STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N103004	A. BUILDING: _____ B. WING _____	03/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNINGSTAR CARE HOMES OF FREDONIA	2111 E WASHINGTON STREET FREDONIA, KS 66736

(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
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: K.A.R. 26-41-101 (f) (1) (B) The facility reported a census of 22 "Residents'". The sample included 4 R's (R's 1, 3 and 4) and 1 (R2) closed record review. Based on observation, interview, and record review the operator neglected to provide health services to R' 1 and 2 for wandering and exit seeking behaviors upon admission to the facility. This placed R1 in jeopardy when he exited the facility without staff knowledge at approximately 02:00 PM and was assisted back in the facility-by facility staff. The operator failed to place interventions when the resident was not in his room, which allowed R1 to exit the facility again at an unknown time and was picked up by the local sheriff patrol approximately 0.4 miles from the facility. The family notified the facility that R1 was not in the building. The facility staff did not know R1 was absent from the facility for approximately one hour. The operator failed to provide health services for R2 when he admitted with the diagnoses of dementia and altered mental status. R2 started exhibiting documented	S3026		

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

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S3026	Continued From page 1	S3026		

wandering and exit seeking behaviors that the operator neglected to address. This placed R2 in jeopardy when he exited the building without staff knowledge in January 2022, with a reported temperature of 46 degrees Fahrenheit, wearing a button up shirt, pajama pants, a hat and house shoes. R2 was outside the building without staff knowledge for approximately 20 minutes.

Findings include:

- Record review on 03/23/23 for R1 revealed an admission date of 02/02/23 with diagnoses of major depressive disorder, unspecified dementia, and history of falling.

R1 "Functional Capacity Screen" (FCS) dated 02/06/23 identified R1 required physical assistance with bathing and dressing. He was independent with toileting, transferring, and walking. He required supervision with eating, he lacked the ability to manage his own medications, and he was continent. He had impaired short-term memory, impaired long-term memory, impaired memory recall and impaired decision making. He was usually able to make himself understood and he sometimes understood others. He was marked with falls/unsteadiness, impaired hearing, wandering, and impaired decision making.

R1 "Negotiated Service Agreement" (NSA) dated 02/02/23 identified the following health care services to be provided by the facility: the facility staff would aid with eating, three meals a day and snacks between meals. R1 would receive assistance with shaving, bathing, and dressing.

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S3026	Continued From page 2 The NSA lacked services for R1's identified risk of wandering, falls, impaired cognition, impaired decision making and impaired communication. R1 "Health Service Plan" (HSP) dated 02/02/23 instructed facility staff to ensure R1 wore his hearing aids, assist R1 in going outside, R1 was to be able to look outside when desired, staff to ensure environment was free of clutter, and had adequate lighting to reduce risk of falls, reorient and supervise or assist R1 as needed," use task segmentation to support short term memory deficits, staff to notify nurse if redirection is unable to help. The HSP lacked instruction for staff to address resident's risk of wandering. Review of the facility document titled "Wandering Risk Assessment" dated - 02/03/23 identified R1 as a "high risk for wandering". Review of the "Office/Clinic Note-Physician" dated 02/02/23 revealed the following entries: "Patient's apple watch called 911 and he was found on the garage floor", "family reports days and nights mixed up. His dementia worsened from last year", "Family reports they are getting him moved to an assisted living tomorrow due to worsening dementia and safety concerns". Record review of facility electronic "Progress notes" dated 02/05/22 to 03/23/22 revealed the following entries: 02/05/23 at 01:40PM "Continues to be monitored due to recent admit to facility. Pleasantly confused gentleman who is cooperative with	S3026		

