| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 265832 | A. Building<br>B. Wing | 01/17/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Senath South Health Care Center | 300 East Hornbeck Street<br>Senath, MO 63876 |

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) |
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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32751<br><br>Based on observation, record review and interview the facility failed to provide protective oversight by not monitoring one resident (Resident #1), who had been assigned a staff member for one on one (1:1) oversight for previous elopement attempts. The assigned staff member left the resident unattended and the resident broke out a locked exit door, climbed an 11 foot fence, used the dusk to dawn light attached to the top of the fence to pull him/herself over and left the facility grounds. The resident crossed a busy, rural two lane highway, in the dark and was found 1 1/2 miles northeast of the facility in a field held at gunpoint by the owner of the property. A sample of eight residents were reviewed. The facility census was 123.<br><br>The Administration was notified on 1/17/23 of a Past Non-compliance Immediate Jeopardy (IJ) which began on 1/16/23. Upon discovery, the administrator identified Certified Nurse Aid (CNA) A left his/her assigned duty of 1:1 monitoring Resident #1, who used the opportunity to elope. Staff immediately put their policy and procedure in action to search for the resident. Facility staff reviewed their 1:1 monitoring policies and inserviced staff on new actions to take if they need to leave a 1:1 monitoring assignment. The IJ was corrected on 1/17/23.<br><br>Record review of the facility's policy on Intensive Monitoring/Visual Checks dated 3/25/22, showed residents who are showing poor impulse control including verbal/physical aggression, elopement ideation's, suicidal/homicidal ideation's, decompensation mentally or medically may be placed one on one or two on one (within eyesight of staff at all times) monitoring at the discretion of the Administration staff. Residents who require intensive monitoring of one on one will always have a dedicated staff member within eyesight.<br><br>1. Record review of Resident #1's medical record showed:<br><br>- An admitted [DATE];<br><br>- Diagnoses included paranoid personality disorder (a mental illness characterized by suspiciousness and mistrust of others), Schizophrenia (a mental illness characterized by disorganized thinking and hallucinations), major depression disorder (a mental disorder characterized by low mood and loss of interest in normal enjoyable activities), and anxiety.<br><br>(continued on next page) |

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.

