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	B089081	A. BUILDING: _____ B. WING _____	06/24/2024

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S 000	INITIAL COMMENTS The following citations represent the findings of a resurvey with complaints #185831 and 188545 at the above named Home Plus conducted on 06/18/24 and 06/24/24.	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: 5026 KAR 26-42-101(f)(1)(B) The facility reported a census of eight residents. The facility identified two residents at risk for elopement. Based on observation, interview and record review the operator failed to ensure resident (R)101 was not subjected to neglect by the failure to ensure the back courtyard door was kept shut with the alarm activated. This resulted in cognitively impaired R101 exiting the facility and being unaccounted for by staff for approximately 54 minutes until facility staff located him across the street at a busy intersection. Findings included:	S5026		

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

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- R101's medical record revealed he moved into the facility on 02/22/24 with a diagnosis of Lewy body dementia.

R101's "Functional Capacity Screen" (FCS) dated 02/22/24 failed to identify R101 had severe cognitive impairment. R101 was independent with transfers and mobility and triggered for wandering.

R101's "Negotiated Service Agreement/Healthcare Service Plan" (NSA/HCSP) dated 02/22/24 lacked interventions for wandering.

Review of R101's medical record revealed the following:
The 03/04/24 "Nursing Note" documented staff relayed in a report that R101 was more agitated during the night and did not sleep well. R101 was more aggressive with staff regarding leaving the facility. Staff were unsure of exactly how much R101 slept between being awake and wandering around the facility.

An observation on 06/18/24 at 12:30 PM revealed R101 wandered around the facility and entered the nurse's office. R101 appeared to be cognitively impaired and stared out a window with a view to a busy street.

An observation on 06/18/24 at 11:30 AM revealed there was a locked and alarmed exit door off the living room/dining area that led to a fenced-in courtyard. The courtyard had a wrought-iron fence with a gate that was not locked which led to a grassy area that sloped downhill to a neighbor's backyard to the east of the facility. There was

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unimpeded access to the north of the facility that led to a busy four-lane street.

An observation on 06/18/24 at 03:45 PM revealed the facility was in a mixed residential/commercial neighborhood at a relatively busy intersection with stop lights and crosswalks. The streets were paved and had a speed limit of 40 miles per hour. Weather conditions at the time of the elopement as verified on https://www.wunderground.com/ revealed it was daylight outside with a temperature of 90 degrees Fahrenheit.

On 06/18/24 at 03:00 PM "Certified Nurse Aide" (CNA) D stated R101 was more active with exit-seeking in the afternoon hours and was easily redirected. On 06/11/24 at approximately 03:47 PM, another resident, R104, asked staff to let him out to the courtyard where he could sit in his wheelchair. CNA D stated he used a planter to prop open the door and kept an eye on R104 through the window while working. Staff stated CNA E came on shift around 03:55 PM and wheeled R104 back into the facility and closed the door which was open approximately 8-10 minutes. At approximately 04:00 PM CNA E asked the other two staff on duty if they had seen R101 because she was not able to find him. CNA D stated he had last seen R101 around 03:30 PM when he took him to use the restroom and took R101back to his room. Staff on duty immediately checked all rooms inside the facility and when they were not able to locate R101 they called the nurse who was next door.. Staff proceeded to go outside of the facility to look for R101. CNA D stated that at approximately 04:43 PM he noticed R101 across the street, caddy-corner from the facility looking at a pole. CNA D stated he reviewed the video footage with the facility director which revealed that within two minutes of

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taking R104 out to the courtyard R101 walked out of the sunroom, went through the open door and headed straight to the gate. CNA D stated he went to answer another resident's call bell and did not notice R101 exiting through the open door into the courtyard.

Review of the "Nursing Notes" dated 06/11/24 documented, Administrative Nurse B received a call at approximately 04:30 PM from CNA E who reported that she had been looking for R101 for approximately fifteen minutes. Administrative Nurse B went directly over to the facility and scanned the premises and looked behind closed doors. Two other aides were outside searching for R101. Approximately ten minutes later R101 was located, standing in the alleyway (across the intersection) caddy-corner to the facility. CNA D was able to run over to the resident and wait until Administrative Nurse B picked up the resident with the company vehicle. The resident was returned to the facility at 04:50 PM. R101 was assessed, and vital signs were taken and were within normal limits. No bumps, bruising or obvious trauma or injury was noted. R101's wife and medical provider were notified of the elopement. After arriving back at the facility R101 was relaxed and walking around the facility. R101 had lots of fluid offered and did accept some of the fluids.

On 06/25/24 at 04:25 PM Administrative Nurse B stated at the time R101 eloped from the facility he wore jogging pants, a white t-shirt, a baseball cap, and tennis shoes.

The operator failed to ensure R101 was not subjected to neglect when staff failed to ensure the rear exit door was kept closed with the alarm activated. This resulted in cognitively impaired

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R101 exiting the facility without staff knowledge and being unaccounted for approximately 54 minutes.

On 06/18/24 at 03:26 PM Administrative Staff A was informed of the findings which resulted in immediate jeopardy when staff failed to ensure the rear exit door was kept shut, locked and with the alarm activated allowing a cognitively impaired resident to exit the facility unaccompanied by staff.

