STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B089080	A. BUILDING: _____ B. WING _____	R 07/01/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BOGART HOUSE LLC-II	3535 SW 6TH ST TOPEKA, KS 66606

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{S 000}	INITIAL COMMENTS The following citations represent the findings of a revisit for correction order 14-55 at the above named home plus facility conducted on 7-1-14.	{S 000}		
{S5155} SS=E	26-42-204 (a) Health Care Services (a) The administrator or operator in each home plus shall ensure that a licensed nurse provides or coordinates the provision of necessary health care services that meet the needs of each resident and are in accordance with the functional capacity screening and the negotiated service agreement. This REQUIREMENT is not met as evidenced by: KAR 26-42-204(a) The facility reported a census of 3 residents. The sample included 3 residents. Based on record review and interview for 1 (#1200) of 3 sampled residents, the operator failed to ensure the licensed nurse provided or coordinated the provision of necessary health care services that met the needs of the resident and addressed the resident's risk for elopement. Findings included: - Record review for resident #1200 revealed admission on 6-30-13 with diagnoses Bipolar, Depressed with Psychotic Behavior, Osteoarthritis, Insomnia due to Mental Disorder, Allergic Rhinitis, Stress Incontinence and Hypothyroidism.	{S5155}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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{S5155}	Continued From page 1 The Functional Capacity Screen dated 6-20-14 recorded resident independent with bathing dressing, toileting, transfers and eating; supervision with medication and treatment management. Continent of bladder. Cognition: problems with decision-making. No problems with communication. The Negotiated Service Agreement dated 6-20-14 recorded services for a regular diet, monitoring of vital signs, medication assistance, reporting of changes in function and condition, and escort to medical appointments. The NSA identified licensed nurse A as the nurse responsible for the implementation and supervision of nursing plan. The NSA lacked health care services to address the resident's elopement risk. The Intake Assessment Form "Clinical Summary of Current Symptoms and Behaviors: "For instances of elopement: see policy. Notify Nurse/Administrator; Notify police; Search premises; Notify guardian; Notify Veterans Administration; Assessment upon re-admit. Signed by licensed nurse A on 6-20-14. Nurses Notes recorded the following: 7-18-13 (no time documented): "Went to a group meeting at the hospital and took off from meeting never returning or calling the facility. Operator notified resident's family member, was called around 4:45 pm. Family member said it was resident's birthday and maybe his/her other children had talked to resident. The family member later called and said no luck. He/She pleaded with us from the first time we spoke to not call the police. We said it's in our protocol to do so...Resident later showed up to the hospital	{S5155}		

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{S5155}	Continued From page 2	{S5155}		

and said he/she had alcohol and wanted to be admitted. We have kept in contact with resident's nurse from the hospital." 7-22-13 (no time documented): "Spoke with resident briefly, he/she still not feeling well. I, certified staff B, spoke with resident's nurse 7-19-13 and 7-22-13 several times both day." Signed by certified staff B.

No Date: "Returned to facility at 4:00 pm 7-24-13. " Signed by certified staff B. The record lacked documentation of an assessment by a licensed nurse upon return from the hospital to examine the resident for any injuries (per facility policy); and to evaluate resident's safety awareness and determine whether he/she could be away from the facility unattended.

9-5-13 at 11:00 am: "Resident said he/she was going to coffee shop downtown by bus. He/She did not come back for lunch nor dinner. Was called several times on his/her cell phone but no answer. Final medication pass was at 7:45 pm that Thursday night and still no show. Resident's family was called some time around dinner. He/She said hadn't heard from resident and would try his/her phone and other family member. The family member said maybe resident would be home by 9:00 pm and to give resident until then and call back. In the meantime, I, certified staff B, called 911 to report him/her as a wanderer or missing resident. Gave the police resident's description and age. They said they would call us back and bring resident here if found. No word from police or resident.

9-6-13 (no time documented): Friday morning around 8:00 am resident's family came by to ask if any lead. We said hadn't heard from him/her or police. Around 11:00 am a staff member that

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{S5155}	Continued From page 3	{S5155}		

was downtown called and said they seen resident walking around downtown. They said he/she waved at them and kept walking. The facility then notified the police with his location so they could pick him/her up and take him/her to the hospital to be checked out since he/she had substance abuse in the past. The police never called.

9-7-13 (no time documented): "I, certified staff B, had our other staff member call the police for missing persons. They came over and made a report. the police did not find him/her but resident's family member called later at 3:30 and said resident had called and asked to be picked up. They brought the resident to facility and staff told them to take resident to the hospital to be evaluated since resident was off his/her medications and wd did not know if resident was under the influence of drugs or alcohol. Resident then left with family member."

9-8-13 (no time documented): "No word from resident or family member."

9-9-13 (no time documented): "Resident's family member took resident to hospital to see case worker who is also resident's nurse there. They said they could not admit resident so he/she was brought to facility around 9:00 am where he/she received medications. We all had a sit down conference with operator, resident's family member, resident and certified staff B. We thought we made some head way but resident still had a serious attitude and made comments of not knowing what he/she wanted and he's/she's almost 60 years old." Signed by certified staff B.

9-24-13 (no time documented): "Certified staff B took resident to get shot of Risperdone at the hospital at 9:30 am that Tuesday morning. Then

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{S5155}	Continued From page 4	{S5155}		

we came back and later he/she had lunch. I then took him/her to a 1:30 hair appointment where I picked him/her up from. He/she said wanted to go for a walk. He/She never came home for supper so we called his/her family member and the authorities later that evening around 9:00 pm. We called his/her phone several times no answer. Resident called his/her lawyer and was given $200.00 by him/her. Resident then stayed gone until Sunday morning at 8:45 am. So he/she was taken to the hospital where he/she admitted to doing speed and marijuana. The nurse said they would admit him/her." Monday 9-30-13 (no time documented): "We were called to pick him/her up at the hospital. I picked him/her up at 3:30 pm so he/she is here at the facility." Signed by certified staff B. The record lacked documentation of an assessment by a licensed nurse upon return from the hospital to examine the resident for any injuries (per facility policy); and to evaluate resident's safety awareness and determine whether he/she could be away from the facility unattended.

Interview on 7-1-14 at 2:05 pm with certified staff B stated licensed nurse A reassessed resident and re-wrote the NSA on 6-20-14. Confirmed the NSA lacked documentation of interventions to address resident's elopement risk.

Interview on 7-1-14 at 4:04 pm with licensed nurse A confirmed he/she wrote the NSA for resident #1200 on 6-20-14 and the NSA lacked documentation of interventions to address resident's elopement behavior/risk.

For resident #1200, a resident with a history of elopements, the operator failed to ensure the licensed nurse provided or coordinated the provision of necessary health care services that

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{S5155}	Continued From page 5 addressed the resident's risk for elopement.	{S5155}		