

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265555	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/23/2025
NAME OF PROVIDER OR SUPPLIER Eldon Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 1001 East North Street Eldon, MO 65026	

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 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>43024</p> <p>Based on interview and record review, facility staff failed to accurately complete elopement assessments for one resident (Resident #1), who staff identified as a resident who wanders daily. The facility census was 63.</p> <p>Review showed the Facility's Elopement Policy, undated, did not direct staff on how to complete an elopement assessment.</p> <p>Review of Resident #1's Minimum Data Set (MDS), a federally mandated assessment tool used to assess resident, dated 10/08/24, showed staff assessed the resident as follows:</p> <ul style="list-style-type: none"> -Cognitively impaired; -Suffers from delirium (a temporary state of mental confusion and disorientation that can cause significant changes in behavior, thinking, and perception); -Wanders daily; -Inattention and disorganized thinking that comes and goes. <p>Review of the resident's elopement/wandering assessment form, dated 06/26/24, showed staff documented the resident as a one, a low elopement risk.</p> <p>Review of the resident's elopement/wandering assessment form, dated 10/04/24, showed staff did not complete the assessment form.</p> <p>Review of the resident's elopement/wandering assessment form, dated 01/07/25, showed staff did not complete the assessment form.</p> <p>Review of resident's nurses notes, dated 1/8/25 at 2:12 P.M., showed staff documented the resident wanders about the facility and at times trying to get out the doors.</p> <p>Review of resident's nurses notes, dated 1/13/25 at 9:44 A.M., showed staff documented the resident up wandering around facility today.</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
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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of resident's nurses notes, dated 1/14/25 at 12:26 P.M., showed staff documented the resident wandered around door to door and looking out windows.</p> <p>Review of resident's nurses notes, dated 1/16/25 at 4:02 A.M., showed staff documented the resident wanders the hallways, going to the exit doors, and looks out, and at times will push on the doors.</p> <p>During an interview on 1/22/25 at 11:30 A.M., the Director of Nursing (DON) said the resident has had three incomplete or incorrect elopement assessments since he/she has been here. The first elopement assessment, dated 6/24/24, showed the resident scored a one, a low elopement risk, which is inaccurate. The DON said he/she expected for an assessment to be redone if it was inaccurate, because from day one the resident showed signs of elopement and exit seeking behavior. The resident has had two more elopement assessments, dated 10/4/24 and 01/07/25, and both were not completed. He/She said the MDS/Assessment coordinator is responsible for all elopement assessments and does not know why they were not completed as required.</p> <p>During an interview on 1/29/25 at 9:34 A.M., the MDS/Assessment coordinator said he/she has only been at the facility for five months and was instructed to open the assessments. He/She said the nurses fill out the elopement assessments and then he/she or the DON goes in and completes them. He/She said the resident's elopement assessments must have fallen through the cracks.</p> <p>During an interview on 2/3/25 at 10:53 A.M., the DON said the nurses are only responsible for filling out and completing the resident's first admission elopement assessment, the MDS/Assessment coordinator is responsible for quarterly and annual assessments. He/She said the admission assessment is filled out with the knowledge the facility received upon admission and fourteen days later when the care plan is completed. The admission assessment should be redone if not accurate when there is a clearer picture of the resident's behavior. The DON said he/she does not know why the MDS/ assessment coordinator believed the nurses were in charge of all the elopement assessments. He/She said corporate runs reports and alerts the facility if they are behind on assessments and he/she does not know why they were not alerted for the resident's elopement assessments that were not completed.</p> <p>MO00248228 / MO00248234</p>

