STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265729	A. Building B. Wing	06/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Daviess County Nursing and Rehabilitation	1337 West Grand Gallatin, MO 64640

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 - Some	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** Based on observation, interview and record review, the facility failed to ensure adequate supervision to prevent elopement for one resident, Resident #44, failed to provide adequate supervision to prevent falls for Resident #10, and failed to provide safe transfers for Resident #10 and Resident #31. This affected three of 14 sampled residents. The facility census was 55.Review of the facility's Wandering and Elopement Policy dated 03/2019 showed:-Facility will identify residents who are at risk of unsafe wandering and strive to prevent harm;-Residents identified as high risk for elopement, the resident's care plan will have strategies and interventions to maintain resident safety;-Any time a resident elopes, the attending physician and legal representative are notified. 1.Review of Resident #44's Quarterly Minimum Data Set (MDS, a federally mandated assessment completed by facility staff) dated 04/14/26, showed:-Severe cognitive impairment;-He/She was independent with mobility and wandered;-Diagnoses included Alzheimer's Dementia, high cholesterol, and malnutrition. Review of the resident's Electronic Medical Record (EMR) showed:-An Elopement Risk Evaluation dated 01/07/26 that resident was at risk for elopement related to cognitive impairment and history of wandering and that an elopement care plan was initiated;-Event Report dated 03/09/26 that resident had been found outside on the front patio with continued follow-up charting for 72 hours that included additional exit seeking behaviors and documentation of agitation and outbursts, additionally the resident was placed on 15-minute checks (facility staff to visually confirm resident location and activity every 15 minutes);-Event Report dated 03/29/26 that resident had been seen walking along the sidewalk in front on the facility, resident was initiated on 15-minute checks, and continued follow-up charting for 72 hours;-Nurse's note dated 04/06/26 that resident had been found on the facility's back dock standing on the steps, looking for his car;-Elopement risk evaluation dated 04/08/26 that resident was continued risk for elopement related to cognitive impairment, history of wandering, verbal statements that he/she wanted to leave facility and that he/she had displayed behaviors that indicated an elopement attempt was forthcoming;-Nurse's note dated 04/23/26 that resident was found at the exit door to the facility's back dock looking for his car;-Nurse's note dated 04/27/26 that resident had walked out of the front door, the facility's transport staff was outside at that time and staff assisted resident into facility van and took resident to another facility door and assisted him/her inside;-Nurse's note dated 04/29/26 that resident had attempted to leave the facility to go to the bank;-Nurse's note dated 05/06/26 that resident had been wandering the facility and needed frequent redirection;-Nurse's note 05/07/26 that the resident had wandered the facility through the entire facility requiring several staff members to intervene;-Note dated 05/18/26 that the Inter Disciplinary Team (IDT) had met to discuss resident's wandering and exit seeking behavior, the facility decided there was no change to plan of care and the facility to attempt to transfer him to a secure unit at a different facility;-Nurse's note dated 05/24/26 that resident had wandered during the afternoon and repeating that he/she needed to leave the facility; Review of the resident's care plan dated 05/31/26 showed:-He/She is forgetful and may have difficulty communicating feelings or needs;-He/She had fallen at least three times in the last 12 months;-He/She had memory loss and (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 - Minimal harm or potential for actual harm Residents Affected - Some	was at increased risk for elopement related to dementia;-He/She had no problems/categories regarding elopement. Review of the resident's Electronic Medical Record (EMR) showed:-Nurse's note dated 06/02/26 that resident had exit seeking behavior overnight;-Nurse's note dated 06/03/26 that resident had been aggressive and combative during cares and that he/she was wandering and attempting to enter other resident's rooms;-Nurse's note dated 06/04/26 that resident had been exit seeking and needed redirection from staff;-Nurse's note dated 06/07/26 that resident had been exit seeking and was assisted back to a locked unit to ensure safety;-Nurse's note dated 06/09/26 that resident had been wandering and needed to be redirected by facility staff, that the resident had been restless;-Nurse's note dated 06/11/26 that resident had been wandering and seeking exit doors;-Nurse's note dated 06/15/26 that another resident had seen the resident walking outside in the facility's parking lot and he/she needed assistance from two staff members to return to building; Review of the facility's resident elopement investigation dated 06/19/26, showed: -The resident had initially been admitted to the secured memory care unit in 2024, until he/she had displayed behaviors consistent with depression and social isolation, so after an integration period, resident was moved to a room in the main unit of facility on 01/27/26; -In April 2026, the facility leadership team and resident's responsible party discussed resident's frequent exit seeking behavior and made the decision to start an application for a secured, single gender unit at a different facility; -06/04/26 The resident had an increase in negative behavior, lab work was ordered by the physician, and the resident did require antibiotic treatment for 10 days; -06/14/26 Staff alerted that the resident was seen in the parking lot and near the street. The resident was found and returned to facility and the facility implemented a room change, placing the resident in the secure memory care unit. Observation on 06/23/26 at 09:27A.M., showed that the exterior door to secure unit that required a code to exit, was left ajar and was not secure. Interview on 06/23/26 at 09:30A.M., Certified Nursing Aid (CNA) E said:-The unlocked door was hard to close, -The door is often stuck in the open position because family members enter and exit through the door often; - He/she and other staff had reported the door not closing and it has not been fixed. -The facility was attempting to change the secure unit to be a single sex unit and there are several room changes needed to make room for the resident on the secure unit;-The resident had made it out of the facility several times and he/she could be difficult to redirect. 