

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

PRINTED: 03/16/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>175413</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>03/16/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>MEDICALODGES PAOLA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>501 ASSEMBLY LANE</b> <b>PAOLA, KS 66071</b>		
(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>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 83 residents. Based on observation, interview, and record review, the facility failed to ensure 1 (#1) of 5 residents sampled for elopement, did not leave the facility without staff knowledge.</p> <p>Findings included:</p> <ul style="list-style-type: none"> <li>- The facility's medical record for resident #1 evidenced the facility admitted the resident on 3/24/10. Diagnoses listed on the physician order sheet included schizophrenia disorder (psychotic disorder characterized by gross distortion of reality, disturbances of language and communication and fragmentation of thought) and Peripheral vascular disease (PVD) - abnormal condition affecting the blood vessels.</li> </ul> <p>The MDS (minimum data set), dated 3/2/16 included a BIMS (Brief interview for mental</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>status) score of 12 (moderate cognitive impairment), independent with locomotion (ambulation) on the unit with need for supervision of locomotion off the unit.</p> <p>The 9/19/15 CAA ( care area assessment) for cognition, included disorganized thinking, moderate cognitive impairment, with varied mental functioning, mood and behavior variations throughout the day.</p> <p>The 9/19/15 CAA for psychotic drug use documented the resident's routine use of antipsychotic medications for his/her schizoactive disorder.</p> <p>Elopement risk assessments completed by the facility on 3/2/16, 9/10/15 and on 3/24/15 scored the resident from 15 to 18 indicating a high risk for elopement.</p> <p>The care plan, updated on 12/25/15, included timed safety checks initiated for ongoing observation related/to potential for elopement. On 30 minute checks.</p> <p>Review of the resident's interdisciplinary notes, on 3/2/16 at 7:30 P.M., documented direct care staff noted the resident watching TV in his/her room. At 8:00 P.M., the medication aide failed to locate the resident for scheduled medication pass. A search was immediately implemented inside the building, outside the building on the facility grounds and in the surrounding area. The facility staff notified the police department at 8:35 P.M. for assistance as staff continued to search via private vehicles.</p> <p>Interview on 3/15/16 at 9:00 A.M., with</p>	F 323			

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F 323	<p>Continued From page 2</p> <p>administrative staff A revealed the resident was last reported seen using the convenience store bathroom, about 0.4 mile north of the facility, by the store clerk, after 7:45 P.M. The clerk did not know where the resident went when he/she left the store. The facility staff and police continued to search for the resident all night.</p> <p>Nurses notes on 3/3/16 at 7:30 A.M., (approximately 11 Hours and 45 minutes following the elopement), staff from a building next door to the facility noted the resident sitting in the ditch approximately 0.1 mile north, of the facility along the paved street. They notified the nursing facility and staff immediately went and brought the resident back to the facility.</p> <p>Nurses notes documented the resident wore a sweat pant suit, tee shirt, hoodie, jacket and tennis shoes. The temperature low point at night was 42 degrees. An assessment revealed a scratch on his/her lateral left thigh. The resident was sent to the emergency room for evaluation for a complaint of lower back pain.</p> <p>The resident was returned to the facility from the ER (emergency room) with no injury noted on the evaluation. The facility placed the resident on 15 minutes visual checks and the resident was moved into a room close to the nurses desk. Nursing staff continued to perform vital signs and neurological checks routinely. He/she was supervised by staff with smoke breaks on the patio.</p> <p>On 3/15/16 at 9:00 A.M., administrative staff reported questioning if the resident was met and picked up by someone he/she saw at the AA (Alcohol anonymous) meeting the evening before</p>	F 323			

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F 323	<p>Continued From page 3 (3/1/16). Staff confirmed that the resident often voices delusional statements.</p> <p>Observation, on 3/15/16 at 10:00 A.M., revealed the resident resting on top of the bed, fully clothed. The resident later at 10:25 A.M., ambulated to the bathroom without need for assistance or any assistive device. After lunch, at 12:25 P.M., the resident ambulated in the hallway with a steady gait.</p> <p>On 3/15/16 at 11:10 A.M., when questioned the resident provided various stories as to his/her whereabouts with delusional statements, while out of the facility. The resident did comment that he/she was on the way back to the facility.</p> <p>The facility resident elopement policy and procedure, dated 2/2015, included 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> <p>The facility failed to prevent his dependent, delusional resident from eloping from the facility without staff knowledge, when the resident left the facility after 7:30 P.M. and his/her whereabouts was unknown until the next morning at 7:30 A.M.</p>	F 323			