

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

Printed: 02/12/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175413	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/12/2016
NAME OF PROVIDER OR SUPPLIER MEDICALODGES PAOLA		STREET ADDRESS, CITY, STATE, ZIP CODE 501 ASSEMBLY LANE PAOLA, KS 66071		
(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 323 SS=D	<p>The following citations represent the findings of complaint investigations #96687 and #93170.</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <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 82 residents. The sample included 4 residents. Based on observation, interview, and record review, the facility failed to ensure 1 of the 4 sampled residents (#1) did not leave the facility without staff knowledge.</p> <p>Findings included:</p> <ul style="list-style-type: none"> - Resident #1's POS (Physician Order Sheet), dated 1-26-16, documented the resident readmitted to the facility on 1-21-16, with diagnoses including: Schizophrenia (psychotic disorder characterized by gross distortion of reality, disturbances of language and communication and fragmentation of thought) and psychosis (any major mental disorder characterized by a gross impairment in reality testing). <p>The Medicare 5-Day MDS (Minimal Data Set), dated 1-27-16, documented the resident was not steady but able to stabilize without staff assistance. His/her BIMS (Brief Interview for</p>	F 323		
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>Mental Status) score was 15, indicating the resident was cognitively intact. He/she had experienced a fall in the 2-6 months prior to readmission. Resident had hallucinations and delusions present. The resident experienced inattention, disorganized thinking and an altered level of consciousness. He/she had no wandering or rejection of care.</p> <p>The CAA (Care Area Assessment) for cognition, dated 1-27-16, documented the resident had impaired cognition which could lead to poor decision making, injury, changes in moods and behaviors, a decline in cognition and physical functioning, decreased independence and impaired communication.</p> <p>The CAA for psychotropic drug use, dated 1-27-16, documented the resident triggered related to his/her use of antipsychotic medication for his/her chronic persistent mental illnesses.</p> <p>The care plan, dated 7-13-15, instructed the staff to monitor, document and report any changes in the resident's cognitive function to the doctor.</p> <p>Review of the resident's chart revealed an elopement risk assessment, completed on 1-21-16, documented the resident to not be at risk for elopement.</p> <p>Review of the resident's nursing notes on 1-30-16 at 4:36 p.m., revealed the resident had eloped from the facility at 12:15 p.m. that afternoon. The resident was reported to be sitting on the porch of a neighbor one block from the facility. The resident refused to return to the facility with staff members and the facility called the police department to help return the resident to the facility. The resident did return to the facility with</p>	F 323			

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F 323	<p>Continued From page 2</p> <p>staff when the police responded to the house where the resident was at.</p> <p>Review of the resident's nursing notes in the 72 hours leading up to the elopement incident, revealed the resident had an increase in hallucinations and delusions, was displaying manic behavior, and had been refusing some medications and had stated he/she believed the food was poisoned. The resident's physician had been notified of the increase in behaviors and some medication changes had been made on 1-28-16.</p> <p>Nurses notes on 1-30-16 at 9:21 p.m., also documented upon return to the facility following the elopement, the resident was placed on 15 minute safety checks. An assessment was completed by the charge nurse and the resident was found to have no injuries. A screener from a State Hospital was called to assess the resident for placement. The screener determined the resident met the requirements for hospitalization at that time, but no bed was available. After determining the resident qualified for hospitalization, staff began 1:1 observation with the resident. A bed was found available for the resident in another special facility and the resident left the facility via secure transport at 11:55 p.m. that evening where he/she remained.</p> <p>On 2-09-16 at 9:48 a.m., licensed nursing staff D stated, the resident had been refusing some of his/her medications because of paranoia before the elopement. The resident was manic and delusional at times, would be hypervocal and experienced flight of ideas. The resident would often go outside and walk on the sidewalk, but always came back into the facility on his/her own.</p>	F 323			

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F 323	<p>Continued From page 3</p> <p>On 2-09-16 at 10:00 a.m., direct care staff H stated, the resident had been having behaviors before he/she eloped. The resident would hear voices. He/she was talking non-stop and the staff were not able to understand what he/she was saying.</p> <p>On 2-09-16 at 2:21 p.m., administrative staff A stated, the resident had been having delusions before his/her elopement on 1-30-16.</p> <p>On 2-09-16 at 2:54 p.m., licensed nursing staff C stated, the resident had been very talkative. He/she had paranoid behavior, but had not attempted to elope before January 30th.</p> <p>On 2-09-16 at 3:04 p.m., direct care staff E stated, the resident had not talked about leaving the facility. He/she had become paranoid believing the staff were poisoning the food and not giving him/her the correct medications.</p> <p>On 2-10-16 at 10:42 a.m., administrative nursing staff B stated, the staff will use the resident's BIMS and elopement risk assessment to determine who is at risk for elopement. Staff B was not aware of the resident making any threats of attempting to elope. The last time the resident was seen before the elopement was between 10:30 and 11:00 a.m. when he/she was in their room. The resident had declined both breakfast and lunch that day.</p> <p>The facility policy for Resident Elopement Policy and Procedure, dated 2/2015, documents elopement occurs when a resident leaves the premises or a safe area without the necessary supervision or authorization to do so. The facility is to have a process to monitor security of the premises on a routine basis.</p>	F 323			

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F 323	Continued From page 4 The facility failed to prevent this dependent, delusional resident from eloping from the facility without staff knowledge.	F 323			