STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B006003	A. BUILDING: _____ B. WING _____	12/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLSIDE GUEST HOME	1115 227TH STREET FORT SCOTT, KS 66701

(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 a resurvey with a complaint #184231 at the above named Home Plus conducted 12/05/23 and 12/06/23.	S 000		
S5026 SS=J	26-42-101 (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 26-42-101(f)(1)(B) The facility reported a census of five residents. Based on observation, interview and record review the operator failed to ensure resident (R)101 was not subjected to neglect when R101 exited the building during the night without staff knowledge. This resulted in cognitively impaired R101 exiting the facility and being unaccounted for by staff for approximately three hours, in the dark, when the temperature outside was 30 degrees Fahrenheit (F) until local law enforcement located him across the street, approximately 200 feet from the facility front door. This placed R101 in Immediate Jeopardy.	S5026		

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

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S5026	Continued From page 1 Findings included: - R101's medical record revealed the resident moved into the facility on 09/01/22 with a diagnosis of carotid aneurysm. R101's "Functional Capacity Screen" (FCS) dated 08/31/23 revealed he required physical assistance with transfers and mobility and had a cognitive score of two, indicating he was cognitively impaired with short term memory and memory recall deficits. R101's "Negotiated Service Agreement" (NSA) dated 08/31/23 documented staff monitored R101 for safe transfers and reminded him to use his walker. The NSA did not identify R101 was at risk for wandering or elopement. Review of R101's medical record revealed the following: On 06/02/23 an "Elopement Assessment" was completed and R101 was found to not be at risk for elopement. The 11/24/23 "Nurses Note" documented R101 informed the nurse with a big smile, "My son...and his wife came to see me yesterday." R101 ambulated with his walker out to meals but he did not use his walker when he returned to his room. The nurse reminded R101 to use his walker and R101 voiced his agreement. The 11/25/23 "Nurses Note" documented that around 02:00 AM, Administrative Staff A	S5026		

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S5026	Continued From page 2	S5026		

contacted Licensed Nurse (LN) B to report that R101 could not be found inside the facility and was going to call the local police and R101's family. LN B arrived at the facility at approximately 02:35 AM and found local law enforcement on the scene. LN B joined others in searching the immediate area outside of the facility. At approximately 03:30 AM law enforcement informed LN B that R101 had been found across the street on the cemetery parking lot laying on the ground between a large metal railing and rock wall not too far from a white car.

Review of report submitted to the complaint hotline by the facility on 11/27/23 revealed R101 was found wearing jeans, a sweatshirt, long-sleeved shirt, shoes, and socks.

An observation on 12/05/23 at 08:45 AM revealed the front door of the facility had a loud door chime which sounded loudly when the door was opened. The facility had three dogs inside the building which continuously barked until staff quieted them down. There was a cemetery office parking area located across the street approximately 200 feet West of the facility front door. The road was paved with asphalt, both the cemetery and facility parking lots consisted of crushed gravel. The road was in a rural, residential area and had only occasional traffic with a speed limit of 35 miles per hour. Weather conditions at the time of the elopement as verified on https://www.wunderground.com/ revealed it was nighttime outside with no precipitation and a temperature of 30 degrees F.

An observation on 12/05/23 at 09:15 AM revealed the North exit door had a loud, piercing

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S5026	Continued From page 3	S5026		

alarm which sounded when the door was opened and turned off when the door was shut again.

On 12/05/23 at 10:48 AM Certified Nurse Aide (CNA) C stated R101 was independent with transfers and walking and used a walker and was able to express his wants and needs. CNA C stated R101 would go on walks by himself down the street to the park or outside on the facility property and would always return. CNA C stated R101 was happy at the facility and considered it to be his home.

