

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175363	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/20/2025
NAME OF PROVIDER OR SUPPLIER Medicalodges Frontenac		STREET ADDRESS, CITY, STATE, ZIP CODE 206 S Dittman Street Frontenac, KS 66763	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34056</p> <p>The facility reported a census of 38 residents with three residents reviewed for elopement. Based on interview, interview and record review, the facility failed to prevent one Resident (R)1 from exiting the facility, unattended.</p> <p>Findings included:</p> <ul style="list-style-type: none"> - Review of Resident (R)1's electronic medical record (EMR) revealed a diagnosis of depression (a mood disorder that causes a persistent feeling of sadness and loss of interest). <p>The Admission Minimum Data Set (MDS), dated [DATE], documented the resident had a Brief Interview for Mental Status (BIMS) review of 13, indicating intact cognition. He had limitation in range of motion (ROM) on one side of his upper extremity and used a motorized wheelchair. He was independent in wheeling 150 feet in his wheelchair.</p> <p>The Functional Abilities Care Area Assessment (CAA), dated 02/02/25, documented the resident required substantial to maximal assistance of staff for transfers.</p> <p>The care plan, revised 02/25/25, lacked staff information regarding the resident being at risk for elopement.</p> <p>The care plan, revised 03/16/25, instructed staff the resident had a history of an attempt to exit the facility unattended. The staff were instructed the resident had an impairment in his safety awareness.</p> <p>Review of the resident's EMR revealed an Elopement Assessment, dated 01/29/25, which revealed the resident was not at risk for elopement.</p> <p>Review of the resident's EMR revealed an Elopement Assessment, dated 03/16/25, which put the resident at risk of elopement.</p> <p>Review of the resident's EMR from 01/29/25 through 03/15/25, revealed no documentation of the resident having a behavior of wandering.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175363	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/20/2025
NAME OF PROVIDER OR SUPPLIER Medicalodges Frontenac		STREET ADDRESS, CITY, STATE, ZIP CODE 206 S Dittman Street Frontenac, KS 66763	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the resident's EMR, on 03/16/25, revealed staff visualized the resident at the dining room table in his motorized wheelchair awaiting dinner, at approximately 05:00 PM.</p> <p>The facility investigation into the elopement revealed on 03/16/25 at approximately 05:03 PM, video surveillance showed the resident exiting the facility by the front doors in his motorized wheelchair. The door alarm sounded, and a family member of another resident was visualized turning the alarm off. Staff were unaware a resident had exited the facility. The facility was notified the resident was out of the facility and staff retrieved the resident and returned him to the facility 20 minutes after exiting the facility. Assessment revealed no injury to the resident.</p> <p>On 03/20/25 at 11:45 AM, Certified Nurse Aide (CNA) M stated there was an elopement book at the nurses' station which contained photos and resident information of each resident who was at risk for elopement.</p> <p>On 03/20/25 at 03:29 PM, CNA N stated the elopement book had all the staff information for the residents who are at risk of elopement.</p> <p>On 03/20/25 at 04:01 PM, CNA O stated the elopement book was kept in the nurses' station with the names and pictures of the residents who were at risk of elopement. CNA O stated she would report any exit seeking behavior to the nurse.</p> <p>On 03/20/25 at 02:07 PM, Licensed Nurse (LN) G stated she had seen the resident at the dinner table at approximately 05:00 PM on the day of the elopement. The facility was notified of the resident being out of the facility and staff went to pick up the resident approximately one block from the facility. LN G stated she assessed the resident, and he had no injuries upon return to the facility.</p> <p>On 03/20/25 at 01:04 PM, Administrative Staff A stated he had been notified of the resident being outside of the facility via phone call on 03/16/25. Administrative Staff A stated he notified the facility immediately and went into the facility to begin an investigation into how the resident was able to exit the facility without staff knowledge. Administrative Staff A stated he obtained staff interviews and reviewed the video footage which showed the resident exit the facility in his motorized wheelchair, unassisted. The video revealed another resident's family member turn the door alarm off using the code. The family member did not notify staff that she had turned the alarm off. Administrative Staff A stated staff returned the facility to the facility where he was assessed and found to be uninjured. Administrative Staff A completed staff education on elopement.</p> <p>The facility policy for Resident Elopement Policy and Procedure, revised 12/2017, included: The facility strives to promote a safe and secure environment to help minimize risk of residents leaving the premises without the necessary supervision or authorization to do so.</p> <p>The facility failed to prevent this dependent resident from exiting the facility unattended.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175363	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/20/2025
NAME OF PROVIDER OR SUPPLIER Medicalodges Frontenac		STREET ADDRESS, CITY, STATE, ZIP CODE 206 S Dittman Street Frontenac, KS 66763	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0732</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Post nurse staffing information every day.</p> <p>34056</p> <p>The facility reported a census of 38 residents. Based on observation, record review and interview, the facility failed to display accurate, publicly accessible, and identifiable staffing information, daily, for the 38 residents who reside in the facility.</p> <p>Findings included:</p> <ul style="list-style-type: none"> - Review of the facility's Daily Staffing Sheets, from 01/01/25 through 03/19/25, revealed the actual hours worked had not been completed on the daily staffing sheets. <p>On 03/20/25 at 03:07 PM, Administrative Nurse D, stated she noticed on 03/20/25 that the forms did not include actual hours worked, as required</p> <p>The facility policy for Benefits Improvement Protection Act (BIPA) Nurse Staff Posting, revised 12/19, included: The actual hours worked by licensed and unlicensed nursing staff directly responsible for resident care by shift will be recorded on the Daily Staff Posting form.</p>