STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265520	A. Building B. Wing	08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Webco Manor	1687 West Washington Marshfield, MO 65706

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 - Minimal harm or potential for actual harm 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** 45176 Based on observation, interview, and record review, the facility failed to provide protective oversight to all residents when staff did not put new interventions in place after, or make all working staff aware of, elopement attempts made by one resident (Resident #1) with a history of wandering and talking about leaving the facility. The resident eloped later the same day and was found in a nearby [NAME], located between the facility and the interstate. The facility census was 53. Review of the facility's policy titled, Elopement Policy & Procedure, undated, showed the following: -Elopement included when a resident left the premises or a safe area, without authorization and/or necessary supervision placing the resident at risk for harm or injury; -It is the intent of the facility to be aware of its residents usual habits and locations as reasonably practicable; -If the resident used an electronic device that alarms, the supervisor or designee will determine location of device on resident and test any used electronic device attached to the resident; -In the event there is any doorway equipment malfunction, supervision of that area will be provided unless there is only one resident at risk in which case the assigned staff member will provide 1:1 or other frequency of observation to the resident determined by the physician and or supervisor; -Re-evaluate the resident's risk for possible elopement regardless if this event may constitute an elopement or not. Review of the facility's policy titled Safety and Supervision of Residents, revised on July 2017, showed the following: -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; (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265520	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/07/2024
NAME OF PROVIDER OR SUPPLIER Webco Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 1687 West Washington Marshfield, MO 65706	

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-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; -Resident risks and environment hazards included unsafe wandering. 1. Review of Resident #1's face sheet (a brief resident summary) showed the following: -admitted [DATE]; -Diagnoses included major depressive disorder (persistent feeling of sadness and loss of interest), nontraumatic intracerebral hemorrhage (subtype of stroke where hematoma is formed within the brain), non-traumatic intracranial hemorrhage (often occurs secondary to hypertensive damage to cerebral blood vessels, which eventually burst and bleed into the brain), and cognitive communication deficit. Review of the resident's July 2024 Physician's Order Sheet (POS) showed the following: -An order, dated 01/02/24, to check code alert (electronic monitoring device to help prevent elopements) expiration date every Sunday and turn in dates to medical records office; -An order, dated 01/02/24, to check code alert placement on left ankle and verify it is active each shift for elopement risk. Review of the resident's care plan, last updated on 07/22/24, showed the following: -On 11/21/23, staff updated the care plan to show resident had cognitive loss/dementia with signs and symptoms of inattention, disorganized thinking, and diagnosis of dementia. Staff to provide resident with opportunities to make decisions. Staff to ask short, simple, direct questions and provide reality orientation as needed; -On 12/04/23, staff updated the care plan to show resident at risk for falling related to unsteady balance and or history of falls. Staff to give resident verbal reminders not to ambulate/transfer without assistance. Staff to encourage resident to use environmental devices such as hand grips and hand rails. Staff to provide resident with proper, well maintained footwear, nonskid soles/socks, and anti roll backs placed on wheelchair; -On 12/12/23, staff updated the care plan to show resident had pain problems as evidenced by his/her complaints of pain related to fractures of the spine; -On 12/12/23, staff updated care plan to show resident had behavioral problems as evidenced by rejection of cares and exit seeking. Resident to remove resident from other residents' rooms and unsafe situations as needed and divert behaviors to activities; -On 12/12/23, staff updated care plan to show resident had communication problems as evidenced by impaired hearing; (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 01/02/24, staff updated the care plan to show resident would try to leave the facility to tend to his/her farm and cattle. The resident doesn't always remember he/she is in the facility. A personal electronic monitoring device (used to prevent possible elopements) had been placed on the resident's left ankle. Review of the resident's May 2024 progress notes showed the following: -On 05/11/24, at 1:36 P.M., staff noted the resident had been wandering the facility all day in his/her wheelchair. The