STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675037	A. Building B. Wing	09/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pittsburg Nursing Center	123 Pecan Grove Pittsburg, TX 75686

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19401 Based on observation, interview, and record review the facility failed to develop and implement a comprehensive person centered care pan for residents in measurable objectives and timeframes to meet the residents mental and psychosocial needs for 1 of 5 residents sampled for care plans (Resident #1.) The facility failed to develop a care plan or have interventions in place to prevent Resident #1 from prolonged exposure to the sun. They failed to ensure resident #1 had a care plan in place for her smoking and her elopement tendencies This failure could place residents at risk for not receiving the care and services they need in order to maintain their care. Findings included: Record review of Resident #1's face sheet indicated she was an [AGE] year-old female admitted to the facility on [DATE] with a diagnosis which included dementia without behavioral disturbances. Record review of Resident #1's quarterly MDS, dated [DATE], indicated a BIMS score of 8, which indicated the resident's mental status was moderately impaired. Resident #1's functional status indicated with balance during transitions and walking, she required the physical help of one person when moving from seated to standing position. She did not walk and required the assistance of one person when moving from surface to surface. She required the assistance of a walker or wheelchair for mobility. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's care plan, dated 2/5/22, indicated a problem of cognitive loss and dementia. The resident had long and short-term memory deficits. She had inattention and disorganized thinking that fluctuated. She could make her needs known but had difficulty finding words and completing sentences. Some of the approaches were to explain care procedures, observe for change in mental status, and decision-making ability and report to physician. Resident #1's care plan, dated 2/27/22, indicated a problem of ADL function. The resident used a wheelchair for mobility, could propel self about the facility and was propelled by the staff at times. One of the approaches was to assist the resident with mobility as needed. There were no care plan interventions regarding the resident's desire to sit outside in the sun, smoking, or her wander guard and elopement tendencies. The care plans last revision date was 8/31/22. Record review of Resident #1's elopement assessment, dated 7/14/22, indicated she was ambulatory in a wheelchair, exhibited Alzheimer's, symptoms, had a history of wandering into unsafe areas, and displayed behaviors that indicated an attempt to leave. The assessment indicated the resident was at risk for elopement. One of the interventions was to place a wander guard on the resident. Record review of Resident #1's computerized physician orders indicated, on 7/15/22, Resident #1 had a wander guard to the left ankle and to verify placement every shift. Record review of Resident #1's smoking assessment dated [DATE] indicated she was a safe smoker and the care plan action was the care plan would continue. Record review of Resident #1's EMS report, dated 9/10/22, indicated they were dispatched to the facility on [DATE] at 4:44 p.m., they were enroute at 4:46 p.m., and arrived at the scene at 4:55 p.m. for a patient that got too hot. The patent was found sitting in a wheelchair between the dining area and the back patio door. Two staff members were standing near the patient with one of them fanning her with paper. When EMS walked around to the front side of the patient, she was found to be unresponsive, and slumped backwards in the chair with shallow but rapid respirations. When asked how long the patient had been like this, both staff members looked at EMS, shrugged their shoulders and held their hands out as if they had no clue. EMS insisted they figure out a better answer to how long the patient had been outside and when she was last seen as normal. Initial vitals were quickly taken where the patient was sitting, and she was hypotensive. Per staff the patient had wheeled herself outside at least one hour ago, when asked the state, she is normally alert and verbally communicates but is usually confused due to dementia. The EMS departure time was 5:11 p.m. During an interview and record review on 9/13/22 at 11:50 a.m., the DON said they tied to make sure all residents were in a safe environment Record review of the care plan with the DON revealed there was no care plan intervention regarding Resident #1 going outside repeatedly to sit in the sun. There was no care plan regarding Resident #1 being a wanderer, or a smoker. During an interview on 9/14/22 at 9:00 a.m., the Administrator said an investigation into the incident on 9/10/22 with Resident #1 had determined she had be in and out of the smoking area most of the day. Around 3:45 p.m. she was brought in by CNA P and she must have gone back out. She said around 4:30 p.m. Resident #1 was discovered unresponsive by MA Q. LVN M said they applied cold packs to her neck and EMS was called. She always said she was cold and would go in and out or sit in the doors so she could get sunshine. The Administrator said they did not know what happened on 9/10/22 until the hospital called on 9/12/22 to say Resident #1 had a hyperthermia (body temperature above normal). She Said Resident # 1's care plan was updated to include infomation about heat exhaustion.

