

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

PRINTED: 04/23/2013
FORM APPROVED
OMB NO. 0938-0391

| | | | | | |
|---|--|---|---|----------------------|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175418 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 04/22/2013 |
| NAME OF PROVIDER OR SUPPLIER PROVIDENCE LIVING CENTER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1112 SE REPUBLICAN TOPEKA, KS 66607 | | |
| (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) COMPLETION DATE | |
| F 000 | INITIAL COMMENTS | F 000 | | | |
| F 202 SS=D | <p>483.12(a)(3) DOCUMENTATION FOR TRANSFER/DISCHARGE OF RES</p> <p>When the facility transfers or discharges a resident under any of the circumstances specified in paragraph (a)(2)(i) through (v) of this section, the resident's clinical record must be documented. The documentation must be made by the resident's physician when transfer or discharge is necessary under paragraph (a)(2)(i) or paragraph (a)(2)(ii) of this section; and a physician when transfer or discharge is necessary under paragraph (a)(2)(iv) of this section.</p> <p>This REQUIREMENT is not met as evidenced by: The facility identified a census of 72 residents. Sample size included 1 resident reviewed for involuntary discharge from the facility. Based on observation, record review, and interviews the clinical record lacked justification of the discharge for 1 of 1(#1) resident of the sample.</p> <p>Findings included:</p> <ul style="list-style-type: none"> - Resident #1 had a diagnosis listed on the physicians order sheet of 3/2012 of Bipolar Disorder (a mental illness that causes episodes of severe high and low moods), and history of depression (condition of general emotional dejection, and withdrawal). <p>The Admission Minimum Data Set (MDS) 3.0 dated 4/12/12 documented a BIMs (Brief</p> | F 202 | | | |

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.

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

PRINTED: 04/23/2013
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175418 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 04/22/2013 |
|---|---|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER PROVIDENCE LIVING CENTER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1112 SE REPUBLICAN TOPEKA, KS 66607 | | |
| (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) COMPLETION DATE | |
| F 202 | <p>Continued From page 1</p> <p>Interview for Mental Status) score of 15 (cognitively intact), had a mood score of 9 (mild depression) had verbal behaviors symptoms directed toward others, screaming at others, cursing, at others, and rejected care 1-3 days in the 7 day observation period.</p> <p>The Quarterly MDS 3.0 dated 1/3/13 documented the BIMs score of 15, (cognitively intact) had a mood score of 11 (moderate depression) had verbal behaviors symptoms directed toward others, screaming at others, cursing, at others, and rejected care 1-3 days in the 7 day observation period.</p> <p>The updated care plan dated 1/17/13 listed the resident does not redirect when angry- yells and kicks doors- this behavior has decreased since admit. The resident did best when left alone, he/she will calm down and eventually apologize.</p> <p>A care plan intervention dated 4/30/12 listed when he/she becomes upset and began to yell he/she was rarely easily redirected. He/she followed staff, blocked staff and yelled repeatedly to attempt to resolve his/her issues although they were usually based on the fact he/she did not want to be here.</p> <p>Review of the resident's Quarterly treatment plan with psychologist dated 2/27/13 revealed the resident continued to have disruptive verbal yelling outbursts of anger which subsequently blew over. He/she did not like being slighted or ignored. He/she participated in resident council and would still like to go out to events despite his/her past proactivites.</p> | F 202 | | | |

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

PRINTED: 04/23/2013
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175418 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 04/22/2013 |
|---|---|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER PROVIDENCE LIVING CENTER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1112 SE REPUBLICAN TOPEKA, KS 66607 | | |
| (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) COMPLETION DATE | |
| F 202 | <p>Continued From page 2</p> <p>Review of nurses' notes from 10/12/12 to 4/3/13 revealed the resident continued to have episodes of yelling at staff and other residents, but no evidence of resident to resident physical altercations.</p> <p>The Notice of 30 Day Discharge dated 3/16/13 listed the reason: continued to have disruptive, aggressive behaviors that affected peers and was unable to diffuse these behaviors or the derogatory belittling comments to both staff and peers.</p> <p>Observation on 4/17/12 at 11:00 A.M. revealed the resident on the patio smoking, and responded in a calm voice to staffs' request for the resident to interview with the surveyor.</p> <p>Interview with the resident on 4/17/13 at 11:05 A.M. the resident stated he/she had a bad week in March around the 8th. He/she had bipolar disorder and post traumatic stress disorder (a mental health condition that is triggered by a terrifying event) (not listed in the resident's diagnoses) since 2001. He/she worked for a government agency and was not allowed to get medical treatment. He/she was at another nursing facility in the city and was " kicked out". The resident stated he/she had lived at the facility a year and wanted to return to the Kansas City area. I had some behaviors, I dropped a vase, and threw some things out of my room but I take an as needed medication and that helps. I told my friend that he/she could get some money out of my drawer and he/she did not put it back in the right spot and that was when I got upset about the money, and they would not let me go to talk to him/her about it. The quarters were found they</p> | F 202 | | | |

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

PRINTED: 04/23/2013
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175418 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 04/22/2013 |
|---|---|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER PROVIDENCE LIVING CENTER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1112 SE REPUBLICAN TOPEKA, KS 66607 | | |
| (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) COMPLETION DATE | |
| F 202 | <p>Continued From page 3</p> <p>were put back in the wrong spot. I also got upset when the beautician came and I had to wait for the order listed on the sheet, when it was always a first come first serve basis in line.</p> <p>Interview with licensed staff A and administrative staff A on 4/17/13 at 12:07 P.M. revealed the resident had verbal altercations with staff and residents. He/she would occasionally swing but would not connect. If a resident engaged in physical altercations with another resident it was be reported to the state agency as required, and if the resident wanted to report to the police, we would. The same was true if a resident struck a staff member, if staff wanted a police report, we would notify the police. Facility staff confirmed reports were made to the state agency on a regular basis for a resident who engaged in a physical altercation, but could not confirm those residents received a discharge notice from the facility.</p> <p>Interview on 4/17/13 at 12:55 P.M. with direct care staff A revealed the resident was very bullying and intimidating if there was something he/she wanted. He/she would not leave you alone. The resident got loud and would upset everyone until he/she got his/her way. This was not new.</p> <p>The clinical record lacked evidence the resident was a danger to the other resident's in the facility.</p> | F 202 | | | |