resident required constant redirection due to exit seeking most of the time; -On 05/11/24, at 4:08 P.M., staff noted the resident was up walking with exit seeking behaviors. Staff were able to redirect the resident for an hour. Review of the resident's Abnormal Involuntary Movement Scale, completed 05/14/24, showed the following: -The resident was commonly found near facility exits or employee/services areas; -The resident verbalized a serious intent to leave facility, or has a history of previous elopement or unsafe wandering; -The resident had the physical capability of leaving the building; -The resident commonly became agitated, confused, or disoriented. The resident showed poor judgment or impulsive decision making; -Staff assessed the resident as a high risk for elopement. Review of the resident's May 2024 progress notes showed the following: -On 05/20/24, at 11:39 A.M., staff observed resident wandering the halls during the morning with no elopement attempts; -On 05/20/24, at 6:39 P.M., staff noted resident wandered around the facility and required constant cueing and reminders; -On 05/27/24, at 1:51 P.M., staff noted resident wandered around the facility and did required constant cueing and reminders. Review of the resident's June 2024 progress notes showed the following: -On 06/03/24, at 11:06 A.M., staff noted the resident wandered around the facility and required constant cueing and reminders; -On 06/10/24, at 12:33 P.M., staff noted the resident wandered around the facility and required constant cueing and reminders; (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 06//17/24, at 10:41 A.M., staff noted the resident wandered all around the facility and required constant cuing and redirection; -On 06/17/24, at 5:59 P.M., staff noted the resident roamed around building at times and was at exits; -On 06/19/24, at 8:00 P.M., staff caught the resident multiple times during the shift exit seeking and up walking without his/her wheelchair. A few times, the resident had been bent over pushing his/her chair backwards; -On 06/24/24, at 12:36 P.M., staff noted the resident wandered around the facility and required constant cuing and redirection. Review of resident's Physician Provider Note, dated 07/09/24, showed the following: -Resident conscious, alert, confused, oriented to person, and unable to name place or current year; -Resident impaired short term memory. The resident could recall some remote events; -Resident had impaired concentration and unable to stay on topic and maintain concentration throughout assessment; -Resident was asked to to state the days of the week, months and year in reverse order and he/she was unable to initiate the tasks. Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment tool completed by facility staff), dated 07/19/24, showed the following: -Severe cognitive impairment, with inattention and disorganized thinking present; -Wandering behavior daily; -Required partial assist with toileting hygiene, showers, upper and lower body dressing, sit to stand and lying to sitting; -Used an wheelchair for ambulation. Review of the facility's investigation, undated, showed the following: -The resident's elopement risk was high upon admission and an electronic monitoring device was placed on the resident's ankle; -Electronic monitoring devices are checked each shift for placement, working order, and replaced quarterly; -The resident was last seen in the television room at on 07/21/24, at 8:00 P.M.; -During rounds, the resident was not seen in his/her room; (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Registered Nurse (RN) J was notified of the missing resident; -Current staff were instructed to start a facility search inside and outside the facility premises; -RN J notified the Administrator and RN Consultant at 9:14 P.M.; -When the resident was not located, the Director of Nursing (DON) notified additional staff to complete search; -The RN Consultant arrived to the facility at 9:30 P.M. to assist in the search; -Police department notified at 9:45 P.M. of the missing resident; -Law enforcement, including the Highway Patrol, began to search with a drone and had picked up movement in the nearby [NAME] around 10:30 P.M., but thought it was a deer; -Weather was 70 degrees outside; -Resident was able to self propel in his/her wheelchair; -Staff notified the resident's family at 10:20 P.M.; -On 07/21/24, at 10:20 P.M., the Maintenance Assistant found the resident in the corn field, approximately 100 yards from the facility; -Resident said he/she was checking on his/her cows; -Maintenance checked all exit doors for working order and all were found to alarm; -All doors with electronic monitoring capabilities all alarmed appropriately when electronic monitoring devices were close to the doors. Review of RN J's written statement, dated 07/22/24, showed the following: -The resident's family had been in to visit with the resident in the afternoon and left around 430 P.M. to 5:30 P.M.; -On 07/21/24, at approximately 5:40 P.M., the resident attempted to leave through the front door as the Activities Assistant exited at the end of his/her shift; -On 07/21/24, at approximately 6:00 P.M., the alarm for the 500 hall door sounded, triggered by the resident's