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(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 to resident health or safety 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** 19401 Based on observation, interview and record review the facility failed to ensure each resident received adequate supervision and assistance devices to prevent accidents for 1 of 5 residents reviewed (Resident #1) for accidents and supervision. 1. The facility failed to ensure staff were aware of how long Resident #1 was outside, exposed to the sun on 9/10/22 with temperatures around 88 degrees. 2. The facility failed to develop a care plan or have interventions in place to prevent Resident #1 from prolonged exposure to the sun. 3. The facility failed to ensure Resident #1 was dressed in long pants and shirt that she normally wore. The resident was dressed in a tank top and shorts which exposed her fragile skin to the sun. 4. The facility failed to follow their policy for wandering residents regarding intervention strategies. 5. The facility failed to ensure Resident # 1 had increased supervision for elopement and left the resident unattended in an area that was not locked. 6. The facility failed to have a care plan in place regarding her wander guard and potential elopement tendencies. An Immediate Jeopardy (IJ) situation was identified on 9/14/22 at 4:00 p.m. While the IJ was removed on 9/15/22 at 2:00p.m., the facility remained out of compliance at actual harm, due to the facility's need to evaluate the effectiveness of the corrective systems. These failures could place residents at risk of harm, injury and possible death to residents left unattended in the heat without monitoring or supervision for an unknown length of time. Findings include: Record review of Resident #1's face sheet indicated she was an [AGE] year-old female admitted to the facility on [DATE] with a diagnosis which included dementia without behavioral disturbances. Record review of Resident #1's quarterly MDS, dated [DATE], indicated a BIMS score of 8, which indicated the resident's mental status was moderately impaired. Resident #1's functional status indicated with balance during transitions and walking, she required the physical help of one person when moving from seated to standing position. She did not walk and required the assistance of one person when moving from surface to surface. She required the assistance of a walker or wheelchair for mobility. (continued on next page)

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(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 to resident health or safety Residents Affected - Few	Record review of Resident #1's care plan, dated 2/5/22, indicated a problem of cognitive loss and dementia. The resident had long and short-term memory deficits. She had inattention and disorganized thinking that fluctuated. She could make her needs known but had difficulty finding words and completing sentences. Some of the approaches were to explain care procedures, observe for change in mental status, and decision-making ability and report to physician. Resident #1's care plan, dated 2/27/22, indicated a problem of ADL function. The resident used a wheelchair for mobility, could propel self about the facility and was propelled by the staff at times. One of the approaches was to assist the resident with mobility as needed. There were no care plan interventions regarding the resident's desire to sit outside in the sun, smoking, or her wander guard and elopement tendencies. The care plans last revision date was 8/31/22. Record review of Resident #1's nursing notes, dated 7/2/22 at 9:39 a.m., indicated she propelled herself down the walkway in the patio area to the gate and attempted to open the gate. When asked where she was going, she said, just out. Record review of Resident #1's nursing notes, dated 7/3/22 at 7:40 a.m., indicated Resident #1 propelled self out the dining room door to the patio area and to the gate off the fence and attempted to open gate. The staff intervened and assisted her back into the facility. She said she was going home. Record review of Resident #1's nursing notes, dated 7/3/22 at 8:31 a.m., indicated Resident #1 propelled self away from dining room table and was not eating breakfast, she attempted to go out the patio door unsupervised. She was redirected, ate about 75 percent of her breakfast, and tried to push door making an alarm sound. The nurse intervened, Resident #1 said she was going home. She was placed on 15-minute monitoring. Record review of Resident #1's elopement assessment, dated 7/14/22, indicated she was ambulatory in a wheelchair, exhibited Alzheimer's, symptoms, had a history of wandering into unsafe areas, and displayed behaviors that indicated an attempt to leave. The assessment indicated the resident was at risk for elopement. One of the interventions was to place a wander guard on the resident. Record review of Resident #1's computerized physician orders indicated, on 7/15/22, Resident #1 had a wander guard to the left ankle and to verify placement every shift. Record review of Resident #1's nursing note, dated 9/10/22 at 4:15 p.m., indicated at 4:30 p.m., a medication aide could not arouse Resident #1. Two nurses got vital signs at 4:35 p.m. blood pressure 90/40, pulse 123, blood sugar 220 and temperature was 98.8, 911 was called. EMTs exit with resident at 5:03 p.m. (continued on next page)

