STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087247	A. BUILDING: _____ B. WING _____	C 08/14/2023

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COMFORT CARE HOMES INC 29TH #1	8631 W 29TH ST N WICHITA, KS 67205

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S 000	INITIAL COMMENTS The following citations represent the findings of an abbreviated survey for complaints #181978 of the above named facility conducted on 08/10/23 and 08/14/23.	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: K.A.R. 26-41-101 (f)(1)(B) The facility reported a census of 11 cognitively impaired residents with 2 residents marked with wandering behaviors. The sample included one -"Resident"- (R)1. Based on observation, interview, and record review the operator failed to protect R1 from neglect when on 08/02/23 R1 exited the facility by way of the front door on 2 separate occasions without staff knowledge. The first time R1 walked out the front door without staff knowledge was at 09:54 AM. R1 walked out the front door after a staff member walked out the door first. The staff returned her to the facility at 09:56 AM through the same door the resident exited. The second time R1 exited the front door	S3026		

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

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S3026	Continued From page 1	S3026		

was 09:58 AM. R1 was seen on camera footage re-entering the facility at 11:12 AM with staff member A. The resident was out of the facility for 70 minutes with an outside temperature of 91 degrees Fahrenheit and was found by staff from the convenience store, located approximately 200 feet from the facility to the northwest. She was rummaging through the car of one of the convenience store staff. This failure placed R1 in immediate jeopardy.

Findings included:

- Observation on 08/10/23 at approximately 12:25 PM; R1 was observed by the French doors on the south end of the front of the house. These doors lead to a fenced in secured back yard with rocking chairs. R1 then walked to the front door, pushed the egress bar, and the door alarm activated, staff immediately responded. It is loud and can be heard through the house.

Record review for R1 revealed an admission date of 11/22/22 with diagnoses of Dwarfism, Diverticulosis, Dementia, hypochondrodysplasia, and depression.

Review of R1 "Functional Capacity Screen" (FCS) dated 11/22/22 identified R1 required supervision with bathing and dressing. She was independent with toileting, transferring, walking/mobility, and eating. She lacked the ability to manager her own medications. She was continent of her bladder, and had impaired short-term memory, memory recall and impaired decision making. She was able to make herself understood and she usually understood others. She was marked with wandering and impaired

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S3026	Continued From page 2 decision making. Review of R's 1 "Negotiated Service Agreement "(NSA) dated 11/22/22 identified the facility would provide the following health services: The facility staff would assist with bathing 2 times a week and provide redirection and guidance for wandering behaviors. Facility staff administered all resident medications. Review of R1's "Health Service Plan" (HSP) dated 11/22/22 instructed facility staff to provide encouragement for bathing activities, reminders for dressing, cueing and reminders for self-care. She was marked as an elopement risk and the note stated she liked to wander and required redirection at times. Record review of R1 "Resident Notes" dated 07/30/23 to 08/02/23 revealed the following entry on 08/02/23 at 01:15 PM: "This writer was sitting in my office when I received a knock at the office door from a caregiver stating that the gas station that is on the corner next to our houses called an asked if we had a short resident that was missing. The caregiver stated that he went over to the gas station and found the resident with money and said that he gave it back to the staff and he walked with R1 back to the house, but also stated that the gas station had called the police. This writer went to assess R1. Vital signs were within normal limits, range of motion done on all extremities with no limitations, water was given to resident, durable power of attorney called, "Advanced Practice Registered Nurse" (APRN) from the facility on call medical clinic was notified. "	S3026		

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Record review of facility provided document titled "House Call Medical Services" and dated 12/11/22 and signed by APRN F revealed the following note:

Patient was seen at the request of staff to establish care. She recently moved into memory care after needing more assistance with "Activity of Daily Living" (ADL) cares due to dementia. She has been exit seeking since moving in. She stays outside most of the time with her suitcase. She has not been aggressive or combative. She is seen outside as she is sitting on the ground folding her clothes and putting them into her suitcase.