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</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>43024</p> <p>Based on observation, interview, and record review, facility staff failed to provide protective oversight for one cognitively impaired resident (Resident #1) with a history of elopement, when facility staff left the transport van keys in the vehicle and the resident with a history of exit seeking, wandering and elopement attempts eloped from the facility, got into the facility van, and drove nine miles. Facility staff were not aware the resident was missing. The facility census was 63.</p> <p>The administrator was notified on 1/22/25 at 3:17 P.M., of an Immediate Jeopardy (IJ) which began on 1/18/25. The IJ was removed on 1/22/25, as confirmed by surveyor onsite verification.</p> <p>Review of the Facility's Elopement Policy, undated, showed staff are directed as follows:</p> <ul style="list-style-type: none"> -Determine when resident was last seen and by whom, description of their clothing, and where last seen; -Notify all departments and begin a thorough search of the facility and grounds, including bathroom storage areas, and crawl spaces; -Search streets and neighborhoods adjacent to facility; -Notify Director of Nursing and Administrator; -Notify attending physician; -Notify responsible party, and request notification if resident makes contact with them; -If absence exceeds 30 minutes, notify law enforcement agency and give dispatch all the residents identifying information. <p>Review of the resident's Minimum Data Set (MDS), a federally mandated assessment tool, dated 10/08/24, showed staff assessed the resident as follows:</p> <ul style="list-style-type: none"> -Cognitively impaired; -Suffers from delirium (a temporary state of mental confusion and disorientation that can cause significant changes in behavior, thinking, and perception); -Wanders daily; -Inattention and disorganized thinking that comes and goes. <p>Review of the resident's elopement/wandering assessment form, dated 06/26/24, showed staff documented the resident as a one, a low elopement risk.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of the resident's nurses notes, dated 8/8/24, showed staff documented the resident activated the fire alarm system and exited the dining room door, resident brought back into the facility without incident.</p> <p>Review of the resident's nurses notes, dated 9/30/24, showed staff documented the resident tried to get out the hall door and did exit the 400 hall door and was returned to the center.</p> <p>Review of the resident's care plan, dated 12/18/24, showed no interventions were put into place for the resident's elopement and exit seeking behavior after the 8/8/24 and 9/30/24 incidents.</p> <p>Review of the resident's elopement/wandering assessment form, dated 10/04/24, showed staff did not complete the assessment form.</p> <p>Review of the resident's elopement/wandering assessment form, dated 01/07/25, showed staff did not complete the assessment form.</p> <p>Review of resident's nurses notes, dated 1/8/25 at 2:12 P.M., showed staff documented the resident wanders about the facility and at times trying to get out the doors.</p> <p>Review of resident's nurses notes, dated 1/13/25 at 9:44 A.M., showed staff documented the resident up wandering around facility today.</p> <p>Review of resident's nurses notes, dated 1/14/25 at 12:26 P.M., showed staff documented the resident wandered around door to door and looking out windows.</p> <p>Review of resident's nurses notes, dated 1/16/25 at 4:02 A.M., showed staff documented the resident does wander the hallways, going to the exit doors, and looks out and at times will push on the doors.</p> <p>Review of the resident's care plan, dated 12/18/24, showed no documented interventions for elopements or the resident's exit seeking behaviors.</p> <p>Review of the resident's nurses notes, dated 1/18/25, showed staff documented Certified Nursing Assistant (CNA) B reported the local Sheriff on the phone, the officer reported being at a residential house on Highway 52 and evaluating the safety of Resident #1. Will return call and discuss safety. Spoke with resident's family on the phone about coming to facility for the resident's return. Officer returned call to come get the resident. Sent CNA B and van driver to return resident to facility. He/She arrived safely without injury. Physical and mental assessment within normal limits.</p> <p>Review of the facility's investigation, dated 1/18/25, showed Resident #1 exited the facility and drove the facility van to a residential area where a homeowner contacted the local Sheriffs office. The resident was picked up by facility staff. Did not have injuries.</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 1/22/25 at 9:39 A.M., the administrator said the resident was exit seeking and did go to doors often. Staff know to redirect the resident. The resident had eloped once, but did not make it off the property. The resident often talks about going home to be with his/her brother and dog. The administrator said on 1/18/25 he/she did not know how the resident got out of the building, if an alarm was set off, or if the resident was let out by a guest. The administrator said he/she did not know how the resident drove the company van, because he/she had delusions and was not of sound mind. He/She said the keys were left in the van the previous day by the transport driver.</p> <p>During an interview on 1/22/25 at 10:07 A.M., the transport driver said he/she takes full responsibility for leaving the keys in the van. He/She was in a hurry and did not realize they were left in there. He/She does not know how the resident drove the van because he/she is not cognitive to do so. He/she does not know how the staff at the facility did not catch the resident leaving, because everyone knows to watch him/her, because he/she was constantly exit seeking and wanting to go home.</p> <p>During an interview on 1/22/25 at 10:43 A.M., CNA B said he/she gave the resident a shower and took him/her to the dining room for lunch, unsure of the exact time. He/She then left for his/her own lunch break, and was not sure what time it was. He/She came back from his/her lunch break after 25-30 minutes on 1/18/25 through the employee entrance and heard a faint door alarm. CNA B said he/she started to check doors for residents and found the door alarm at the end of the 100 hall was tripped. He/She said Resident #2 was by the door, but he/she checked outside and did not see any other residents. CNA B said CNA C told him/her to check for the resident because he/she is always exit seeking, CNA B said he/she turned off the alarm and went to the nurses station to look for the resident and that is when the sheriff's office called that they had the resident. He/She said the resident was known for trying to leave the building.</p> <p>During an interview on 1/22/25 at 10:25 A.M., Registered Nurse (RN) A said he/she was on the unit when CNA B came to him/her and said the sheriff's department was on the phone and the resident was missing. RN A said he/she could not say how long the resident was gone or if the alarm went off when he/she left. He/She said the resident was not cognitively intact to operate a vehicle and often had delusions. He/She said the resident had eloped before and had exit seeking behaviors and was very fixated about what was outside.</p> <p>NOTE: At the time of the survey, the violation was determined to be at the immediate and serious jeopardy level J. Based on observation, interview and record review completed during the onsite visit, it was determined the facility had implemented corrective action to remove the IJ violation at the time. A final revisit will be conducted to determine if the facility is in substantial compliance with participation requirements.</p> <p>At the time of exit, the severity of the deficiency was lowered to the D level. This statement does not denote the facility has complied with State law (Section 198.026.1 RSMo.) requiring prompt remedial action to be taken to address Class I violation(s).</p> <p>MO00248228 / MO00248234</p>		