STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087095	A. BUILDING: _____ B. WING _____	03/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMFORTCARE HOMES INC #441	441 S MORNINGSIDE STREET WICHITA, KS 67218

(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 attached complaint #189193 at the above named home plus conducted on 03/12/25.	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 10 residents with three residents included in the sample. Based on observation, interview, and record review the operator failed to protect one resident from neglect by the failure to ensure staff secured all exit doors. Cognitively impaired Resident (R) 3 exited the facility through an unsecured door to the outside without staff knowledge on 07/09/24 at 04:37 PM. This placed the resident in Immediate Jeopardy. Findings included: - Record review for R3 revealed an admission	S5026		

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

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date of 02/12/24 with a diagnoses of dementia and memory impairment.

The 02/12/25 "Functional Capacity Screen" (FCS) identified R3 was independent and used no assistive devices for transfers and walking/mobility; she had short-term memory and memory/recall cognitive difficulties.

The 02/13/25 "Negotiated Service Agreement" (NSA) identified R3 was not able to leave the facility unsupervised due to a diagnosis of dementia.

The 02/12/24 "Admission Resident Note" documented R3 felt like her family "tricked" her into going to the facility. She was alert and oriented to self and family with short-term memory loss.

The 02/13/24 "Admission Follow Up Resident Note" documented R3 appeared agitated and expressed she was ready to leave.

The 03/11/24 "Check up Resident Note" documented R3 threatened to "jump over the fence and go home."

The 04/12/24 "Resident Note" documented R3 wrote a letter to staff informing them she would heal soon and go back home.

Review of the "Chore Recap Check Doors and Gates" log from 07/08/24 night shift to 07/10/24 day shift revealed facility staff documented doors and gates secured each shift.

The 07/16/24 facility's "Investigation Report" to

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the department documented facility staff observed R3 walking the pathway in the secured back courtyard on 07/09/24 during a 30-minute visual check at an unreported time. She was on visual checks every 30 minutes because of her anger at having to be at the facility. Facility administrative staff reviewed video footage from 07/09/24 and documented the following in the "Investigation Report":

04:37 PM - R3 entered the back door of the building.
04:38 PM - R3 walked from the back of the building to the front and exited the front door to the outside. R3 walked in the driveway and across the front yard before she went out of view of the camera.
04:58 - R3 returned within view of camera, walked to front porch and rang the doorbell.

The facility's "Investigation Report" further documented staff on duty when R3 exited the building reported they checked the back courtyard gates which were secured. Staff reported they had to manually push the front door shut. The nurse checked the door and observed it did not close adequately. She notified maintenance who repaired the door to ensure it closed properly. R3 did not remember she had been outside.

The 03/12/25 "Witness Statement" by Certified Medication Aide (CMA) C reported she last saw on R3 on 07/09/24 walking the pathway in the secured back courtyard at approximately 04:30 PM before R3 rang the front doorbell at approximately 05:00 PM.

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S5026	Continued From page 3 Review of the facility's quarterly reviews of the emergency management plan revealed the plan included how to respond if a resident was missing. Designated staff reviewed the plan with residents and staff on 05/03/24 and 07/26/24. Observation on 03/12/25 at approximately 09:00 AM revealed the vicinity of the facility where R3 may have walked while she was out of the facility without staff supervision for 20 minutes. The facility was located on the southwest corner where a residential street intersected a four-lane heavily traveled street with a speed limit of 40 miles per hour (mph). To the north and west of the facility was an area of curved streets that wound through a residential area. South of the facility was a six-lane elevated freeway with direct access from the four-lane street near where the facility was located. The distance per web-based map application from the facility to the six-lane freeway was 0.3 miles with an estimated walking time of seven minutes. Observation on 03/12/25 at 10:51 AM revealed the back yard to the building was surrounded by a tall wood fence with one gate that was locked. A concrete curved pathway circled through the backyard. Observation 03/12/25 at 10:53 AM revealed the front door was keypad locked and unable to open. Administrative Nurse B used a code to unlock the door and opened it. An auto-close mechanism installed on the door ensured the door closed, latched, and locked. An alarm installed on the door did not activate when the door opened.	S5026		

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On 03/12/25 at 11:35 AM Administrative Nurse B stated R3 had short-term memory loss.

On 03/12/25 at 12:53 PM Administrative Staff A stated she viewed the video footage when R3 exited the facility and observed she first walked west toward the residential neighborhood then walked east toward the four-lane street before R3 disappeared out of view of the camera.

On 03/12/25 at approximately 01:15 PM Administrative Staff A stated the alarm installed on the front door was turned off at the time R3 exited the facility. Facility staff utilized the alarm only when residents lived there who exhibited wandering behavior. There were no current residents who wandered. Facility staff completed visual checks for R3 every thirty minutes because she R3 verbalized she did not want to be in the facility. She was angry with her family for making her move there. R3 never tried to leave the facility unsupervised before 07/09/25.

On 03/12/25 at 01:49 PM Administrative Nurse B stated staff provided R3 visual checks every 30-minutes while she was in the facility and documented the time and R3's location in a notebook. Staff removed all documentation of visual checks prior to 03/01/25 from the notebook and shredded it.

