

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265665	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Hill Crest Manor		STREET ADDRESS, CITY, STATE, ZIP CODE  801 South Colby Hamilton, MO 64644	

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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 44395</p> <p>Based on observation, interview and record review the facility failed to provide adequate supervision, identify an elopement risk, implement safety measures and prevent one resident (Resident #1), from eloping from the facility through the front door, and exiting from the building for approximately one hour. The facility census was 50.</p> <p>Review of the facility provided policy Elopement Precautions/Missing Resident, revised July 2017 showed:</p> <ul style="list-style-type: none"> <li>-Prevention of residents leaving the facility without supervision when assessed to be an elopement risk and measures to take when a resident is found missing.</li> <li>-A resident will be considered an elopement risk when unsafe to leave the facility without supervision, and they have made attempts to leave without supervision since admission, they give verbal indicators that they have intent to leave, they demonstrate elopement behavior or there is an elopement incident since admission.</li> <li>-Any resident that demonstrates or verbalizes elopement will immediately be considered an elopement risk and immediate care interventions will be adopted to prevent unplanned elopement.</li> <li>-Residents who are an elopement risk are to have their whereabouts confirmed at least every 30 minutes.</li> </ul> <p>Review of Resident #1's Admission Minimum Data Set (MDS a federally mandated assessment tool completed by facility staff) showed:</p> <ul style="list-style-type: none"> <li>-admitted [DATE]</li> <li>-Brief Interview of Mental Status (BIMS) of 8, indicated moderate cognitive loss.</li> <li>-Feeling down or depressed 2 to 6 days of the week.</li> <li>-Behavioral symptoms not directed at others such as pacing, and verbal or vocal symptoms 4 to 6 days of the week.</li> </ul> <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>-Supervision to touch assistance of staff for Activities of Daily Living (ADL's: tasks completed in a day to care for oneself)</p> <p>-Diagnoses of: Bipolar disorder (a mental illness that causes unusual shifts in a person's mood, energy, activity levels, and concentration), Paranoid Schizophrenia (a condition in which your mind doesn't agree with reality, and affects how you think and behave), psychosis (a person's thoughts and perceptions are disrupted and they may have difficulty recognizing what is real and what is not.), neurocognitive disorder (decreased mental function and loss of ability to do daily tasks).</p> <p>Review of the resident's Initial Care Plan dated 5/3/24 showed:</p> <p>-He/She was independent with mobility, poor safety awareness, no known behaviors, no elopement risk, long term placement and was a smoker.</p> <p>-Orientation to person, place, and time was not marked.</p> <p>Review of the resident's medical record showed:</p> <p>-On 5/3/24 Elopement Risk Assessment completed by the Director of Nursing (DON) showed the resident was no risk;</p> <p>-On 5/10/24 Elopement Risk Assessment completed by the DON showed no changes;</p> <p>-On 5/13/24, the untimed Daily Skilled Note said the resident was exit seeking;</p> <p>-On 5/14/24, the untimed Daily Skilled Note said the resident was wandering and had exit seeking behaviors;</p> <p>-On 5/15/24, the untimed Daily Skilled Note said Resident #1 followed another resident out the front door, and was placed on 15 minute checks;</p> <p>-On 5/16/24, the untimed Daily Skilled Note said the resident often talked of going to an area convenience store to obtain a job and was exit seeking;</p> <p>-On 5/17/24, the untimed Daily Skilled Note said the resident needed reminders of time and location of room and he/she wandered;</p> <p>Review of the resident's progress notes showed: On 5/17/24 at 7:15 P.M. the resident received a phone call at the nurse's station.