Record review of facility document titled "For Redirection of Behaviors prior to "Pro Re Natas" (PRN's/as the situation demands) and signed by APRN F revealed the following instructions:

1. Sit and visit one-on-one to try and help calm the resident
2. Back away and reapproach
3. Walk with or wheel resident to a quiet, more calm area
4. Engage resident in a one-on-one activity
5. Offer food or drink
6. Ask if they need to go to the bathroom or are they already soiled
7. Are they hot/cold/bored/scared
8. Hand off to another caregiver
9. Play music
10. Massage hand, neck, scratch back.

Interview on 08/10/23 at approximately 03:14 PM with R1, revealed she answered simple yes and no questions nonsensically.

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S3026	Continued From page 4 Review on 08/10/23 at 01:42 PM of facility provided video tape footage dated 08/02/23 revealed the following actions: 09:46AM "Certified Nursing Assistant" (CNA) A is observed to be on a cellular phone while putting away a grocery delivery. 09:48AM R1 is observed walking in the common area in the front of the kitchen. 09:50 CNA A is off the cellular phone 09:53 AM R1 is observed sitting in a recliner in the common area 09:54 AM CNA C puts in the code at the front door and exits the front door. CNA A is back on the cellular phone, and CNA A and CMA B are observed to be putting groceries away. R1 went to the front door and exited. 09:56 AM CNA C comes in the front door with R1, and is speaking to CNA A and CMA B. CNA A is on the cellular phone. 09:57 AM R1 is seen walking around the common area, she sat down at the kitchen bar, and then got up and walked to the kitchen and went into the laundry room. CNA A, still on the cellular phone while putting away groceries, redirected R1 out of the kitchen. 09:58 AM R1 walked out of the kitchen and to the front door where the door freely opened when the resident pushed the egress bar, and she walked out of the front door.	S3026		

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S3026	Continued From page 5 11:12 AM CNA D walked in the front door with R1. He took her and sat her down and got her a glass of water while he spoke to CNA A and CMA B. Review of the facility document titled "Elopement" - dated 08/02/23, included CNA D's written statement. He stated that on 08/02/23 he was working at the "house" next door when the doorbell rang. It was an employee/manager of the convenience store. The person stated that "a short person was out in front of their store, and they wanted to see if they belonged to us". CNA D statement continued when he arrived at the convenience store there were two other people standing with R1. R1 was sitting on the ground and soaked. R1 had money in her hand, the other people told CNA D that R1 would not return the money. CNA D managed to convince R1 to give CNA D the money and CNA D gave it to the owner. As they left the convenience store CNA D noticed she had a grey jacket with red stripes on the sleeves and a "random t-shirt". He then walked with her back to the house/facility and told CNA A and CMA B to call "Licensed Nurse" (LN) E immediately. Interview on 08/10/23 with CNA D at approximately 02:00 PM, he stated that he was not working in R1's house that day, he had been asked to work the house next door. He stated that he did go over to the convenience store and walk R1 back to the facility. He continued to state that R1 usually wandered, and he redirected her or engaged her in an activity. Review of the facility provided document titled	S3026		

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S3026	Continued From page 6 "Investigation Statement - Caregiver" and signed by CMA B, revealed that on the day of the incident she was helping another resident with their medication when she was notified that R1 had eloped. She confirmed that she did not hear the door alarm go off. Interview on 08/10/23 at approximately 02:15 PM with CMA F, she confirmed that on the day of the elopement she did not hear the door alarm go off. Review of LN E witness statement revealed she received a phone call from the caregiver from R1 house that they felt like the doors were not working correctly, while she was on the phone, someone knocked on her office door and told her that R1 had eloped from the house next door. Her statement continued to state that had failed to notify her of the incident when R1 exited the facility behind CNA C earlier that morning, she continued that she should have been notified at that time of that incident. Interview on 08/10/23 at 04:03 PM with LN E, she stated that she was not notified of there being any issues with the front door locks of R1 house, or of the time earlier that morning when R1 first walked out of the facility after CNA C, until she was being notified that R1 was at the convenience store. Record review of LN G witness statement revealed that the management did notify the door company to ensure that the door alarms were working on 08/02/23 and that staff were "re-educated to make sure they are checking residents every 30 minutes".	S3026		