wander guard device; -RN K responded to the door along with Certified Medication Tech (CMT) I; -The resident had opened the exterior door and attempted to get his/her wheelchair over the threshold; (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-RN J approached the resident and the resident said he/she was trying to go home; -RN J escorted the resident to his/her room on 100 hall; -RN J had a conversation with the resident regarding the facility being his/her home; -The resident was seen by other certified nurse aides working the floor over the next 60 to 90 minutes; -RN J last saw the resident on 07/21/24, at 8:00 P.M., ambulating in his/her wheelchair in the common area adjacent to the east and west nurses' station; -On 07/21/24, at approximately 8:40 P.M., Certified Nurse Aide (CNA) K asked if anyone had seen the resident lately; -CNA K went back to the resident's room and the resident was not found. CNA K reported this information to RN J about five minutes later; -RN J notified CNA E the resident was missing and RN J began to assist CNA K in searching the parameters for the resident; -All staff began to search inside and outside and the resident was not located; -On 07/21/24, at 9:14 P.M., RN J notified the DON and the Administrator of the missing resident. The DON began calling in more staff to assist in the search; -At 9:44 P.M., RN J called the police department. They arrived at 9:50 P.M.; -The resident was found at 11:42 P.M., by the Maintenance Assistant. During an interview on 08/07/24, at 12:52 P.M., RN J said the following: -Nurses have orders on the MAR that pops up when the electronic monitoring devices are to be checked; -Staff know which residents are an elopement risk and watch for the behaviors; -When the behaviors are observed, this is passed on to the aides and management is notified; -There is also a binder at the nurses' station that has a list of residents with wander guards; -When a resident is exit seeking, or has an attempt to elope, staff notify management, put the resident on 15-minute checks, redirect, and provide a higher frequency of care; -The resident had a history of going into empty rooms and closets. Until 07/21/24, he/she had not seen the resident push on doors; -The resident would talk about checking on his/her cows and the farm; (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-When a resident with a electronic monitoring device gets close to the doors, the keypad disengages and can't be used; -If the door is pushed for 15 seconds it will open and the alarm will sound; -On 07/21/24, he/she worked on the 300 hall and he/she and CMT I heard the alarm overhead. He/she looked at the control panel and saw that 500 hall door was open; -He/she and CMT I took off running and the resident had the door open and was trying to get his/her wheelchair over the threshold; -RN J asked the resident if they could move elsewhere so RN J could turn off the alarm. The resident said he/she wanted to go home, but agreed to move; -RN J took the resident outside to the courtyard, a locked in area, and talked to the resident who eventually came back inside; -RN J did not hear the door alarm the rest of the night; -RN J told CNA K, the aide working the hall, that the resident attempted to elope, and that staff would all be keeping a closer eye on the resident. -He/she did not do official 15-minute checks, but knows he/she probably should have done them; -The resident was in his/her room for a while with his/her roommate and watching television; -Around 8:30 P.M., or 8:45 P.M., CNA K came around the corner when RN J was doing med pass and CNA K said he/she hadn't seen the resident; -CNA K had been doing bedtime rounds, helping residents to bed and came out of one room and into the resident's room and didn't see the resident; -The resident usually went to bed early; -The resident needed some assistance with bedtime routines. The resident is care planned for one assist; -RN J saw the resident in the hallway between his/her room and the nurses' station around 8:00 P.M. No other staff had seen the resident since that time; -The 500 hall is where the resident gravitates so staff started an inside search; -The three staff each took a hall and went into each room, door-to-door. Once all rooms were cleared RN J told CNA E and CNA K to switch halls; -CMT H, searched non-care area around the building, then around the perimeter; -During the second round, RN J called the DON and he/she called other staff to assist; (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-RN J also called the Administrator who gave guidance; -After about 30 minutes, he/she called 911; -The Maintenance Assistant located the resident in the corn field; -He/she had not been told that the resident attempted to leave the facility while another staff have been going out the door earlier that day. During an interview on 08/07/24, at 1:47 P.M., CNA K said the following: -The nurse tells him/her when there are residents that exit seek or wander; -Staff redirect residents back to the front of the facility around other residents; -If a resident attempted to elope, they're placed the resident on 15-minute checks; -Residents with a history of wandering or attempting to elope have electronic