

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

PRINTED: 05/23/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175491	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/12/2022
NAME OF PROVIDER OR SUPPLIER HOEGER HOUSE			STREET ADDRESS, CITY, STATE, ZIP CODE 20911 WEST 153RD STREET OLATHE, KS 66061		
(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 689 SS=D	The following citations represent the findings of complaint investigation #KS00171557. The 2567 was sent on 05/23/22. Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: The facility reported a census of 27 residents. The sample included four residents reviewed for elopement (when a cognitively impaired resident leaves the facility without staff knowledge and supervision). Based on record review, observation, and interview, the facility failed to ensure staff identified Resident (R)1's risk for elopement and failed to provide adequate supervision to prevent an elopement when R1 exited through an alarmed door after activating the required door release. This placed R1 at risk for injury related to elopement. Findings included: - The Electronic Medical Record (EMR) recorded R1 admitted to the facility on 05/06/22. The EMR under the "Diagnosis" tab, listed diagnoses of: cerebral infarction (stroke- a disruption of blood flow to the brain), vascular dementia (changes to memory, thinking, and behavior resulting from	F 689			

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

TITLE

(X6) DATE

05/23/2022

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 689	Continued From page 1 conditions that affect the blood vessels in the brain), and syncope (fainting or passing out). The "Admission Minimum Data Set (MDS)" dated 05/10/22 recorded R1 had a Brief Interview for Mental Status (BIMS) score of four, which indicated the resident's cognition was severely impaired. R1 had no wandering behaviors during the assessment period. R1 required limited assistance of one staff member with most activities of daily living (ADL's), and ambulated with the use of a rolling walker. R1's initial "Elopement Risk Assessment" dated 05/06/22 documented R1 was recently admitted to the facility, had increased confusion and forgetfulness, and had a diagnosis of dementia. The assessment recorded the resident was not at risk for elopement. The resident's initial "Care Plan" dated 05/06/22 documented R1 had an ADL self-care performance deficit related to cognitive status and weakness. The care plan directed staff to provide limited assistance for ambulation of one staff member with use of a gait belt and rolling walker. The 05/06/22 "Care Plan" for behaviors recorded the resident had a diagnosis of dementia and directed staff to attempt non-pharmacological interventions when R1 looked for his spouse. R1's "Care Plan," updated on 05/07/22, acknowledged the resident was at risk for elopement, due to a diagnosis of dementia. A "Health Status Note" note, under the "Notes" tab dated 05/09/2022 at 06:34 AM recorded R1	F 689			

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F 689	Continued From page 2 was in the hallway early in the shift, looking for the parking lot. R1 was redirected easily. R1 did not wander the rest of the shift. A "Progress Note" dated 05/09/22 at 8:25 P.M. recorded a Certified Medication Aide (CMA) reported a dietary employee brought R1 to the nurse and stated R1 was in the parking lot. Staff assesses no new skin issues were noted. R1's vital signs were within normal limits. R1 denied any complaint of pain or discomfort; staff notified Administrative Nurse D, Consultant GG and R1's emergency contact immediately. A "Witness Statement" from Licensed Nurse (LN) J on 05/09/22 documented she dropped off medications to the medication room and observed R1 outside his room. LN J stated she asked R1 if he needed help and R1 said "no." LN J went to the back of the building and assisted a different resident. LN J recorded she did not hear the alarm sound. A "Witness Statement" from Licensed Nurse (LN) K on 05/09/22 recorded she prepared medications and then assisted a resident in the bathroom. LN K documented she was not aware the alarm sounded until she exited the resident's room and entered the hallway. LN K stated she went to the door that was alarming and opened it, went outside and looked around each side of the building and in the parking lot and did not see anyone. LN K documented she went back in the building and back to a resident's room. She stated she went to the laundry room to get linens and then to the restroom. While in the restroom LN K heard the door alarming. Dietary Staff (DS) BB notified LN K R1 was found in the parking lot. LN K stated she was not aware R1 left the	F 689			

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F 689	Continued From page 3 building and had not seen R1 that shift. LN K recorded she received information in shift report which indicated R1 was an elopement risk. A "Witness Statement" from Certified Medication Assistant (CMA) R on 05/09/22 documented CMA R passed medications in the back of the building. CMA R recorded DS BB approached her and said R1 was in the parking lot. CMA R stated she walked with DS BB to the front of the building where R1 sat outside his room. CMA R recorded she altered the other staff. A "Witness Statement" received from DS BB on 05/09/22 recorded at approximately 08:10 AM on 05/09/22 DS BB observed R1 exit the side door. DS BB stated he thought R1 was a visitor. DS BB stated he went to his vehicle and waited for a friend to arrive. DS BB recorded R1 ambulated to the parking lot. DS BB pulled his car around to the front of the parking lot at approximately 08:15 PM and R1 approached him and asked for a ride. DS BB documented he then realized R1 was not a visitor and escorted R1 back into the facility. DS BB directed R1 to sit in a chair by R1's room while DS BB obtained nursing staff to assess R1. Review of camera footage for 05/09/2022 at 08:10 PM revealed R1 pushed on east exit door emergency release for 15 seconds and the door opened. At 08:13 PM a staff member exited the door then reentered after approximately one minute. At 08:20 PM a dietary staff member returned with R1. On 05/12/22 at 12:15 PM R1 propelled his wheelchair towards the dining room. Staff accompanied R1.	F 689			

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F 689	Continued From page 4 On 5/12/22 at 12:22 PM R1 stated he came to the facility after a hospital stay. Interviewed on 05/12/22 at 12:10 PM Licensed Nurse I (LN I) stated R1 had no elopement attempts during the time LN I worked. LN I stated R1 did ambulate in hall on occasion. LN I said R1 was easily redirected and was just confused about where to go and what to do. Interviewed on 05/12/22 at 12:10 PM Certified Nurse's Aide (CNA) N stated she did not typically work with R1. CNA N stated R1 had not had any elopement behaviors prior to the elopement on 05/09/22. Interviewed on 05/12/22 at 2:20 P.M. Administrative Nurse D acknowledged R1's initial elopement risk assessment was inaccurate and stated immediate training would be conducted with nursing staff. The facility's "Elopement/Rehab/Skilled " policy revised on January 01/12/2022 documented: "All residents would be assessed for elopement through the preadmission and/or admission process and as needed, Each location will put measures in place to minimize the risk of elopement that are individualized to resident needs and identified on the care plan ..." The facility failed to identify R1's elopement risk and failed to provide adequate supervision to prevent an elopement. This placed R1 at risk for injuries related to elopement.	F 689			