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(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 to resident health or safety Residents Affected - Few	Record review of Resident #1's EMS report, dated 9/10/22, indicated they were dispatched to the facility on [DATE] at 4:44 p.m., they were enroute at 4:46 p.m., and arrived at the scene at 4:55 p.m. for a patient that got too hot. The patent was found sitting in a wheelchair between the dining area and the back patio door. Two staff members were standing near the patient with one of them fanning her with paper. When EMS walked around to the front side of the patient, she was found to be unresponsive, and slumped backwards in the chair with shallow but rapid respirations. When asked how long the patient had been like this, both staff members looked at EMS, shrugged their shoulders and held their hands out as if they had no clue. EMS insisted they figure out a better answer to how long the patient had been outside and when she was last seen as normal. Initial vitals were quickly taken where the patient was sitting, and she was hypotensive. Per staff the patient had wheeled herself outside at least one hour ago, when asked the state, she is normally alert and verbally communicates but is usually confused due to dementia. The EMS departure time was 5:11 p.m. Record Review of Resident #1's Emergency Department History and Physical, dated 9/10/22, indicated this [AGE] year-old female with a history or hypertension, hyperlipidemia, hypothyroidism, diabetes, COPD, and dementia. She presented to the emergency room with hyperthermia of 103 degrees F, tachycardia and alerted mental status. She was found unresponsive outside in her wheelchair and had been in the sun for a length but uncertain of the amount of time. On presentation her Glasgow Coma Scale was 4 (3 being the worst and 15 the best) Her right side was flaccid, and she had left sided deviation. However, she eventual improved and currently has a Glasgow coma [NAME] 9 (moderate.) She received IV fluids, IV Antibiotic and ice packs for cooling. She did not report feeling any pain, nausea, vomiting, or bowel problems. She was admitted for careful monitoring and treatment in the ICU. She had a defused (rash caused by hot or humid weather) sunburn on skin, from her head and chest down on her arms and legs. Sparing covered areas of skin Petechiae (tiny brown-purple spots due to bleeding under the skin) on thighs and 2 bullac (blisters) noted on left thigh. Record review of a nursing note, dated 9/14/22 at 6:57 p.m., indicated Resident #1 was admitted back to the facility. She presented with several blisters to her right arm, left upper chest, abdomen, left breast, left forearm, and bilateral thighs. The blisters were cleaned, triple antibiotic ointment was applied and covered with non-adherent pad and secured with dressing. During an observation on 9/13/22 at 9:20 a.m. of the smoking area revealed a patio area with two doors, leading outside from the dining room area. These doors did not have wander guard alarms on them. The patio area was covered and looked to be about 12 feet by 10 feet. It had chairs and tables and cigarette disposal area set up. There were a few chairs along the walkway. The area had a large fenced in courtyard area with a gate at the end of a walkway. That area had full exposure to the sun and no shade. The gate was not locked. It had a hook bolt latch on the double door gate to hold the two gates together. The one side of the gate had a security latch into the ground. The gate was hard to open. The one side would open about 8 inches without opening the latch to the ground on the other side. It was hard to open and close. Record review of the list of smoking times provided by the Administrator indicated the Smoke Schedule was: 9:00 a.m. 11:00 a.m. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	1:30 p.m. 3:30 p.m. 7:00 p.m. Record review of the weather statement for the location of the facility provided by the Administrator dated 9/10/22 indicated the temperature was around 88 to 90 degrees that day. (Verification via internet.) During an interview on 9/13/22 at 9:22 a.m., Resident #2 was a smoker and sat on the patio. He said on 9/10/22 Resident #1 sat outside in the sun most of the day. He said the staff tried to get her back inside, but she went out again. He said she came in and out of the facility that day but spent most of the day outside in the sun. He said Resident #1 liked to sit in the sun and be close to the gate. She tried to get out the gate when no one was watching. She was an escape artist, he had seen her try to get out of the gate in the past. During an interview on 9/13/22 at 9:24 a.m., Resident #3 said she went out to smoke on a regular basis. Resident #1 was always trying to sneak away from the facility. She sat outside in the sun all the time. According to Resident #3, Resident #1 tried to open the gate and leave. During an interview on 9/13/22 at 9:26 a.m., Resident #4 said she noticed Resident #1 sat outside most of the day on 9/10/22 or 9/11/22 she could not remember which day, but it was the weekend. She said Resident #1 was hardheaded and liked to sit outside in the sun. During an interview on 9/13/22 at 9:28 a.m., Housekeeper A said she took the residents out to smoke on occasion on the patio. Resident #1 was a smoker and most of the time she would come back inside. If she would not listen, she would let some of the nursing staff know she would not come back in. Housekeeper A said Resident #1 was not supposed to be outside by herself. During an interview on 9/13/22 at 9:59 a.m. the Activity Director said she took the residents out to smoke at 11:00 a.m. and 1:30 p.m. during the week, she was not there on 9/10/22. The Activity Director said Resident #1 liked to go outdoors and come back in all the time. Resident #1 liked to stay outside, not in the covered area but in the sun. During an interview on 9/13/22 at 10:18 a.m., Resident # 5 said she knew Resident #1 was outside at 1:30 p. m. to smoke on 9/10/22. She did not know if she came back in after. Resident #5 said Resident #1 had on shorts and short sleeves that day, and that was unusual for her. Resident #1 always had on a long sleeve shirt and pants. During an interview and record review on 9/13/22 at 10:32 a.m. the DON stated Resident #1 rolled herself up and down the halls all day. She would go outside to the smoke area and back inside. Resident #1 was always cold and always wore long sleeves and long pants. She would sit in the sun, and when she was not outside, she would sit in the doorway to get sun. The DON said she had received a report from LVN N on Saturday, 9/10/22, that they sent Resident #1 to the hospital. LVN N had not told her why only she had altered mental status. On 9/12/22 the hospital called to say Resident #1 had hyperthermia. After reviewing the EMS record with the DON, she said it was unacceptable for the nurses to shrug their shoulders with no answer as to how long the resident had been outside. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a telephone interview on 9/13/22 at 11:10 a.m., LVN M said the staff told her they tried to get Resident #1 inside on 9/10/22. She did not know she was outside or how long she had been outside. LVN M said she was not her nurse, but MA Q went to the dining room door and called for a nurse. Resident #1 was outside she told them she needed to get her inside, they put ice packs on her neck and cool rags. She said the resident was hot from sitting in the sun, her skin was hot to the touch, she was not red, and she was not sweating. Resident #1's temperature was 99.1. LVN M said she notified Resident #1's nurse, LVN N. LVN M said she did not know what time it was. She was hot from sitting in the sun. Resident #1 had altered mental status and they called 911. LVN M said Resident #1 constantly tried to go out the door. On 9/10/22, Resident #1 went out and came back in constantly during breakfast. LVN M said Resident #1 was inside for lunch and that was the last time she saw Resident #1 until the MA called her to the door. LVN M said she knew Resident #1 tried to get out the gate one time in the past. During an interview on 9/13/22 at 11:20 a.m., CNA O said she got Resident #1 dressed for breakfast on 9/10/22. Resident #1 had on short pants and a short sleeve shirt. She said there was a jacket on the back of her chair. CNA O said Resident #1 moved around a lot and would not stay in one place. She said around 3:00 p.m. they went outside to smoke. Resident #1 was sitting in the sun. Resident #1 would always complain she was cold. CNA O said she had to move her away from some of the doors during the day because Resident #1 had the wander guard that would cause the door alarms to go off. CNA O said she always had to look for Resident #1 because she was hard to keep up with. Resident #1 had gone in an out the smoking area all day. CNA O said she did not remember giving her any water. According to CNA O when the smoke break was over Resident #1 came back inside. She said it was brought to her attention by MA Q on 9/10/22 about 4:20 p.m., Resident #1 was outside and unresponsive. She said they brought her back inside. Resident #1 was warm, but she was not sweating. She had her eyes closed and was slobbering from her mouth. They (CNA O, MA Q, LVN M, put ice on her and cold towels. The nurses, LVN N or LVN M called 911. During a telephone interview