monitoring devices; -The resident had a electronic monitoring device; -He/she didn't know who checked the electronic monitoring device to ensure it's working properly; -He/she didn't know if the door would alarm when a resident wearing a electronic monitoring device went through the door; -He/she knew the door would open after pushing on it for 15 seconds and the alarm sounds; -The resident constantly wants to go to work and when staff try to redirect the resident, he/she kept saying he/she had to go to work; -The resident went down 400 hall and looked at the door. He/she knew of one time the resident tried to open the door, but staff redirected the resident; -The resident wandered throughout the facility; -He/she worked the evening of 07/21/24; -He/she didn't hear the alarm go off at anytime during her shift; -He/she saw RN J bring the resident back up the hall and RN J said he/she caught the resident trying to get out the door; -RN J did not give any direction on increased monitoring or doing 15-minute checks; -He/she tried to keep an eye on the resident while working; -There were two CNAs working the evening shift. The two will take one hall and split the other two; (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/she hadn't seen the resident since 6:00 P.M. or 6:30 P.M.; -He/she looked in the resident's room, unsure of the times, and he/she did not see the resident. He/she assumed the resident was in the dining room; -Around 7:30 P.M., he/she went to help the resident get to bed and the resident wasn't in his/her room; -He/she got the other CNAs and told RN J, and then he/she went to look for the resident; -RN J said he/she pushed the resident into his/her room around 6:30 P.M.; -He/she thought the resident was still in the lobby and didn't know RN J had pushed the resident back to his/her room. Observation and interview on 08/06/24, at 9:48 A.M., with the RN Consultant showed the following: -The door at the end of 300 hall, going into the daycare area, did not have a electronic monitoring device alarm; -When the daycare closes, the outside door to get into the daycare is alarmed; -He/she believed the resident might have gone through the 300 hall door and then down the hall and out the daycare door; -Once through the 300 hall door, there is another door to the left that was not locked that lead to a fenced area with a gate that's kept locked; -The resident had been found in closets and other people's beds; -The resident walked, but he/she was not real steady on his/her feet; -The resident went to doors and the door alarmed; -The resident used to stay away from 500 hall, until the facility began having activities at the end of 500 hall. During an interview on 08/06/24, at 12:13 P.M., CMT A said the following: -Staff are oriented on which residents wander, exit seek, or have those types of behaviors; -Staff are to keep a closer eye on residents that talk about leaving, exit seek, or wander and those with wander guards; -Has not seen the resident close by doors. He/she wandered and talked about leaving to go feed his/her cows or check on the tractor; -He/she does not know how the resident got out of the facility on 07/21/24; (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-There are codes on all doors and when someone pushes the handle down for a period of time it will open, but the alarm sounds loudly; -When the door alarm sounds, staff checks all of the doors. During an interview on 08/06/24, at 12:23 P.M., CNA B said the following: -He/she was told by staff which residents have a tendency to exit seek and wander; -He/she learned which residents have a tendency to exit seek and wander; -The resident talked about his/her farm and things he/she needs to do at the farm; -He/she had not seen the resident push on the door handles or attempt to put in codes; -When anyone pushed on the door handle, it eventually opened and the alarm sounded; -Staff check all doors when the alarm sounds, and the alarm doesn't stop until staff put in a code. During an interview on 08/06/24, at 12:32 P.M., Licensed Practical Nurse (LPN) C said the following: -Nurses check the residents' electronic monitoring devices each shift when they pop up on the MAR; -Staff are told from shift-to-shift which residents are an elopement risk; -Residents at risk of elopements wear electronic monitoring devices; -Resident rounds are completed at least every two hours and sometimes hourly; -The resident wandered. He/she will go down 300 hall. He/she had been known to sleep in the day room; -The resident wore a electronic monitoring devices; -When a resident pushed the door handle and the door opened there was a loud alarm and staff check all doors; -The box at the nurses' station tells staff which door sounded the alarm. During an interview on 08/06/24, at 3:28 P.M., LPN G said the following: -All residents that wander or exit seek wear wander guards; -Staff know which residents wander or exit seek as they're told during report; (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/she redirected the resident to do something else; -The resident was being stubborn on 07/21/24; -He/she said they usually put residents by the nurses' station to keep a closer eye on residents when they try to elope; -He/she