

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265163	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/29/2025
NAME OF PROVIDER OR SUPPLIER Macon Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 29612 Kellogg Avenue, Macon, MO 63552	

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 - Minimal harm or potential for actual harm</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>Based on observation, interview and record review, the facility failed to ensure one resident (Resident #1), in a review of three sampled residents, did not leave the facility without staff knowledge. Further review showed the facility had not addressed the resident's history of exit seeking and had not ensured effective interventions were put in place that all staff were aware of both before and after the resident's elopement. The census was 51.</p> <p>Review of the facility policy, Elopement Prevention and Response Policy, dated 04/07/25, showed the following:</p> <ul style="list-style-type: none"> -The facility is committed to ensuring resident safety through vigilant prevention, monitoring and timely intervention related to elopement and exit-seeking behaviors. Elopement is defined by Center for Medicare Services as a resident leaving the premises or a safe area without authorization and/or necessary supervision, placing themselves at risk. Our policy treats all observed exit-seeking behavior as a near-miss and responds with immediate action, documentation, and systemic review; -Elopement is defined as a resident leaving the premises or a safe area without authorization and/or necessary supervision or within line of site; -Near-Miss: Any exit-seeking behavior where the resident does not leave the safe area due to timely staff intervention; -All staff will monitor for residents with known cognitive impairment, dementia, or exit-seeking behavior; -Residents identified as high-risk for elopement will have care plans reviewed and updated if deemed appropriate due to change; -All staff are responsible for maintaining secured doors and ensuring supervision in high-traffic and visitor areas; -If a resident attempts to leave the building, staff must: <ul style="list-style-type: none"> -a. Immediately intervene and redirect the resident; -b. Notify the charge nurse and the Director of Nursing (DON); <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
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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Indications of dementia or delirium or diagnosis;</p> <p>-Score of zero for elopement risk (not at risk for elopement).</p> <p>Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument, completed by the facility and dated 03/12/25, showed the following:</p> <p>-Moderately impaired cognition;</p> <p>-Highly impaired hearing;</p> <p>-Moderate vision impairment/wore glasses;</p> <p>-Substantial to maximum assist for transfers;</p> <p>-Set up/ manual wheelchair for locomotion;</p> <p>-No wandering.</p> <p>Review of the resident's Physician Order Sheet (POS), dated April 2025 showed his/her diagnoses included dementia (group of thinking and social symptoms which interfere with daily functioning) with mood disturbance, depression and anxiety. There was no order for a wanderguard (a device that is integrated with a security system to alert caregivers when residents have wandered past a protected area), .</p> <p>Review of the resident's progress notes showed facility staff documented the following:</p> <p>-On 04/11/25 at 9:05 P.M., resident out and about halls via wheelchair, had been sitting in the front lobby and brought back to TV area;</p> <p>-On 04/12/25 at 1:47 P.M., resident followed family member out of the front door, resident redirected to his/her room, family notified;</p> <p>-On 04/18/25 at 3:45 A.M., resident attempted to enter locked unit; thinks his/her room was down that hall. Resident upset he/she cannot go down that hall;</p> <p>-On 04/22/25 at 1:39 A.M., resident wandered about halls earlier in the evening looking lost, not sure what he/she wanted or was looking for, assisted back to room.</p> <p>Review of the resident's care plan on 04/24/25 at 9:30 A.M., showed the care plan did not address the resident's behaviors of wandering, following the family to the door or exit seeking.</p> <p>Review of the resident's medical record showed no documentation of the following:</p> <p>-The care plan had not been updated or an adjustment made, after the 04/12/25 incident, as the facility policy directed;</p> <p>-The care plan had not been updated with the 04/12/25 incident;</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-The care plan had not been updated with the addition of the wanderguard;</p> <p>-There was no additional elopement risk assessment completed after the incident of 04/12/25.</p> <p>During an interview on 04/24/25 11:10 A.M., Family Member I said the resident attempts to follow them out of the facility (when they leave) after a visit.</p> <p>During an interview on 04/24/25 at 11:47 A.M., Family Member J said the following:</p> <p>-He/She had visited the resident around 11:00 A.M. on 04/12/25 and sat with him/her while he/she ate lunch;</p> <p>-After lunch, he/she and the resident went back to the resident's room where he/she visited a bit longer;</p> <p>-When he/she left, the resident was not following him/her. When the resident tried to follow him/her in the past, he/she would let staff know so they could watch the resident;</p> <p>-He/She was notified via text from Family Member I) that the resident had gotten outside and one of the nursing staff had gone outside and found the resident.