

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265468	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/25/2025
NAME OF PROVIDER OR SUPPLIER  Granby House		STREET ADDRESS, CITY, STATE, ZIP CODE  301 South Main Granby, MO 64844	
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 - Actual harm  Residents Affected - Few	<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> 31464</p> <p>Based on record review and interviews, the facility failed to ensure the resident's environment remained free of accident hazards when the front door alarm was turned off resulting in one resident (Resident #1) exiting the building and obtaining injuries from a fall. The facility also failed to document a complete investigation into the elopement and fall including a root cause analysis. The census was 54.</p> <p>Review of a facility policy entitled Accidents and Incidents - Investigating and Reporting (revised July 2017) showed the following:</p> <p>-All accidents or incidents involving residents occurring on our premises shall be investigated and reported to the administrator;</p> <p>-Data, as applicable, shall be included on the Report of Incident/Accident form included -the date and time the accident or incident took place; the nature of the injury/illness (e.g., bruise, fall, nausea, etc.); the circumstances surrounding the accident or incident; the injured person's account of the accident or incident; the name(s) of witnesses and their accounts of the accident or incident; -the date/time the injured person's attending physician was notified, as well as the time the physician responded and his or her instructions; the date/time the injured person's family was notified and by whom; the condition of the injured person, including his/her vital signs; any corrective action taken; follow-up information; other pertinent data as necessary or required; and the signature and title of the person completing the report;</p> <p>-Incident/Accident Reports will be reviewed by the safety committee for trends related to accident or safety hazards in the facility and to analyze any individual resident vulnerabilities.</p> <p>Review showed the facility did not provide a policy specific to the door alarms and locking mechanisms.</p> <p>1. Review of Resident #1's face sheet (gives basic profile information at a glance) showed the following:</p> <p>-admitted [DATE];</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:	Facility ID: 265468
		If continuation sheet Page 1 of 5

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F 0689  Level of Harm - Actual harm  Residents Affected - Few	<p>-Diagnoses included Parkinson's disease (central nervous system disorder that affects movement often including tremors), chronic obstructive pulmonary disorder (COPD - breathing disorder), anxiety, major depressive disorder, dementia, high blood pressure, muscle weakness, difficulty in walking, repeated falls, and cognitive communication deficit.</p> <p>Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment tool completed by facility staff), dated 02/24/25, showed the following information:</p> <ul style="list-style-type: none"> <li>-Severely impaired cognition;</li> <li>-Independent use of manual wheelchair;</li> <li>-Required partial to moderate assist with toileting, standing, and transfers;</li> <li>-Required substantial to maximum assist with bathing, dressing, and personal hygiene;</li> <li>-Did not walk.</li> </ul> <p>Review of the resident's care plan, dated 07/30/24, showed the following:</p> <ul style="list-style-type: none"> <li>-Resident had poor safety awareness and was at risk for falls. Despite interventions in place, the resident will continue to fall;</li> <li>-Resident chooses to remain as independent as possible;</li> <li>-Staff to ensure resident is wearing appropriate footwear such as non-slip socks or shoes when ambulating or mobilizing in wheelchair;</li> <li>-Staff to remind resident that he/she can't walk like they used to;</li> <li>-Resident needs a night light to help see at night;</li> <li>-Resident uses a wheelchair for mobility;</li> <li>-Staff to round frequently;</li> <li>-Staff to distract from wandering by offering pleasant diversions, structured activities, food, conversation, television, book;</li> <li>-Staff to identify pattern of wandering (purposeful, aimless, or escapist; looking for something).</li> </ul> <p>Review of the resident's progress note dated 02/23/25, at 1:30 A.M., showed Registered Nurse (RN) A documented the following:</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>-Resident observed to be lying on ground, hollering help. Staff assisted with resident to observe bruising to back of right shoulder and blood to back of head. Staff cleaned blood to find superficial abrasions to back of head. Resident was in wheelchair prior. Fall was un-witnessed fall. Staff informed physician, family member, Director of Nursing (DON), and Administrator. Resident responsive and verbalizing with staff. Staff observed no change from baseline. Nurse attempted to clean abrasion and resident kept moving head;</p> <p>-Staff notified physician notified, family informed of incident, and informed staff to monitor resident and that they will check in the morning. Neurological checks per fall protocol;</p> <p>-Resident oriented to person;</p> <p>-Predisposing environmental factors: poor lighting;</p> <p>-Predisposing physiological factors: impaired memory, weakness;</p> <p>-Predisposing situation factors: wanderer.</p> <p>Review of a Fall Documentation Checklist, dated 02/23 (no year specified) at 1:30 (no indication of A.M. or P. M.), for the resident showed the following information:</p> <p>-Concerns noted: open wound back of head, bruising on right shoulder;</p> <p>-Neighbor statement: (left blank);</p> <p>-Checklist indicated completion of: head to toe skin assessment including baseline comparison, legs are equal length and no rotation, grips equal or at baseline, family notified, physician notified, incident report completed, and neurological checks completed and documented;</p> <p>-Handwritten note stated to continue with 72-hour follow-up with required information.