STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087036	A. BUILDING: _____ B. WING _____	10/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD OF DERBY	1701 WALNUT GROVE ROAD DERBY, KS 67037

(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 citations represent the findings of the abbreviated survey for complaint number for the above named facility conducted on 10/02/23 and 10/03/23.	S 000		
S3081 SS=D	26-41-201 (c) Functional Capacity Screen Reassessment (c) Designated facility staff shall conduct a screening to determine each resident ' s functional capacity according to the following requirements: (1) At least once every 365 days; (2) following any significant change in condition as defined in K.A.R. 26-39-100; and (3) at least quarterly if the resident receives assistance with eating from a paid nutrition assistant. This REQUIREMENT is not met as evidenced by: K.A.R. 26-41-201 (c)(2) The facility reported a census of 28 residents. The sample included 1 "Resident" (R)1. Based on interview and record review the operator failed to ensure R1 "Functional Capacity Screen" (FCS) was conducted when R1 had a significant change in behavior which included wandering and exit seeking. Findings included: - Record Review for R2 revealed an admission date of 08/02/23 with diagnoses of unspecified injury of kidney, age related cataract, asthma,	S3081		

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

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S3081	Continued From page 1	S3081		

hyperlipidemia, personal history of nicotine dependence and altered mental status.

Review of R1 combined FCS / "Negotiated Service Agreement" (NSA) dated 08/02/23 revealed R1 was independent with all "Activities of Daily Living" (ADL)'s, and mobility. He lacked the ability to manage his own medications, and had impaired short-term memory, impaired long term - memory, impaired memory recall, and impaired decision making. He was able to make himself understood and he understood others.

Review of R1 "Health Service Plan" (HSP) updated on 09/19/23 instructed facility staff to address wandering: "keep R1 busy with activities, make sure the elopement bracelet is on and is functioning properly every shift", and to take Seroquel, Buspar, and Ativan (anti-anxiety medications) to help control behaviors as ordered by physician.

Record review of R1 electronic "Progress Notes" dated 08/02/23 to 09/25/23 revealed the following entries:

08/21/23 at 05:09 PM "Resident came to common area of facility carrying belongings in a bag. Stated he was going to go home. Staff reminded him that he was at his home. He stated that he lived in [city] staff reminded him that he was in [same city]. Staff asked if he would like to go to his apartment to put his belongings away. He said he would like too. Staff escorted resident to his apartment and helped him put his belongings away."

08/24/23 at 06:34 PM "Resident has been

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S3081	Continued From page 2	S3081		

increasingly anxious and agitated in the afternoons. Came to common area of facility stating he needed to leave to get back to [city]. Redirected resident. Spoke to son about increased wandering and agitation. Son would like us to speak to the "Primary Care Physician" (PCP) regarding current medications and see if there is anything that PCP would like to try to decrease resident anxiety and agitation. Executive Director (ED) had to remove resident from another resident's apartment. Resident stated to ED that he had not been sleeping. ED advised that resident looked very tired, and his eyes were bloodshot. Advised staff to do extra checks on resident overnight until they heard back from the PCP.

08/25/23 at 05:42 PM "Wander Guard [device to block exiting] placed on resident right wrist".

09/15/23 at 05:49 PM "Resident removed Wander Guard bracelet. Wander Guard replaced by ED".

09/21/23 at 11:39 AM "Advanced Practice Registered Nurse" (APRN) reviewed resident medications. Resident continued wandering. APRN gave order to increase bedtime Seroquel to 50 milligrams and add morning dose of 12.5 milligrams".