</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>At 7:40 P.M. Resident #2 reported to Certified Nurse Aide (CNA) A, Resident #3 had told him/her that Resident #1 had left the building. CNA A went outside to look for Resident #1. CNA A asked CNA B to find the Charge Nurse and notify him/her, Resident #1 was missing. CNA A searched the perimeter of the building and surrounding area. The Charge Nurse searched outside the facility and CNA B searched the interior of the building. At 8:20 P.M. the Director of Nursing was notified Resident #1 was missing. CNA #2 was sent to the convenience store and highway to look for the resident. At 8:30 P.M. the resident returned to the facility accompanied by a neighbor. The neighbor reported the resident was found in his/her home when he/she arrived home. The resident was returned inside and placed 1:1 (one resident to one staff member) until 9:15 P.M. At 9:15 P.M. the resident went to bed and staff increased monitoring to every 15 minutes.</p> <p>-On 5/18/24, the untimed Daily Skilled Note said the resident was difficult to redirect, was exit seeking, and had a verbal altercation with another resident who would not allow him/her to go outside. He/She wandered throughout the facility.</p> <p>-On 5/18/24 Elopement Risk Assessment completed by the DON showed the resident was an elopement risk.</p> <p>During an interview on 5/21/24 at 11:23 A.M. the resident said he/she went for a walk. He/She then refused to answer any other questions.</p> <p>During an interview on 5/21/24 at 12:45 P.M. the Administrator said:</p> <p>-The resident often went out to the front of the building to smoke.</p> <p>-She was unaware the resident had left the building behind another resident, had been placed on 15 minute checks or talked about getting a job at the convenience store.</p> <p>-She was aware the resident would talk about walking to the convenience store for cigarettes.</p> <p>During an interview on 5/21/24 at 1:32 P.M. Resident #3 said:</p> <p>-He/She saw Resident #1 leave the facility, walk down the sidewalk and called out to him/her to come back.</p> <p>-Resident #1 told him/her that he/she was not coming back.</p> <p>-He/She reported to CNA A immediately.</p> <p>-CNA A went outside and looked around.</p> <p>-Resident #1 was brought back in about dark.</p> <p>During an interview on 5/21/24 at 2:56 P.M. Registered Nurse (RN) A said:</p> <p>-Resident #1 stood at the front door often.</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>-The resident followed another resident out the door and staff had to bring him/her back inside the building.</p> <p>-He/She talked with the DON after the resident went out and placed him/her on 15 minute checks on 5/15/24.</p> <p>-He/She was worried about the resident walking out again.</p> <p>During an interview on 5/21/24 at 2:42 P.M. CNA C said:</p> <p>-He/She did not know if Resident #1 was on 15 minute checks.</p> <p>-He/She did not complete the checks if the resident was on them.</p> <p>-He/She was not sure when the resident eloped from the building.</p> <p>-The resident gets confused.</p> <p>-He/She was not sure which residents were elopement risks.</p> <p>During an interview on 5/21/24 at 2:57 P.M. RN B said:</p> <p>-The resident did say he/she wanted to go to the convenience store.</p> <p>-The resident would often ask where his/her room was.</p> <p>-He/She did not report the resident talked about going to the convenience store because it was not a big deal.</p> <p>During an interview on 5/21/24 at 3:26 P.M. the DON said:</p> <p>-The charge nurse usually called her when a resident is placed on 15 minute checks.</p> <p>-She was aware of the 15 minute checks the resident was place on 5/15/24.</p> <p>-15 minute checks should be evaluated in morning meeting, and the team determines to continue or discontinue checks.</p> <p>-Elopement assessments were completed weekly for four weeks after admission and quarterly, unless there was an event.</p> <p>-Resident #1 stood at the door all the time.</p> <p>-No alarms sounded when the resident went out.</p> <p>-He/She did not know why 15 minute checks were stopped on 5/15/24.</p> <p>-The 15 minute checks on 5/15/24 were not reviewed in morning meeting.</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 aware why the checks weren't reviewed.</p> <p>During an interview on 5/21/24 at 4:32 P.M. the Administrator said:</p> <p>-The neighbor found the resident sitting on his/her couch when he/she got home, and walked the resident back to the facility.</p> <p>During an interview on 5/22/24 at 3:29 P.M. the Primary Care Physician said:</p> <p>-He was notified of the resident's elopement by a phone message the day after the resident eloped.</p> <p>-He was not aware the resident was an elopement risk.</p> <p>MO236425</p>		