STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175208	A. BUILDING _____ B. WING _____	**10/13/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PITTSBURG OPERATOR LLC	**1005 E CENTENNIAL DRIVE PITTSBURG, KS 66762**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0689 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 60 residents, with three residents reviewed for elopement (to leave a locked or secured psychiatric institution without notice or permission). Based on observation, record review, and interview the facility failed to provide the necessary supervision for one cognitively impaired resident who left the secured memory unit of the facility through an unlocked gate and walked unsupervised outside of the facility, approximately 20 yards of grass onto the adjoining store parking lot without staff knowledge. The facility did not know Resident (R) 1 was outside of the facility for approximately ten minutes, when the local police department returned the resident to the facility. This placed R1 in Immediate Jeopardy. Findings included: - The signed Physician order [REDACTED]. The Admission/5-day Minimum Data Set (MDS), dated [DATE], documented the resident admitted [DATE]. The MDS revealed the resident had a Brief Interview for Mental Status (BIMS) score which was not obtained as the resident was rarely/never understood and indicated he had a severely impaired cognition. The MDS documented the resident wandered one to three days of the look back period. The resident's functional status documented the resident needed supervision with walking and locomotion. He did not use any mobility devices and no history of falls. The Cognitive Loss/Dementia Care Area Assessment (CAA), dated 09/29/20, triggered due to the resident's short term/long term memory problem, BIMS score, life decision making skills, severely impaired cognition, and wandering. The resident's Baseline Care Plan, dated 09/17/20, documented to minimize the risk of elopement and provide resident safety the resident would be on a secure unit. The resident's Care Plan, revised on 10/10/20 (after the resident wandered unsupervised from the facility), documented the resident was at risk for elopement due to his wandering. The resident did exit seek and had history of elopement at the facility and had a history of [REDACTED]. Staff were directed to try to anticipate the resident needs, validate his thoughts, and redirect him as possible. The staff were to intervene as necessary to protect the rights and safety of others, to approach and speak to him in a calm manner, divert his attention, and remove from situations and take to alternate location as needed. The resident became agitated and combative with staff when they attempted to redirect him. Staff were directed to back off, monitor for safety, and make sure the unit doors were locked/secured. Monitor him when he wandered and provide one to one to keep him safe. The resident's Wandering and Elopement Risk Evaluation dated 09/17/20, identified the resident at a low risk of elopement, with a score of nine. The residents Wandering and Elopement Risk Evaluation dated 10/09/20, identified the resident at a moderate risk of elopement with a score of 16. The resident's Admission Note in the EMR, dated 09/17/20 at 10:32 PM, documented the resident was a new admission, who had a history of [REDACTED]. The resident was alert and confused. The Progress Note dated 10/09/20 at 10:19 PM, documented the Licensed Nurse (LN) G exited the back secured unit through the dining room door at approximately 06:40 PM to go to the COVID unit for an emergency with another resident. When the LN G exited, she ensured the dining room door on the secured unit locked and noted the resident had started to wander. The note revealed that another resident (R4) was outside smoking at that time. The emergency medical services (EMS) team arrived for another resident in the COVID (coronavirus) unit at approximately 06:50 PM. At the time of the EMS arrival, documentation revealed the outside gate to the secured courtyard was locked. The RN opened the gate for the EMS team to enter the facility to transport the other resident. EMS left at 06:57 PM. The RN did not see R1 outside when she locked the gate after their departure, or when she entered the ACU (secured memory unit). At approximately 7:00 PM, the police department phoned the facility and inquired if the resident lived at the facility. The local police department transported the resident back to the facility at approximately 07:00 PM. R1 had previously wandered in the hallway and into other residents' rooms prior to the resident leaving the facility unsupervised. Observation on 10/13/20 at 11:15 AM revealed the resident in his room folding his clothing and stacking the clothing on the bed. He appeared alert and he stood and walked independently with steady balance. Observation on 10/13/20 at 12:00 PM revealed the resident went to the doorway of his room, leaned against the door frame, and watched people in the hall for a short while, then returned into his room. Observation, on 10/13/2020 at 5:15 PM, revealed the area was in business district with other