STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175457	A. Building B. Wing	03/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Peabody Health and Rehab	407 N Locust Street Peabody, KS 66866

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 0742 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. 46960 The facility reported a census of 35 residents which included three residents sampled for appropriate treatment and services for mental disorders and safety. The facility failed to ensure staff provided appropriate supervision, monitoring, and interventions in response to Resident (R)1's suicidal ideation/actions and self-harm. At an unknown time on 03/10/24, R1, who suffered from delusions and hallucinations, jumped from an open window in her room, falling 12 feet to the sidewalk, and sustained multiple injuries that required hospitalization and surgery. Staff last saw R1 between 09:00 PM and 09:30 PM and found R1 on the sidewalk underneath her window at 10:54 PM. This deficient practice placed R1 in immediate jeopardy. Findings included: - The Electronic Health Record (EHR) documented R1 had diagnoses which included multiple sclerosis (MS - a progressive disease of the nerve fibers of the brain and spinal cord), severe bipolar (major mental illness that caused people to have episodes of severe high and low moods) disorder with psychotic (any major mental disorder characterized by a gross impairment in reality perception) features, suicidal ideations (contemplations, wishes and/or preoccupation with death and suicide), anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear) disorder, schizophrenia (a psychotic disorder characterized by gross distortion of reality, disturbances of language and communication and fragmentation of thought), and unspecified psychosis. The 12/15/23 Admission Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) of 15, which indicated intact cognition. R1 had hallucinations and no behaviors directed towards self or others during the look-back period. R1 had a Patient Health Questionnaire (PHQ - a screening and diagnostic tool to assess for depression) score of eight, which indicated mild depression. The resident took antipsychotic (a class of medications used to treat psychosis and other mental emotional conditions), antianxiety (a class of medications that calm and relax people), and antidepressants (a class of medications used to treat mood disorders) daily during the seven-day look-back period. The 12/15/23 Psychosocial Well-Being Care Area Assessment (CAA) documented the resident had the potential for manic (mood characterized by an unstable expansive emotional state, extreme excitement, hyperactivity) and depressive (a mood disorder that causes a persistent feeling of sadness and loss of interest) episodes and received antipsychotic and antidepressant medications. (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 0742 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The 12/15/23 Falls CAA documented the resident was a high risk for falls due to her diagnoses of MS and bipolar disorder and knew of her current limitations. The 12/15/23 Psychotropic (classes of medications that alters mood or thought) Drug Use CAA documented the resident had a diagnosis of bipolar disorder with potential for manic and depressive episodes and received antidepressant and antipsychotic medications. The Care Plan included the following interventions: An intervention dated 12/14/23, revealed staff were to monitor for side effects of antidepressant medication, which included suicidal ideations, and report to the physician any ongoing symptoms unaltered by medication therapy. An intervention dated 12/14/23, revealed staff were to monitor for side effects of antipsychotic medication which included suicidal ideations and behavior not usual for the person, and to report to the physician. The Care Plan lacked further instructions for staff in the event of suicidal ideations or episodes of actual or attempted self-harm. The facility lacked a formal suicide risk assessment for R1. The Behavior Monitoring Record task, dated 03/01/24 to 03/10/24, directed staff to monitor for the following: crying, repetitive movements, yelling/screaming, kicking/hitting, pushing, grabbing, pinching/scratching/spitting, biting, wandering, abusive language, threatening behavior, sexually inappropriate behaviors, and rejection of care. The Behavior Monitoring Record task did not include monitoring for suicidal ideations/self-harm. The Progress Notes documented the following: On 12/18/23, the physician documented R1 had a history of suicidal ideations, but no current thoughts of self-harm. On 01/13/24 at 09:01 PM, staff documented R1 attempted to drown herself in the toilet water in her bathroom and R1 expressed suicidal intent. R1 made a contract with staff that she would make no further attempts at self-harm. The staff then placed R1 on increased observation and removed items that could potentially be used for self-harm from the resident's room. On 01/13/24 at 12:04 PM, the physician documented R1 had suicidal ideations but could not get to her therapist due to severe weather outside. On 02/02/24 at 10:43 AM, staff documented attempts were made to find alternate placement for the resident due to family request and the resident's recent behavior outbursts. Other facilities declined to accept the resident. (continued on next page)

