STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265462	A. Building B. Wing	04/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beloved Health and Rehabilitation Center	328 Munger Lane Hannibal, MO 63401

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** 35615 Based on observation, interview and record review, the facility failed to ensure one resident (Resident #1), who was identified as at risk for elopement, in a review of six sampled residents, did not leave the facility without staff knowledge. Staff failed to ensure an interior, alarmed, coded double door, as well as the front entrance door alarms were activated and secured on 3/27/25. The resident exited the facility through the interior, alarmed, coded double doors, leading from the dining room to the facility front entrance and exited through the front entrance door without the alarm sounding and without staff knowledge. He/She walked one mile to a convenience store across four lanes of traffic and fell by the roadway. A passing car assisted the resident and called the police who returned the resident to the facility. Facility staff failed to complete face checks every two hours and the resident was out of the facility for four hours before staff identified the resident was missing. The facility census was 78. On 4/4/25 the administrator was notified of the Past Non-Compliance Immediate Jeopardy (IJ) which occurred on 3/27/25. On 3/27/25, the administrator identified Resident #1 eloped from the facility. Upon discovery, staff conducted an investigation and notified appropriate parties including the police. In-service education was provided for all facility staff including updated elopement policies, face check policies and door monitoring policies. Staff completed elopement risk assessments for all residents and the elopement risk and code white procedure books were updated with current risk assessments and code white procedures. The IJ was corrected on 3/28/25. Review of the facility's facility Elopement Policy, dated 2/15/23, showed the following: -The purpose was to ensure the safety of the residents by establishing a clear and effective protocol for responding to incidents of elopement, defined as a resident leaving the facility without authorization; -The facility was committed to maintaining a safe and secure environment for all residents. In the event that a resident was discovered missing, the following steps must be taken immediately by all staff members to initiate a thorough search and ensure the resident's swift and safe return; -Call a Code White, begin an in-building search immediately, notify the designated supervisor or facility manager, initiate an outside search if the resident is not found inside the facility, call the police, document the incident in detail; (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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-All staff members receive training on the elopement policy as part of orientation and ongoing education to ensure familiarity with procedures and responsibilities. During an interview on 4/4/25 at 9:55 A.M., the Assistant Administrator said the facility did not have a written policy regarding expectations or frequency of staff completing resident face checks or on securing the entrance doors at night. Review of Resident #1's Elopement Risk Assessment, dated 3/2/24, showed staff documented the following: -The resident was cognitively impaired and independently mobile; -History of a desire to leave the facility and wandering activity; -At risk for elopement, proceed with interventions and elopement risk care plan; -Elopement risk factors included an active mental illness and anger related to placement in the facility; -Interventions put in place to prevent the resident from eloping included a secure unit and frequent visual monitoring. Review of the resident's Care Plan, initiated 6/18/24, showed the following: -Diagnoses of schizophrenia (a serious mental illness characterized by disorganized thinking, distorted perceptions, and impaired social and emotional behavior), restlessness and agitation, lung cancer, and muscle weakness; -At risk for injury and alteration in health. The resident had lung cancer and refused treatment; -Highly functional and able to complete activities of daily living with supervision and cues. Allow time to complete task and intervene as needed and monitor for decline in function; -At risk for falls. Ensure proper footwear, keep pathway cleared for safety. Review of the resident's quarterly Minimum Data Set (MDS) a federally mandated assessment instrument, completed by facility staff, 12/2/24 showed the following: -Moderately impaired cognition; -The resident had hallucinations (perceptual experiences in the absence of real external sensory stimuli) and delusions (misconceptions or beliefs that are firmly held, contrary to reality); -Independent in mobility; -Shortness of breath with exertion of walking, bathing, transferring and lying flat. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the resident's record showed staff had not documented any additional elopement risk assessments since 3/2/24. Review of the resident's annual MDS dated [DATE], showed the following: -Cognitively intact; -No hallucinations or delusions; -Independent in mobility. Review of the resident's Care Plan, revised 3/23/25, showed no staff direction or interventions regarding the resident's elopement risk and no staff direction to complete face checks every two hours. Review of the resident's Point of Care (electronic system used to document completed tasks. Staff click on the task box indicating the task was completed) face check documentation showed the following: -On 3/27/25 at 10:00 P.M. the face check task was green indicating staff completed a face check and visualized the resident; -On 3/28/25 at 12:00 A.M. and 2:00 A.M. showed the face check task was red indicating staff did not complete face checks at those times. Review of the resident's nurses' note, dated 3/28/25 at 5:05 A.M., showed Licensed Practical Nurse (LPN) C documented he/she was notified at 2:45 A.M. the resident was not on the unit. A thorough search was completed throughout the facility and staff were unable to locate the resident. The local police department, Director of Nursing (DON) and Administrator were notified. At 3:55 A.M. the resident was located and brought back to the facility by the local police department. Resident noted to have