</p> <p>During an interview on 04/24/25 at 2:15 P.M., Certified Nurse Aide (CNA) E said the following:</p> <p>-He/She only worked part time, (day shift/weekends) and had worked on 04/12/25;</p> <p>-He/She had reported to Registered Nurse (RN) A he/she had to go to his/her car located outside of the facility;</p> <p>-When he/she was in his/her car, he/she looked up and saw the resident at the front entrance door;</p> <p>-He/She looked down and then back up again and the resident was out of the door, in his/her wheelchair, rolling down the sloped area of the pavement in the parking lot;</p> <p>-He/She ran up and grabbed the resident;</p> <p>-The resident said, I am going home. They are waiting on me.;</p> <p>-He/She assisted the resident back into the facility. There were no staff waiting at the facility front door. He/She pushed the resident to the nurse's desk and reported the incident to Registered Nurse (RN) A.</p> <p>During an interview on 04/24/25 at 1:15 P.M., Registered Nurse (RN) A said the following:</p> <p>-He/She worked day shift on 04/12/25;</p> <p>-On 04/12/25, he/she had observed the resident around 12:30 to 1:00 P.M. in the dining room with his/her family visiting;</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the resident's Treatment Administration Record dated April 2025 showed staff should check placement of the wanderguard every shift (7:00 A.M.-7:00 P.M. and 7:00 P.M. to 7:00 A.M.), date initiated 4/28/25.</p> <p>Review of the resident's medical record showed no documentation staff placed a wanderguard or that it was checked to ensure it worked by passing it through the door prior to, or after, placement.</p> <p>During an interview on 04/24/25 at 3:50 P.M. the Administrator and Director of Nurses (DON) said the following:</p> <ul style="list-style-type: none"> -They thought the resident had a wanderguard alarm on his/her wheelchair; -They did not know who placed the alarm or when it was placed; -There was no documentation of staff placing the alarm, when it was placed or who placed it. <p>During an interview on 4/24/25 at 1:50 P.M. and 5/13/25 at 3:34 P.M , the DON said the following:</p> <ul style="list-style-type: none"> -RN A notified her the resident had followed his/her family member out of the building on 04/12/24. She was told that CNA E, who was returning from lunch and in the parking lot, brought the resident back inside; -The resident liked to watch family leave after they visited. The front office personal (the Receptionist and SSD) usually monitored the resident, but since the incident happened on a weekend, there was no receptionist or SSD in the area at that time; -She did not know if the resident had a wanderguard alarm; -The front doors were alarmed for residents who have a wanderguard device; -Documentation of monitoring of a wanderguard should begin with the placement of the device; -She did not know if the care plan had been updated but would have expected it to be updated; -She was not sure of inservicing completed, but the facility has stand up meetings daily at 9:30 A.M., 3:30 P.M. and 11:30 P.M., and she believed the Administrator had mentioned the incident in stand up meetings; -She had not performed a review of the incident or near-miss as the policy instructed. <p>Observation on 04/24/25 at 3:55 P.M. showed the following:</p> <ul style="list-style-type: none"> -The Administrator pushed the resident's empty wheelchair to the front entrance doors; -A wanderguard alarm hung from the underside of the chair and an alarm detector hung from the left, lower wall just inside the front entrance doorway; <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-The administrator pushed the wheelchair near and then through the front door exiting the building and then back inside. The alarm did not activate;</p> <p>-The Administrator turned the chair sideways in the doorway, pointed the front of it directly at the detector on the wall at which time the alarm did activate;</p> <p>-The Administrator repeated the act again, pushing the chair through and out the front door. The alarm on the chair did not activate when the chair went through the doorway;</p> <p>-Staff moved the alarm to the arm rest of the chair (and on the third attempt), the alarm activated when the chair was pushed through the door way.</p> <p>During an interview on 4/24/25 at 2:20 P.M the Administrator said the following:</p> <p>-There was no video surveillance for 04/12/25;</p> <p>-RN A told her that he/she had interviewed CNA E about the incident and had completed a quick stand up inservice with staff about elopements on 4/12/25;</p> <p>-There was no documentation or written statements about the incident; she had not performed a review of the incident or near-miss as the policy instructed;</p> <p>-It was her understanding that the resident did not get outside of the door as this is what RN A reported.</p> <p>During an interview on 4/24/25 at 2:45 P.M. the DON and the Administrator said the facility had no documentation of facility inservices, as the policy directed, related to the resident leaving the facility as of 04/24/25 at 2:45 P.M.</p> <p>MO#252686</p>		