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F 0742 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 02/06/24 at 03:11 PM, staff documented R1 could verbally commit to safety when asked and had delusions of persecution about her children. The staff were able to redirect the resident away from the delusional thought. On 02/11/24 at 06:28 PM, staff documented R1 had experienced delusions and displayed withdrawn behaviors and voiced suicidal ideations. Staff notified the provider and required an unspecified medication for anxiety. On 02/27/24 at 05:18 AM, staff documented R1 experienced delusions that her children were able to watch her through the heating/air-conditioning vent in the bathroom and remained fixated on this delusion despite multiple redirection attempts by staff. On 02/28/24 at 03:04 AM, staff documented R1 experienced delusions of persecution with people outside her window (second floor) and the people threatened to harm her. The resident expressed suicidal ideations and staff were able to partially redirect the resident away from delusion. The record lacked additional documentation related to suicidal ideations. On 02/29/24 at 08:23 AM, staff documented R1 attempted to cut her tongue out with the blunt end of a metal spring from her hairclip. Staff were able to redirect R1 and staff moved R1 to the common area for easy observation by staff. Additionally, staff documented R1 was able to commit to safety. On 03/10/24 at 04:23 AM, staff documented that at approximately 03:00 AM, R1 was found army crawling on the floor in the hallway to another resident's room and expressed delusions of persecution about her children. Staff were able to redirect R1 away from the delusional thoughts. On 03/10/24 at 11:04 AM, staff documented that R1 displayed behaviors of self-harm and pulled some of her hair out but was easily redirected and her physician was notified and ordered medication. The Medication Administration Record (MAR) revealed that hydroxyzine (an antihistamine medication that can be given to treat mild to moderate anxiety) 25 milligrams (mg) related to anxiety disorder was administered to R1. On 03/10/24 at 07:24 PM, staff documented R1 had not taken her evening medication doses but had put them in her cheek and later spit them out. R1 stated to the staff that the medication was for her son, and he needed to take them. R1 maintained this delusion and refused to take the medication as prescribed. On 03/11/24 at 12:28 AM, staff documented that on 03/10/24 at approximately 10:54 PM, CNA staff observed R1 was not in her room and was found on the ground, on the sidewalk, outside R1's room. Staff called 911 on 03/10/24 at 10:55 PM, and two staff members left the facility to render aid to the resident on the ground. Staff documented R1 was naked from the waist down, lying face down with obvious injuries with blood from an unseen wound on her head and an abrasion (scraping or rubbing away of skin) to her right knee. Staff further documented R1 clearly stated that she had attempted suicide and expressed delusions that an unseen person had told her to do it. Staff covered her with a sheet to protect her dignity and remained with R1 until emergency personnel arrived and assumed care of R1 and transported her to the hospital. Staff documented telephone notification of Administrative Nurse B and R1's durable power of attorney (DPOA- a person named in a legal document that named a person to make healthcare decisions when the resident was no longer able to). (continued on next page)

