

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265787	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/25/2024
NAME OF PROVIDER OR SUPPLIER  Laverna Manor Health & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  904 Hall Avenue Savannah, MO 64485	

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)
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 47195</p> <p>Based on observation, interview, and record review, the facility failed to provide adequate supervision of one cognitively impaired resident (Resident #1) with a known elopement risk and history. On 7/18/24, the resident became combative when staff attempted to redirect the resident back inside the facility from an outside activity, made multiple attempts to leave the facility unassisted, reached the facility parking lot in one attempt, and threw objects out the dining room window. On 7/20/24, the resident eloped out of a dining room window (six feet from the bottom of the windowsill to the grass below) around 4:00 P.M. and was brought back into the facility. The resident was placed on one-on-one at that time until the dining room windows could be secured. The facility staff did not continue the one-on-one or secure the resident's bedroom window. The resident removed his/her window screen and went out his/her second story window (approximately 13 feet 5 inches above the paved sidewalk below) between 8:15 P.M. - 8:23 P.M. on 7/20/24, resulting in sustained fractures to both heels and his/her lumbar spine 1 (L1). The facility census was 58.</p> <p>The Director of Nursing was notified on 7/24/24 at 3:23 P.M. of an Immediate Jeopardy (IJ) which began on 7/20/24. The IJ was removed on 7/24/24 as confirmed by surveyor onsite verification.</p> <p>Review of facility policy, Accidents and Incidents - Investigating and Reporting, revised July 2017, showed:</p> <p>-All accidents or incidents involving residents, employees, visitors, vendors, etc , occurring on facility premises shall be investigated and reported to the administrator.</p> <p>Review of facility policy, Wandering and Elopements, revised March 2019, showed:</p> <p>-The facility will identify residents who are at risk of unsafe wandering and strive to prevent harm while maintaining the least restrictive environment for residents;</p> <p>-If identified as a risk for wandering, elopement, or other safety issues, the resident's care plan will include strategies and interventions to maintain the resident's safety;</p> <p>-If an employee observes a resident leaving the premises, he/she should attempt to prevent the resident from leaving in a courteous manner, get help from other staff members in the immediate vicinity, if necessary; and instruct another staff member to inform the charge nurse or director of nursing services that a resident is attempting to leave or has left the premises.</p> <p>(continued on next page)</p>

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:  265787	Facility ID:  265787  If continuation sheet Page 1 of 13

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of facility policy, Safety and Supervision of Residents, undated, showed:</p> <ul style="list-style-type: none"> <li>-Supervision/Adequate supervision: refers to the intervention and means of mitigating the risk of an accident. Facilities are obligated to provide adequate supervision to prevent accidents. Adequate supervision is determined by assessing the appropriate level and number of staff required, the competency and training of the staff, and the frequency of supervision needed. This determination is based on the individual resident's assessed needs and identified hazards in the resident environment. Adequate supervision may vary from resident to resident and from time to time for the same resident;</li> <li>-The facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities;</li> <li>-When accident hazards are identified, the Quality Assurance Performance Improvement (QAPI)/Safety committee shall evaluate and analyze the cause of the hazards and develop strategies to mitigate or remove the hazards to the extent possible;</li> <li>-The care team will target interventions to reduce individual risks related to hazards in the environment, including adequate supervision and assistive devices;</li> <li>-Implementing interventions to reduce accident risks and hazards shall include, communicating specific interventions to all relevant staff, assigning responsibility for carrying out interventions, providing training as necessary, ensuring that interventions are implemented, documenting interventions;</li> <li>-Resident supervision is a core component of the systems approach to safety. The type and frequency of resident supervision is determined by the individual resident's assessed needs and identified hazards in the environment.