

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265423	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/10/2025
NAME OF PROVIDER OR SUPPLIER Westview Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 301 West Dunlop Street Center, MO 63436	

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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47246</p> <p>Based on interview and record review, the facility failed to provide protective oversight for one resident (Resident #4), in a review of eight sampled residents. Resident #4, who resided on the facility's locked unit, had a history of elopement. Resident #4 obtained the fenced courtyard door access code and left the facility without staff knowledge, unaccompanied and without prior authorization. He/She returned 20 minutes later, using the same door code access to regain entry into the facility courtyard, without staff knowledge. The resident used the front door access code to leave through the locked unit courtyard door; the door codes were the same and had not been changed to two different codes every week per the facility's procedure. The resident said he/she had planned to hitch-hike, but the weather was too cold, so he/she returned to the facility. The facility census was 59.</p> <p>Review of the facility policy, Elopements and Wandering Residents, revised 06/12/24, showed the following:</p> <ul style="list-style-type: none"> -The facility ensures that residents who exhibit wandering behavior and/or are at risk for elopement, receive adequate supervision to prevent accidents and receive care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering or elopement risk; -Elopement occurs when a resident leaves the premises or a safe area without authorization (for example, an order for discharge or leave of absence) and/or any necessary supervision to do so; -The facility is equipped with door locks/alarms to help avoid elopements; -The facility shall establish and utilize a systematic approach to monitoring and managing residents at risk for elopement or unsafe wandering, including identification and assessment of risk, evaluation and analysis of hazards and risks, implementing interventions to reduce hazards and risks and monitoring for effectiveness and modifying interventions when necessary; -Residents will be assessed for risk of elopement and unsafe wandering upon admission and throughout their stay by the interdisciplinary care plan team; -Adequate supervision will be provided to help prevent accidents or elopements. <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>1. Review of the facility staffing schedule for 02/18/25 showed Certified Nurse Aide (CNA) A and CNA D were assigned to the locked unit and responsible for Resident #4 (no specific shift or time frame).</p> <p>2. Review of Resident #4's admission record face sheet, undated, showed the following:</p> <ul style="list-style-type: none"> -The resident admitted to the facility on [DATE]; -The resident had a legal guardian; <p>-2. Diagnoses included bipolar disorder (a serious mental illness that causes unusual shifts in mood, ranging from extreme highs-mania or manic-to extreme lows-depression), moderate intellectual disabilities (a condition characterized by significant limitations in intellectual functioning and adaptive behaviors) and major depressive disorder (a common and serious mental health condition characterized by persistent feelings of sadness, hopelessness and loss of interest or pleasure in activities).</p> <p>Review of the resident's admission elopement evaluation, dated 10/08/24, showed the following:</p> <ul style="list-style-type: none"> -The resident had a history of elopement or an attempted elopement while at home; -The resident had a history of elopement or attempted leaving the facility without informing staff; -A score value of one or higher (one yes response) indicated risk of elopement; -The resident was identified as a risk for wandering/elopement. <p>Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument, completed by facility staff, dated 12/31/24, showed the following:</p> <ul style="list-style-type: none"> -Cognitively intact; -Exhibited wandering behavior one to three days of the seven day look back period; -Independent for mobility; -Received antipsychotic (psychiatric medications used to treat psychosis, a collection of symptoms that can make it difficult to distinguish reality), antianxiety, antidepressant and hypnotic (psychoactive medications that help people fall asleep). <p>Review of the resident's quarterly elopement evaluation, dated 01/09/25, showed the following:</p> <ul style="list-style-type: none"> -The resident did not have a history of elopement or an attempted elopement while at home; -The resident did not have a history of elopement or attempted leaving the facility without informing staff; <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>-He/She (Resident #5) had known the door codes to the front and outside (courtyard) door of the locked unit for some time;</p> <p>-The facility staff were not very careful when they put the door codes in, so the residents could see the numbers;</p> <p>-Resident #4 came to his/her room when Resident #4 got back to the facility the day he/she eloped, around lunchtime, and told him/her that he/she (Resident #4) had left but came back because it was cold outside;</p> <p>-Resident #4 pulled his/her pant legs up and had him/her touch Resident #4's legs; Resident #4's legs were like ice;</p> <p>-The temperature outside that day was really cold, like negative one degree;</p> <p>-The staff did not know Resident #4 left because the staff do not do regular face checks on the residents on the locked unit;</p> <p>-There are cameras on the unit and in the back courtyard so the staff would have seen this on video.</p> <p>During an interview on 03/10/25 at 11:15 A.M., an anonymous employee said the following:</p> <p>-A resident from the locked unit told him/her that Resident #4 left the facility and came back; this was a couple of days after it had happened;</p> <p>-The fenced courtyard door on the locked unit opens to the facility parking lot;</p> <p>-This event occurred on 02/18/25 at 12:24 P.M.;</p> <p>-He/She remembered it was very cold the day Resident #4 left the facility.</p> <p>During an interview on 03/07/25 at 9:00 A.M., CNA A said the following:</p> <p>-He/She was on the locked unit on 02/18/25;</p> <p>-Sometime in the afternoon, Resident #4 made a statement that he/she was going to leave the facility;</p> <p>-He/She had another staff member go and get the administrator right away; the administrator was right outside the locked unit door;</p> <p>-The administrator came into the locked unit and saw that Resident #4 had just opened the fenced courtyard door using the code;</p> <p>-The administrator had the maintenance director change the access code to the courtyard door right away;</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>-She was not sure why the resident's admission elopement evaluation showed the resident was an elopement risk, but the resident's quarterly elopement evaluation indicated the resident was not an elopement risk;</p> <p>-The front and back doors of the locked unit had keypads with a different number for each door;</p> <p>-The door keypads had a covering over them to prevent others from watching numbers being put in;</p> <p>-It was the maintenance director's responsibility to change the keypad codes to the locked unit every week;</p> <p>-The maintenance director would send the door codes out to the facility staff in a secured group chat;</p> <p>-She saw the resident (she was on the unit) putting in a door code to the fenced courtyard door off the locked unit during the afternoon of 02/18/25, around 2:00 P.M.;</p> <p>-The resident got the door open and put one foot out the door, but when she called his/her name, the resident turned and came back in; he/she did not leave the facility;</p> <p>-The resident told her he/she got the front door access code by watching the staff key in the numbers;</p> <p>-She was not sure why the front door access code worked on the courtyard door, each door was supposed to have its own number;</p> <p>-She had the maintenance director change the door access code right away when this occurred;</p> <p>-She was unaware the resident had left the facility for 20 minutes on 02/18/25 at 12:25 P.M.;</p> <p>-She would expect staff to use the covers provided over the door keypads to prevent residents from seeing the access codes put in;</p> <p>-She would expect staff not to share the door access codes with residents or anyone else.</p> <p>Observation of facility door access codes during on-site visits showed the following:</p> <p>-On 02/25/25: locked unit front door 1492;</p> <p>-On 03/06/25 (the day the elopement investigation began by the state agency), locked unit front door 1492 (this code had not been changed on Monday, 03/05/25 as the Maintenance Director indicated in his interview that he changed codes weekly on Monday), back door 3860 (same code as the Maintenance Director reported as being the code on 02/18/25; the code had not been changed on 02/24/25 or 03/03/25 per the report that codes were changed every Monday).</p> <p>Review of the outside temperatures by wunderground.com for the city where the resident resided, when he/she eloped on 02/18/25, was four degrees Fahrenheit at 11:54 A.M. and six degrees Fahrenheit at 12:54 P.M.</p> <p>(continued on next page)</p>		

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