doesn't know if they put the resident by the nurses' station after he/she attempted to elope; -He/she said they weren't fully staffed and had only two aides working the floor; -Resident rounds are done first thing when the shift begins at 2:00 P.M., and then they usually get residents up to eat around 4:00 P.M.; -Around 6:00 P.M., some residents want to get ready for bed so they assist them and that can take until 8:00 P.M. and then it's time to do rounds again; -Neither CNA had seen the resident in awhile; -The resident usually got him/herself ready for bed. The resident was sometimes incontinent and needed staff assistance; -He/she believed CNA K found the resident missing when CNA was doing rounds between 8:00 P.M. and 8:30 P.M.; -CNA K said he/she couldn't find the resident; -He/she didn't hear the door alarm go off after the first elopement attempt. During an interview on 08/06/24, at 3:15 P.M., CMT F said the following: -He/she was in charge of reordering the electronic monitoring devices when they expire; -When the codes aren't put into the keypads and the doors are pushed, the lights flash on the panels at the nurses' station; -If the door is pushed in 10 to 15 seconds it opens and the door alarms. It alarms at the nurses' station; -If staff unlock the door from the outside, it alarms at the door and the nurses' station too. During an interview on 08/06/24, at 4:00 P.M., CMT H said the following: -The resident goes to the door and he/she had pushed on it at times. This happened about every two to three days; -The wander guard sets off the alarm when the resident is close to the door; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265520	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Webco Manor	1687 West Washington Marshfield, MO 65706

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 - Minimal harm or potential for actual harm Residents Affected - Few	-When the door is pushed for 15 to 20 seconds, the door opened and a loud alarm went off that sounded at the nurses' station; -Earlier in the evening the resident tried to go out the door with another staff and staff got to the resident before he/she got out; -The resident was not put on 15-minute checks. He/she just tried to keep an eye on the resident; -He/she was doing medication pass in the dining room when the resident tried to get out the door on 500 hall; -Alarms were going off all day. He/she heard the alarm go off for 500 hall, but before he/she got the chance to check the door, RN J and CMT I went to investigate; -The resident was found trying to go out the door; -He/she doesn't know of any interventions put in place. He/she just tried to keep and eye on the resident; -He/she did not hear an alarm the rest of the night; -When the resident wasn't located, it was thought the resident left with his/her family; -He/she gave the resident his/her medications earlier; -He/she saw the resident shortly after dinner, and that's the last time he/she remembered seeing the resident; -Close to 9:00 P.M., one of the aides said the resident was missing; -Usually the resident was in bed by 8:00 P.M. or 8:30 P.M.; -The aides were looking for the resident; -The resident did need some help getting ready for bed; -Resident rounds are completed every two hours and it's thought the resident eloped when the two CNAs were putting residents to bed; -The resident has dinner around 5:00 P.M. and then goes to the dining room; -Around 6:00 P.M., to 6:30 P.M., the aides lay residents down; -The aide checked on the the resident around 8:30 P.M. to 8:40 P.M., and the resident wasn't in his/her room; -He/she is not sure how the resident eloped. The resident will try to go out the front door after people when they're leaving; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265520	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/07/2024
NAME OF PROVIDER OR SUPPLIER Webco Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 1687 West Washington Marshfield, MO 65706	

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(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 - Minimal harm or potential for actual harm Residents Affected - Few	-He/she doesn't know if the electronic monitoring device would sound if the keypad code is put in and a resident tries to leave; -Nurses were responsible for checking the electronic monitoring device and ensuring it's working; -If the resident went out the door, the alarm should have gone off; -The resident did go to locked doors and check to see if they would open, but generally staff are nearby and redirect; -The resident goes down 400 and 500 halls. During an interview on 08/06/24, at 4:27 P.M., CMT I said the following: -There was a book at the nurses' station with a list of residents who have electronic monitoring devices and are an elopement risk; -When residents with electronic monitoring devices go near the door, there is an alarm that sounds, and if the code is attempted it doesn't work; -If the resident pushed the handle for 10 seconds, it will open and staff put in a different code to shut the alarm off; -There are two panels at the nurses' station and depending on the door, the light flashes by the number; -He/she responded to door alarms by going to the sound he/she hears