

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175417	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/09/2024
NAME OF PROVIDER OR SUPPLIER Frankfort Community Care Home		STREET ADDRESS, CITY, STATE, ZIP CODE 510 N Walnut Street Frankfort, KS 66427	

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 - Immediate jeopardy to resident health or safety</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** 43204</p> <p>The facility identified a census of 33 residents with three residents reviewed for elopement. Based on record review, observation, and interview, the facility failed to provide adequate supervision to prevent cognitively impaired Resident (R) 1, identified at high risk for elopement, from eloping through a facility window. On 03/30/24 at 03:00 PM, R1 sat at the end of the North hall and looked out the window. R1's home was visible from the North hall window. At 03:05 PM, R1's neighbor in the community noticed R1 walking towards the resident's home. A little while later, the neighbor noticed R1 sitting on his porch at his home and at 03:40 PM, the neighbor called the facility and alerted Administrative Nurse D to R1's location. Upon investigation, Administrative Nurse D noted the window at the end of the North hall was missing the screen, which was observed on the ground outside the facility. It appeared R1 removed the screen and stepped through the full-size window. R1 wore a Wander Guard (a bracelet that sets off an alarm when residents wearing one attempt to exit the building without an escort), but it did not alert as R1 exited via the window and not the door. R1's DPOA came to the facility after being alerted by the neighbor that R1 was at the house. R1 refused to return to the facility initially but after speaking to Law Enforcement, R1 returned to the facility with no apparent injuries. R1 wore a shirt, sweater, jeans, and shoes. The temperature at the time was 60 degrees Fahrenheit. The facility staff was unaware R1 was outside the facility for 40 minutes when staff were alerted by a community member. This facility failed to provide adequate supervision to R1 to prevent elopement. This placed R1 in immediate jeopardy.</p> <p>Findings included:</p> <ul style="list-style-type: none"> - R1's Electronic Medical Record (EMR) documented R1 had diagnoses of dementia (a progressive mental disorder characterized by failing memory, and confusion), a need for assistance with personal care, and localized swelling of bilateral (both sides) lower limbs. <p>The Admission Minimum Data Set (MDS) dated [DATE] documented R1 had a Brief Interview for Mental Status (BIMS) score of 10, which indicated moderately impaired cognition. The MDS documented R1 required supervision or touching assistance for ambulation. R1 was independent with most other activities of daily living (ADL) except bathing and transfers into and out of the shower. The MDS documented R1 had verbal behaviors directed towards others, other behavioral symptoms, and wandering for one-to-three days during the assessment period. The MDS documented R1 did not have a history of falls.</p> <p>The Cognitive Loss/Dementia Care Area Assessment (CAA), dated 03/28/24, documented R1 was cognitively impaired and was at risk for elopement and an ADL decline.</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 175417
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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>The Health Status Note, dated 03/23/24, documented R1 was resistant to hands-on assistance and was unsteady on his feet. Staff provided one-on-one to R1. R1 stated, I just want to walk around by myself. Staff informed R1 they did not want him to fall.</p> <p>The Health Status Note, dated 03/23/24, documented R1 had no safety awareness, was unsteady on his feet, and did not have the cognitive ability to ask for help. R1 walked toes-out and his heels hit each other, which at times caused R1 to trip himself.</p> <p>The Health Status Note, dated 03/23/24, documented R1 wandered out of his room that evening. Staff found R1 attempting to go into another resident's room and take their wheelchair. Staff redirected R1 back to his room. R1 was disoriented but did know his house was down the street. R1 remembered his family dumped him here and continued to be upset.</p> <p>The Health Status Note, dated 03/24/24, documented R1 was wandering and exit seeking and pushing hard on the North door. One-to-one was provided to R1 and R1 settled down to sit in the North hall and gaze at his house with tears in his eyes.</p> <p>The Health Status Note, dated 03/27/24, documented R1 had been upset all day. R1's family member and the assessment coordinator from a local agency visited R1. R1 became agitated and threw his clothes and candy out in the hall and yelled at his family member. R1's visitors left and R1 continued to yell at staff saying he needed to get out and go home. The staff allowed R1 to voice his frustration and provided reassurance. R1 calmed down but remained alert to the doors.</p> <p>The Health Status Note, dated 03/29/24, documented R1 was upset that morning. Multiple families and children were at the facility for the Easter egg hunt. R1 banged on the North door and yelled at staff to get back when they attempted to redirect R1. A Certified Nurse Aide (CNA) tried to have R1 sit in a chair at the end of the hall to watch the children and R1 went to the chair and flipped it over stating, I've got to get out!</p> <p>The Incident Note, dated 03/30/24, documented Administrative Nurse D received a phone call from an unknown caller who reported R1 was sitting on the front porch at R1's house. The caller reported he also called R1's son and R1's son was on his way to the care home. Administrative Nurse D met R1's son outside the care facility and phoned 911. R1's son stated R1 was sitting on the porch and refused to return to the care home. Administrative Nurse D sent Licensed Nurse (LN) G to R1's house to sit with R1 until the Sheriff's officer arrived. Administrative Nurse D notified Administrative Staff A and Administrative Nurse E. Administrative Nurse D started to investigate possible exit routes R1 took to elope from the facility. Administrative Nurse D walked down the North hall and noted the window at the end of the hall was slightly open. Administrative Nurse D observed the window screen was not in place and the screen was found outside the window on the ground. R1 admitted to LN G he climbed out the window. R1 ambulated back to the facility with standby assistance from LN G. Staff provided one-to-one supervision with R1 and a skin assessment was completed that showed no signs of injury or harm.