The weather per Weather Underground at Wunderground.com on 07/09/24 at 04:53 PM was sunny and fair with a temperature of 88 degrees Fahrenheit (F) and a wind speed of 9 mph.

The facility's 08/11/23 "Elopement Prevention"

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policy documented open doors, unsecured doors, or deactivated door alarms put all residents at risk for elopement. Staff would do walking rounds at the beginning and end of each shift to ensure all residents were accounted for and in a safe location, and that all doors and gates were locked and functioned properly. Staff observed residents a minimum of every 15 minutes while in the back courtyard to ensure it was still safe for them to continue being outside, offer them water if the temperature was above 70 degrees F, and redirect them back inside if they appeared distressed.

The administrator failed to protect R3 from neglect by the failure to ensure staff secured all exit doors. Cognitively impaired R3 exited the facility through an unsecured door to the outside without staff knowledge on 07/09/24 at 04:37 PM and returned at 04:58 PM

Jeopardy was removed when the following actions were implemented by the facility as outlined in the 03/12/25 "Abatement Plan" and accepted by the department on 03/12/25 at approximately 05:30 PM.

1) Facility staff continued to provide previously implemented 30-minute visual checks for R3.
2) On 07/10/24 staff reported to the operator the front door had to be pushed closed because it did not always close securely and R3 had exited the front door on 07/09/24.
3) On 07/10/24 a handwritten note was posted on the front door with instructions for users to ensure the door closed securely when entering or exiting the building.
4) On 07/10/24 alarms previously installed on

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S5026	Continued From page 6 all exit doors were turned on to alert staff when doors opened. 5) On 07/10/24 administrative staff educated staff to observe location of residents and follow elopement precautions. 6) On 07/11/24 staff replaced the handwritten note with a laminated sign informing users to ensure the door closed securely when entering or exiting the building. 7) On 07/11/24 administrative staff educated staff to report immediately when doors would not close properly. 8) On 07/12/24 administrative staff entered a work order in the facility's electronic maintenance system to assess the front door for repair needs. Maintenance staff adjusted the auto-close mechanism at 11:21 AM, noted the mechanism needed replacement, and ordered a new heavier auto-close mechanism. 9) On 07/19/24 maintenance staff installed the new auto-close mechanism on the front door. 10) From 07/24/24 through 07/29/24 administrative staff provided all staff on all shifts elopement education. 11) Maintenance staff complete routine checks on all doors weekly on Tuesday to ensure doors worked properly .	S5026		
S5028 SS=D	26-42-101 (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 home 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:	S5028		

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S5028	Continued From page 7 (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. This REQUIREMENT is not met as evidenced by: KAR 26-42-101(f)(3) The facility reported a census of 10 residents with three residents included in the sample. Based on interview and record review the operator failed to complete an investigation and submit it within 24 hours of an initial report to the department of alleged neglect. Findings included: - Record review for Resident (R) 3 revealed an admission date of 02/12/24 with the following	S5028		

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S5028	Continued From page 8 diagnoses: memory impairment, recurrent falls, alcoholic gastritis, dementia. The 02/13/24 "Functional Capacity Screen" (FCS) identified R3 was independent with walking and mobility but unable to perform management of medications and treatments and was identified as having impaired cognition. The 02/13/24 "Negotiated Service Agreement" (NSA) identified facility staff would provide R3 administration and ordering of medications and management of treatments. Cognition was not addressed on R3's "NSA." The 07/15/24 Intake Report indicated that on 07/09/24 at 04:58 PM, R3 rang the front doorbell attempted to re-enter the facility. The security camera later showed that R3 had eloped at 04:38 PM through the same front door. Interview on 03/12/25, administrative staff A confirmed she did not report the incident on 07/09/44 to the department within 24 hours. Administrative staff A failed to complete an investigation and report to the department within 24 hours of an initial report of alleged neglect.	S5028		
S5251 SS=D	26-42-105 (f) (11) Resident Records 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.	S5251		

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S5251	Continued From page 9 This REQUIREMENT is not met as evidenced by: KAR 26-42-105(f)(11) The facility reported a census of 10 residents with three residents included in the sample. Based on interview and record review, the operator failed to ensure designated staff provided adequate documentation when Resident (R)3 exited the facility without staff knowledge. Findings included: Record review for R3 revealed an admission date of 02/12/24 with diagnoses of memory impairment, recurrent falls, alcoholic gastritis, dementia. The 02/13/24 "Functional Capacity Screen" (FCS) identified R3 was independent with walking and mobility but unable to perform management of medications and treatments and was identified as having impaired cognition. The 02/13/24 "Negotiated Service Agreement" (NSA) identified facility staff would provide R3 administration and ordering of medications and management of treatments. Cognition was not addressed on R3's "NSA." The 07/15/24 Intake Report indicated that on 07/09/24 at 04:58 PM, R3 rang the front doorbell attempted to re-enter the facility. The security camera later shows that R3 had exited the facility without staff knowledge at 04:38 PM through the same front door.	S5251		

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S5251	Continued From page 10 Administrative staff A confirmed in an email dated 03/13/25 that the shift nurse failed to document the incident on 07/15/24. Operator A failed to ensure designated staff provided adequate documentation when R3 exited the facility without staff knowledge from the facility and returned 20 minutes later.	S5251		