STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265702	A. Building B. Wing	12/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Troy Manor	200 Thompson Drive Troy, MO 63379

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 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** 33955 Based on interview and record review, the facility failed to provide one resident (Resident #1), who had diagnosis of schizophrenia (mental illness) and a history of elopement and exit seeking behaviors from the facility, with sufficient supervision and monitoring to ensure the resident did not leave the facility grounds without staff knowledge. Staff said they last saw the resident on 12/2/22 at approximately 9:45 P.M. in the resident smoking area outside the facility. Housekeeper A, who was responsible to supervise the residents' smoke break, did not ensure the resident returned inside the facility on 12/2/22 after the 9:30 P.M. scheduled smoke time. The resident said he/she walked away from the facility on 12/2/22 during the 9:30 P.M. smoke break. Facility staff identified the resident was missing on 12/2/22 at approximately 10:30 P.M. Staff contacted the police who located the resident on 12/2/22 at approximately 11:30 P.M. walking down a busy four lane divided highway. The facility census was 92. The administrator was notified of the Immediate Jeopardy (IJ) on 12/12/22 at 3:46 P.M. which began on 12/2/22. The IJ was removed on 12/13/22 as confirmed by surveyor onsite verification. Review of the facility's undated Smoking Policy showed the following: -Residents are supervised at all times when smoking; -An enclosed courtyard is available for residents to smoke during good weather. A staff person will supervise them; -Smoking times were 8:30 A.M. supervised by housekeeping staff, 11:00 A.M. supervised by activity staff, 1:30 P.M. supervised by dietary staff, 3:30 P.M. supervised by nursing staff, 7:00 P.M. supervised by the floor technician, and 10:00 P.M. supervised by night shift laundry staff. 1. Review of Resident #1's face sheet showed the following: -Original admitted [DATE]; -Diagnoses included anxiety, seizures, altered mental status, schizophrenia, major depressive disorder, and stroke. Review of the resident's care plan, dated 8/20/22, showed the following: (continued on next page)