09/21/23 at 03:11 PM "Resident removed Wander Guard bracelet. Wander Guard bracelet replaced. Spoke to son about hospice evaluation and he was supportive of having resident evaluated. ED also spoke to son about possibly moving resident to memory care when needed and son verbalized that memory care may be

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S3081	Continued From page 3 needed in the future". 09/23/23 at 08:21 PM Resident had eloped from the facility and was returned without injury. Interview on 10/02/23 at 04:47 PM Operator A confirmed the facility licensed nurse did not conduct a FCS when R1 exhibited a significant change of condition which included wandering and exit seeking. The operator failed to ensure R1 "Functional Capacity Screen" (FCS) was conducted when R1 had a significant change in behavior which included wandering and exit seeking.	S3081		
S3092 SS=D	26-41-202 (d) Negotiated Service Agreement Revisions (d) Each administrator or operator shall ensure the review and, if necessary, revision of each negotiated service agreement according to the following requirements:(1) At least once every 365 days; (2) following any significant change in condition, as defined in K.A.R. 26-39-100; (3) at least quarterly, if the resident receives assistance with eating from a paid nutrition assistant; and (4) if requested by the resident or the resident ' s legal representative, facility staff, the case manager, or, if agreed to by the resident or the resident ' s legal representative, the resident ' s family. This REQUIREMENT is not met as evidenced by:	S3092		

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S3092	Continued From page 4 K.A.R. 26-41-202 (d)(2) The facility reported a census of 28 residents. The sample included 1 "Resident" (R)1. Based on interview and record review the operator failed to ensure R1 "Negotiated Service Agreement" (NSA) was revised when R1 had a significant change in behavior which included wandering and exit seeking. Findings included: - Record Review for R2 revealed an admission date of 08/02/23 with diagnoses of unspecified injury of kidney, age related cataract, asthma, hyperlipidemia, personal history of nicotine dependence and altered mental status. Review of R1combined FCS / NSA dated 08/02/23 revealed R1 was independent with all "Activities of Daily Living" (ADL)'s, and mobility. He lacked the ability to manage his own medications, and had impaired short-term memory, impaired long term - memory, impaired memory recall, and impaired decision making. He was able to make himself understood and he understood others. Review of R1 "Health Service Plan" (HSP) updated on 09/19/23 instructed facility staff to due the following to address wandering: "keep R1 busty with activities, make sure the elopement bracelet is on and is functioning properly every shift", and to take Seroquel, Buspar, and Ativan to help control behaviors as ordered by physician. Record review of R1 electronic "Progress Notes"	S3092		

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S3092	Continued From page 5 dated 08/02/23 to 09/25/23 revealed the following: 08/21/23 at 05:09 PM "Resident came to common area of facility carrying belongings in a bag. Stated he was going to go home. Staff reminded him that he was at his home. He stated that he lived in Derby, staff reminded him that he was in Derby. Staff asked if he would like to go to his apartment to put his belongings away. He said he would like too. Staff escorted resident to his apartment and helped him put his belongings away." 08/24/23 at 06:34 PM "Resident has been increasingly anxious and agitated in the afternoons. Came to common area of facility stating he needed to leave to get back to Derby. Redirected resident. Spoke to son about increased wandering and agitation. Son would like us to speak to the "Primary Care Physician" (PCP) regarding current medications and see if there is anything that PCP would like to try to decrease resident anxiety and agitation. Executive Director (ED) had to remove resident from another resident's apartment. Resident stated to ED that he had not been sleeping. ED advised that resident looked very tired, and his eyes were bloodshot. Advised staff to do extra checks on resident overnight until they heard back from the PCP. 08/25/23 at 05:42 PM "Wander Guard [device to prevent exiting] placed on resident right wrist". 09/15/23 at 05:49 PM "Resident removed Wander Guard bracelet. Wander Guard replaced by ED".	S3092		

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S3092	Continued From page 6 09/21/23 at 11:39 AM "Advanced Practice Registered Nurse" (APRN) reviewed resident medications. Resident continued wandering. APRN gave order to increase bedtime Seroquel to 50 milligrams and add morning dose of 12.5 milligrams". 09/21/23 at 03:11 PM "Resident removed Wander Guard bracelet. Wander Guard bracelet replaced. Spoke to son about hospice evaluation and he was supportive of having resident evaluated. ED also spoke to son about possibly moving resident to memory care when needed and son verbalized that memory care may be needed in the future". 09/23/23 at 08:21 PM Resident had eloped from the facility and was returned without injury. Interview on 10/02/23 at 04:47 PM Operator A confirmed the facility licensed nurse did not revise the NSA when R1 exhibited a significant change of condition which included wandering and exit seeking. The operator failed to ensure R1 "Negotiated Service Agreement" (NSA) was revised when R1 had a significant change in behavior which included wandering and exit seeking.	S3092		
S3261 SS=D	26-41-105 (f) (11) Resident Record Documentation of Incidents (f) (11) documentation of all incidents, symptoms, and other indications of illness or injury including the date, time of occurrence, action taken, and results of the action	S3261		

