STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E183	A. BUILDING _____ B. WING _____	**08/12/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GOVE COUNTY MEDICAL CENTER LTCU	**520 W 5TH STREET, PO BOX 129 QUINTER, KS 67752**

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 37 residents. The sample included three residents. Based on observation, record review, and interview the facility failed to adequately monitor and provide effective elopement interventions for one of three sampled residents, Resident (R) 1. Staff failed to adequately monitor R1, who had significant hallucinations (sensing things while awake that appear to be real, but the mind created) and delusions (untrue persistent belief or perception held by a person although evidence shows it was untrue), and failed to place a code alert alarm (bracelet that sets off an alarm and locks the door when a resident attempts to exit the building unattended) on R1's body or electric wheelchair. R1 used the electric wheelchair to leave the building through an exit door with an alarm system unable to be heard by staff at the nurse station or in the residential halls. R1 remained outside in the dark without staff knowledge for over 20 minutes, traveled one block over uneven, rough concrete and asphalt, and staff found the resident seated in the street in her electric wheelchair. This deficient practice placed R1 in immediate jeopardy. Findings included: - R1's Quarterly Minimum Data Set (MDS), dated [DATE], recorded the resident had a Brief Interview for Mental Status (BIMS) score of 12 (cognitively intact) with hallucinations, delusions, and behaviors of rejecting cares. The MDS recorded R1 required extensive staff assistance with Activities of Daily Living (ADL's), unable to walk, used a wheelchair for mobility, and no wandering behaviors. The Elopement Care Plan, dated 07/24/20, directed staff to place a code alert alarm on R1's manual wheelchair and check the alarm placement and function every day. The Mental Health Care Plan, dated 08/03/20, recorded R1 received scheduled and PRN (as needed) antipsychotic medications (class of medication used to treat [MEDICAL CONDITION] (sudden severe onset of a major mental disorder characterized by a gross impairment in reality)and other adverse mental conditions) for the [DIAGNOSES REDACTED]., and provide a safe, quiet environment. The Physician's Progress Note, dated 08/03/20, recorded R1 was extremely agitated with difficult insight and judgement due to profound delusions that she strongly believed despite the outrageous nature of the delusions. The Elopement Assessment, dated 08/03/20, recorded R1 had hallucinations and delusions, used an electric wheelchair for mobility, exit seeking, and an elopement risk. The assessment directed staff to place a code alert alarm on R1 and monitor her location every 20 to 30 minutes. The Physician's Discharge Summary, dated 08/05/20, recorded R1 discharged to the Long Term Care Unit (LTCU), with a [DIAGNOSES REDACTED]. The summary directed staff to continue to seek geriatric behavior hospitalization and continue R1's antipsychotic medication regimen. The Progress Note, dated 08/05/20 at 01:12 PM, recorded R1 returned from the local hospital, and had a code alert alarm attached to her manual wheelchair. The Progress Note, dated 08/05/20 at 04:31 PM, recorded R1 pushed and hit exit doors, and made statements about leaving the facility. The note recorded staff moved R1 away from the doors and redirected her behaviors. The Progress Note, dated 08/06/20 at 03:59 AM, recorded R1 was restless, not able to sleep, rejected cares, and made statements about leaving the facility. The Progress Note, dated 08/06/20 at 05:10 AM, recorded night staff provided one on one supervision for R1 due to her continued delusions and anxiety. Certified Medication Aide (CMA) R's Witness Statement signed on 08/06/2020, documented on 08/06/20 at 05:54 AM CMA R observed R1 sat in an electric wheelchair on the side of the street across from the local hospital's emergency entrance. The witness statement further documented CMA R immediately called the LTCU charge nurse to report the incident, and waited with R1 until hospital staff arrived. The Risk Management Elopement Investigation, dated 08/10/20, recorded the local hospital admitted R1 on 08/01/20 due to increased behaviors and emotional distress related to hallucinations, delusions and paranoia. The investigation recorded the LTCU readmitted R1 on 08/05/20, and the resident continued to have hallucinations, delusions, and exit seeking behaviors. The investigation recorded staff placed a