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

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-The resident had impaired decision making related to schizophrenia; -Calm the resident if signs of distress develop during the decision making process; -Determine if decisions made by the resident endanger the resident or others; -Encourage the resident to verbalize feelings, concerns, and fears, and clarify misconceptions; -Give objective feedback when inappropriate decisions are made; -Set expectations and limits; -Support and reassure the resident in new situations; -The resident was a supervised smoker. He/She would smoke in a safe environment with supervision. Review of the resident's care plan, updated 10/11/22, showed the following: -On 10/11/22 at 1:23 A.M. the Certified Nurse Aide (CNA) alerted the nurse the resident was not on the special care unit and the exit door at the end of the hall was alarming; -The facility contacted the police who assisted in searching for the resident; -On 10/11/22 the resident was located at the church next to the facility; -Assess the resident for signs of restlessness, anger, or distress, and report to the physician; -The resident would reside on the secured unit with monitoring of whereabouts; -Possible evaluation for discharge to a more appropriate and secure environment. Review of the resident's smoking assessment, dated 10/30/22, showed the resident required supervision from staff while smoking. Review of the resident's Minimum Data Set (MDS, a federally mandated assessment instrument required to be completed by facility staff), dated 11/10/22, showed the following: -Diagnoses included non-traumatic brain dysfunction, stroke, seizure disorder, and schizophrenia; -Cognition was intact; -Independent with activities of daily living. Review of the resident's elopement risk assessment, dated 11/22/22, showed the resident was at high risk for elopement. Review of the facility's undated investigation showed the following: (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Elopement 12/2/22; -The resident managed to escape the facility and was found by police walking down the road; -Staff realized the resident was missing right after change of shift (2nd to 3rd shift) and they started elopement procedures; -The resident was last seen during resident supervised smoking (approximately 9:45 P.M.) by Housekeeper A; -Housekeeper A did not recall seeing the resident after smoking due to another resident causing a disturbance during the break; -Summary: During or after resident supervised smoking, the resident managed to get away from supervision unnoticed. The resident claims to have left during smoking time. Review of a written statement from Housekeeper A, obtained by the facility, dated 12/6/22 at 9:30 P.M. showed the following: -Housekeeper A took the smokers out for smoke break; -Housekeeper A did not remember if Resident #1 came back inside. During an interview on 12/12/22 at 1:35 P.M. Housekeeper A said he/she took residents out to smoke like he/she usually did on 12/2/22 around 9:30 P.M. There were about seven or eight residents, including Resident #1, outside during the smoke break. Housekeeper A had to assist some of the residents in wheelchairs over the threshold of the door and then pass out cigarettes and ensure residents who needed smoking vests had them on. Housekeeper A also had to assist residents back into the facility as they finished smoking. Resident #1 would have had plenty of time to walk off undetected while Housekeeper A was assisting others. Housekeeper A was not aware Resident #1 was at risk for elopement. Housekeeper A did not recall Resident #1 coming back inside after the smoke break. Housekeeper A said he/she should have double checked, but got busy with something else and forgot. Typically, Housekeeper A would watch the residents walk back to the unit and let themselves in through the unit doors which did not require a code. Review of a written statement from CNA B, obtained by the facility and dated 12/8/22 at 3:44 P.M., showed the following: -Around 9:30 P.M., Housekeeper A came back (to the special care unit) to clean and took Resident #1 out to smoke; -CNA B assisted Resident #1's roommate at approximately 10:15 P.M. While assisting the roommate, CNA B heard the toilet and figured Resident #1 was in the bathroom. CNA B did not open the bathroom door due to privacy; -CNA B gave report to the oncoming aide and left. (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 12/12/22 at 3:00 P.M. CNA B said he/she saw Housekeeper A take Resident #1 off the unit to go out and smoke about 9:45 P.M. CNA B never saw the resident come back to the unit. CNA B assisted the resident's roommate about 10:15 P.M. and could hear the toilet running and assumed Resident #1 was in the bathroom. CNA B did not open the door to the bathroom to verify the resident was in the bathroom. CNA C arrived about 10:20 P.M. CNA B gave report and left. CNA B got a call about 11:00 P.M. from staff saying the resident was missing. The last time CNA B saw the resident was when Housekeeper A had taken him/her outside to smoke at 9:45 P.M. CNA B said he/she should have gone back to check to ensure Resident #1 was actually back on the unit, but didn't. CNA B felt there should be better communication between the aides and the staff who supervise the smokers when they take residents off the unit and when they bring them back. It would be nice to know when the residents leave the unit and when they come back because the staff on the unit don't always see this happen if they are in a room with another resident. During an interview on 12/12/22 at 1:30 P.M. CNA C said he/she arrived at the facility around 10:20 P.M. on 12/2/22. The evening shift aides told CNA C they had just done rounds and everything was fine. CNA C noticed Resident #1's room door was open, which was unusual, about 10:30 P.M. CNA C looked and did not see the resident in his/her room or anywhere else on the unit. CNA C alerted the charge nurse who looked for the resident off the unit and did not find him/her. The charge nurse contacted the off going aide staff to find out when they had last seen the resident and contacted the police. The police located the resident and returned him/her to the facility around 11:40 P.M. The resident told CNA C he/she walked off during the smoke break. The resident was calm at that time, but it appeared he/she had been crying. During an interview on 12/12/22 at 3:45 P.M. Registered Nurse (RN) D said Resident #1 went out for a smoke break on 12/2/22 around 9:30 P.M. After shift change, CNA C reported the resident was missing. RN D notified the administrator and Director of Nursing (DON) and called 911. The police located the resident walking down the highway. It was typically housekeeping and dietary staff that took the residents to smoke. RN D said all residents who required supervision for smoking should be monitored closely, regardless of their elopement risk, during smoke times to ensure everyone who goes outside comes back in to the facility. During an interview on 12/12/22 at 1:18 P.M. the resident said he/she walked away during the smoke break. The resident did not want to be in this facility or any facility. Housekeeper A was outside with the resident during the smoke break and must not have seen him/her walk off. The resident said he/she walked down to the highway, but did not remember how far he/she walked. The police picked the resident up and returned him/her to the facility. The resident said he/she did not have a plan in place when he/she left. The resident just wanted to get away from the facility. During an interview on 12/27/22 at 3:30 P.M. police department staff said the call log showed officers picked up the resident on 12/2/22 who was walking north bound along the highway approximately a half mile away from the facility. Review of www.wunderground.com showed the weather on 12/2/22 at 11:00 P.M. in the town the facility is located the temperature was 56 degrees Fahrenheit and there was no precipitation. The sun set at 5:11 P.M. The sky was overcast with low visibility. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Observation on 12/12/22 at 4:30 P.M. showed the highway where the resident was located was a high traffic, four lane, divided highway. The speed limit was 60 miles per hour. There was a grassy slope with a slight decline that led to the highway, approximately an eighth of a mile from the facility. Observation on 12/12/22 at 1:50 P.M. showed dietary staff E was outside with residents during the scheduled smoke times. During an interview on 12/12/22 at 1:50 P.M. dietary staff E said he/she was not aware of which residents were at risk for elopement. During an interview on 12/12/22 at 3:40 P.M. the DON said anyone from the special care unit should be considered at risk for elopement. The DON expected staff who took residents off the unit to escort them back to the unit and they should also communicate with staff on the unit when leaving with residents and upon returning them to the unit. The DON expected staff to lay eyes on the residents during rounds to ensure there whereabouts. It was most likely that Resident #1 walked off during the smoke break undetected by staff. Police did locate the resident walking down the highway and returned him/her to the facility. During an interview on 12/12/22 at 12:40 P.M. and 3:10 P.M. the administrator said the resident went out for smoke break on 12/2/22 at 9:30 P.M. with Housekeeper A. There was another resident causing a disturbance about wanting to be an unsupervised smoker. Resident #1 said he/she snuck away during the smoke break. Staff realized the resident was missing at shift change between second and third shifts (10:30 P.M.). Staff contacted the police who found the resident walking along the highway, and returned the resident to the facility before midnight. Housekeeping and dietary staff usually supervised the resident's smoking as not to pull nursing staff away from their duties. The administrator expected any staff supervising residents' smoking to monitor them closely and ensure the residents come back inside the facility. The administrator figured everyone knew Resident #1 was at risk for elopement because of his/her history of elopement. The administrator expected Housekeeper A to ensure Resident #1 came back inside and expected Housekeeper A to walk with the resident back to the special care unit. The administrator said staff who supervise smoking should communicate with the staff working on the special care unit when they take residents off the unit and when they bring them back. Staff should also visually see residents when conducting rounds. NOTE: At the time of the abbreviated survey, the violation was determined to be at the immediate jeopardy level J. Based on observation, interview and record review completed during the onsite visit, it was determined the facility had implemented corrective action to remove the IJ violation at the time. A final revisit will be conducted to determine if the facility is in substantial compliance with participation requirements. At the time of exit, the severity of the deficiency was lowered to the D level. This statement does not denote that the facility has complied with State law (Section 198.026.1 RSMo.) requiring that prompt remedial action to be taken to address Class I violation(s). MO210789