STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175417	A. Building B. Wing	05/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Frankfort Community Care Home	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)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43204 The facility identified a census of 37 residents with three residents reviewed for abuse and neglect. Based on record review, observation, and interview, the facility failed to protect Resident (R) 1 from intimidation and abuse. This placed R1 at risk for impaired psychosocial well-being and ongoing abuse. Findings included: - R1's Electronic Medical Record (EMR) documented R1 had diagnoses of dementia (a progressive mental disorder characterized by failing memory, and confusion), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), and high blood pressure. The Admission Minimum Data Set (MDS), dated [DATE] documented the Brief Interview for Mental Status (BIMS) could not be completed because R1 was rarely/never understood. The MDS documented R1 had short-term and long-term memory problems and had severely impaired cognition. The MDS documented R1 required substantial/maximum assistance with all her activities of daily living (ADLs) except eating. The MDS documented R1 had physical and verbal behaviors directed towards others and had wandered. The MDS documented R1 had a history of falls and R1 had fallen once since admission resulting in a minor injury. The Cognitive Loss/Dementia Care Area Assessment (CAA), dated 04/20/24, documented R1 was a new admission from the hospital due to a fall with a head injury. R1 presented with dementia. R1 had cognitive impairment. R1 had exhibited frequent crying, repeated movements, pinching, scratching or spitting, wandering, and threatening behaviors. R1 was at risk for declines in functioning, communication, and falls. The goal was to avoid complications related to R1's cognitive impairment and meet R1's needs. R1's Care Plan directed staff R1 required assistance with all of her ADLs and staff to provide the necessary assistance for all ADLs to be completed. The care plan documented R1 had frequent agitation and anxiety and directed staff to anticipate and meet R1's needs and assist R1 when she was feeling restless by offering her a drink, or a snack, toileting, and assessing her pain or discomfort. The care plan directed staff to monitor R1's social and environmental factors such as sleep disturbance, poor or excessive lighting, loud noises, or uncomfortable temperatures. (continued on next page)

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Health Status Note, dated 04/18/24, documented R1 was alert only to herself and had extremely poor short-term memory. R1 had no safety awareness and remained one-on-one with staff at all times. R1 continued to be restless, anxious, and agitated. Staff attempted to lay R1 in her bed per her request at 10:45 PM but R1 began to talk loudly and would not stay in bed. R1 constantly attempted to get up from the recliner and wheelchair and asked to walk. Staff ambulated with R1 and R1 attempted to discard the walker along the way. R1 became argumentative and agitated when staff reminded R1 that the walker was for her safety and balance. R1's gait remained unsteady. R1 was difficult to redirect. R1 remained in the living room area. The Health Status Note, dated 04/29/24, documented R1 was in the nurse's station for one-on-one staff supervision. R1 started to cry. This nurse went to her and hugged R1. R1 stated, Please hold me, please hold me, and don't let go. I'm so scared. I don't know what's happening. This nurse held R1 for a few minutes and she settled down some. R1 was covered with a blanket. The intervention was effective for seven minutes and then R1 began to get agitated again. The Health Status Note, dated 05/02/24, documented recent medication changes had helped R1's mood in the evening significantly. R1 was anxious and restless that evening per her baseline but not as agitated. R1 remained on one-on-one staff supervision at all times while awake. R1 spent the evening eating snacks, playing with fidgets, looking at crossword puzzles, and ambulating around the facility with one staff assistant and walker to aid with restlessness. R1 napped briefly on the couch in the living room before being assisted to bed at 10:30 PM. The certified nurse aide (CNA) sat with R1 until she fell asleep. R1 remained in bed with her eyes closed. Frequent visual checks were performed. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility Incident Report, dated 05/07/24, documented on 05/04/24 at approximately 07:00 PM, Administrative Nurse D received a text message from Social Services Designee/Certified Medication Aide (CMA) X who reported Licensed Nurse (LN) G had pulled R1 down in her chair super hard. Administrative Nurse D called Social Services Designee X for more information and Social Services Designee X stated LN G had slammed R1 down in her chair. Administrative Nurse D and Administrative Nurse E entered the facility immediately and had LN G fill out a witness statement and then took over LN G's shift as she was escorted out of the facility. A review of camera footage revealed R1 was resting in her wheelchair at approximately 06:50 PM in the nurse's station. R1 stood up, LN G turned in her chair, reached out her arm and R1 leaned back and sat back down in her wheelchair. A skin assessment was completed on R1 with no signs of injury from the incident. On 05/06/24, the sheriff's office was notified and a sheriff's officer entered the building reviewed the camera footage and witness statements, and stated it did not appear anything criminal had happened. R1's responsible party was notified. R1's primary care physician was notified. The facility's medical director was notified. The ombudsman was e-mailed and notified of three resident interviews being completed with no concern noted. Upon further investigation, the facility did not have LN G's education and credentials from her agency on file before she began her shift. LN G did have the abuse education as of 02/01/24. After a review of the statements, the facility care team found the abuse allegation unsubstantiated. It was found LN G needed education regarding dementia care and the safe handling of residents. Going forward, the facility will ensure that all agency staff have completed the facility's staffing agency policy training and orientation. Verification would be obtained to confirm the staff agency meets long-term care regulatory guidelines for hiring processes and safety. The following policies were e-mailed to LN G's supervisor for educational purposes: Activities of Daily Living support, Programming for residents with cognitive impairment and other special needs, Safe Lifting and Moving of Residents, and Behavioral Assessment, Interventions, and Monitoring. The facility will not have LN G back to work at this facility. Staff will continue to follow the facility's abuse policy. The allegation was reported immediately per policy. LN G was removed from work immediately. Staff will ensure that all agency staff will complete the facility's training and orientation policy. Social Service Designee/CMA X's Witness Statement, dated 05/08/24, documented Social Service Designee/CMA X documented LN G was sitting at the nurse's station on her phone with R1 nearby. R1 stood up and as Social Service Designee/CMA X was telling LN G R1 was standing up LN G turned around, grabbed R1 by her pants, and pulled R1 back. As R1 was falling back into her chair, R1 screamed and plopped into her wheelchair. LN G then started scolding R1 very loudly. CNA M's Witness Statement, dated 05/08/24, documented CNA M had stopped by the nurse's station and LN G asked CNA M if R1 was in bed. CNA M stated no R1 stayed up fairly late and was a total one-on-one. CNA M noted that LN G stated she was not going to put up with R1 all night because it would drive her crazy. LN G then proceeded to tell CNA M she did not like dementia patients because they were dumb, and you could not have a conversation with them. CNA N's Witness Statement, dated 05/08/24, documented that CNA N went to the nurse's station and heard LN G state she was about to jump out the window because R1, who was sitting in the nurse's station was talking a lot. CNA O's Witness Statement, dated 05/08/24, documented, that CNA O was at the nurse's station and LN G told her LN G had worked with pediatrics and old people, but demented patients got on her nerves because you cannot have a conversation with them. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	LN G's undated Witness Statement documented R1 was left in the nurse's station to be babysat because she was unable to control herself. R1 was constantly getting up out of her chair claiming she had to go to work. R1 had already had one fall in the past twenty-four hours and for her safety, she needed to stay in the safety of her wheelchair. LN G stated she was trying to get her work and charting done and behind her back, R1 was standing and trying to walk away. LN G stated she quickly turned around to see R1 and LN G put her arm out to keep her in the chair. It happened so quickly it may have looked not so smooth but the staff did not need another fall by R1 in two days. On 05/20/24 at 10:30 AM, observation revealed R1 sat in a recliner in the living room with her legs elevated. A blanket covered R1. R1 slept. On 05/20/24 at 10:45 AM, observations revealed video footage of the nurse's station. LN G was sitting at the desk in front of a computer. R1 was sitting to the right and back of R1 in her wheelchair. R1 stood up and took a couple of shuffled steps. LN G reached out her arm and R1 plopped down into her wheelchair. On 05/20/24 at 10:50 AM, Administrative Nurse D stated the facility had decided not to have LN G back to the facility as an agency nurse as it appeared she needed more training with dementia care. Administrative Nurse D stated the facility did not feel there was enough evidence to substantiate abuse. On 05/20/24 at 10:55 AM, Administrative Staff A stated that based on the video footage and the angle of the camera the facility could not substantiate the allegation of abuse. The facility's Abuse and Neglect Clinical Protocol, revised March 2018, documented abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish and will not be tolerated by the facility. The facility failed to protect R1 from intimidation and abuse. This placed R1 at risk for impaired psychosocial well-being and ongoing abuse.