Administrative Staff A submitted an abatement plan which included the following:
On 06/11/24 at 10:00 PM, oncoming staff were notified of elopement and reviewed elopement prevention with Administrative Nurse B.

On 06/12/24 the oncoming day shift was notified of elopement and reviewed elopement prevention with Administrative Nurse B.

Notifications and review of door procedures and elopement prevention continued at shift change until all staff were notified on 06/15/24.

Written door lock training and elopement prevention training created on 06/18/24. Individual staff training and obtaining signatures on training began 06/18/24 and will be completed by 06/21/24.

R101's Negotiated Service Agreement/Health Care Service Plan was updated on 06/18/24 to include elopement history and prevention techniques. Plan included, "Staff to redirect when resident attempts to try doors. Resident typically easily redirectable by encouraging him to assist staff or to participate in an activity of his liking. Elopement risk- staff to always remain with the

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S5026	Continued From page 5 resident in an unsecure environment." Elopement Prevention techniques training will be included in quarterly emergency procedure training. On 06/20/24 rearranged nurse station desk to assist in providing additional monitoring of exit doors. On 06/20/24 implemented signature forms to verify that every fifteen minutes staff checks door maglocks and resident placement for residents identified as elopement risk. On 06/20/24 placed signs on both sides of exit doors alerting people entering of elopement risk The immediate jeopardy was abated on 06/20/24 at 10:53 AM based on the facility's plan of correction and approved by the department.	S5026		
S5095 SS=D	26-42-201 (d) Functional Capacity Screen Accurate (d) Designated staff shall ensure that each resident ' s functional capacity at the time of screening is accurately reflected on that resident ' s screening form. This REQUIREMENT is not met as evidenced by: 5095 KAR 26-42-201(d) The facility reported a census of eight residents	S5095		

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S5095	Continued From page 6 with three included in the sample. Based on observation, interview, and record review the operator failed to ensure Resident (R) 101's "Functional Capacity Screen" (FCS) accurately reflected the resident's cognitive status. Findings included: - Resident (R)101's medical record revealed he moved into the facility on 02/22/24 with a diagnosis of Lewy body dementia. The 02/22/24 Admission FCS identified R101 had an impairment with decision-making but no other cognitive deficits. The 09/12/23 FCS identified R101 was independent with transfers and ambulation and did not require the use of an assistive device. Observation on 06/18/24 at 12:30 PM R101 wandered around the facility and entered the nurse's office. R101 appeared to be cognitively impaired and stared out a window facing a busy street. On 06/18/24 at 02:28 PM Administrative Staff A acknowledged that the 02/22/24 FCS was not accurately coded and should have been coded at least a three instead of just one for Cognition and memory, recall. The operator failed to ensure R101's FCS accurately reflected his status concerning his cognition.	S5095		
S5105 SS=E	26-42-202 (a) Negotiated Service Agreement	S5105		

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S5105	Continued From page 7 a) The administrator or operator of each home plus shall ensure the development of a written negotiated service agreement for each resident, based on the resident ' s functional capacity screening, service needs, and preferences, in collaboration with the resident or the resident ' s legal representative, the case manager, and, if agreed to by the resident or the resident ' s legal representative, the resident ' s family. The negotiated service agreement shall provide the following information: (1) A description of the services the resident will receive; (2) identification of the provider of each service; and (3) identification of each party responsible for payment if outside resources provide a service. This REQUIREMENT is not met as evidenced by: 5105 KAR 26-42-202(a)(1) The facility reported a census of eight residents with three residents included in the sample. Based on interview, and record review the operator failed to ensure the "Negotiated Service Agreement" (NSA) was fully developed based on the resident's "Functional Capacity Screen" (FCS), service needs, and preferences for resident (R)101 and R103. Findings included: - R101's medical record revealed he moved into the facility on 02/22/24 with a diagnosis of Lewy body dementia.	S5105		

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S5105	Continued From page 8 The 02/22/24 FCS identified R101 had difficulty decision-making and wandered. The 02/22/24 NSA did not address R101's cognition or his wandering. On 06/24/24 at 05:39 PM Administrative Nurse B stated R101's NSA did not address his cognition and did not include interventions to address his wandering. The operator failed to ensure R101's NSA was fully developed to include all items that triggered in the FCS. - R103's medical record revealed he moved into the facility on 06/19/23 with a diagnosis of peripheral neuropathy. The 08/12/23 FCS identified R103 required physical assistance with transfers and triggered for falls. The 08/12/23 NSA did not address the use of a bed assist device and did not address falls. On 06/24/24 at 04:57 PM Administrative Nurse B stated R103's NSA did not address falls specifically and did not address the use of a bed assist device. The operator failed to ensure R103's NSA was fully developed to include all items that triggered in the FCS and failed to identify that he used a bed assist device.	S5105		
S5171 SS=D	26-42-204 (i) Health Care Services Standards of Practice	S5171		