On 12/06/23 at 08:45 AM LN B stated R101 was a very proud and independent person. He was able to understand instructions from staff, followed through with them and told staff he wanted to be compliant with the rules of the facility. R101 admitted to this facility from a nursing home and when he arrived, he remarked that he was glad that he was able to go outside to walk and not be locked up in a facility. LN B stated R101 always told staff when he was going to go outside and say, "Hey lady I'm going for a walk to the park." or "I'm going to walk around the sidewalk on the property." LN B stated R101 seemed to be content to be at the facility and understood that this facility was his home. LN B stated R101 would take his walker outside with him and was able to dress himself and chose what clothes he was going to wear. LN B stated R101 dressed appropriately when he went outside to include wearing a jacket when it was cold. LN B stated on the morning R101 exited the facility she got a call around 02:19 AM from Administrative Staff A. LN B stated she got into her car and started searching the general area around the facility as she made her way to the

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facility. When she arrived at the facility law enforcement were already on the scene. LN B stated she remembered R101 telling her that he was interested in a car across the street, so LN B took her flashlight and looked around the car several times and called out his name, but R101 never responded. LN B stated soon after this the Sheriff's Deputy found R101 located between a guardrail and a rock wall right in front of the same car.

On 12/05/23 at 10:54 AM Administrative Staff A stated R101 was independent with transfers and walking. When he arrived, he didn't need to use a walker and would exercise on his own. Administrative Staff A stated R101 enjoyed walking on a trail around the baseball and soccer field across the street and north of facility. R101 enjoyed walking by himself or with staff when they took the facility dogs for a walk. Administrative Staff A stated when R101 started using a walker he would limit his walking to the property sidewalks and would tell staff when he went outside. Administrative Staff A stated elopement risk assessments were completed and R101 was never found to be at risk for elopement. She stated R101 never verbalized that he wanted to "go home" but instead would refer to his room at the facility as being his home.

On 12/06/23 at 09:34 AM Administrative Staff A stated when she visited R101 at the hospital she asked him if he knew what had happened to him. R101 responded that he didn't know. Administrative Staff A asked him if he had his walker with him, he responded, "NO!!". R101 commented that he wanted to see if the car across the street was for sale and as he looked

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at the car, he got tired and sat down. Administrative Staff A stated the front door of the facility did not have an alarm, but the dogs barked anytime the door was opened. Administrative Staff A said she installed the front door alarm the day after the incident and replaced the alarm on the North door with a new, louder alarm. Administrative Staff A stated she did not have documentation of door alarm function checks.

The operator failed to ensure R101 was not subjected to neglect when the operator failed to ensure the front exit door had a working alarm and failed to document door alarm checks. This resulted in cognitively impaired R101 exiting the facility without staff knowledge and being unaccounted for approximately three hours, at night in 30-degree weather.

On 12/05/23 at 01:47 PM Administrative Staff A and LN B were informed of the findings which resulted in immediate jeopardy for a cognitively impaired resident exiting the facility unaccompanied by staff, failure of staff to ensure the front exit door had a working alarm in place to notify staff when a resident exited the building without staff being aware.

Administrative Staff A submitted an abatement plan which included the following:
A. On 11/26/23 an alarm was installed on the front door and the North exit door alarm was replaced with a louder unit.
B. Facility will revisit with residents and family regarding the importance of using the sign out and return book when leaving the facility by 12/06/23.

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S5026	Continued From page 6 C. Operator or Nurse will monitor sign out and return book daily for 30 days starting 12/06/23. D. Staff will do weekly checks and document for proper functioning of door alarms starting 12/05/23. E. Staff will have in-service on door alarms usage and document that they are functioning on 12/06/23. The immediate jeopardy was abated on 12/05/23 at 05:01 PM based on the facility's plan of correction and approved by the department.	S5026		
S5192 SS=F	26-42-206 (e) Food Preparation (e) Food shall be prepared using safe methods that conserve the nutritive value, flavor, and appearance and shall be served at the proper temperature. (1) Food used by facility staff to serve to the residents, including donated food, shall meet all applicable federal, state, and local laws and regulations.(2) Food in cans that have significant defects, including swelling, leakage, punctures, holes, fractures, pitted rust, or denting severe enough to prevent normal stacking or opening with a manual, wheel-type can opener, shall not be used. (3) Food provided by a resident ' s family or friends for individual residents shall not be required to meet federal, state, and local laws and regulations. This REQUIREMENT is not met as evidenced by: KAR 26-42-206 (e)	S5192		

