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THE HOMESTEAD OF WICHITA	12221 W MAPLE ST WICHITA, KS 67235

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S 000	INITIAL COMMENTS The following represent the findings of a complaint investigations 174067, 173004 and 172804 at the above named Assisted Living conducted on 08/22/22 - 08/23/22.	S 000		
S3026 SS=J	26-41-101 (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 26-41-101(f)(1)(B) The facility reported a census of 38 residents. The sample included three residents. The facility identified two residents at risk for elopement who wore Wanderguard alarms. Based on observation, interview and record review the Operator failed to ensure Resident (R)822 was not subjected to neglect, by the failure to provide adequate supervision and ensure a resident headcount was completed after the front door alarm was activated. This resulted in cognitively impaired R822 exiting the facility and being unaccounted for by staff for approximately six hours. The failure of staff to complete hourly checks as ordered and the failure to complete a	S3026		

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

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headcount after the front door alarm sounded placed R822 in immediate jeopardy. The Operator also failed to ensure staff monitored the placement of Wanderguard elopement bracelets and testing of the Wanderguard alarms were completed each shift for R823 and R824.

Findings included:

- R822's medical record revealed the resident moved into the facility on 08/06/21 with a diagnosis of Alzheimer's Disease.

R822's "Functional Capacity Screen" (FCS) dated 08/04/22 revealed he was independent with transfers and mobility, had a cognitive score of four indicating he was severely cognitively impaired and triggered for impaired decision making.

R822's "Negotiated Service Agreement" (NSA) dated 08/15/22 did not indicate staff would complete hourly checks as ordered.
A physician's order dated 10/09/21 revealed R822 required hourly checks.

The August 2022 Electronic Treatment Administration Record (ETAR) revealed there were 74 out of 336 opportunities where staff did not document hourly checks. Hourly checks were documented for 08/15/22 from 0000 through 0600 by nightshift CMA C during the time R822 was not in the building.

The 08/16/22 "Occurrence Note" documented review of the camera footage revealed R822 pushed on the entry/exit doors until the egress

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released and he exited the facility at 01:22 AM. Certified Medication Aide (CMA) C arrived at the entry/exit doors at 01:28 AM, looked around, exiting the doors to look outside in front walkway and parking area. At 01:29 AM CMA C came back inside and called Memory Care staff to ensure she had not exited the building or done anything to set off the alarm. At 01:39 AM CMA C called Administrative Nurse A to notify her that the door alarm to front entry doors had been activated, that she had searched the front area and parking lot, and verbalized that all residents were accounted for, and stated that she thought someone had attempted to come into the community from the outside. CMA C was instructed to notify the police. The police arrived at the facility at 02:07 AM and completed a perimeter search around community twice but did not find anything of suspicion and left. On 08/15/22 at 06:19 AM Administrative Nurse A reviewed camera footage to see if an attempt had been made to enter the facility and discovered R822 had exited out of the front entry doors. Elopement protocol was immediately initiated and at 07:13 AM staff found R822 at a nearby business approximately 0.2 miles from the facility. Upon return to the facility it was noted that R822 was not injured and had vital signs within normal limits.

On 08/22/22 at 04:45 PM an observation of the area surrounding the facility revealed the area was relatively flat. There was a large pond directly to the south of the facility and a park to the west of the facility. To the east there was a commercial property located at the intersection of Maple St. and 119th St., a four-lane divided road with stop lights and could be busy with

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traffic at various times of the day. This commercial property had numerous businesses and was accessible from the facility property on the southeast corner where there was a small grassy rise that led to a well-lit parking lot. The facility itself was located directly off Maple St. to the north which was a four-lane undivided road with sidewalks on both sides of the street.

On 08/23/22 at 10:18 AM R822 was observed sitting in a chair in the common area of the memory care unit. He seemed to be restless but was not attempting to get up to walk around the unit.

On 08/23/22 at 10:52 AM CMA D stated she usually worked 3rd shift and stated R822 would walk around the assisted living unit but never tried to get out the door. CMA D thought R822 wore a Wanderguard on his ankle.

On 08/23/22 at 03:25 PM Licensed Nurse (LN) B stated she expected staff to physically visualize the resident for one-hour checks, and document this in the medical record. LN B stated she expected that in the event of a possible elopement staff complete a head count of all residents.

The 12/2015 "Policy for Elopement Prevention, and Management of Missing Residents" documented, "The EMR elopement assessment is utilized to assess the various risk factors that may precipitate an elopement event. The risk score includes a defined parameter which, when reached, indicates an increased risk and prompts prevention strategies. Some of these strategies may include: Frequent observation of the

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resident's whereabouts to assure he or she remains in the community."

The Operator failed to ensure R822 was not subjected to neglect by the failure to provide adequate supervision and ensure a resident headcount was completed after the front door alarm was activated. This resulted in cognitively impaired R822 exiting the facility and being unaccounted for by staff for approximately six hours.

