the facility's plan of correction which was approved by the department.	S5026		