</p> <p>(The checklist did not address the resident's fall being outside of the facility or how the resident got outside of the facility.)</p> <p>Review showed the facility did not provide any additional investigation of the root cause for the fall or elopement and did not address interventions would prevent future falls and elopements.</p> <p>Review of the resident's care plan showed staff updated the care plan with the following:</p> <p>-On 02/23/25, staff to monitor resident whereabouts when up wandering;</p> <p>-On 02/24/25, elopement risk, wanders aimlessly.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 02/25/25, at 10:37 A.M., RN A said on 02/23/25, around 1:00 A.M., he/she noted the resident was in his/her wheelchair in the hallway. At approximately 1:30 A.M., he/she noticed the resident was not in the hallway or in his/her room. RN A asked Nurse Aide (NA) B and NA C if they knew the location of the resident. They said they had seen him/her in the hallway a short time prior, but did not know his/her current location. A search was made of all rooms in the building. RN A and NA B exited the front door of the building and heard the resident hollering for help. They found him/her on the ground on the parking lot pavement at the edge of the driveway with his/her the wheelchair was close by. Upon assessment, the staff noted bleeding from the back of the resident's head and an abrasion to his/her right shoulder. The resident said he/she didn't know what happened. RN A put his/her own sweatshirt on the resident while NA B went inside and quickly brought out blankets to wrap around the resident. RN A and NA B assisted the resident into the wheelchair and took him/her inside. RN A said he/she did not see the alarm system unplugged and did not know why the door would have been left unlocked and the alarm disconnected. RN A said another staff member's family members did go in/out the front door several times that evening.</p> <p>During an interview on 02/23/25, at 12:34 P.M., Certified Medication Technician (CMT) D said he/she worked on 02/22/25, from 2:00 P.M. until 10:00 P.M. CMT D said if the doors are not alarmed the staff should monitor the doors. He/she said they have several wanderers who would probably need frequent/15 minute checks.</p> <p>During an interview on 02/23/25, at 12:42 P.M., NA B said on 02/23/25, around 1:30 A.M., he/she and NA C were doing rounds to check residents. RN A came and asked them if they knew the whereabouts of the resident. They said they had seen him/her in the hallway awhile earlier, but did not know where he/she was currently. A search was made of the entire building. NA B said he/she and RN A noted the front door was not locked and the alarm did not sound when they exited the building. They heard the resident yelling for help and found him/her on the ground at the edge of the parking lot driveway. NA B ran back inside for blankets while RN A calmed and assessed the resident. NA B said the resident kept thanking them and apologizing, saying, You saved my life! NA B called the DON, and they could both hear the DON on the speaker phone. The nurse quickly assessed the resident, they assisted him/her back into the wheelchair, and took him/her back inside the building to warm him/her up. NA B said RN A tried to bandage the resident's head, but the resident kept taking of the dressing. NA B said the resident does wander around the facility in his/her wheelchair, but didn't appear to be exit seeking.</p> <p>During an interview on 02/23/25, at 12:00 P.M., the Maintenance Director said he/she had not received any reports of the door alarms not working, and he/she was not aware of the front door alarm being found unplugged. Staff should document any maintenance requests on the log in the employee break room or tell him/her directly if something needs immediate attention. He/she was always available by phone.</p> <p>During interviews on 02/23/25, at 1:40 P.M. and 3:03 P.M., the DON said the following:</p> <p>-The facility's front and back (employee) doors were alarmed and would emit a loud beep whenever the door was opened. He/she had not heard any reports that the front door or alarm were or had been inoperable prior to the incident.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>-RN A called her on 02/23/25, at approximately 1:30 A.M. and told him/her the resident was found outside on the ground in front of the building. The DON said he/she instructed the RN to complete a full assessment, clean the wounds, and to notify the family.</p> <p>-The resident's family was very concerned that the resident got outside in the cold temperature, but said to monitor the resident's condition and not to send the resident to the emergency department based on the current assessment. The family was going to come to the facility in the morning to see the resident.</p> <p>-The DON said he/she came to the facility and found the front door alarm system to be unplugged (located above the door).</p> <p>During interviews on 02/23/25, at 3:20 P.M. and 3:40 P.M., the Administrator the following:</p> <p>-He/she was not aware that the front door alarm was found unplugged;</p> <p>-The only reason the alarm would ever be unplugged was when the maintenance director was testing the system. No other staff should unplug the alarm system.;</p> <p>-Staff must enter a code on the keypad by the front and back doors before opening the door. A loud beep is heard briefly. When the front and back doors were opened without entering a code on the keypad, a loud beeping noise begins and remains sounding until the code is entered. The door alarms will also sound if the code is entered, but the door is held open too long.</p> <p>-If the doors are not alarmed, staff should monitor the front and back doors;</p> <p>-Staff should notify the Maintenance Director as soon as possible regarding immediate needs, like the door alarms not working.</p> <p>MO00250027</p>		