Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N019011	A. BUILDING: _____ B. WING _____	01/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD OF GIRARD	950 WEST ST JOHN ST GIRARD, KS 66743

(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 represents the findings of a resurvey with review of facility report #185292 at the above named assisted living conducted on 01/24/24.	S 000		
S3028 SS=D	26-41-101 (f) (3) Staff Treatment of Residents Reporting (f) (3) Each allegation of abuse, neglect, or exploitation shall be reported to the administrator or operator of the facility as soon as staff is aware of the allegation and to the department within 24 hours. The administrator or operator shall ensure that all of the following requirements are met: (A) An investigation shall be started when the administrator or operator, or the designee, receives notification of an alleged violation. (B) Immediate measures shall be taken to prevent further potential abuse, neglect, or exploitation while the investigation is in progress. (C) Each alleged violation shall be thoroughly investigated within five working days of the initial report. Results of the investigation shall be reported to the administrator or operator. (D) Appropriate corrective action shall be taken if the alleged violation is verified. (E) The department ' s complaint investigation report shall be completed and submitted to the department within five working days of the initial report. (F) A written record shall be maintained of each investigation of reported abuse, neglect, or exploitation.	S3028		

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

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S3028	Continued From page 1 This REQUIREMENT is not met as evidenced by: KAR 26-41-101(f)(3) The facility reported a census of 18 residents with three residents included in the sample and one closed record review. Based on interview and record review the operator failed to ensure staff reported when cognitively impaired Resident (R) 4 exited the facility through one door, walked around to the other side of the building, and attempted to re-enter through a locked door. Findings included: - Record review for R4 revealed an admission date of 04/03/20 diagnoses of Parkinson's disease and dementia. The 12/08/23 "Functional Capacity Screen" (FCS) identified R4 required supervision with transfers and walking/mobility; had short-term and long-term memory, memory recall, and decision-making difficulties; and was marked for impaired decision making, wandering, and inappropriate behavior. The 12/28/23 combined "Negotiated Service Agreement/Healthcare Service Plan" (NSA/HCP) identified facility staff would provide minimal assistance with transfers; he was ambulatory with and without assistance depending on the day for walking/mobility; keep his routine as constant as possible and break tasks into small steps for cognitive difficulties; keep him busy with	S3028		

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S3028	Continued From page 2	S3028		

activities, ensure elopement bracelet was on and functioning every shift, and redirect if he was near a door or trying to get out for wandering and inappropriate behavior; and he had a durable power of attorney (DPOA) for impaired decision-making.

The 01/16/24 at 03:12 PM "Nurses Note" documented Administrative Staff A and Administrative Nurse B were notified R4 had been exit-seeking.

The 01/19/24 facility's report to the department documented R4 exited the building on 01/12/24 at approximately 07:00 PM which was not reported to Administrative Staff A and Administrative Nurse B until 01/16/24.

On 01/24/24 at 11:28 AM Administrative Nurse B confirmed she and Administrative Staff A were first made of aware R4 exited the facility through one door, walked around to the other side of the building, and attempted to re-enter through a locked door four days after it happened.

The operator failed to ensure staff reported when cognitively impaired R4 exited the facility through one door, walked around to the other side of the building, and attempted to re-enter through a locked door.