STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175363	A. BUILDING _____ B. WING _____	C 11/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICALODGES FRONTENAC	**206 S DITTMAN STREET FRONTENAC, KS 66763**

(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 The following citations represent the findings of complaint investigation # KS00135348. The 2567 was electronically sent to the facility on 11/26/18.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced	F 609		

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

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F 609	Continued From page 1 by: The facility reported a census of 53 residents with 3 selected for sample review regarding elopement. Based on record review and interview, the facility failed to thoroughly investigate and report to the state agency, as required, an incident of elopement. Findings included: - Resident #1, re-admitted to the facility on 6/25/18 after a psychiatric in-patient hospitalization. The physician order sheet, signed/dated 10/3/18 included diagnosis of bi-polar disorder (major mental illness that caused people to have episodes of severe high and low moods), psychotic disorder (any major mental disorder characterized by a gross impairment in reality testing) with delusions (untrue persistent belief or perception held by a person although evidence shows it was untrue) due to a known physiological condition, abnormality of gait and mobility, insomnia (the inability to sleep), and a cognitive communication deficit (a deficit causing problems with attention, memory, organization, problem solving/reasoning and executive functions). An admission MDS (minimum data set), dated 3/2/18, included a BIMS (brief interview of mental status) score of 13/15, indicating intact cognition. The resident expressed having trouble with sleep, feeling tired, and appetite concerns, but lacked any behavioral concerns. The staff identified the resident as independent to supervised for ADLs (activities of daily living), including mobility.	F 609	Past noncompliance: no plan of correction required.	

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F 609	Continued From page 2	F 609		

The quarterly MDS, dated 7/28/18, scored the resident with a BIMS of 14/15, indicating intact cognition, without mood or behavioral concerns, and required supervision for most ADLs including mobility.

The quarterly MDS, dated 10/13/18, scored the BIMS of 14/15, indicating intact cognition and identified the resident with appetite concerns. The staff identified the resident needed supervision for mobility off the unit. The assessment lacked identification of wandering.

The staff assessed the resident for elopement risk on admission, 2/23/18, and determined the resident was not at risk. However, additional assessment identified an increased risk, as follows:
On 6/25/18 the resident scored 10 indicating moderate risk (8-12)
On 7/23/18 the staff assessed the resident at a score of 18 indicating high risk (13+)

Review of a care plan meeting and care plan review, on 10/25/18 lacked evidence of any planned interventions for elopement risk.

Review of nursing and interdisciplinary notes from 5/25/18 to 8/19/18 included the following:

On 5/25/18 at 8:52 PM, a police officer arrived at the facility, stating the resident called 911, indicating he/she needed fresh ice water.

On 8/3/18 at 8:34 AM, documentation identified the resident required supervision with ambulation and exhibited poor judgement due to mental illness.

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On 8/10/18 at 8:28 AM the resident reported to staff he/she vomited his/her breakfast and wanted to know why staff were poisoning him/her.

On 8/19/18 at 9:00 PM, the resident locked him/herself into an employee's vehicle and told the staff he/she was trying to escape. Staff documented placing the resident on 15-minute checks until staff could develop a more permanent care plan.

The facility failed to have an investigation of the 8/19/18 incident.

On 11/20/18 at 12:53 PM, licensed nursing staff C reported the residents at risk for elopement are posted with pictures at the nursing desks and pertinent information was available in the elopement books.

On 11/20/18 at 2:10 PM, direct care staff H reported the residents at risk are posted at the desk for quick staff review. Posting included this resident and staff H reported this resident displayed exit seeking at times and staff monitor the resident every 15 minutes for that reason.

On 11/20/18 at 4:20 PM, direct care staff J reported he/she had heard some rumors about the resident getting into an unlocked vehicle but did not know anything except through rumors.

On 11/20/18 at 4:50 PM, social services/activity staff L reported he/she visited with the resident at the time of the resident locking him/herself into an employee's vehicle. The staff and resident discussed the resident's impulsive behaviors and the staff encouraged the resident to talk to staff L or another staff member whenever feeling like

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that. Additionally, staff L recalled that the facility placed the resident on 15-minute checks, at that time. The staff recalled that staff implemented a care plan, however, indicated being unaware why that was not addressed at the following care plan meeting on 10/25/18.

Interview with administrative nursing staff B, on 11/20/18 at 5:02 PM, identified vague recollections of the incident on 8/19/18 and indicated he/she did not investigate the incident to determine any changes needed to keep the resident safe. The staff recalled the staff initiated 15-minute visual checks for the resident, at that time.