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S3261	Continued From page 7	S3261		

This REQUIREMENT is not met as evidenced by:
K.A.R. 26-41-202 (f)(11)

The facility reported a census of 28 residents. The sample included 1 "Resident" (R)1. Based on interview and record review the operator failed to ensure documentation of all incidents, actions taken, and results of actions taken when R1 exhibited a significant change in behavior which included wandering and exit seeking behaviors.

Findings included:

- Record Review on 10/02/23 R2 revealed an admission date of 08/02/23 with diagnoses of unspecified injury of kidney, age related cataract, asthma, hyperlipidemia, personal history of nicotine dependence and altered mental status.

Review of R1combined FCS / NSA dated 08/02/23 revealed R1 was independent with all "Activities of Daily Living" (ADL)'s, and mobility. He lacked the ability to manage his own medications, and had impaired short-term memory, impaired long term - memory, impaired memory recall, and impaired decision making. He was able to make himself understood and he understood others.

Review of R1 "Health Service Plan" (HSP) updated on 09/19/23 instructed facility staff to due the following to address wandering: "keep

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S3261	Continued From page 8	S3261		

R1 busty with activities, make sure the elopement bracelet is on and is functioning properly every shift", and to take Seroquel, Buspar, and Ativan to help control behaviors as ordered by physician.

Record review of R1 electronic "Progress Notes" dated 08/02/23 to 09/25/23 revealed the following:

08/21/23 at 05:09 PM "Resident came to common area of facility carrying belongings in a bag. Stated he was going to go home. Staff reminded him that he was at his home. He stated that he lived in Derby, staff reminded him that he was in Derby. Staff asked if he would like to go to his apartment to put his belongings away. He said he would like too. Staff escorted resident to his apartment and helped him put his belongings away."

The document lacked an entry for results of actions taken after R1 put his belongings away.

08/24/23 at 06:34 PM "Resident has been increasingly anxious and agitated in the afternoons. Came to common area of facility stating he needed to leave to get back to Derby. Redirected resident. Spoke to son about increased wandering and agitation. Son would like us to speak to the "Primary Care Physician" (PCP) regarding current medications and see if there is anything that PCP would like to try to decrease resident anxiety and agitation. Executive Director (ED) had to remove resident from another resident's apartment. Resident stated to ED that he had not been sleeping. ED advised that resident looked very tired, and his

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S3261	Continued From page 9	S3261		

eyes were bloodshot. Advised staff to do extra checks on resident overnight until they heard back from the PCP.

The document lacked an entry for how staff was redirecting resident, and the results of the staff redirection.
08/25/23 at 05:42 PM "Wander Guard placed on resident right wrist".

The record lacked entries for why the facility placed the "Wander Guard" bracelet. The only note in the electronic progress notes that addressed exit seeking prior to the placement of the Wander Guard was on 08/21/23, and the note stated R1 was easily redirected.

09/15/23 at 05:49 PM "Resident removed Wander Guard bracelet. Wander Guard replaced by ED".

09/21/23 at 11:39 AM "Advanced Practice Registered Nurse" (APRN) reviewed resident medications. Resident continued wandering. APRN gave order to increase bedtime Seroquel to 50 milligrams and add morning dose of 12.5 milligrams".

09/21/23 at 03:11 PM "Resident removed Wander Guard bracelet. Wander Guard bracelet replaced. Spoke to son about hospice evaluation and he was supportive of having resident evaluated. ED also spoke to son about possibly moving resident to memory care when needed and son verbalized that memory care may be needed in the future".

Interview on 10/03/23 at approximately 09:30 AM

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S3261	Continued From page 10 with Licensed Nurse B, she confirmed the records lacked documentation of the results of the actions taken. The operator failed to ensure documentation of all incidents, actions taken, and results of actions taken when R1 exhibited a significant change in behavior which included wandering and exit seeking behaviors.	S3261		