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F 0742 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 03/11/24 at 08:18 PM, staff documented that the facility called the hospital and were notified that the resident required surgery for her injuries and was in surgery and would be taken to the ICU (intensive care unit) after the operation was completed. On 03/11/24 at 12:54 PM, staff documented the facility called and spoke with R1's DPOA, who stated that seven days prior to the incident, R1 expressed to them that she was contemplating suicide by jumping from the window in her room and expressed regret that they had not notified the facility about the intent with a plan for self-harm. Review of the facility's investigation dated 03/11/24, revealed the cause of the incident was suicidal intent, and the root cause of the event was that the window was not secured correctly. Review of hospital records revealed R1 sustained the following injuries that required surgery and subsequent hospitalization : 1. A fracture (broken bone) of her 10th thoracic vertebra (bone of the spinal column) and was treated with a TLSO (Thoracic Lumbar Sacral Orthosis - a rigid brace that restricts movement of the trunk of the body) brace. 2. A right femur (thigh bone) head/neck fracture which required an open reduction internal fixation (ORIF - a surgery in which the broken bone is exposed and put back together with plates/screws/rods/etc.) surgery and she was non-weight bearing. 3. A left elbow olecranon (the bony formation at the top of the ulna [one of the bones in the forearm] that forms the point of the elbow) fracture, which required immobilization with a splint and sling. 4. A right radial head (the knobby end of the radius [one of the bones in the forearm] where it meets the elbow) fracture which required immobilization with a splint/sling. 5. A right patella (kneecap) fracture which required a knee immobilizer and ORIF. 6. A left patella fracture which required a knee immobilizer. 7. A facial laceration (a wound to the skin) that was three centimeters (cm) long and treated with four sutures (a medical device used to hold body tissues together to approximate wound edges after an injury or surgery). Review of weather data for the facility area from the National Weather Service (www.weather.gov) revealed on 03/10/24 at 10:00 PM, the temperature was 48 degrees Fahrenheit, winds were out of the south at 12 miles per hour (MPH) with clear skies and no precipitation. A facility tour on 03/13/24 at 08:15 AM with Administrative Nurse A revealed the area where staff found R1, after she had jumped or fallen from the window in her room. It was approximately 10-12 feet to a cement sidewalk on the ground. Maintenance Staff C stated the measured distance from the bottom of the window to the ground was 12 feet. (continued on next page)

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F 0742 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 03/18/24 at 12:10 PM, Certified Nurse Aide (CNA) E stated she arrived on shift on 03/10/24 at approximately 10:00 PM, and she and CNA G started the night ice and water pass with visual checks on all the residents. When staff got to R1's room, the resident was not in the room, so CNA E went and asked CNA G to verify that the resident was not in her room. Once CNA E went into the room, CNA E noticed that the window was open and verified by the other aide. CNA G ran to the window and saw the resident laying on the ground and verified by CNA E. CNA G then ran to get the nurse on duty, then ran outside to the resident with the nurse. CNA E stated she stayed in the room at the window and talked to the resident, who was responsive, then and dropped a blanket and gloves out the window to the staff that were outside. CNA E stated R1 was wearing only a sweater. On 03/18/24 at 12:17 PM, surveyor was unsuccessful at an attempted interview with CNA F via telephone, however, a written witness statement from CNA F in the facility's investigation revealed that she had checked on R1 during evening rounds on 03/10/24 between approximately 09:00 PM and 09:30 PM. On 03/18/24 at 12:45 PM, CNA G stated at approximately 10:45 PM when CNA E and CNA G were doing the night ice/water pass, CNA E noticed R1 was not in her room and her wheelchair sat empty in the room. Both aides searched the room and the bathroom and did not locate the resident. CNA E noticed the bedroom window was open, and CNA G went to the window and looked down and saw the resident laying on the sidewalk. R1 wore only a long-sleeve shirt and was naked from the waist down. CNA G stated she ran and notified the nurse that the resident was out the window. The nurse ran to the window to verify, then both the nurse and CNA G ran outside to the resident, while the nurse called 911. CNA G went back inside to get a sheet to cover the resident, while they waited for Emergency Medical Services (EMS). On 03/18/24 at 12:23 PM, Licensed Nurse (LN) H revealed after the CNA told her the resident was outside, on the ground, LN H went into the room and saw the open window and peered out. It was dark outside and with the aid of a flashlight, they saw how the resident was laying on the ground and immediately ran to the door and called 911 on the