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S3026	Continued From page 3 staff". 02/09/23 at 05:39 AM At 05:35 AM resident opened sunroom door, staff asked R1 what he was doing, R1 stated that he was just checking the weather. 02/12/23 at 06:43 PM Resident went outside looking for his car, staff redirected him back inside. R1 was outside for 1 to 2 minutes. "Will continue to watch resident". The progress notes lack documentation of actions taken and results of actions related to R1 wandering behaviors. 02/24/23 at 12:37AM R1 observed going to the front door. R1 was asked where he was going and R1 replied he did not know. R1 was redirected "back inside" and walked back to his apartment. 03/04/22 at 09:18 PM resident left out of front door and returned back into the facility. The progress notes lacked an entry for results of actions taken after escorting R1 back to his apartment after he was observed to be going to the front door, and further lacked actions taken and results of those actions when resident left again out the front door, and further lacked documentation of how long R1 was outside. 03/20/23 at 06:13 PM Notified family of R1 getting out of door with another resident. Resident was found by the dumpster by the maintenance man and was brought back in the facility. While on the phone with R1 family, the	S3026		

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call was interrupted, and family stated they would call the facility back. R1 family called back and stated R1 had been picked up by the sheriff patrol and R1 had been taken to the sheriff department. R1 family stated she was going to pick him up. R1 was found by the dumpster at approximately 02:00 PM, and R1 family called the facility back at approximately 03:56 PM. It was uncertain what time R1 left the facility the second time.

03/20/23 at 07:31PM R1 saw another resident leave facility and followed him. R1 walked beside the building and was found by the dumpster by the maintenance man. R1 was easily redirected back into the facility. Staff was told by the director to monitor resident. Resident has chime on door in room to alert the phone system of when resident is leaving the room.

03/21/23 at 03:46 AM Resident was redirected from the dumpster earlier that day after following a resident outside that was going for a walk. This director last saw resident at 03:00 PM in the dining room reading a newspaper with the other residents.

Review of the facility provided investigation of the elopement dated 03/20/23 revealed the following statements provided by the facility:

Corrective actions taken in response to the incident: Monitor resident and watch the front door, listen to notification on phones of resident opening front door and/or his room door. Staff were given verbal reminders to watch door and listen to phones.

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S3026	Continued From page 5 Under the section "Plan for monitoring the ongoing effectiveness of the corrective action plan through quality assurance assessment program or other: the facility responded, "This corrective action did not work, resident eloped again". The action of placing the door alarm on the resident door after he went out the door with staff unaware the first time was reported in the facility investigation as ineffective, the resident was observed in the dining room at approximately 03:00PM as noted in the resident progress notes, prior to leaving the building without staff knowledge the second time, where he was found approximately 0.4 miles away from the facility in 57 degree Fahrenheit weather dressed in jeans, a long sleeved shirt, long sleeved sweater and appropriate footwear, for approximately one hour. Observation at 03/23/23 04:35 PM the facility had six doors leading to the outside. The sunroom door and the front door were the only two doors that did not have keypad locks, they were linked into the alarm system, and it did alert staff when these doors were opened. The keypad box had been wired to the right side of the interior side of the front door and was not activated at the time of observation. Observation 03/23/23 at 03:00 PM R1 and an individual identified as a member of R1 family sat in the chairs right inside the facility front doors. Interview with "Licensed Nurse" (LN) A on 03/23/23 at 03:25 PM, revealed this was the first time R1 had left the facility without staff. She	S3026		

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stated after the resident was brought back in the facility after being found by the dumpster, she told staff to listen for the phones when the front door alert goes off, and to check the front door. She continued to state she was unaware the resident had left the facility the second time and continued to state the family told her that R1 was at the sheriff's department. She confirmed that when the resident came back to the facility after leaving the second time, is when she placed the resident on thirty-minute checks.

Operator B and LN A were informed the facility was in immediate jeopardy on 03/23/23 at 04:20 PM, for failure to protect R1 after identifying he was at high risk for wandering, had identified impaired cognition, and documented exit seeking behaviors on five occasions with no documented plan in place to protect R1 from elopement. R1 was successful in elopement on 03/20/23 at an undetermined time, and the facility was informed by the family R1 had been picked up by the sheriff's patrol, facility staff were unaware that R1 was missing/not in the facility.