code alert alarm on R1's manual wheelchair (resident would not allow code alert alarm on her body) but did not place a code alert alarm on R1's electric wheelchair. The investigation recorded R1 used her electric wheelchair to exit the South Hall exit door, the alarm sounded, but was not able to be heard by staff at LTCU nurse's station or resident halls. The investigation recorded R1 eloped for over 20 minutes without LTCU staff knowledge and was found in the street one block from the facility door she exited. On 08/11/20 at 01:29 PM, observation of the facility's security video from 08/06/20 at 05:31:14 AM recorded R1 sat in her electric wheelchair, engaged the South hall exit door push bar for 15 seconds, exit door released, and R1 went through door. The video recorded R1 crossed the foyer, opened the outside exit door, and left the facility at 05:31:30 AM. On 08/12/20 at 10:31 AM, observation of the probable route R1 took after she left the building (based on the direction R1 faced in her electric wheelchair when found in the street) revealed R1 traveled sidewalks and/or parking lots to the street one block from the exit door. Continued observation revealed multiple sloped sidewalk ramps and driveways, sidewalks with eight to ten inch curb edges, and uneven, rough concrete and asphalt all along the route. On 08/11/20 at 10:00 AM, Administrative Nurse D stated the local hospital admitted R1 on 08/01/20 due to increased behaviors and emotional distress related to hallucinations, delusions and paranoia. Administrative Nurse D stated the LTCU readmitted R1 on 08/05/20, and the resident continued to have hallucinations, delusions, and exit seeking behaviors. Administrative Nurse D stated staff placed a code alert alarm on R1's manual wheelchair (resident would not allow code alert alarm on her body) but did not place a code alert alarm on R1's electric wheelchair. Administrative Nurse D stated she arrived at work on 08/06/20 at 05:50 AM, found the exit door alarming, checked the area outside, re-entered the building, and staff informed her they found R1 in the street across from the hospital emergency entrance (one block from exit door). Administrative Nurse D stated the alarm on the south exit door could not be heard at the LTCU nurse's station, and R1 eloped from building for approximately 20 minutes without staff knowledge. On 08/11/20 at 12:44 PM, Administrative Staff A stated the LTCU readmitted R1 from the local hospital with significant hallucinations and behaviors, R1 refused the code alert bracelet on her body, so staff placed the code alert bracelet on R1's manual wheelchair only. Administrative Staff A stated R1 used her electric wheelchair to leave through South Hall exit door, and eloped from the facility for over 20 minutes without staff knowledge. Administrative Staff A stated the facility was aware the South Hall exit door alarm could not be heard by staff at the nurses' station or resident halls. Administrative Staff A stated if staff placed a code alert alarm on R1's electric wheelchair the South Hall exit door would have locked, and an alarm would have sounded on the facility communication system to alert staff at the nurse's station and resident halls. On 08/11/20 at 02:10 PM, Licensed Nurse (LN) G stated R1 returned from the local hospital and continued to have hallucinations, agitation, restlessness, and exit seeking behaviors. LN G stated staff placed a code alert alarm on R1's manual wheelchair only, and the south hall exit door alarm could not be heard at the nurse's station or in the resident halls. The facility's Resident Elopement Prevention Policy, dated 07/25/17, directed staff to assess the resident and place a code alert alarm on most appropriate location: person, walker or wheelchair. The policy also directed staff to account for high risk residents every hour or as needed. The facility failed to adequately monitor and provide effective elopement interventions for R1, placing the resident in immediate jeopardy. The facility removed the immediate

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) jeopardy on 08/12/20 at 08:35 PM, when the facility implemented education to all staff to identify, provide interventions, monitor, and document changes in condition for elopement risk residents, and ensure placement of code alert alarms on the resident or appropriate mobility equipment. The facility implemented a system to prevent resident access to the South Hall at nights until the exit door alarm repaired to alert staff at the nurse's station and resident halls. The deficient practice remained at a scope and severity of a D.