

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: B105114	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 08/03/2020
NAME OF PROVIDER OR SUPPLIER JOHNSONVILLE HOME LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 2419 N 22ND STREET KANSAS CITY, KS 66104		
(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 citation represents the findings of an abbreviated survey with complaint investigations # 154337, #154617 along with the special infection control survey for COVID-19 for the above named facility conducted on 7/30/20 and 8/3/20.	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: K.A.R. 26-42-102(f)(1)(B) The facility reported a census of 8 residents. The sample included 1 resident. Based on observation, record review and interview for resident #1, the operator failed to ensure that no resident was subjected to neglect when a resident with a history of wandering and poor decision making, left the facility through an unlocked laundry room door, was unaccounted for by staff for at least 3 hours and returned to the facility by family after she was taken to the hospital by the police. The resident continued to be at risk for elopement when she continued to	S5026		

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

TITLE

(X6) DATE

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S5026	Continued From page 1 reside in the facility without documented staff observation checks. Findings included: - Record review for resident #1 recorded admission date of 1/4/20 with diagnoses of: dementia with behavioral disturbances. Functional Capacity Screen (FCS) dated 1/4/20 recorded resident required physical assistance with bathing, dressing and toileting, required supervision with transfer, walk/mobility and eating and unable to perform management of medications and treatments. Resident has problems with cognition: long term memory, short term memory, memory recall and decision making. Resident has problems with communication: sometimes able to be understood, sometimes able to understand others. She has a history of/ problem with: falls, impaired decision making and wandering. Negotiated Service Agreement/ Health Care Service Plan (NSA/HCSP) dated 1/4/2020 recorded staff to provide physical assistance with bathing, dressing and toileting, all medications and treatments to be administered by nurse and medication aides and staff will monitor resident for fall risk and wandering. The NSA/HCSP lacked documentation of interventions to address wandering and potential for elopement risk. Interview on 7/30/20 at 12:18pm with operator #A stated resident typically just wanders inside the house. She confirmed NSA/HCSP lacked specific interventions for wandering and an	S5026		

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S5026	Continued From page 2 addendum/update to the careplan has not been completed since 1/4/20. Resident roster recorded 8 residents in the facility, all 8 have impaired cognitive status. Nurse's note dated 2/14/20 at 11:30am recorded: " ... Resident requires redirection as she gets confused on where to go or what to do. Resident does not like to be told what to do, as she believes she works at facility" Signed by licensed nurse #B Nurse's note dated 4/13/20 at 11:50am recorded: "Resident in good spirits today. Resident slept well, staff reports sometimes resident will stay up late. Resident used to work nights" signed by licensed nurse #B Nurse's note dated 7/18/20 (no time) recorded: "At 5:30 am this morning aide received a phone call from [resident's sister] asking her if her sister was still in bed. Aide stated that she had checked on her at 12:00 midnight and at 2:00 am this morning. Aide went to client's room and realized that she was not there. Client's sister informed her that she was at [hospital name] and had been found by an innocent bystander off 20th and Quindaro around 3:30am. Client's sister stated that the police was called out to the scene. The police department called dispatch and had client transported to [hospital]for an assessment and to determine if patient had any injuries Patient arrived at the facility at 9:30 am. Nurse came by the facility to perform an assessment on patient At this present time patient denies pain. Patient shows no signs of bruises or scars on her extremities [facility] will add safety alarms with child proof doorknobs. Patient will also have small bells attached to her shoes. All	S5026		

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S5026	Continued From page 3 interventions have been set in place effectively 7/18/2020." Signed by licensed nurse #C. [hospital] after visit summary dated 7/18/20 at 8:37am recorded resident had the following procedures/tests performed: CT scan (computed tomography) of head without contrast, CT of spine, cervical without contrast, hip 2-3 views with pelvis right side, femur 2 views right, knee 3 views right, CBC and Differential and comprehensive metabolic panel (standard blood tests), urinalysis (urine test) with culture, Point of Care Troponin test (heart test) and Electrocardiogram 12- lead (heart test). Resident was given lidocaine (pain medication) at 6:51am. Incident report dated 7/18/20 completed and signed by certified staff #D recorded: " 5:20am residential phone rang, I answered, it was [resident #1 sister] asking where [resident] was, I stated she was in bed 2 hours ago, I proceeded to [resident's] room to account for her, she was not present in bed. [sister] stated the police had informed her that [resident] went missing at 9pm, I objected, [resident] did not go to bed until around 10pm. I did a routine bed check at 12pm and again around 2-2:18am and [resident] was present with the covers pulled over her head (as usual). I did not physically touch her but however when I went into her room at 5:20am the covers were pulled down and it looked as if [resident] exited the bed on the left closest to the wall and window. (that was not the state of the bed on my last check. I was present in the dayroom in full view of the front exit door and the rear exit door (kitchen). I assume [resident] eloped at the rear exit of the residential establishment (laundry room exit)" Observation on 7/30/20 at 11:35am revealed	S5026			

