STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B019004	A. BUILDING: _____ B. WING _____	10/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMFORTCARE HOMES OF PITTSBURG, LLC COLEI	704 LAKEVIEW DRIVE PITTSBURG, KS 66762

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S 000	INITIAL COMMENTS The following citations represent the findings of an abbreviated survey with complaint investigation 134186 at the above named home plus facility conducted on 10-11-18 and 10-15-18.	S 000		
S5028 SS=F	26-42-101 (f) (3) Staff Treatment of Residents Reporting (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: (A) An investigation shall be started when the administrator or operator, or the designee, receives notification of an alleged violation. (B) Immediate measures shall be taken to prevent further potential abuse, neglect, or exploitation while the investigation is in progress. (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. (D) Appropriate corrective action shall be taken if the alleged violation is verified. (E) The department ' s complaint investigation report shall be completed and submitted to the department within five working days of the initial report. (F) A written record shall be maintained of each investigation of reported abuse, neglect, or exploitation. This REQUIREMENT is not met as evidenced by:	S5028		

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

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S5028	Continued From page 1 KAR 26-42-101(f)(3)(A)(F) The facility a census of 9 residents. The sample included 2 residents. Based on interview for all residents the operator failed to insure each allegation of abuse or neglect shall be reported to the department within 24 hours, and an investigation shall be started when the operator received notification of an alleged violation and a written record shall be maintained of each investigation of reported abuse, neglect of exploitation. Findings included: - Review of resident roster on 10-11-18 revealed 9 residents, all residents identified to have cognitive impairment. - Interview on 10-11-18 beginning at 8:50 am with Licensed Nurse B stated, "we had a fire...we couldn't figure out what happened, a closet was set on fire...when the aide opened the closet door, fire blazed up but no clothing was burned...there was a sprinkler head in the closet, the alarm went off, but the sprinkler did not go off...staff could smell the smoke. The police and fire department searched, couldn't find what caused the fire..." Confirmed that when the staff changed the bed linens while cleaning the room after discharge of the fire extinguisher, a lighter was found under the resident's mattress." Stated resident had been out with family members and a family member admitted resident could have picked the lighter up in his/her vehicle. Also stated resident had no memory of starting the fire due to dementia. Licensed Nurse B confirmed he/she failed to put interventions in place to monitor resident for lighters or other dangerous items when he/she returned from outings with	S5028		

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S5028	Continued From page 2	S5028		

family.

The facility lacked documentation of investigation of the incident and failed to notify the department of an alleged incident of abuse or neglect.

Per written statement by Licensed Nurse B:
"...Did not report to state - because no definitive cause noted."

Per written statement by Operator:
"On 9-8-18 I was notified that there was a small fire in a resident's closet. the staff confirmed that the fire was out and residents were evacuated. Fire Department was notified...I myself with the police department searched resident's room for any kind of accelerant. Nothing was found at that time. We also went through basket of clothes in which we found nothing...just clothes , a purse strap and melted plastic...we did notify all family members in home. I did not document an investigation. I failed to notify state..."

The Operator failed to insure an allegation of abuse or neglect was reported to the department within 24 hours, and an investigation documented when a fire broke out in the home inside of a resident's closet from an unknown cause resulting in evacuation of all residents.

- Record review for Resident #1 revealed admission on 10-12-17 with diagnoses Alzheimer's Dementia with Paranoia and Hypertension.

The Functional Capacity Screen (FCS) dated 6-23-18 for a significant change recorded the resident required supervision with bathing and dressing; independent with toileting, transfers,

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S5028	Continued From page 3	S5028		

walking/mobility and eating' and unable to perform management of medications and treatments. Continent of bladder. Cognition: problem with short term memory, problem with memory/recall and problem with decision-making. Communication: expresses ideas clearly; usually understands with periodic difficulties.
Current problems and risks identified: impaired vision; wandering; impaired decision-making.

The Negotiated Service Agreement dated 6-23-18 recorded:
Ambulation: instructions, supervision and assistance as needed.
Behavior Management: (facility) staff will monitor and observe all behaviors. Any changes will be documented. Concerns will be addressed with the management staff and discussed with the legal responsible party if necessary.

The Health Care Services plan dated 6-23-18 recorded:
Ambulation: Needs no assistance in ambulation. Does not use assistive devices.
Mental Attitude: identified to be pleasant/cooperative, socially interactive, follows instructions at times. "He/She will go in room when the residents are yelling, makes him/her nervous. He/She likes visiting with people. He/She wanders into other resident's rooms. Will at times try to climb over the fence. (Be on alert when outside in yard.)
Cognition: "Resident able to remember long term without any difficulty, however short term is becoming harder at times to put together. He/she gets so confused about when he/she came here and how he/she got here at times we have to call (family member) and (family member) comes in and talks to (resident).

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S5028	Continued From page 4 (Note: The NSA/HCSP failed to plainly identify the resident as an elopement risk with instructions for staff to accompany resident when outside.) Nurse's Notes: 6-4-18 at 9:00 am: "Resident has been climbing the fence over the weekend and continues today. Very confused and argumentative. Slapped and pushed staff away, going into rooms more than usual. Notified (physician) on increased behaviors..." Observation on 10-11-18 during brief tour of facility revealed an alarmed outside door which exits onto a deck. A large grassy yard enclosed by a six-foot wooden privacy fence with three horizontal support boards between the vertical posts. Interviews on 10-11-18 during survey from 8:55 am until around 12:15 pm with Licensed Nurse B stated resident "had been climbing the fence over the weekend." and confirmed staff didn't see resident go outside until they saw her attempting to climb over the wooden fence. Confirmed Resident #1 has actually gotten all the way over the fence and on the other side, "shortly after he/she first got here." (later confirmed this was not documented in the record or reported to the state as an elopement). Per written statement provided on 10-11-18 stated, "I think about 1 1/2 to 2 months after here, resident was confused. He/she wanted to go home. Was asking where (family member) was...(resident #1) went outside, was walking around, then aide made his/her way to door and went outside because he/she couldn't see resident. Walked to side of building and (Resident #1) was over the fence. (Resident #1) was yelling 'help me, they won't let me go.' Got him/her back into the home....On 6-4-18 (per)	S5028		

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S5028	Continued From page 5 staff - resident has been climbing this weekend. Staff noted and got him/her prior to getting over. Was combative...did not add interventions to care plan..." Licensed Nurse B stated no other residents currently residing at the home exhibited exit seeking behaviors. Confirmed he/she had not reported the elopements to the state and had not documented investigations regarding the elopements. Interview on 10-11-18 with Operator confirmed he/she had not reported the elopements to the state. Verbally stated (and per written statement) that the facility had purchased audible window alarms which were to be placed on all windows in the home; and he/she had taken bids to have the fence double sided to prevent climbing. For Resident #1, the Operator failed to ensure incidents of elopement were reported to the department within 24 hours and an investigation documented.	S5028		