The Facility abatement plan included the following immediate measures to ensure R1 safety: one-on-one staff with R1 until the installation of the keypad to the front door is complete. Staff are to notify the operator or the director of nursing if resident approaches doors. This plan was accepted by the department at 05:35 PM on 03/23/23 and removed the immediacy.

- Closed record review for R2 revealed an

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admission date of 11/19/21 with diagnoses of dementia with behavioral disturbances, bradycardia, falls, manic episode, syncope, altered mental status and disorientation.

Review of R2 "Functional Capacity Screen" (FCS) dated 11/19/21 identified R2 required physical assistance with bathing, supervision with transferring and walking, and he was independent with dressing, toileting, and eating. He lacked the ability to manage his own medications, was usually continent, had impaired short-term memory and was understandable and he understood others. He was marked with falls and used a walker mobility device.

Review of R2 "Negotiated Service Agreement" (NSA) dated 11/19/21 identified the following health care services to be provided by the facility: staff to provide activity, snack, encouragement, redirection, or therapeutic conversation if R2 appeared to be "down", qualified staff to administer R2 medications, staff to offer assistance as needed for bathing. R2 is independent with transfers, used a walker at times for ambulation.

The NSA lacked services for fall prevention and impaired cognition.

Review of the "Health Service Plan" (HSP) dated 11/19/21 instructed staff to monitor resident when in eyesight, he used a walker at times for ambulation and was generally independent with ambulation without the assistive device. To reduce fall risk, staff to remind resident to change position slowly and use the call pendant for assistance as needed. Staff were to cue,

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reorient and supervise or assist as needed related to memory loss and disease process.

Record review of the facility document titled "Wandering Risk Assessment" dated 12/28/21 identified R2 was a moderate risk for wandering.

The FCS, NSA and HSP lacked documentation, health services, and instructions on R2 wandering.

Record review of the facility document titled "Record of Visit to Physician's Office/Clinic" dated 11/23/21 revealed the following handwritten order on the bottom left side of the page "#7 check on patient every two hours during nighttime with check list every two hours, dementia (legs elevated, covered with blanket, etcetera).

Record review of R2 history and physical from an in-patient stay at the hospital on 11/17/21 revealed the following: "Altered mental status- his is aware of person but not place or time. He does suffer from dementia, so this is baseline for patient". Under the section titled Assessment / Plan are the following diagnoses: unwitnessed fall at home, history of meningioma of the brain, altered mental state, improved from yesterday not quite back to baseline, closed head injury from fall, and dementia. Patient will be discharged from observation as he is not safe to return home at this time.

Review of R2 electronic "Progress Notes" dated 11/19/21 to 01/22/22 revealed the following entries:

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S3026	Continued From page 9 01/08/22 at 01:14 PM "Resident exit seeking this shift numerus times. Resident going to front door with clothes asking if this is the way out. Resident easily redirected but comes back within minutes." 01/09/22 at 05:35 AM "Resident wandered most of the night". 01/10/22 at 08:58 PM "Resident had confusion this shift and was wandering, unable to redirect". 01/11/22 at 04:33 AM "at 04:00 AM resident was found wandering the hallways, so staff just brought him up to the dining room". 01/22/22 at 01:36 PM The nurse received a call from the certified medication aide at 12:45PM reporting R2 was found outside the building. R2 had eaten lunch and was assisted back to his room by a certified nurse aide. "Resident could have only been outside for between five to ten minutes" when he was found by the facility cook. R2 was redirected back into the building, family notified. Facility requested family provide one-on-one oversight with resident until alternate placement in an appropriate facility could be made. The progress notes lacked documentation of actions taken for resident wandering and further lacked results of the actions taken for resident wandering behavior that included exit seeking behaviors. Record review of the facility provided signed witness statement revealed the following: "Around 1215 PM R2 had finished eating", "R2	S3026		