A finding meeting, on 11/20/18 at 5:00 PM, with administrative staff members A, E, B, D, and social services staff L verified the facility's failure to investigate and report to the state agency the incident on 08/19/18. These staff were unable to recall if any staff were outside at the time of the incident.

The facility policy, dated 12/17, for Elopement instructed staff that elopement occurred when a resident left the premises or a safe area without the necessary supervision or authorization to do so. When a missing resident returned to the facility the policy directed that a Risk Management event would be initiated and reviewed the interdisciplinary team during the risk meeting. Furthermore, consultation with the regional vice president, clinical nurse consultant and legal department by the administrator to determine the need for state survey agency notification.

The facility failed to thoroughly investigate and

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F 609	Continued From page 5 report to the state agency, as required, the incident of the resident exiting the building without staff knowledge, and then locking him/herself into an employee's vehicle and threatening to leave the premises. The deficiency was cited as past non-compliance as of 11/11/18 at 10:15 PM when the facility completed the following: 1) Conducted a QAPI meeting with the Administrator, DON and the Medical Director, on 11/10/18 at 3:56 PM. 2) Provided staff education to all staff including review of the elopement policy and the importance of timely 15-minute visual checks; started on 11/10/18 at 3:50 AM and completed at 11/11/18 at 10:15 PM. Per administrative staff A, 2 additional staff, out of state at the time, received training before working their next shifts. Additionally, 1 person on FMLA (family medical leave act) will receive training prior to returning to work.	F 609		
F 689 SS=J	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 53 residents	F 689	Past noncompliance: no plan of	

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with 3 residents selected for sample review of elopement. Based on observation, interview, and record review the facility failed to ensure one resident (#1) of 3 reviewed received care and services to ensure the resident remained free of elopement. Resident #1 exited from the facility, without staff's knowledge on 11/10/18 at approximately 3:05 AM, and without adequate clothing for the outside temperature of 19 degrees Fahrenheit, which placed the resident in immediate jeopardy.

Findings included:

- Resident #1, re-admitted to the facility on 6/25/18 after a psychiatric in-patient hospitalization.

The physician order sheet, signed/dated 10/3/18 included diagnosis of bi-polar disorder (major mental illness that caused people to have episodes of severe high and low moods), psychotic disorder (any major mental disorder characterized by a gross impairment in reality testing) with delusions (untrue persistent belief or perception held by a person although evidence shows it was untrue) due to a known physiological condition, abnormality of gait and mobility, insomnia (the inability to sleep), and a cognitive communication deficit (a deficit causing problems with attention, memory, organization, problem solving/reasoning and executive functions).

An admission MDS (minimum data set), dated 3/2/18, included a BIMS (brief interview of mental status) score of 13/15, indicating intact cognition. The resident expressed having trouble with sleep, feeling tired, and appetite concerns, but lacked

correction required.

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any behavioral concerns. The staff identified the resident as independent to supervised for ADLs (activities of daily living), including mobility.

The quarterly MDS, dated 7/28/18, scored the resident with a BIMS of 14/15, indicating intact cognition, without mood or behavioral concerns, and required supervision for most ADLs including mobility.

The quarterly MDS, dated 10/13/18, scored the BIMS of 14/15, indicating intact cognition and identified the resident with appetite concerns. The staff identified the resident needed supervision for mobility off the unit. The assessment lacked identification of wandering.

The staff assessed the resident for elopement risk on admission and determined the resident was not at risk. However, additional assessment identified an increased risk, as follows:

On 6/25/18 the resident scored 10 indicating moderate risk (8-12)
On 7/23/18 the staff assessed the resident at a score of 18 indicating high risk (13+)
On 11/10/18 the staff assessed the resident at a score of 16 indicating high risk (13 +)

Review of a care plan meeting and care plan review, on 10/25/18 lacked evidence of any planned interventions for elopement risk.

A care plan developed for elopement risk on 11/10/18 (following the elopement on 11/10/18 at 3:05 AM) included the following problems and interventions:

Provide education to resident on the need to

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communicate with the staff when wanting to go for a walk or exit the facility, for any reason.
Provide education to the resident on the safety of leaving the facility.
Provide supervision to the resident when going out of the building.
When exhibiting exit seeking behavior, please evaluate by completing the elopement assessment in PCC (point click care-computer software).
Encourage the resident to attend activities to keep him/her busy.
Know that if the resident begins packing his/her belongings, that is a sign that the resident may be thinking about leaving.