- Resident (R)823's medical record revealed the resident moved into the facility on 04/21/21 with a diagnosis of dementia without behavioral disturbances.

R823's "Functional Capacity Screen" (FCS) dated 08/04/22 revealed she required supervision with transfers and physical assistance was needed for mobility. R823 triggered for wandering and was identified as being severely cognitively impaired.

R823's "Negotiated Service Agreement" (NSA) dated 08/04/22 did not mention the use of a Wanderguard elopement monitoring system and that staff were to check for placement of the monitor bracelet and functionality of the Wanderguard system.

The August 2022 Task record documented staff did not document monitoring of R823's Wanderguard placement 10 out of 22 opportunities and did not document Wanderguard transmitter checks 22 out of 22 opportunities.

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S3026	Continued From page 5 On 08/23/22 at 10:33 AM R823 sat in her room watching television with her door open to the hallway. Administrative Nurse A located R823's Wanderguard around her ankle and found it to be working. On 08/23/22 at 10:52 AM, Certified Medication Aide (CMA) D stated R823 wore a Wanderguard bracelet but stated she didn't wander around the building or try to exit seek. CMA D stated the CMAs would check the Wanderguard when the task popped up on their computer during their shift. On 08/23/22 at 03:30 PM, Licensed Nurse (LN) B stated it was her expectation that if R823 had a Wanderguard that staff would monitor for placement of the Wanderguard and the functionality of it was tested and documented on the "Electronic Treatment Administration Record" (ETAR) or the TASKs function of the electronic medical records. The 12/2015 "Policy for Elopement Prevention, and Management of Missing Residents" documented, "The EMR elopement assessment is utilized to assess the various risk factors that may precipitate an elopement event. The risk score includes a defined parameter which, when reached, indicates an increased risk and prompts prevention strategies. Some of these strategies may include: Frequent observation of the resident's whereabouts to assure he or she remains in the community." The operator failed to ensure designated staff monitored for placement and functionality of the Wanderguard for R823.	S3026		

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S3026	Continued From page 6 - Resident (R)824's medical record revealed the resident moved into the facility on 11/30/21 with diagnoses of depression and anxiety. R824's "Functional Capacity Screen" (FCS) dated 06/15/22 revealed she required supervision with transfers and mobility. R824 triggered for wandering and was identified as being severely cognitively impaired. R824's "Negotiated Service Agreement" (NSA) dated 06/15/22 did not mention the use of a Wanderguard elopement monitoring system and that staff were to check for placement of the monitor bracelet and functionality of the Wanderguard system. R824's 07/30/22 Elopement care plan documented she wore a Wanderguard around her ankle for safety and she liked to sit and look out the windows and doors, and staff were to provide re-direction away from the door as needed. The August 2022 Task record documented staff did not document monitoring of R824's Wanderguard placement 10 out of 22 opportunities and did not document Wanderguard transmitter checks 22 out of 22 opportunities. On 08/23/22 at 10:33 AM R824 sat in her room watching television with her door closed. Administrative Nurse A located R824's Wanderguard around her ankle and found it to be working.	S3026		

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S3026	Continued From page 7 On 08/23/22 at 01:08 PM, Certified Medication Aide (CMA) E stated R824 wore a Wanderguard. CMA E stated that R824 wandered into other resident rooms but had never seen the R824 exit seek. CMA E stated Wanderguard checks did not show up on her shift for her to check for placement and testing. On 08/23/22 at 03:30 PM, Licensed Nurse (LN) B stated it was her expectation that if R824 had a Wanderguard that staff would monitor for placement of the Wanderguard and the functionality of it was tested and documented on the "Electronic Treatment Administration Record" (ETAR) or the TASKs function of the electronic medical records. The 12/2015 "Policy for Elopement Prevention, and Management of Missing Residents" documented, "The EMR elopement assessment is utilized to assess the various risk factors that may precipitate an elopement event. The risk score includes a defined parameter which, when reached, indicates an increased risk and prompts prevention strategies. Some of these strategies may include: Frequent observation of the resident's whereabouts to assure he or she remains in the community." The operator failed to ensure designated staff monitored for placement and functionality of the Wanderguard for R824. On 08/23/22 at 12:36 PM Administrative Nurse A was informed of the findings which resulted in immediate jeopardy regarding a cognitively impaired resident exiting the facility, staff not completing a head count to ensure no residents	S3026		