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

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Review of Resident #1's Pre-Admission Screening and Resident Review ((PASRR) a federal requirement to help ensure that individuals who have a mental disorder or intellectual disabilities are not inappropriately placed in nursing homes for long term care) form, completed 7/24/2019 showed the need for a Level II screening (PASRR Level II is a comprehensive evaluation by the appropriate state-designated authority and determines whether the individual has MD, ID or a related condition, determines the appropriate setting for the individual and recommends what, if any, specialized services and/or rehabilitative services the individual needs). The Level II Screening, dated 8/1/2019 showed:<br><br>- Diagnoses included stimulant use disorder, amphetamines and drug induced psychosis;<br><br>- A legally appointed public administrator as guardian and conservator;<br><br>- A need for physical assist to go outdoors safely and respond to emergencies;<br><br>- Exhibits poor judgement, poor insight and does not make good decisions;<br><br>- Problematic behaviors included destruction of property, verbal and physical threats, verbal abuse, suspicion of others and trying to escape;<br><br>- Indicators for Nursing Facility (NF) services included a maximum need for monitoring due to elopement risk;<br><br>- The Assessor completing the screening noted in the final summary that the accepting facility will need to plan for behavioral supports for issues including medication and treatment on compliance, and maintain safety/prevent elopement as well as limit access to substances of abuse<br><br>Record review of Resident #1's Care Plan, dated 9/15/22, showed:<br><br>- At risk for elopement related to history of elopement;<br><br>- Has made multiple attempts to elope or threaten to elope;<br><br>- Exhibits exit seeking behaviors and requires one on one monitoring and redirection;<br><br>- On 7/16/21 the resident exited the facility through the emergency entrance, was found and placed one on one<br><br>- On 3/2/22 staff noted the resident continued to make focused attempts to elope over the courtyard fence on the men's unit. The resident will now require two staff members to escort him outside and deter his efforts as needed;<br><br>-Interventions for the identified risk of elopement problem included putting the resident on one on one monitoring as needed, perform frequent checks for safety and place on a secured unit.<br><br>Record review of the facility's investigation dated 1/16/23 showed:<br><br>- CNA A was assigned to monitor Resident #1 one on one for the evening shift;<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | - At 5:45 P.M., CNA A told CNA B to watch Resident #1 while CNA A took a bathroom break;<br><br>- CNA B said Resident #1 was sitting in the dining area and he/she walked away to put up cleaning supplies;<br><br>- At 6:00 P.M., CNA B noticed the resident was missing and notified the charge nurse;<br><br>- The facility enacted their policy and procedure for missing residents;<br><br>- Staff notified the local authorities and guardian;<br><br>- At 9:45 P.M., local Sheriff Deputy located the resident 1 1/2 miles northeast of the facility, across the highway at a farm house being held at gunpoint by the owner of the farm;<br><br>- Resident #1 was taken to the facility and assessed with scratches on his/her hand;<br><br>- A written statement from CNA A showed he/she did leave Resident #1 in the dining area and told CNA B to monitor the resident;<br><br>- A written statement from CNA B showed he/she knew Resident #1 was in the dining area, but left to secure cleaning supplies on the unit;<br><br>- A written statement from Resident #1 showed<br><br>- He/she was left unsupervised in the dining area;<br><br>- He/she broke open a side door and exited into the courtyard;<br><br>- He/she used a chair and climbed over a fence;<br><br>- He/she was stopped at a farm house by the owner and held at gunpoint until authorities arrived.<br><br>Observation on 1/17/23, of the facility's location showed:<br><br>- One main road to the facility;<br><br>- The road is a two lane highway with farmland in various stages of growth on either side along with a few houses and buildings amid the open fields;<br><br>- Sections of the road have large ditches off the shoulder;<br><br>- The road has many curves and secondary road cross-sections;<br><br>- There are few street lights on the road.<br><br>Review of the historical weather data from www.worldweather.com showed the temperature at 9:00 P.M. on 1/16/23 in the area where the resident eloped was 59 F.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | During an interview on 1/17/2023 at 4:15 P.M., CNA A said:<br><br>-On 1/16/23, evening shift, he/she was assigned to monitor Resident #1 one on one;<br><br>-He/She needed to take a break after the evening meal;<br><br>-The hall monitor, CNA B, was in the dining room cleaning up after the meal;<br><br>-The resident was sitting quietly in the dining room;<br><br>-He/She asked CNA B to keep an eye on the resident while he/she ran to the bathroom. He/She assumed CNA B heard the request and would do it;<br><br>-When he/she came back to the dining area CNA B was searching for Resident #1;<br><br>-He/She was aware CNA B was the monitor for the entire hall.<br><br>During an interview on 1/17/23 at 1:35 P.M., CNA B said:<br><br>-He/She was assigned as hall monitor for the evening shift on 1/16/23;<br><br>-He/She saw Resident #1 in the dining area after the evening meal;<br><br>-He/She was trying to clean up after the meal and keep an eye on the hall;<br><br>-He/She did not confirm hearing CNA A asking for assistance in watching Resident #1;<br><br>-There was no way he/she could have properly monitored any resident 1:1, as he/she had all the residents on the hall to monitor and he/she was finishing cleaning;<br><br>-He/She left the area to secure the cleaning supplies, which cannot be left out due to safety issues for other residents;<br><br>-All the doors in the dining area were shut and locked;<br><br>-When he/she arrived back, after a very brief absence, Resident #1 was gone and the door to the outside had been busted open;<br><br>-CNA A should have found someone else to monitor Resident #1 prior to leaving the area.<br><br>During an interview on 1/17/23 at 1:15 P.M., Resident #1 said his/her written statement was an accurate statement. He/she said by kicking the side door open he/she was able to get to the yard. Resident #1 said he/she left, because he/she does not like being monitored 1:1 at the facility.<br><br>During an interview on 1/17/23 at 3:30 P.M., Significant Other (SO) said he/she became Resident #1's legal representative on 5/3/19. The facility knew the resident was an elopement risk and he/she would have expected them to provide monitoring at all times. SO said the resident is in a secured facility because he/she tries to elope wherever he/she lives.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | During an interview on 1/17/23 at 3:45 P.M., the Physician's Assistant (PA) said Resident #1 is not safe unaccompanied outside of the facility. He/She said the resident does not make good decisions, so things like crossing the highway in the dark is very concerning.<br><br>During an interview on 1/17/23 at 5:00 P.M., the Administrator said she would have expected staff to keep their eyes on the resident at all times. If one staff needed a break and asked for help, the other staff member should have monitored until the the return.<br><br>Complaint #MO00212682 |