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S5171	Continued From page 9 (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: 5171 KAR 26-42-204(i) The facility reported a census of eight residents with three residents included in the sample. Based on observation, interview and record review the operator failed to ensure health care services were provided in accordance with acceptable standards of practice for resident (R)102 when staff failed to follow his "Negotiated Service Agreement/Health Care Service Plan" (NSA/HCSP) when they attempted to transfer him using a Hoyer lift with only one staff which resulted in R102 slipping to the floor. Findings included: - Review of R102's medical records revealed he was admitted to the facility on 09/13/22 with a diagnosis of Parkinson's Disease . The 09/13/23 "Functional Capacity Screen" (FCS) documented R102 required staff assistance with transfers and required the use of a mechanical lift. The 04/09/24 NSA/HCSP documented R102 required two staff to assist with transfers using a Hoyer lift. The 02/07/24 "Nursing Notes" documented R102 fell when "Certified Nurse Aide" (CNA) I attempted to transfer him from his recliner to his	S5171		

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S5171	Continued From page 10 wheelchair using Hoyer lift with no other staff assistance. R102 slid out of his wheelchair when CNA I attempted to lower him. Review of the 02/07/24 "Fall Investigation Form" documented, R102 was care planned for staff assist of two people for transfers. CNA I attempted to use a Hoyer lift to transfer R102 to his wheelchair by herself. CNA I was unable to get R102 situated in his wheelchair correctly as the Hoyer lift was being released down. As a result, R102 slid directly out of wheelchair onto the floor. Intervention: Staff to follow care plan as written. An observation on 06/24/24 at 04:35 PM revealed R102 sat at the dining room table in his wheelchair eating dinner. There was a Hoyer lift located in the hallway outside of his room. On 06/24/24 at 05:14 PM Administrative Nurse B stated R102 required two-person assist with transfers using a Hoyer lift at the time of the incident. Administrative Nurse B stated all staff were re-educated that two staff were required when they operated the Hoyer lift. On 06/25/24 at 10:38 AM Administrative Nurse B stated the facility did not have a set policy concerning transfers but there was an expectation that staff followed professional standards of care and two staff should be present when operating a Hoyer lift. The operator failed to ensure health care services were provided in accordance with acceptable standards of practice.	S5171		

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S5230	Continued From page 11	S5230		
S5230 SS=F	26-42-207 (b)(5)(6) (c) Infection Control Policies (b)(5) prohibiting any employee with a communicable disease or any infected skin lesions from coming in direct contact with any resident, any resident ' s food, or resident care equipment until the condition is no longer infectious; (6) providing orientation to new employees and employee in-service education at least annually on the control of infections in a health care setting; (c) Each administrator or operator shall ensure the home ' s compliance with the department ' s tuberculosis guidelines for adult care homes adopted by reference in K.A.R. 26-39-105. This REQUIREMENT is not met as evidenced by: 5320 KAR 26-42-207(c) The facility reported a census of eight residents. Based on interview and record review for three residents and five new employee records, the operator failed to ensure the facility remained in compliance with the department's tuberculosis (TB) guidelines for adult care homes adopted by reference in KAR 26-39-105. Findings included: - Review of five newly hired staff records revealed the following: "Certified Nurse Aide" (CNA) F's employee record revealed a hire date of 04/26/24. The TB Symptom Screening Questionnaire was not dated	S5230		

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S5230	Continued From page 12 to show when it was completed. CNA G's employee record revealed a hire date of 02/20/24. The first step of the two-step TB skin test (TST) was read as not positive on 02/22/24 and the second step of the TST was not administered until 04/09/24 which was 26 days late. "Certified Medication Aide" (CMA) H's employee record revealed a hire date of 02/13/24. The TB Symptom Screening Questionnaire was not dated to show when it was completed. The first step of the two-step TB skin test (TST) was read as not positive on 02/21/24 and the second step of the TST was not administered until 04/07/24 which was 25 days late. On 06/24/24 at 04:57 PM Administrative Nurse A stated it was her expectation that the second step of the two-step TST be administered according to the TB guidelines. The June 2013 "Tuberculosis (TB) Guidelines for Adult Care Homes" documented, "Each new resident and new employee shall have an initial TB symptom screen that includes the components of the TB symptom questionnaire within seven days of residency or employment ...If the first TST is read as not positive, a second TST shall be administered within 1 to 3 weeks." The operator failed to ensure the facility remained in compliance with the department's tuberculosis guidelines for adult care homes adopted by reference in KAR 26-39-105 regarding newly hired employees. - Resident (R)103 moved into the facility on 06/19/23.	S5230		

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S5230	Continued From page 13 R103's medical record revealed the first step of the two-step TST was not administered until 08/09/23 which was 44 days late. On 06/24/24 at 04:57 PM Administrative Nurse A stated it was her expectation that the first step of the two-step TST be administered to R101 within seven days of his admission to the facility. The June 2013 "Tuberculosis (TB) Guidelines for Adult Care Homes" documented, "Each new resident ...shall receive a two-step TST ...within 7 days of residency ..." The operator failed to ensure compliance with the department's TB guidelines for adult care homes adopted by reference to K.A.R. 26-29-105.	S5230		