on 9/13/22 at 11:35 a.m., CNA P said Resident #1 kept going in an out of the facility all day on 9/10/22, and about 3:30 p.m. she was outside talking to her. CNA P said she told Resident #1 to come back inside, and she came in. The CNA said she went back to the front and Resident #1 must have gone back outside. CNA P said she did not know how long Resident #1 had been outside that day. She said Resident #1 went in and out all the time, they would try to keep her inside, however, it was a constant battle. Resident #1 could come in and go out on her own at the patio doors only. When she was called at about 4:30 p.m. on 9/10/22 to assist with Resident #1, the resident was hot when MA Q found her. She said when MA Q hollered for help, we all ran to try and help. Resident #1's skin was hot to the touch, and she was drooling from her mouth. During a telephone interview on 9/13/22 at 11:39 a.m., CNA R said she worked on 9/10/22. She said the only thing she observed was Resident #1 sitting outside in the sun. She said she would bring Resident #1 inside and she would go back out. CNA R said Resident #1 would go back and forth, after the smoke break. CNA R said the last time she saw Resident #1, was at the smoke break after lunch at about 1:30 p.m. and she was outside. The next time she saw her was when MA Q called for help around 5:00 p.m. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview and record review on 9/13/22 at 11:50 a.m., the DON said they tied to make sure all residents were in a safe environment. She said residents did not stay out too long and they made sure they were hydrated. Record review of the care plan with the DON revealed there was no care plan intervention regarding Resident #1 going outside repeatedly to sit in the sun. There was no care plan regarding Resident #1 being a wanderer, or a smoker. During an interview on 9/13/22 at 12:24 p.m., MA Q said Resident #1 could get outside on her own and would always say she was cold. MA Q said at breakfast, she did not know if Resident #1 was outside or not. She said at lunch she did see Resident #1 and she was fine. After the resident ate, she was at the back door. MA Q said she did not see Resident #1 go outside. The next time she saw Resident #1 was around 4:30 p.m. she was sitting alone outside in the sun in her wheelchair. MA Q said she called Resident #1's name and tapped her on the shoulder. The resident did not respond. She said Resident #1 was drooling from her mouth. She stepped to the door and hollered for a nurse. She said LVN M came out and helped her bring Resident #1 inside. LVN M tried to arouse Resident #1. Then LVN M called LVN N and they got her blood pressure. They told us to put cold towels on her neck and forehead. She was not sweating, she was not red, just hot. She had on shorts and a worn (old, loose around the neck) tee shirt, socks, and shoes. The neck of shirt was exposed. MA Q said she did not know how long Resident #1 had been outside. The EMTs tried to get an answer on how long from her and other staff and no one knew. She said she tried to keep Resident #1 gate, because she would try to get out sometimes and cars came around the back of the building driving fast. During an observation and interview on 9/13/22 at 4:12 p.m., Resident #1 was observed in her hospital bed. She had an IV bag connected. She was in good spirits and said she felt much better. She had two large bandaged on her right arm and her left arm from her wrist to elbow. She said the hospital staff told her she was out in the sun to long. She did not feel sick before that day, and then she was just sick. She said she did not know how long she was in the sun but had been out most of the afternoon. She had gone back in the building a few times but went back out. Resident #1 said she was cold. She did not remember if she had water or not. During an observation and interview on 9/13/22 at 4:20 p.m. with Hospital RN revealed Resident #1 had scattered areas of discolored skin on her shoulders, chest, and upper arms. There was an area on her right upper chest area that was about 3.5 to 4 inches long and about an inch wide. It was dark in color and had no skin on top of the area. The Hospital RN said the places where the bandages were, there were areas where the blisters had burst. The Hospital RN said Resident #1 had blisters and red marks on both arms, and on her left leg there was a cluster of blisters that had burst and were covered with a large bandage. She said she did not know how long the resident was in the sun, but it was likely more than 30 minutes due to the damage of her skin. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 9/14/22 at 9:00 a.m., the Administrator said an investigation into the incident on 9/10/22 with Resident #1 had determined she had be in and out of the smoking area most of the day. Around 3:45 p.m. she was brought in by CNA P and she must have gone back out. She said around 4:30 p.m. Resident #1 was discovered unresponsive by MA Q. LVN M said they applied cold packs to her neck and EMS was called. They added an incident report that was not completed on 9/10/22. Resident #1's care plan was also updated to include information about heat exhaustion. The Administrator said Resident #1 did participate in activities of her choice. She always said she was cold and would go in and out or sit in the doors so she could get sunshine. The Administrator said they did not know what happened on 9/10/22 until the hospital called on 9/12/22 to say Resident #1 had a hyperthermia (body temperature above normal). Then they started their investigation into the incident and called it in to the state survey agency. During an interview on 9/14/22 at 9:53 a.m., LVN B said she did not work on the hall with Resident #1. However, she knew she liked to exit seek a lot and she was a resident they tried to watch. During an interview on 9/14/22 at 9:55 a.m. the Activity Director said Resident #1 liked Bingo. She would watch them do the other activities sometimes but usually did not participate. She said Resident #1 liked activities with food, and entertainment. The Activity Director said on occasion you could distract Resident #1 with activities, but Bingo was her favorite. Resident #1 would almost always take food or drinks, and she loved popcorn. During an interview on 9/14/22 at 10:01 p.m., LVN C said she did not work on 9/10/22. She said Resident #1 was confused and a wanderer. She could self-propel herself. She was easily redirected and liked to be outside where she was found on 9/10/22. She required incontinent care and had a pressure area. She had on a wander guard so the doors would alarm if she tried to go out all the doors except the patio doors. She would go out the smoke area and sit in the sun. LVN C said sometimes Resident #1 was cognitively fine and other times she is confused. It depended on the time of day or her moods if she was cognitive or not. During an interview on 9/14/22 at 11:23 a.m., the DON said she had been in her position since 7/25/22 but had worked at the facility prior to being the DON. She said on 7/3/22 Resident #1 tried to get out one of the exit doors on one of the halls. She said there was no care plan for the elopement issues and the DON initiated an elopement care plan today (9/14/22). She also said there was no care plan about her smoking. During a telephone interview on 9/14/22 at 12:04 p.m. Resident #1's physician said he had already talked to the Administrator regarding Resident #1. He said Resident #1's skin was fragile but likely no more fragile than anyone else her age and in the nursing home population. He said it was hard to determine how long it may have taken for her to sunburn. It was dependent on the condition of her skin elasticity. It could have been an hour and maybe a half hour. He said she could also be on some medications that could have contributed to her being more susceptible to the sun. The physician said he did know Resident #1 liked to be outside and sit in the sun. The Physician said the Administrator said normally Resident #1 had on long sleeves and pants compared to the shorts and short sleeves she had on 9/10/22 which also contributed to her sunburn. . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675037	A. Building B. Wing	09/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pittsburg Nursing Center	123 Pecan Grove Pittsburg, TX 75686

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 9/14/22 at 12:51 p.m., CNA G said she worked at the facility for two years. She was not there on 9/10/22. CNA G said Resident #1 was easily redirected, she would give her water, or push her to the door so she could sit in the sun. She said Resident #1 always said she was cold. CNA G said when she got Resident #1 dressed, she would always put her in long sleeves and pants, although Resident#1 did have a variety of clothes in her closet. This was determined to be in an Immediate Jeopardy (IJ) situation on 9/14/22 at 4:00 p.m. The Administrator and Regional nurse Consultant were notified. The Administrator and the Regional Nurse Consultant were provided with the IJ template on 9/14/22 at 4:00 p.m. The following Plan of Removal submitted by the facility was accepted on 09/15/2022 at 9:25 a.m.: (Plan of Removal 1. Immediate actions The resident's physician and responsible party were notified by the Director of Nursing on 09/14/2022. Care Plan was developed on 09/14/2022 with interventions in place to prevent the resident from prolonged exposure to the sun which include: o Assess and monitor residents' temperature o Contact Physician if signs and symptoms worsen o Educate Staff of signs and symptoms of hyperthermia o Encourage Resident to sit in a shaded area o Ensure adequate fluids are given and encourage resident to consume fluids o Monitor resident carefully for heat related symptoms Care Plan was developed on 09/14/2022 regarding her wander