</li> </ul> <p>1. Review of Resident #1's admission face sheet, dated 7/24/24, showed:</p> <ul style="list-style-type: none"> <li>-He/She was admitted to the facility on [DATE];</li> <li>-Diagnoses included dementia (condition involving loss of memory, language, problem-solving, and other thinking abilities that are severe enough to interfere with daily life), and infection of the bladder.</li> </ul> <p>Review of the resident's progress notes, dated 7/15/24-7/17/24, showed staff documented:</p> <ul style="list-style-type: none"> <li>-On 7/15/24, resident was admitted to the facility;</li> <li>-On 7/16/24, Licensed Practical Nurse (LPN) D wrote the resident was wandering on the unit, but easily redirected;</li> <li>-On 7/17/24, LPN C wrote the resident was exit seeking frequently throughout the day.</li> </ul> <p>Review of the resident's baseline care plan, dated 7/17/24, showed:</p> <ul style="list-style-type: none"> <li>-The resident was at risk for falls;</li> </ul> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>-He/She worked the special care unit a lot;</p> <p>-On 7/18/24 the resident went to the door to attempt to get out. He/She was standing next to the activity assistant to help block the resident and the resident bulled (pushed) his/her way through CNA B and other the staff to go out the door;</p> <p>-The resident walked out of the courtyard door on 7/18/24 during an activity.</p> <p>During an interview on 7/24/24 at 10:48 A.M., LPN C said:</p> <p>-On 7/18/24 there was an activity that occurred outside and the resident went out with the rest of the residents. It took three staff members to redirect the resident back through the front doors of the facility due to the resident being combative and staff had to use their bodies as a block to try and guide the resident back inside the facility;</p> <p>-On 7/18/24 during the day shift the resident pushed on the courtyard door three times and the door at the end of the hallway to the main nursing unit one to two times.</p> <p>Review of the resident's progress notes, dated 7/18/24 at 4:24 P.M., showed LPN C wrote the resident had been exit seeking for the last hour. He/She had been pushing the alarmed doors open and rushing out of the door into the courtyard. He/She opened windows and attempted to get out the various windows. The resident did not redirect easily. He/She became aggressive and combative when redirected back into the unit. The primary care physician (PCP) made aware of exit seeking and elopement plus behaviors. New orders were received for Depakote and as needed Trazodone. The resident received medication and it made him/her calmer. Contact made with the family.</p> <p>Review of the resident's physician's orders, dated July 2024, showed:</p> <p>-Order started 7/18/24, Depakote Sprinkles oral capsule delayed release sprinkle 125 mg, give 125 mg by mouth three times a day for agitation and anxiety related to dementia with agitation;</p> <p>-Order started 7/18/24, Trazodone HCL tablet, give 50 mg by mouth every 12 hours as needed for agitation and anxiety related to dementia with agitation.</p> <p>Review of the resident's Medication Administration Record (MAR), dated July 2024, showed:</p> <p>-Order started 7/18/24 at 4:00 P.M., Depakote Sprinkles 125 mg was administered on 7/18 at P.M. dose, 7/19 at A.M., Midday, and P.M. dose, and on 7/20 at AM, Midday, and P.M. dose.</p> <p>-Order started 7/18/24 at 4:15 P.M., Trazodone HCL Tablet 50 mg as needed medication was administered on 7/18/24 at 7:15 P.M., on 7/19/24 at 7:04 P.M., and on 7/20 at 3:38 P.M.</p> <p>During an interview on 7/23/24 at 1:44 P.M., CMT A said:</p> <p>-He/She worked with Resident #1 on 7/18/24 and 7/19/24;</p> <p>-The resident had been exit seeking on 7/18/24 by going to doors;</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 7/24/24 at 9:18 A.M., CNA E said:</p> <ul style="list-style-type: none"> <li>-He/She started his/her shift on 7/20/24 at 6:30 P.M.</li> <li>-The resident was a newer resident that he/she had met briefly and was told the resident had been a wanderer;</li> <li>-He/She had been told during shift report the resident had gotten out the window earlier in the day and he/she had been put on one on one until the windows had been fixed;</li> <li>-Maintenance staff had been to facility and fixed windows prior to him/her starting the shift by bolting the windows in the dining room;</li> <li>-He/She had been told the resident was well versed in the facility's type of windows, because the resident had the same type at home;</li> <li>-The resident was on 15-minute checks from the time he/she started his/her shift at 6:30 P.M.,</li> <li>-He/She completed 15-minute checks on the resident at 8:15 P.M. The resident had been out in the