Review of nursing and interdisciplinary notes from 5/25/18 to 11/20/18 included the following:
On 5/25/18 at 8:52 PM, a police officer arrived at the facility, stating the resident called 911, indicating he/she needed fresh ice water.

On 8/3/18 at 8:34 AM, documentation identified the resident required supervision with ambulation and exhibited poor judgement due to mental illness.

On 8/10/18 at 8:28AM the resident reported to staff he/she vomited his/her breakfast and wanted to know why staff were poisoning him/her.

On 8/19/18 at 9:00 PM, the resident locked him/herself into an employee's vehicle and told the staff he/she was trying to escape. Staff documented placing the resident on 15-minute checks until staff could develop a more permanent care plan.

On 10/12/18 at 3:10 PM, staff documented the

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resident as alert and oriented times 3 (person, place and time) with some confusion and he/she ambulated independently.

On 11/10/18 at 3:45 AM, staff documented the facility received a phone call at 3:13 AM from the police department, indicating a resident walked away from the facility and knocked on a neighbor's door. The resident told the neighbors he/she was cold and that he/she lived at the facility. The staff documented reporting to the police the staff were unaware of a resident being gone and immediately alerted staff to do visual checks on the residents. The police reported the resident was safe and the police would return the resident to the facility. The police arrived at the facility with the resident, who was dressed in a pair of jeans, a light weight shirt, and without a coat. The nurse completed one on one with the resident while conducting an assessment and discussing the dangers of going outside without protective clothing, such as a coat, with the cold temperature. The resident laughed stating that he/she went out the back door. Staff documented the resident had knowledge of the code as he/she would use the code to go to the courtyard during the daytime, however always returned inside. Staff placed the resident on a one on one status for the duration of the shift. Vital signs were monitored with a temperature of 97.9 degrees Fahrenheit. Extremities were pink in color, with the resident exhibiting full range of motion. Staff assisted the resident into pajamas and into bed with covers on the resident.

Additional information in the investigation included a witness statement from the direct care staff M, which documented he/she returned from break at 1:30 AM and began bed check on

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residents on the hall. Staff documented checking on resident #1 at approximately 2:00 AM. The staff indicated the resident was in a good mood and staff M visited with the resident until approximately 2:30 AM. The staff continued with bed checks and when completed returned to the desk to start charting. Another CNA (certified nurse aide) ran from the other hall and reported that the resident eloped, and staff M immediately went to look for him/her. Per the documentation the staff failed to complete every 15-minute checks on the resident.

Observation of the resident, on 11/20/18 at 1:21 PM, identified the resident seated in a wheelchair, in his/her room, propelling about the room independently. The resident reported he/she felt safe at the facility and then began expressing delusional thoughts, such as receiving shocks through his/her bed, which was not electrical (per the resident).

On 11/20/18 at 12:48 PM, direct care staff F reported knowledge of the residents at risk for elopement and reported the facility updated a book containing the residents pictures and information at each nursing desk which occurred when the resident eloped from the facility. The staff reported he/she was not on duty at the time the elopement occurred however, stated that all staff are expected to monitor the resident and the others at risk closely. This resident remained on 15-minute monitoring and ensure the resident does not actively exit seek. The staff reported being surprised the resident left the premises as he/she often sat outside unattended and never left the grounds previously.

On 11/20/18 at 12:53 PM, licensed nursing staff C

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reported the residents at risk for elopement are posted with pictures at the nursing desks and pertinent information was available in the elopement books. The staff reported the resident eloped last weekend when the resident decided in the middle of the night to go star gazing. The staff reported being unaware of the resident ever attempting to elope previously and used to sit outside on the patio unattended.

On 11/20/18 at 2:03 PM, direct care staff G reported he/she was now only aware of 3 residents being able to go outside without any assistance. They are all smokers and are mostly independent.

On 11/20/18 at 2:10 PM, direct care staff H reported the residents at risk are posted at the desk for quick staff review. The staff included this resident and reported the resident displayed exit seeking at times and staff monitor the resident every 15 minutes for this reason.

On 11/20/18 at 3:10 PM, direct care staff I verified the resident was an elopement risk and at the time of the elopement the resident lived on another hall, where more independent residents lived. The staff reported the resident remained on frequent checks which are documented in the computer.

On 11/20/18 at 4:20 PM, direct care staff J reported that evening before the resident eloped the resident had not been any different than usual. Often sat near the front door, watching anyone who exited or entered the building. The staff further reported he/she had heard some rumors about the resident getting into an unlocked vehicle but did not know anything

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except through rumors.