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S5192	Continued From page 7 The facility had a census of five residents. All five residents ate food prepared in the same kitchen. The operator failed to ensure food items were served at the proper temperature. Findings included: - On 12/05/23 at 09:23 AM an inspection of the facility kitchen revealed there was no documentation of food temperatures taken prior to serving to the residents. On 12/06/23 at 10:09 AM Administrative Staff A stated the previous cook recently retired. Administrative Staff A stated she has not documented food temperatures since she took over cooking for the facility. According to the Kansas Department of Agriculture "Focus on Food Safety" revised August 2017, hot foods must be maintained at an internal temperature of 135 Fahrenheit (F) or higher and cold foods must be maintained at an internal temperature of 41 F or below. The operator failed to ensure food items were served at the proper temperature.	S5192		
S5195 SS=F	26-42-206 (f) (g) Facility Food Storage (f) Staff shall store all food under safe and sanitary conditions. Containers of poisonous compounds and cleaning supplies shall not be stored in the areas used for food storage, preparation, or serving. (g) Each home shall maintain at least a three-day supply of food to meet the	S5195		

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S5195	Continued From page 8 requirements of the planned menus. This REQUIREMENT is not met as evidenced by: KAR 26-42-206 (f) The facility had a census of five residents. All five residents ate food prepared in the same kitchen. The operator failed to ensure food items were stored under safe and sanitary conditions by the failure to ensure foods stored in the refrigerators were kept at 41 degrees Fahrenheit (F) or lower according to Food Safety Guidelines. Findings included: - On 12/05/23 at 09:23 AM an inspection of the facility kitchen revealed there was no documentation posted of temperature checks of the refrigerators or freezers. On 12/06/23 at 10:09 AM Administrative Staff A stated the previous cook recently retired. Administrative Staff A stated she has not documented refrigerator/freezer temperatures since she took over cooking for the facility. According to the Kansas Department of Agriculture "Focus on Food Safety" revised August 2017, "Cold foods must be maintained at an internal temperature of 41F or below." "Date mark foods appropriately, cover foods after completely cooled, cover foods to maintain cold holding temperature."	S5195		

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S5195	Continued From page 9 The operator failed to ensure food items were stored under safe and sanitary conditions by failing to document refrigerator/freezer temperatures.	S5195		
S5215 SS=F	26-42-104 (d) Disaster and Emergency Preparedness Education (d) Each administrator or operator shall ensure disaster and emergency preparedness by ensuring the performance of the following: (1) Orientation of new employees at the time of employment to the home ' s emergency management plan; (2) education of each resident upon admission to the home regarding emergency procedures; (3) quarterly review of the home ' s emergency management plan with employees and residents; and (4) an emergency drill, which shall be conducted at least annually with staff and residents. This drill shall include evacuation of the residents to a secure location. This REQUIREMENT is not met as evidenced by: KAR 26-42-104(d)(3) The facility reported a census of five residents. Based on record review and interview for all residents and all facility employees, the operator failed to ensure disaster and emergency preparedness by ensuring performance of quarterly review of the "Emergency Management Plan" (EMP) with employees and residents.	S5215		

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S5215	Continued From page 10 Findings included: - On 12/05/23 the facility provided documentation for EMP reviews. No documentation was provided for resident and staff reviews of the EMP for the first and third quarters of 2023. On 12/05/23 Administrative Staff A acknowledged there was no documentation of quarterly reviews of the EMP with staff and residents completed for the first and third quarters of 2023. The operator failed to ensure the performance of quarterly reviews of the emergency management plan with employees and staff.	S5215		