company cell phone. When LN H arrived to where the resident laid on the ground outside, LN H reported the resident was responsive. LN H briefly assessed for injuries and made the decision to not move R1 due to the potential for major injury. There was blood on the ground around R1's head coming from an unseen wound and abrasions to her knees. She wore a shirt, but otherwise had no clothing on. EMS transferred R1 to the hospital. R1 had documented instances of delusions prior to the incident in the progress notes. On 03/18/24 at 12:40 PM, Administrative Nurse B stated the staff's actions and reactions to the incident were appropriate, and nothing could have happened differently to prevent the incident from happening. However, Administrative Nurse B stated that immediately following the incident, window locks were placed on all the windows in the facility to prevent them from opening fully. Administrative Nurse B confirmed the facility lacked a formal suicide screening tool and had initiated a task for nursing staff to ask the resident to commit to safety daily. Administrative Nurse B confirmed that R1's care plan lacked interventions specific to suicide prevention and would be updated to reflect these changes when and if the resident returned to the facility. On 03/18/24 at 01:55 PM, Social Services Designee (SSD) C confirmed that R1's care plan lacked interventions specific to suicide prevention and said that residents whose PHQ score was greater than five (which indicated more than minimal depression) received a more specific safety assessment and the physician should be notified. SSD C confirmed that the facility lacked a formal suicide screening assessment tool. (continued on next page)

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F 0742 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility's policy Behavior Assessment and Monitoring, dated 04/2023, documented that problematic behavior will be identified and managed appropriately. A resident with problematic behavior or mood would have ongoing reassessments of changes in behavior, mood, and function. The facility failed to ensure staff provided appropriate supervision, monitoring, and interventions in response to Resident (R)1's suicidal ideation/actions and self-harm when at an unknown time on 03/10/24, R1, who suffered from delusions and hallucinations, jumped from an open window in her room, falling 12 feet to the sidewalk, and sustained multiple injuries that required hospitalization and surgery. Staff last saw R1 between 09:00 and 09:30 PM and found R1 on the sidewalk underneath her window at 10:54 PM. This deficient practice placed R1 in immediate jeopardy. On 03/18/24 at 04:58 PM, Administrative Staff A and Administrative Nurse B were provided the Immediate Jeopardy (IJ) Template for failure ensure staff provided appropriate supervision, monitoring, and interventions in response to Resident (R)1's suicidal ideation/actions and self-harm. The facility immediately implemented corrective measures following R1's departure from the facility to the hospital. The facility's corrective measures included the following, which were verified by the surveyor on-site during the investigation: 1. The facility implemented education for all staff on QAPI Plan: Injury From Failure To Follow Care Plan which outlined steps and instructions for staff to follow immediately following an injury caused by failure to follow a resident's care plan and Behavior Assessment and Monitoring which outlined steps and instructions for staff to follow for residents with problematic behavior on 03/11/24 at 12:01 AM and completed with all employees on 03/12/24 at 10:00 PM. 2. The facility provided documentation that immediately following the event, all windows in the facility were secured with mechanical window locks to prevent the windows from opening more than 5 inches and completed at 03/11/24 at 02:00 AM. 3. The facility provided documentation of daily checks of the window locks from 03/11/24 to 03/13/24 and Maintenance staff D revealed that checks were to be performed daily for three weeks, then checked twice a week for two weeks, then weekly checks would continue indefinitely. 4. The facility performed a PHQ and suicide screen on all residents in the facility on 03/11/24 at unknown time and identified five additional residents with scores that indicated more than minimal depression and no additional residents with suicidal ideations or thoughts of self-harm. 6. The facility provided documentation of a Quality Assurance Process Improvement (QAPI) meeting that occurred on 03/11/24. All corrections were completed prior to the onsite survey, therefore the deficient practice was cited as past noncompliance at a scope and severity of J.