guard and potential elopement tendencies for [Resident #1]. Care Plan was developed on 09/15/2022 regarding resident's tendency for heat exhaustion/tendency to want to sit outside in the sun. Interventions include offering diversional activities such as food, music, bingo etc . An audit was conducted to ensure that any resident triggering for at risk for elopement had: o a care plan in place, and o a photo, face sheet, and care plan in the wandering resident book (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An audit was conducted to ensure that an elopement assessment was completed on all residents in the past quarter. An alarm was placed on the gate in the courtyard on 09/14/2022 to ensure no resident at risk for wandering could elope. Q 1-hour checks were initiated on residents in the courtyard area during daylight hours on 09/14/2022. 2. Education (provided by DON or ADON) ALL STAFF were trained on Avoiding Heat Exhaustion and Heat Stroke by the Director of Clinical Services on 09/14/2022. This will be completed by 09/15/2022 at 2:00 PM. Staff will not return to shift without completing this in-service. ALL STAFF were in-serviced on ensuring residents are dressed appropriately for all weather conditions by the Director of Clinical Services on 09/14/2022. This in-service will be completed by 09/15/2022 at 2:00PM. Staff will not return to shift without completing this in-service. ALL STAFF were in-serviced on the Wandering Resident Policy and Wandering Resident Book by the Director of Clinical Services on 09/14/2022. This in-service will be completed by 09/15/2022 at 2:00 PM. Staff will not return to shift without completing this in-service. ALL STAFF were in-serviced on resident specific information regarding: o Wearing a UV rated shirt o Wearing a sun hat o Applying sunscreen to resident o Encourage resident to sit in the shade This in-service will be completed by 09/15/2022 at 2:00 PM. Staff will not return to shift without completing this in-service. All nursing staff were in-serviced on performing Q 1-hour checks on residents in the courtyard area during daylight hours on 09/14/2022 by the Director of Clinical Services. This in-service will be completed by 09/15/2022 at 2:00 PM. Nursing will not return to shift without the in-service. 3. Medical Director - The Medical Director has been notified of the Immediate Jeopardy. 4. QAPI Committee Review - An interim QAPI committee meeting was completed on 9/14/2022. 5. Plan of removal date: 09/15/2022) (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 9/15/22 at 9:26 a.m., the Administrator said they had in serviced staff on supervision of residents in the courtyard area from 8 a.m. to 8 p.m. The nurse at the front nurse's station was responsible for monitoring residents at least hourly. There was a book with monitoring sheets (attached) at the nurse's station. They had put an alarm on the courtyard gate (it was visible from the parking area.) They had placed two books at the two nurses' station with a list of wandering residents along with their pictures. They had UV shirts that said Ultraviolent protection factor 50 plus that was supposed to block 98 percent of the UV rays for Resident #1 on days they could not keep her inside. They had in-services on heat exhaustion and what to look for. They also included hypothermia and frost bite for the winter. All staff were in-serviced because at one time each discipline could be responsible for taking the residents out to smoke, housekeeping, dietary business office and nursing. During interviews on 9/15/22 staff listed below were able to verbalize they had been in- serviced on Avoiding Heat Exhaustion and Heat Stroke, residents wore appropriate clothing, policy for wandering residents, and the wandering resident books. They verbalized resident specific training regarding Resident #1 which included diversional activities such as food or activities and encouraging residents to drink fluids. Staff said they were in-serviced on a wandering resident and what actions to take if a resident could not be found. At 10:13 a.m. Activity Director At 10:37 a.m. LVN B- day shift At 10:49 a.m. LVN C- Day shift At 10:59 a.m. MA/CNA D -Day shift At11:07 a.m. BOM At 11:36 a.m. Housekeeper E At 11:39 a.m. Dietary Manager At 12:03 p.m. CNA F -day shift At 12:42 p.m. CNA G- day shift At 12:52 p.m. CNA H- day shift At 12:59 p.m. Housekeeper I At 1:24 p.m. CNA J-day shift At 1:30 p.m. RN K PRN - work all shifts At 1:47 p.m. LVN L- PRN - work all shifts (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Administrator, DON, ADON, Regional Nurse Consultant and the Regional [NAME] President of Operations were informed the Immediate Jeopardy was removed on 9/15/22 at 3:00 p.m. The facility remained out of compliance at a severity level of actual harm that in not immediate and a scope of as isolated due to the facility's need to evaluate the effectiveness of the corrective systems that were put into place.