facilities, a hospital, gas station and four lane road with a speed limit of 30 miles per hour. On 10/13/20 at 11:16 AM Certified Nursing Assistant (CNA) M reported the resident was able to walk independently. Staff would keep eyes on him 24/7 (24 hours/7 days a week), and check on him every two hours to make sure he used the bathroom. He packed his clothing, but, did not ever exit seek. Staff received a call from someone stating R1 was at Wal-Mart next door, and the police brought him back to the facility. He was on the back hall. The only way out was the side door, off the back-hall dining room, and out the gate by the trash cans. The door and the gate had a keypad code on the inside. The dining room door had a green push button, but management changed it when this happened. The dining room now had to be locked with a key. The only people who used the gate were the charge nurse and EMS. CNA M stated EMS came for someone on the COVID unit. The nurse was going back and forth to the COVID unit, and to get there you must go out the dining room door. All the doors are locked and alarmed and have key codes to get out and in. CNA M revealed that R1 did not know the code nor how to put it in. If R1 would have pushed on the door for a long time it would have alarmed. On 10/13/20 at 12:28 PM, CNA O reported during the day shift, on the day he eloped, R1 was anxious to get his belongings and go home. The resident became anxious and would get his belongings daily. He had dementia and did not understand he was not safe at home. He would exit seek at times, pack his belongings, and say he wanted to go home. When he went to the door, we tried to redirect him back to the community, give a drink and/or snack, take to him to his room, and try to verbally remind him where he was. CNA O verified the courtyard gate should be locked. On 10/13/20 at 01:27 PM CNA P reported around 06:10 PM, R1 was by the back-hall dining room. He was screaming and yelling and had all his stuff in his hands. He let me put his stuff in his room and R1 sat in the dining room while staff finished putting the other residents to ready for bed. CNA P revealed around 06:50 PM or 06:55 PM, she and CNA Q took the trash out, and did not see R1 leave the building. We take the trash out the front door of the secured unit. CNA P further stated she saw R1 around 06:30 PM or 06:40 PM. On 10/13/20 at 02:25 PM CNA Q reported around 06:30 PM to 06:40 PM, she observed the resident with his belongings in his tote and he stood in the hall. CNA Q revealed the nurse was on the COVID side and she did not hear a door alarm sound. On 10/13/2020 at 02:54 PM, CNA S reported she never heard any door alarms when the resident left the facility's secured area unattended. On 10/13/20 at 3:04 PM LN G reported on the night of the elopement, R1 wandered in and out of other resident's rooms and was agitated. She recalled R4 was outside around that time at 6:55 PM. Staff received a call, at approximately 7:00 PM from the police department stating the resident was with them. LN G reported staff did not hear any alarms at any time, so would have to assume R1 went out when R4 came in from smoking. LN G stated the gate did not get closed after EMS left. On 10/13/2020 at 02:39 PM, Administrative Staff A reported, staff was unable to determine how the resident left the facility. The alarms worked and the doors should have been locked. Staff speculated maybe when R4 came back inside from smoking, the resident went outside. The facility's policy titled, Elopement F689, revised 08/20, documented staff should evaluate,

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 0689 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 1) investigate, and report all cases of missing residents. Upon admission and quarterly, each resident should be evaluated for elopement and wandering risks. Evidence for such would be documented, interventions would be initiated, reviewed and modified, based upon the resident's risk. The facility failed to provide adequate supervision for this cognitively impaired resident, who resided in the locked memory unit, who left unattended, through an unlocked gate without staff knowledge. This deficient practice was cited as past non-compliance when the facility completed the following on 10/10/2020 at 07:30 PM 1. Education provided to all staff on elopement, call lights, door and gate being secured on 10/10/2020 at 02:00 PM. 2. The facility provided one-on-one with the resident from 10/09/2000 at 7:00 PM until 10/12/2020 at 11:00 AM. 3. The facility installed a secure lock with a code on the secured unit dining room door and removed the push button entry on the outside on 10/09/2020 at 07:30 PM, disabled the push lock and installed the lock on 10/10/2020 at 12:00 PM. 4. The facility notified the Medical Director and conducted a quality assurance/performance improvement (QAPI) plan on 10/11/2020 at 1:00 PM. 5. The facility had the resident on fifteen-minute checks starting on 10/09/2020 at 07:00 PM to 10/12/2020 at 11:00 AM. 6. The facility staff check the gate on the courtyard to ensure it was locked every fifteen minutes from 10/09/2020 at 7:00 PM to present time.