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>LN G's Witness Statement, dated 04/01/24, documented Administrative Nurse D called LN G to the nurse's station and told LN G that R1 got out of the facility and walked home. LN G saw R1 around 02:30 PM walking in the hall between the North door and R1's room. The Sheriff's office was notified and R1's son and LN G went to R1's house and sat with R1 on his porch. R1 was cooperative. LN G visited with R1, R1's son, and the Sheriff for a while. R1 had found the hidden key to his house to get in. R1 eventually gave the key to the Sheriff. R1 asked LN G if we knew how he got out. R1 decided he would come back to the facility. R1 ambulated back to the facility and no injuries were noted.</p> <p>CNA M's Witness Statement, dated 04/01/24 documented CNA M saw R1 sitting in the chair at the end of the North all at approximately 03:00 PM (on 03/30/24).</p> <p>The Facility Incident Report, dated 04/04/24, documented at approximately 03:40 PM Administrative Nurse D received a phone call from R1's neighbor who visualized R1 sitting on the porch at R1's house. Administrative Nurse D sent LN G with R1's responsible party to R1's house to sit with R1 until the officer arrived. Administrative Nurse D notified Administrative Staff A and Administrative Nurse E. Administrative Nurse D began investigating the probable exit route R1 took to elope from the facility. Administrative Nurse D walked down the North hall and noted the window at the end of the hall was slightly opened. Upon further inspection, it was noted there was no screen in place and the screen was found outside the window on the ground. The neighbor told LN G he saw R1 walking to his house at about 03:05 PM. The neighbor also stated he had not called anyone for approximately fifteen minutes. Witness statements were obtained, and it appeared R1 was last seen at approximately 03:00 PM sitting in a chair at the end of the North hall looking out the window. R1 wore a checkered white and black button-up shirt, black zip-up sweater, jeans, black shoes, and no glasses or hat. The temperature was around 60 degrees F. The on-call provider was notified of the elopement at approximately 04:00 PM. Per the Wander Risk Scale Assessment, R1 was a high risk of wandering. This information led to a WanderGuard placement and a room selection with a window that led to the locked courtyard. Interventions placed since admission included one-to-one care completed at times, to listen to the resident and attempt to provide comfort and safety, distract the resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, and books. Staff were to identify patterns of wandering and intervene as appropriate. The WanderGuard and elopement binder were updated at the time of admission. R1 had expressed to staff that he felt his family dumped him here. R1 was often seen staring out the North hall window at his house. Staff had placed some plants at the North hall window so R1 was not as easily able to visualize his home. R1 reported during the care meeting that he did not want to be moved to another facility. He stated that he will try to be good. R1's responsible party said R1 enjoyed eating at the nutrition center across the street from the care home. Staff would call the nutrition center to set up scheduled lunches for some days for R1 or offer to assist R1 in the nutrition center to socialize and have a meal there. The activity director would offer to cook with R1 as he stated he enjoyed cooking. Staff would encourage R1 to go on walks as he stated he enjoyed this. Per R1's responsible party, R1 used to enjoy sitting at the local gas station drinking coffee. Staff would encourage R1 to go to the coffee activity every Thursday in the dining hall. R1's responsible party stated he would offer to assist the resident out of the facility for outings. The report documented the root cause was multifaceted and included a dementia diagnosis, the proximity of R1's house to the care facility, which was directly observable from the care home windows, and R1's responsible party's deceptive presentation of his admission as temporary for an ice cream social, which may have prevented R1 from adjusting to placement.</p> <p>On 04/09/24 at 10:30 AM, observation revealed R1 napped in his recliner with the door of his room shut. R1 had a WanderGuard on his wrist.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 04/09/24 at 11:00 AM, Administrative Nurse D stated R1's family did him a disservice when they tricked him into coming to the facility and then left him there. Administrative Nurse D stated at times, R1 remembered everything that happened that day and other times remembered none of it, but it was traumatic for R1.</p> <p>On 04/09/24 at 11:30 AM, Administrative Staff A stated she did not think there was anything the facility could have done to prevent the elopement from occurring. Administrative Staff A stated R1 told her that he was surprised he did not fall on his trip home. Administrative Staff A stated maintenance placed spacers on the windows in the North hall and were in the process of placing spacers on all windows that exited to the outside of the facility, so the windows only opened a bit. Administrative Staff A stated the facility was going to try to get a different placement for R1 that was locked, but R1 pleaded for the facility not to find another placement for him because he would try to be good.</p> <p>The facility's Wandering and Elopements Policy, dated March 2019, documented the facility will identify residents who are at risk for unsafe wandering and strive to prevent harm while maintaining the least restrictive environment for residents. If identified as at risk for wandering, elopement, or other safety issues, the resident's care plan will include strategies and interventions to maintain the resident's safety.</p> <p>The facility failed to provide adequate supervision to prevent cognitively impaired R1, a resident at high risk for elopement, from eloping through a facility window on 03/30/24. This placed R1 in immediate jeopardy.</p> <p>The facility implemented the following corrective actions by 04/08/24:</p> <p>Maintenance ensured a window security system was installed to prevent windows from opening more than 10 inches. Maintenance staff are routinely checking the functioning of the window security.</p> <p>R1's responsible party brought more items from home to enhance a homelike environment for R1.</p> <p>The facility set up R1 to have some meals at the nutrition center and staff will accompany the resident. Staff encourage R1 to perform activities he enjoys like cooking and attending the coffee groups.</p> <p>All staff were educated on the Wander and Elopement Policy and procedures.</p> <p>All corrective actions were implemented before the onsite survey therefore the deficient practice was deemed past noncompliance and remained at the scope and severity of J.</p>		