

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 04/28/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>175353</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C <b>04/28/2016</b>
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NAME OF PROVIDER OR SUPPLIER  <b>ARMA OPERATOR, LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>605 E MELVIN STREET PO BOX 789 ARMA, KS 66712</b>
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F 000	INITIAL COMMENTS	F 000		
	The following citations represent the findings of complaint investigation # 99420.			
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES	F 323		
	<p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This Requirement is not met as evidenced by: The facility reported a census of 38 residents, with 3 residents selected for review of elopement. Based on observation, interview, and record review, the facility failed to ensure 1 of the 3 sampled residents ( #1) reviewed for elopement, received adequate supervision and/or assistive devices to prevent this resident's elopement from the facility without staff knowledge.</p> <p>Findings included:</p> <ul style="list-style-type: none"> <li>- The signed physician orders, dated 4/4/16 of resident #1, documented the resident admitted on 4/4/16 , with the following diagnoses including major depressive disorder (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness), Alzheimer ' s ( progressive mental deterioration characterized by confusion and memory failure), and dementia (progressive mental disorder characterized by failing memory, confusion) with behavioral disturbance.</li> </ul> <p>The admission MDS (minimum data set), dated</p>			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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.

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F 323	<p>Continued From page 1</p> <p>4/12/16, revealed the resident had a BIMS (brief interview for mental status) score of 7, indicating severely impaired cognition. The resident had inattention and disorganized thinking, and the behavior was present continuously.</p> <p>The 14 day MDS, dated 4/18/16, revealed the resident had a BIMS score of 10, indicating moderately impaired cognition. The resident had inattention and disorganized thinking that fluctuated. The resident had wandering behavior which occurred on 1 to 3 days during the assessment.</p> <p>The CAA (care area assessment) completed on 4/16/16, for cognition, revealed the resident had impaired decision making and long term memory loss.</p> <p>The care plan, dated 4/4/16, revealed the resident was unaware of safety needs, and the resident wore a wander bracelet due to the wandering. On 4/13/16, the resident required one to one care. The care plan identified on 4/12/16 an actual elopement. The care plan guided staff to pin the wander guard on the resident's back as the resident attempted to remove the bracelet. The care plan also guided staff to monitor and record occurrence of target behavior symptoms from psychotropic medications.</p> <p>Review of the nurse's notes on 4/5/16, revealed the resident's behaviors increased, and was stating he/she wanted to leave. On 4/6/16, the resident wandered most of the night, and indicated to the staff he/she wanted to leave. On 4/12/16 at 7:15 pm, the resident's family notified the facility staff the resident could possibly be upset because the family was leaving. At approximately 8:30 pm, the staff were unable to</p>	F 323			

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F 323	<p>Continued From page 2</p> <p>locate the resident in the facility. The facility called the family and the police department, and the police department notified the facility they ( the police department) received a phone call indicating someone picked up someone, and it could be the same person. The family had a police scanner, heard the conversation, went to the business, picked up the resident and transported the resident back to the facility.</p> <p>Review of the nurse's notes, dated 4/17/16, in the evening hours, revealed the resident attempted to exit out of the north east door, and was redirected.</p> <p>Review of the follow-up elopement incident, dated 4/13/16, revealed the resident was confused, and identified the resident for active exit seeking, and ambulated without assistance. At approximately 8:30 to 8:35 pm, the front door and the north east exit door alarmed. The staff responded to the front door, and then to the north east door alarm.</p> <p>On 4/27/16 at 12:12 pm, administrative nursing staff A, stated staff notified him/her, on the evening of the resident's elopement at 8:40 pm, that the resident eloped from the facility. The staff searched, and called the police department and family. The family heard the report on the police scanner, went to the business where the resident was taken by a delivery driver, and brought the resident back to the facility. Administrative nursing staff A, stated the delivery driver picked the resident up behind the facility, and across the street by a stop sign.</p> <p>On 4/27/16 at 1:25 pm, direct care staff B, stated the residents are checked "every so often," and all the aides check on the residents. If the exit</p>	F 323			

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F 323	<p>Continued From page 3</p> <p>door alarmed, the staff would search for a resident, and walk around the building to locate the resident. If unable to locate the missing resident, then he/she would notify the head nurse or the management. Most of the residents would have an elopement bracelet on. We just know they are an elopement risk. We just kept an eye on this resident, because he/she was a wanderer.</p> <p>On 4/27/16 at 4:06 pm, direct care staff C, stated being unaware of the exact time when the resident eloped, but in the evening, after everyone's cares were completed. Staff stated the front door sounded, and 5 seconds after the front door alarm sounded, the north east door alarmed. Direct care staff C, stated he/she knew it was this resident that left because the resident was agitated and wanted to go home.</p> <p>On 4/27/16 at 4:49 pm, direct care staff D, stated if a resident was a high elopement risk, the charge nurse would tell the staff. The charge nurse told the staff who had wander guards on. The wander guards work on the front door. There were elopement books at the nurse's station, and staff reviewed the book. If a door alarm sounded, then staff check the panel for the location, and go to that door. Direct care staff D, stated he/she checked the panel, and knew this resident was down the hall, and was aware of the resident's wandering behavior. A room check was conducted, and staff searched for the resident on and off the facility grounds.</p> <p>On 4/27/16 at 6:38 pm, licensed nursing staff E, stated residents at risk for elopement are placed in an book at each nurse's station.</p> <p>The facility's policy for elopement, dated 10/15, revealed for a resident that required increased</p>	F 323			

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F 323	Continued From page 4 monitoring of wandering, the charge nurse would initiate the elopement/wandering form. Staff would promptly report any resident who tried to leave the premises or suspected of being missing to the charge nurse or DON (director of nursing). If a resident was missing from the facility, initiate a search of the premises, if not located, notify the DON and administrator, resident's legal representative, physician, law enforcement, etc.  The facility failed to ensure adequate supervision to prevent this confused resident, from leaving the facility without the staff's knowledge.	F 323			