hallway where he/she could see the resident;</li> <li>-He/She was in with another resident for approximately fifteen minutes when he/she received a phone call from CNA D who had been working on the other hall about the resident being found outside on the ground and his/her bedroom window being open;</li> <li>-He/She hurried to Resident #1's room. He/she looked out of the resident's window that did not have a screen and saw the resident laying on the ground;</li> <li>-All of the resident's belongings were laying around the resident;</li> <li>-Maintenance came in to secure the dining room windows prior to their shift starting at 6:30 P.M.;</li> <li>-The resident was sitting up on top of clothes laying with his/her legs half in grass and his/her upper body half on pavement.</li> </ul> <p>During an interview on 7/23/24 at 3:40 P.M., LPN A said:</p> <ul style="list-style-type: none"> <li>-The evening of 7/20 (around 8:23 PM), he/she had stepped outside and found the resident laying on top of clothing with shoes scattered around him/her. He/She checked his/her phone log and had called the administrator at 8:23 P.M.</li> <li>-The resident was positioned on his/her left side laying underneath an exterior sprinkler piping;</li> <li>-He/She immediately called the administrator and emergency medical responders;</li> <li>-When he/she looked up, the window above the resident was open on the second floor;</li> </ul> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Laverna Manor Health & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  904 Hall Avenue Savannah, MO 64485	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>-The resident had band aids on his/her arm from the previous elopement, that he/she was picking at and had a skin tear to the resident's forearms and blood on the forearms;</p> <p>-The resident began kicking at staff, so he/she removed the resident's shoes;</p> <p>-CNA E called to alert staff that was working on the special care unit;</p> <p>-He/She had not seen the resident before. He/she was working on the floor off the unit;</p> <p>-CNA E told him/her that he/she had been doing fifteen minute checks on the resident due to the elopement attempt from earlier in the day, and last saw the resident at 8:15 P.M.;</p> <p>-The resident tried to get up;</p> <p>-CMT C came down to assist and some dietary staff also came out to courtyard.</p> <p>During an interview on 7/23/24 at 3:20 P.M., CNA D said:</p> <p>-He/She found the resident laying on his/her left side with elbow propped up on ground when he/she went outside facility to smoke at back patio while working on the evening of 7/20/24 (the second time the resident went out the window);</p> <p>-The resident appeared loopy and disorientated and was not able to tell him/her what had happened;</p> <p>-He/She was with LPN A when he/she discovered the resident. LPN A called the facility administrator and 911;</p> <p>-He/She stayed with resident;</p> <p>-He/She noted the bedroom window above was completely open;</p> <p>-He/She called CNA E who had been working on the unit and CNA E came to the window and the CNA stuck his/her head out of the window;</p> <p>-The resident was observed to have a skin tear and a little bit of blood;</p> <p>-He/She was not responsible for the resident and did not know if the resident was on one-on-one observations. CNA E told him/her the resident had been on fifteen-minute checks after getting out a different window and jumping up and running earlier in the day.</p> <p>During an interview on 7/23/24 at 3:52 P.M., CMT C said:</p> <p>-He/She had observed the resident going to locked doors and try to push the locked doors open;</p> <p>-He/She had worked two to three shifts with the resident, but was not working on the special care unit on 7/20/24;</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>-He/She received a call from LPN A about the situation where the resident was outside on the ground and went to the courtyard to assist;</p> <p>-When he/she first observed Resident #1 in the courtyard the resident was laying on ground with his/her top half laying in the grass and his/her legs on the cement;</p> <p>-He/She observed the resident was bleeding from his/her left arm;</p> <p>-He/She knelt down to assess injuries with LPN A and ensure the resident did not close his/her eyes or attempt to get up;</p> <p>-He/She had been aware from shift report that the resident had gone out the window earlier in day;</p> <p>-On 7/20/24 he/she observed the resident's window above to be completely open and there was no screen in the window;</p> <p>-He/She had not observed the resident successfully exit the special care unit while working with him/her previously on the special care unit;</p> <p>-He/She was aware the facility had bolted all the windows in the dining room and of fifteen minute checks until the windows were secured in place after the resident had eloped through the dining room window earlier in the day. The 15 minute checks were in place until the resident was found on the ground in the courtyard.