and if not sure, he/she went to the nurses' station to see which door it is; -He/she would search outside the area if no resident was found by the door; -The resident did set off the alarm on 500 hall on 07/21/24. By the time he/she got there RN J was taking care of the resident; -RN J took the resident outside to the pavilion, a fenced in area, and talked to the resident; -Don't think 15-minute checks were put in place; -He/she didn't remember when he/she last saw the resident; -He/she only worked until 8:00 P.M. on 07/21/24; -He/she was told the resident might have gone through the door that goes to the daycare, even though it is an alarmed door. During an interview on 08/06/24, at 12:51 P.M., the Activities Director said the following: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265520	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/07/2024

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Webco Manor	1687 West Washington Marshfield, MO 65706

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-When residents have history of elopement or wandering, it is placed in the resident's care plan and all staff have access to the care plan; -Staff should be notifying the oncoming shifts when the residents have new behaviors of wandering, talking about leaving or exit seeking; -Residents who attempt to leave are redirected with an activity and put on 15-minute checks; -Residents who wander also have on electronic monitoring devices; -Nurses check the electronic monitoring devices. He/she did not know how often; -Resident rounds are completed every two hours and as needed; -Staff kept a closer eye on residents that exit seek; -He/she had not seen the resident push on doors or keypads to get out; -When the door handles were pushed without putting in codes, the door opened after 15 seconds, alarmed and a code was required to get the alarm to shut off. During an interview on 08/07/24, at 9:40 A.M., the Maintenance Assistant said the following: -He/she had seen the resident go places he/she shouldn't be going; -When remodeling 400 hall, the resident would try to come down the hall and said he/she wanted to go home; -The resident wandered a lot; -He/she had not seen any issues with the doors not working properly; -If someone push on the door, it counts down and then opens but an alarm goes off; -On 07/21/24, he/she came in around 10:30 P.M. to assist in the search of the resident; -The resident goes down 400 hall often to look out the window of the door at the highway; -He/she thought maybe the resident went that direction since he/she looks that way; -He/she seen a couple of corn stalks knocked over, and a path with corn stalks knocked over so he/she went into the corn field; -He/she followed the knocked down corn stalks until he/she came to an open path and he/she seen the resident sitting in his/her wheelchair as the resident couldn't go any further; -He/she told the resident everyone was looking for the resident and the resident said he/she didn't mean to cause problems, he/she just wanted to go home; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265520	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/07/2024
NAME OF PROVIDER OR SUPPLIER Webco Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 1687 West Washington Marshfield, MO 65706	

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/she believed the resident walked behind his/her wheelchair to get to where he/she was located; -The resident was about 250 yards into the [NAME]; -The Maintenance Assistant called everyone and the resident was lifted out of the corn field; -When coming back out of the corn field and at the edge of the grass, he/she shined his/her light and could see marks from the resident's wheelchair in the grass; -He/she has not seen any issues with doors not working. The Maintenance Director checked them monthly and he/she checked them one to two times per week and let the Maintenance Director know. Observation and interview on 08/06/24, at 1:01 P.M., with the Maintenance Director showed the following: -When a resident with a electronic monitoring devices gets close to the doors, there is a sound and the signal turns yellow on the keypad and this disengages the keypad; -He/she had been checking the electronic monitoring system monthly and there had been no issues with any doors not alarming or opening after the 15 seconds of the handle being pushed for fire code reasons; -The door at the end of 300 hall, that leads to another part of the building, locked out at five feet instead of 10 feet; -There are six egress doors with keypads; -The door going to the other part of the building did not lock during the day as there is a daycare open; -The staff are supposed to set the alarm when they close the daycare, but sometimes one staff will call him/her to check the alarm; -He/she came up to help search for the resident when he/she eloped; -He/she had seen the resident scoot up to the door and talked about going to feed cows. He/she had not seen the resident set off the alarms; -Once outside the gate that's located outside the daycare door, after going through 300 hall, was open and the Maintenance Director said the Maintenance Assistance mowed and must have left it open; -Maintenan