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S3026	Continued From page 10 was asking if he could get out the front door." R2 was then escorted to his room. At 1240 PM the facility cook came in from outside and stated that R2 was outside. Staff went outside and found resident wearing a grey button up shirt, grey hat, blue pajama pants and house shoes and carrying a water pitcher on the sidewalk on the east side of the building. Staff accompanied R2 back in the building and notified the operator and director of nursing. Record review of the facility provided investigation revealed the resident was outside in around 46-degree Fahrenheit weather wearing a grey button up shirt, grey hat, blue pajama pants and house shoes, and staff was unaware resident had left the building for approximately 20 minutes. The operator failed to protect R's 1 and 2 from neglect of services for wandering behaviors that included documented exit seeking behaviors, this neglect of services placed R's 1 and 2 in jeopardy when at separate times they exited the building without staff knowledge.	S3026		
S3171 SS=D	26-41-204 (i) Health Care Services Standards of Practice (i) All health care services shall be provided to residents by qualified staff in accordance with acceptable standards of practice. This REQUIREMENT is not met as evidenced by: K.A.R. 26-41-204 (i)	S3171		

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S3171	Continued From page 11 The facility reported a census of 22 residents. The sample included four "Residents'" and one closed record review. Based on interview and record review the operator failed to ensure all health care services were provided to resident R3 in accordance with acceptable standards of practice when R3 was admitted with a physician documentation stating the resident was at risk of elopement and the licensed nurse failed to provide health services for the resident addressing R3 risk of elopement. Findings include: - Record review for R3 revealed an admission date of 06/27/22 with diagnoses of type two diabetes, essential hypertension, dementia, major depressive disorder, and age-related disability. Review of R3 FCS (Functional Capacity Screen) dated 03/26/23 identified resident required physical assistance with bathing, supervision with dressing and toileting, was independent with transferring, walking, and eating. She lacked the ability to manage her own medications and was frequently incontinent. She had impaired short-term memory, impaired memory recall and impaired decision making. She was usually able to make herself understood and she usually understood others. She was marked for falls and impaired decision making and she used no mobility device. Review of R3 NSA (Negotiated Service Agreement) dated 03/25/23 revealed the	S3171		

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S3171	Continued From page 12 following health services to be provided by the facility: facility to manage medications, R3 husband to inject R3 insulin, facility staff to assist with bathing, and supervise /assist as needed with R3 dressing. Facility staff to offer reassurance and encouragement if resident seems "down or tearful, assist and redirect when confused. The NSA lacked health services for impaired cognition and falls. Review of R3 HSP (Health Service Plan) instructed facility staff to assist with bathing, offer reassurance and encouragement if resident is "down". Staff to monitor R3 ambulation and transferring when in eyesight. Staff to monitor R3 to ensure she was wearing clean clothes. "Certified Medication Aides" allowed to dial insulin pen per orders and R3 spouse to administer insulin, qualified staff to administer R3 medications, facility staff to cue, reorient and supervise/assist as needed related to memory loss. Staff to remind resident to use call pendant for assistance as needed, and alert nurse of unsteady gait. Record review of the facility provided document titled "Physician's Order Sheet" dated 06/17/22 revealed the following order: #9 "Activity as tolerated patient is elopement risk due to dementia". Record review of the facility document titled "Wandering Risk Assessment" dated 06/27/22 identified R3 as a "High Risk for Wandering". The FCS, NSA and HSP lack documentation of	S3171		

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S3171	Continued From page 13 services provided to keep R3 safe from wandering/elopement. Interview on 03/27/23 at approximatley 04:00 PM, she confirmed R3 NSA and HSP lacked services for wandering and elopement, she further confirmed the provider order did identify the resident as an elpoement risk. The operator failed to ensure all health care services were provided to resident in accordance with acceptable standards of practice with R3 was admitted with a physician documentation stating the resident was at risk of elopement and, and the licensed nurse failed to provide health services for the resident addressing R3 risk of elopement.	S3171		