2.Review of the facility's Fall and Fall Risk Policy dated 04/18/26 showed:-Based on the post fall assessment completed by facility staff and physician, if able, the staff and facility will implement pertinent interventions to try and prevent further falls;-If underlying causes cannot be readily identified or corrected, staff will try various relevant interventions until falling stops;-If falling recurs despite interventions, staff will implement additional or different interventions and indicate why the current approach remains relevant. Review of the resident's care plan dated 05/08/26 showed:-He/She was at risk for injury related to falls;-He/She had fallen at least eight times in four months;-He/She required substantial assist from one staff member for transferring and occasionally needed assistance from two staff members to safely transfer;-Staff to assist resident with walking to the restroom at least once per shift. Review of Resident #10's Quarterly MDS dated [DATE] showed:-Severe cognitive impairment;-He/She was dependent on staff for transfers and assistance with dressing, grooming and bathing;-He/She was incontinent of bowel and bladder;-Diagnoses included Non-Alzheimer's Dementia and chronic pain. Review of the resident's EMR showed:-Nurse's note dated 02/11/26 that nurse had been called back to secure unit because resident had fallen off his/her bed;-Nurse's notes dated 02/23/26 that the nurse had been called back to secure unit because resident had fallen and was reporting extreme pain, resident was sent to the local emergency room (ER) for evaluation, then sent to hospital further away as resident required surgical evaluation and treatment of right hip fracture;-Nurse's note date 02/27/26 that resident had returned to the facility, now required two people to assist with all transfers, had since been diagnosed with Parainfluenza requiring the resident to be isolated in his/her room, that the resident had previously been continent of bowel and bladder and was now incontinent of both, and additionally, the resident (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	was requiring supplemental oxygen via nasal cannula;-Fall risk assessment dated [DATE] that resident scored a 22 which meant he/she was at high risk for falls;-Nurse's note dated 03/01/26 that the resident had been restless, would not eat much of meals and transfers were difficult due to residents increased pain since surgery;-Nurse's note dated 03/02/26 that resident had fallen from his/her wheelchair while in his/her room;-Nurse's note dated 03/10/26 that resident was found on the floor next to his/her bed on floormats at bedside;-Nurse's note dated 03/13/26 that the resident had been found on the floor in his/her room on knees on fall mat;-Nurse's notes dated 03/14/26 that the resident had been restless and attempting to remove surgical dressings and positioning devices;-Nurse's note dated 03/17/26 that resident had continued restlessness and needed to be stationed at the nurse's station for increased monitoring needs;-Nurse's note dated 03/24/26 that the resident had attempted to get self out of bed and had fallen onto mat at bedside;-Nurse's note dated 03/24/26 that resident needed additional x-rays and needed to be transported to the hospital to obtain images, images revealed non-displaced peri-operative fracture, provider was contacted and no new orders were obtained or additional interventions added to plan of care;-Nurse's note dated 03/28/26 that resident was restless, attempting to get out of bed without assistance and reporting increased pain;-Nurse's note dated 04/06/26 that resident was attempting to get out of recliner without staff assistance, was not able to do so, staff intervened and was able to lower him/her to the ground without injury;-Care plan entry dated 04/06/26 that resident had to be lowered to the floor with assist from staff and that a silent motion sensor had been placed to alert staff when resident attempted to transfer without staff assistance;-Nurse's note dated 04/26/26 that nurse called back to secured unit as resident's seat cushion had slid from under resident, causing him/her to slide to the floor;-Care plan entry dated 04/26/26 that resident's cushion had been removed from wheelchair and therapy to evaluate for a non-slip liner between chair and cushion;-Fall risk assessment dated [DATE] that the resident scored 19 and was at high risk for falls; Review of the resident's EMR showed a Nurse's note dated 06/20/26 that the resident had moved forward in the wheelchair, the cushion underneath him/her slid out of the chair and caused the resident to slide out of the chair to the floor. Observation on 06/24/26 at 06:43A.M. showed CNA G and CMT A toileting Resident #31 in the shared resident bathroom while five residents remained in the day room, unsupervised, and Resident #10 made several attempts to stand from the recliner he/she was in, but both feet were tangled in a blanket and he/she had not closed the footrest of the recliner and did not get up. Observation on 06/24/26 at 6:50A.M. showed CMT A stopped Resident #10's attempts to get out of recliner unassisted; CMT A assisted resident to a standing position and walked with resident to the shared bathroom without utilizing a gait belt (a safety and mobility tool worn by a resident that gives caregivers a secure grip to steady and guide someone while walking or transferring.) During an interview on 06/24/26 at 7:15A.M. CNA G said:-He/She is the only staff member on the secure unit from 10P.M. until the following shift arrives in the morning around 7:00A.M.;-Other facility staff members take turns coming over to the secure unit every two hours to assist him/her with resident care;-Residents should not be left unsupervised. During an interview on 06/24/26 at 8:10A.M., CNA E said it is not safe for all staff members to walk away from residents eating breakfast to complete a task; During an interview on 06/25/26 at 9:57A.M., CMT A said that a gait belt is required for all resident transfers that do not require a mechanical lift to ensure the resident and the staff remain safe and without injury. 3.Review of Resident #31's Quarterly MDS dated [DATE] showed:-Mild cognitive impairment;-Incontinent of bowel and bladder;-Diagnoses included Chronic Obstructive Pulmonary Disease, heart disease and Alzheimer's Dementia. Review of the resident's care plan dared 04/09/26 showed:-Moderate assistance required from staff for all grooming, hygiene and transfers;-He/She was at high risk of falls and had fallen since admission to facility;-He/She had delusional thoughts and had attempted to elope the facility on 06/11/26. Observation on 06/24/26 at 5:28A.M., showed CNA G transfer the resident to and from the toilet in the bathroom without utilizing a gait belt. During an interview on 06/24/26 at 07:15A.M., CNA G said that all transfers except mechanical lift transfers require a gait (continued on next page)

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