skin tear to the left hand. Resident said he/she tripped and fell . During an interview on 4/3/25 at 12:15 P.M., the Administrator said the facility video camera showed on 3/27/25 at 10:32 P.M., LPN B secured the front doors. The alarms were located at the top of the door and the camera footage did not show the door alarm indicators turned red indicating the two front doors were secured. At 11:30 P.M., Resident #1 pushed open the front exit door and exited the facility without any alarms sounding. The resident would not be able to push the door open without it alarming if the doors were secured and the alarms were activated. No other residents, staff, or visitors were seen entering or exiting the facility between 10:32 P.M. and 11:30 P.M. During an interview on 4/3/25 at 2:35 P.M., LPN B said on 3/27/25 he/she secured the facility front double doors sometime after 9:00 P.M. The charge nurse secured the front doors every night around 9:00 P.M. He/She made rounds and found the front exit doors were not secured and the alarm activated. He/She had a key and secured both doors with the key, the alarm lights turned red indicating the doors were secured and the alarm activated. The doors secured like normal, and the lights turned red. He/She saw Certified Nurse Aide (CNA) A at the nurses desk charting that night but was unsure of the time. LPN B did not see Resident #1 in the dining room area after the 10:30 P.M. smoke break. Staff were supposed to complete face checks every two hours on all residents. (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 4/3/25 at 2:00 P.M., CNA A said on 3/27/25 the resident went out to smoke in the courtyard at 10:30 P.M. with other residents. The resident came inside after smoking and went to his/her room. CNA A sat at the nurses desk around 11:00 P.M. charting. He/She did not complete resident face checks at 12:00 A.M. or 2:00 A.M.; he/she completed cleaning duties and other assigned duties. At 2:45 A.M. , he/she completed face checks and noted the resident was missing. Staff searched the entire facility and outside without finding the resident. CNA A did not see the resident walk through the dining room and had not seen the resident since the 10:30 P.M. smoke break. He/She should have completed rounds and face checks at 12:00 A.M. and 2:00 A.M. During an interview on 4/3/25 at 3:05 P.M., LPN C said LPN B secured the front doors around 10:30 P.M., a little later than usual. The charge nurse usually secured and activated the front door alarms between 8:00 P. M. and 9:00 P.M. every night. At 2:45 A.M., CNA A said he/she could not find Resident #1. Staff checked the entire facility and surrounding area outside, called the police and management staff. LPN C saw the resident when the police brought the resident back. The resident was shaken up and had a skin tear on his/her hand. During an interview on 4/3/25 at 1:45 P.M., the resident said he/she wanted to get outside and leave. He/She did not like it at the facility, especially the food. That night he/she went outside to smoke in the courtyard with other residents and a staff member. He/She came back inside after smoking and went to the dining room. He/She wore a coat outside to smoke and did not remove the coat. He/She did not see anyone in the dining room. He/She looked and the double door from the dining room light was green (indicating the door was not secured), and went through the double doors and then on to the front door. The front door code light was green (indicating the door was not secured). He/She went out the front door, walked down the hill to the road, and walked to the convenience store and tried to reach a highway towards home. He/She fell by the roadway and a passing car stopped, helped the him/her up and called the police department. The local police brought him/her back to the facility. It was hard to breathe and walk that far. Observation of the facility on 4/3/25 at 11:55 A.M., showed the following: -Interior, double doors leading from the dining room to the front entrance area. Staff entered a number code in the keypad allowing the doors to open without sounding the alarm when passing through the doors. The alarm code changed from red to green when the number code was entered and remained green for 45 seconds before relocking automatically and the alarm code turned red after the door automatically locked. If the door remained open or the door handle was pushed for 15 seconds, a door alarm sounded; -Exterior double doors at the front entrance. The doors were not alarmed during the day. Observation on 4/3/25 at 5:00 P.M., showed the facility entrance door lead to the parking lot and across a grassy area to a two lane well traveled city street without sidewalks. This led through an underpass that connected one residential area to a shopping area. The resident's path then turned east down a heavily traveled two lane road with sidewalks and across a bridge to a major highway and business area. The resident crossed four lanes of highway traffic with multiple stop lights to a large truck stop convenience store, one mile from the facility. On the night of 3/27/25 the outside environmental temperature ranged between 50 and 60 degrees. (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 4/4/25 at 11:15 A.M., the DON said staff should complete an elopement assessment on every resident on admission and initiate a care plan with interventions to prevent elopements. Staff should be aware of residents at risk for elopement. A book was kept at the nurses desk listing the residents at risk for elopement and the code white procedure. Resident #1 was an elopement risk, but was not included in the elopement book at the nurses desk. Staff should have completed face checks every two hours as assigned on the electronic charting tasks. The dining room interior double doors were not secured, and the front entrance door was not secured. The resident went out the door without any alarms sounding and staff were unaware the resident was missing for four hours. During an interview on 4/3/25 at 12:15 P.M., the Administrator said the nurse was late closing and activating the front entrance door alarms on 3/27/25. Staff failed to do face checks on time that night. Staff needed to complete face checks every two hours and check the front door to make the sure the doors were secured. The resident went out the dining room double doors and front entrance doors without setting off an alarm. MO 00251823