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S3026	Continued From page 7 Interview on 08/10/23 with LN G and "Director of Nursing" (DON) H, they confirmed that education is provided in the monthly staff meetings, the staff are to visualize the residents who wander every 30 minutes and elopement training is reviewed and provided at the time of hire. Record review of the "House Meeting Agenda" for 03/24/23 contained the following items: "Make sure doors and gates are locked" "Make sure you know where your residents, are at all times. Make sure you are doing at a minimum a two-hour check on everyone" Record review of the "House Meeting Agenda" for June 2023 contained the following item: "Rounds and safety checks - These are required. Even if the resident is "independent" we still need to be checking on them at least every thirty minutes to make sure they are not on the floor or deceased. Coaching will be given if this expectation is not followed and cold lead to termination. Not checking on a resident is considered neglect". Record review of the undated facility policy titled "Personal Cell Phones" revealed the following: "Direct Care Staff - Direct care staff do not require the use of a cell phone to do their daily duties, and therefore their cell phones are to be put away while they are on duty. While on the floor, providing resident care, including being a hall monitor or watching residents, staff are not to be utilizing their phones in any way". CNA A violated the facility policy as observed on the facility provided video footage dated	S3026		

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S3026	Continued From page 8 08/02/23 when R1 left the facility twice, undetected, through the front doors at 09:54 AM and 09:58 AM. Observation of the area where R1 walked on 08/02/23 revealed the convenience store sits on a busy corner at 29th and Tyler Road in Wichita, KS. The intersection is 4 lanes with a turning lane in each direction and the posted speed limits in each direction are 40 miles per hour. There are 13 gas pumps in front of the store. the store sits to the northwest of the facility/house and there was construction equipment in the front lot where they were building a new structure. The landscape from the facility to the parking lot is flat, and approximately 75 feet from the front of the facility/house there is a sudden step decline/slope down to the parking lot of the convenience store. On 08/14/23 at 12:56 PM Operator I was notified of Immediate jeopardy for R1's elopement. The Operator failed to protect R1 from neglect on 08/02/23 when staff failed to follow the facility requirements of checking residents every 30 minutes to ensure their safety, of not being on their cell phones while at work, of not reporting to the LN the first time the resident walked out the front door of the facility, and of not reporting the concerns of the front door alarm system. These actions allowed R1 to be out of the facility without staff knowledge for 70 minutes in 91-degree Fahrenheit weather, where she was found going through a stranger's car in a busy convenience store parking lot approximately 200 feet to the northwest of the facility where R1 resides.	S3026		

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S3026	Continued From page 9 Immediate Jeopardy was removed upon acceptance of the facility abatement plan on 08/14/23 at 04:23 PM. The plan included the following: Checking and testing doors/gates to ensure they are locked and secured Walking rounds at the beginning of each shift and for each 30-minute safety check Outlining the new 30-minute safety check sign off form for residents designated as a "Wanderer" or "Elopement risk" and how to utilize the form. Hold in person training with all staff within the next 3 weeks to review policies and procedures surrounding doors, access codes, 30-minute safety checks and specific protocols for wandering residents Written disciplinary actions for staff present the did not report the initial elopement to the nurse or check the doors following the initial elopement. Pinnacle Fire and Automation was called on 08/02/23 to check the door alarm system Doors codes both entering and exiting the home have been changed Door alarm systems will be converted to a traditional Magnetic locking door without delayed egress within one month.	S3026		