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S3026	Continued From page 8 had eloped, and the failure of staff to monitor residents who used elopement monitoring devices. Administrative Nurse A submitted an abatement plan which included the following: Elopement Monitoring: When elopement assessment indicates risk and need for interventions to promote safety and minimize risk of elopement opportunity monitoring will be placed in the Treatment Administration Record (TAR) in the residents Electronic Health Record (EHR). Visual Checks /Monitoring: Visual checks will be implemented to promote residents' safety by visualizing resident and ensuring they are safe and secure. Visualization must occur within specified time frame. During residents' rest or participation in activities monitoring will occur in least interruptive or restrictive environment to promote comfort and sleep hygiene while ensuring location. The Certified Medication Aide (CMA) will be delegated and responsible to complete the monitoring as directed. The monitoring will include the following: Wanderguards: Check proper functional status of battery within a consecutive timeframe covering all shifts by resident ambulating within Wanderguard alarm activation vicinity of exit areas or use of the handheld transmitter and check that battery function is responding appropriately and does not need to be replaced. Batteries will be stored in a designated area for the CMA to have accessible to readily replace when needed.	S3026		

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S3026	Continued From page 9 Visual checks/Monitoring: Visual checks will be completed and signed off on the Treatment Health Record (TAR) as the checks occur in real time. Back documentation or signing off multiple time slots at once is not accurate or acceptable. If processes are not adhered to disciplinary action will result including but not limited to termination and reporting to regulatory agencies due to risk of resident safety and failure to follow plan of care. The immediate jeopardy was abated on 08/23/22 at 04:00 PM based on the facility's plan of correction and approved by the department.	S3026		
S3156 SS=D	26-41-204 (b) Health Care Services (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. This REQUIREMENT is not met as evidenced by: KAR 26-41-204(b) The facility reported a census of 38 residents. Three residents were included in the sample.	S3156		

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S3156	Continued From page 10 Based on observation, record review and interview, the operator failed to ensure the "Negotiated Service Agreement" (NSA) contained a description of the health care services to be provided for Resident (R)823 concerning the use of a Wanderguard elopement monitoring system. Findings included: - Resident (R)823's medical record revealed the resident moved into the facility on 04/21/21 with a diagnosis of dementia without behavioral disturbances. R823's "Functional Capacity Screen" (FCS) dated 08/04/22 revealed she triggered for wandering. R823's "Negotiated Service Agreement" (NSA) dated 08/04/22 did not mention the use of a Wanderguard elopement monitoring system and that staff were to check for placement of the monitor bracelet and functionality of the Wanderguard system. On 08/23/22 at 10:33 AM R823 sat in her room watching television with her door open to the hallway. Administrative Nurse A located R823's Wanderguard around her ankle and found it to be working. On 08/23/22 at 03:30 PM Licensed Nurse (LN) B stated she expected the use of a Wanderguard to be included in a R823's care plan and the NSA.	S3156		

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S3156	Continued From page 11 The facility failed to ensure R823's NSA contained a description of the use of the Wanderguard elopement monitoring system.	S3156		
S3310 SS=D	26-41-207 (b) (5-6) (c) Infection Control Policies (b) (5) prohibiting any employee with a communicable disease or any infected skin lesions from coming in direct contact with any resident, any resident ' s food, or resident care equipment until the condition is no longer infectious; (6) providing orientation to new employees and employee in-service education at least annually on the control of infections in a health care setting; and (c) Each administrator or operator shall ensure the facility ' s compliance with the department ' s tuberculosis guidelines for adult care homes adopted by reference in K.A.R. 26-39-105 This REQUIREMENT is not met as evidenced by: KAR 26-41-207(c) The facility reported a census of 38 residents. Based on record review and interview the operator failed to ensure the facility was in compliance with the department's tuberculosis guidelines for adult care homes adopted by reference in K.A.R. 26-39-105. Findings include:	S3310		

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S3310	Continued From page 12	S3310		

- Resident (R)822's medical record revealed the resident moved into the facility on 08/06/21 with a diagnosis of Alzheimer's Disease.

R822's "Functional Capacity Screen" (FCS) dated 08/04/22 revealed he had a cognitive score of four indicating he was severely cognitively impaired and triggered for impaired decision making.

Review of R822's medical records revealed a "Tuberculosis (TB) Screening Questionnaire" was completed on 09/23/21 which was 41 days late, and a two-step TB skin test was not completed. There was no documentation indicating R822 refused the two-step TB skin test.

On 08/23/22 at 04:36 PM, Licensed Nurse (LN) B stated she was not able to locate a two-step TB skin test completed for R822.

The undated "Tuberculin Testing and Symptom Review" policy documented, "Each new resident...shall receive a two-step tuberculin skin test...within seven (7) days of residency...In addition to the two step tuberculin test a TB symptom screen on admission is required."

Review of the Tuberculosis (TB) guidelines for adult care homes June 2013 revealed: A. Each new resident shall have an initial TB symptom screen that includes the components of the TB symptom questionnaire within seven days of residency. B. Each new resident shall receive a two-step TST or an IGRA for Mycobacterium tuberculosis within seven days of residency.

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S3310	Continued From page 13 The operator failed to ensure the compliance with the department's tuberculosis guidelines for adult care homes adopted by reference in K.A.R. 26-39-105.	S3310		