</p> <p>-He/She did not know what time the windows were secured, but stated it was after 5:30-6:00 P.M. that the resident went from being one on one observation to every fifteen minute checks.</p> <p>Review of the resident's progress notes, dated 7/21/24 at 11:03 P.M., showed Registered Nurse (RN) A wrote the resident was transported to the emergency room (ER) after he/she was found outside last night.</p> <p>Review of the hospital medical record, dated 7/23/24, showed:</p> <p>-7/20/24, Patient seen in ER with abrasions on hands and skin tear on left arm, skin tear measuring 5 centimeters (cm) with abrasion and left index finger, and mild bruising and swelling of left index finger;</p> <p>-He/She was admitted to hospital on 7/20/24 at 9:07 P.M.;</p> <p>-A computerized tomography scan (CT scan) showed the resident had a comminuted (a fracture that often splinters) fracture involving the L1 vertebra, comminuted fracture of the left calcaneus (heel of the left foot) and severely comminuted fracture of the anterior (front), central, posterior (back) portions of right calcaneus (heel) on the right foot.</p> <p>Observation on 7/23/24 at 11:51 A.M., showed:</p> <p>-Maintenance staff measured the base of the resident's windowsill to ground to measure 13 feet 5 inches;</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>-The resident's room was on the second level at the back of the facility and his/her bedroom window was located at the corner of the building;</p> <p>-Beneath the resident's window was a paved sidewalk next to patch of grass and green metal piping that jutted out from the building.</p> <p>During an interview on 7/24/24 at 10:12 A.M., Maintenance said:</p> <p>-He/She received a call at 8:26 P.M. to come back to facility to secure the bedroom window.</p> <p>During an interview on 7/24/24 at 9:30 A.M., DON said:</p> <p>-He/She was notified of the second elopement out of his/her bedroom window by the administrator at 8:23 P. M.;</p> <p>-Staff on the unit assessed the other window in the bedroom and observed the window was not an issue and was not able to be opened when pushed on or attempted to turn the hand crank without the knob. The screen was in place;</p> <p>During an interview on 7/23/24 at 11:51 A.M., Maintenance said:</p> <p>-The windows in the resident's rooms did not have cranks to turn to open the windows, the cranks had been removed from all the windows prior to his/her start of employment with the facility a year ago.</p> <p>-The resident's bedroom window did have a screen in the window that was clipped in with clips that fasten the screen to the window frame.</p> <p>During an interview on 7/23/24 at 1:36 P.M., the DON said:</p> <p>-No windows on the special care unit had cranks to open the windows;</p> <p>-The window screen in Resident #1's room was secured with four clips;</p> <p>-Resident #1's room was at the corner of the building on the second level looking down over the courtyard and grass.</p> <p>During an interview on 7/23/24 at 2:31 P.M., the hospital social worker said:</p> <p>-The resident incurred fractures to the lumbar region and both feet.</p> <p>-The resident was going on hospice and was now bed bound as a result of the injuries from going out the window;.</p> <p>-The resident had significant change in status and was barely talking.</p> <p>During an interview on 7/23/24 at 2:35 P.M., the hospital physician said:</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>-Based on Resident #1's fractures the resident's injuries would have been incurred from a jump or fall from a greater height;</p> <p>-The resident was at high risk for Achilles rupture and required surgery;</p> <p>-The resident was not able to bear weight and was currently bed bound.</p> <p>-Anticipate and meet resident needs;</p> <p>-Review information on past falls and attempt to determine cause of falls. Record possible root causes. Alter, remove any potential causes if possible.</p> <p>NOTE: At the time of the survey, the violation was determined to be at the immediate and serious jeopardy level J. Based on interview and record review completed during the onsite visit, it was determined the facility had implemented corrective action to address and lower the violation at the time. A revisit will be conducted to determine if the facility is in substantial compliance with participation requirements.</p> <p>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 be taken to address Class I violation(s).</p> <p>MO239409, MO239285, MO239283, and MO239364</p>