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S5026	Continued From page 4 resident sitting in a chair in the facility living room. Resident has on tennis shoes (no bells), figits in the chair, repeatedly moving her feet and hands, hums to herself. Resident wears a hospital bracelet on her left wrist. Interview on 7/30/20 at 11:37am with resident: How are you today? Resident reply: "Good. Thinking of if I want to run or stay." Run where? "I don't know yet." Resident could say her name and correct birthdate, stated she was visiting family, believed she was in Coffeyville and this year was 1980. Observation of resident on 7/30/20 at 12:48pm revealed resident ambulated independently approximately 12 feet from dining room to a living room chair, her gait was unsteady, she walked slow and cautious. Observation on 7/30/20 at 11:25am revealed facility's 3 exit doors: #1 front entry has a loud alarm, can be exited from the inside, #2 kitchen exit goes to the backyard, unlocked, an open deck floor under construction is just outside, #3 laundry exit, you must go thru an unlocked door to the laundry to the unlocked laundry exit (both doorknobs have child proof devices on them that made turning the door knobs difficult), door opens into a grass back yard fenced on the east and south sides with a 6-foot wood fence, open to residential houses to the north, open on each side of the facility to the west (grass on the north, driveway on the south). Resident's room is at the end of the hall, directly West (approximately 30 feet) from the laundry exit door. Facility sits in a residential area with houses to the North, East and South, a large park (Klumm Park) is directly West across from the facility after	S5026		

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S5026	Continued From page 5 crossing a narrow residential street (22nd). 22nd street runs North and South, speed limit of 30 mph (miles per hour) is posted. Quindaro street is North of the facility, it is a busier 2 lane road through a business district, speed limit 30mph. A route via streets from 22nd street to the corner of 20th and Quindaro (North East of the facility) crosses 4 residential intersections, is about ½ mile and would take approximately 10-15 minutes to walk. Wunderground.com recorded the weather in Kansas City, Kansas at 2:53am on 7/18/20 to be 80F (degrees Fahrenheit) with 12 MPH (mile per hour) winds from the south. Interview on 7/30/20 at 11:48am with facility operator #A stated police found the resident between 2 and 3am on Quindaro, resident did not give straight answers, so she was taken to [hospital] where she gave her sister's name. The last bed check was at midnight and certified staff saw her in bed at 2am. She stated there was one aide on at night, (certified staff #D) She stated after the elopement, they added alarms to all the doors, child proof door-knob covers to the laundry doors, and are still looking for bells for the resident's shoes. Resident was seen by the physician on 7/22/20 and medication changes were made. Staff were to review the resident elope policy which outlines what staff is to do based upon the number of staff in the facility when the elopement occurs. On 7/30/20 at 11:58am, checks of the doors with Operator #A, revealed alarms are in place and functioning on all 3 exit doors, the alarms are plugged into outlets in the living room area. Operator confirmed laundry room door did not have an alarm prior to the elopement and is not	S5026		

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S5026	Continued From page 6 locked from the inside for fire exit reasons. Interview on 7/30/20 at 12:38am with operator #A stated resident stayed with staff in the living room or dining room following the elopement and staff did checks on the resident every hour at night. She confirmed record lacked documentation of resident checks after elopement event. On 7/30/20 at 1:30pm Operator #A was notified of immediate jeopardy regarding the elopement of resident #1. For resident #1, the operator failed to ensure that no resident was subjected to neglect when a resident with a history of wandering and poor decision making, left the facility through an unlocked laundry room door, was unaccounted for by staff for at least 3 hours and returned to the facility by family after she was taken to the hospital by the police. The resident continued to be at risk for elopement when she continued to reside in the memory care unit each night without documented staff observation checks. The jeopardy was removed on 7/30/20 at 2:00pm when operator #A provided a written plan that included: On July 18, 2020 at 12:00 operator placed child proof door-knobs on exit doors and door alarm on laundry room door. Resident had a follow up appointment with PCP (primary care provider) on July 22, 2020. PCP changed resident's medication. Melatonin 3mg (milligrams) to 10mg (for sleep) and added Depakote sprinkles (treats bi-polar disorder) 125mg twice a day. Operator is looking for small bells to place on resident's shoes.	S5026		

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S5026	Continued From page 7 Staff is required to do bed checks every 2 hours, staff will now be required to check on this resident every 15 minutes for 3 days and will gradually decrease frequency according to resident's behavior. Operator and nurse will train staff of requirements and staff will document each bed check to verify resident is inside of the facility. Operator has made plans to completely fence in backyard area with locked access. Such changes will be added to the resident's NSA.	S5026			