On 11/20/18 at 4:25 PM, licensed nursing staff K reported the resident had reported that day that his/her family were coming to take the resident out for a while. The staff reported he/she checked the book which indicated those planned to go off grounds and did not see plans for the resident. The staff notified the resident of that, who seemed to accept the information well.

On 11/20/18 at 4:50 PM, social services/activity staff L reported he/she visited with the resident at the time of the resident locking him/herself into an employee's vehicle. The staff and resident discussed the resident's impulsive behaviors and the staff encouraged the resident to talk to staff L or another staff member whenever feeling like that. Additionally, staff L recalled that the facility placed the resident on 15-minute checks at that time. The staff indicated believing that staff implemented a care plan, however, indicated being unaware why that was not addressed at the following care plan meeting on 10/25/18.

Interview with administrative nursing staff B on 11/20/18 at 5:02 PM, identified vague recollections of the incident on 8/19/18 and indicated he/she did not investigate the incident to determine any changes needed to keep the resident safe. The staff recalled the staff initiated 15-minute visual checks for the resident, at that time.

A finding meeting with administrative staff members A, E, B, D, and social services staff L verified the failure to adequately monitor and provide supervision for this resident who exited the building and locked him/herself into an

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employee's vehicle. The staff failed to investigate and determine methods of keeping the resident safe and continued to allow the resident access to outdoors, without changing the door codes and the resident again exited the building in the early morning hours, walked approximately 2 blocks, in temperatures of 19 or 20 degree weather, without outer clothing to protect the resident from the cold temperatures.

The facility policy, dated 12/17 included 1) residents are to be assessed for elopement risk within 24 hours of admission, quarterly, annually and with any significant change. 2) If identified risk is present, the interventions implemented are to be documented on the care plan. 3) Social service personnel are to maintain a facility elopement book which was accessible to direct care staff, including photos of the residents, resident's face sheets, resident information sheets and the residents care plan regarding the risk for wandering and elopement.

The facility failed to adequately assess the resident's risk for elopement and failed to develop and implement a plan of care to provide supervision and assistive devices to maintain the resident's safety after the first incident on 8/19/18 when the resident exited the facility and locked him/herself into an employee's automobile; The resident then eloped on 11/10/18 at 3:05 AM, without staff knowledge, with outdoor temperatures of 19 or 20 degrees, and without a coat. The facility was notified by law enforcement personell that the resident was out of the facility and then was returned to the facility by the law enforcement personnel. This placed the resident in immediate jeopardy.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175363	A. BUILDING _____ B. WING _____	C 11/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICALODGES FRONTENAC	206 S DITTMAN STREET FRONTENAC, KS 66763

(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 689	Continued From page 14	F 689		

The deficiency was cited as past non-compliance as of 11/11/18 at 10:15 PM when the facility completed the following:

1) Placed the resident on one to one staff supervision, immediately upon return to the facility on 11/10/18 at approximately 3:45 AM.
2) Nurse assessed resident every 4 hours for 72 hours after return to the facility, starting on 11/10/18 at 3:45 AM.
3) Reviewed the facility camera to establish a timeline.
4) Notified the family and the PCP (primary care physician) on 11/10/18 at 7:30 AM.
5) Completed elopement assessments on all residents, throughout the day on 11/10/18.
6) Updated the care plans of all residents at risk for elopement, throughout the day on 11/10/18.
7) Updated the elopement notebooks, throughout the day on 11/10/18.
8) Emergency elopement drill was conducted on 11/10/18 at 1:00 PM.
9) Moved the resident to another room further into the facility with closer supervision, on 11/10/18.
10) Posted signage at all exits notifying visitors to not let residents exit with them, on 11/10/18.
11) Conducted a QAPI meeting with the Administrator, DON and the Medical Director, on 11/10/18 at 3:56 PM.
12) Changed the door codes on 11/10/18 and again on 11/11/18.
13) Provided staff education to all staff including review of the elopement policy and the importance of timely 15-minute visual checks; started on 11/10/18 at 3:50 AM and completed at 11/11/18 at 10:15 PM. Per administrative staff A, 2 additional staff, out of state at the time, received

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICALODGES FRONTENAC	**206 S DITTMAN STREET FRONTENAC, KS 66763**

(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 689	Continued From page 15 training before working their next shifts. Additionally, 1 person on FMLA (family medical leave act) will receive training prior to returning to work.	F 689		