

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265831	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/20/2026
NAME OF PROVIDER OR SUPPLIER Monarch Springs Wellness & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 894 Leland Avenue University City, MO 63130	
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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one resident with a history of elopement was provided with adequate supervision and staff oversight (Resident #2). On 3/10/26 at approximately 11:20 A.M., staff observed through the window that the resident was outside, across the street from the facility. The resident had a wanderguard (device that sets off an alarm when the person wearing it attempts to exit the facility) on his/her wheelchair and was able exit the building unnoticed through one of two exit doors on the second floor, which were alarmed but did not have a wanderguard sensor. The facility identified 10 residents who were at risk for elopement. The sample was 4. The census was 58. Review of the facility's Wandering and Elopement Policy, dated 08/2020, showed the following:-Purpose: To enhance the safety of residents of the facility;-Policy: The facility will identify residents at risk for elopement and minimize any possible injury as a result of elopement;-Procedure: --The licensed nurse, in collaboration with the Interdisciplinary Team (IDT), will assess residents upon admission, readmission, quarterly, and upon identification of significant change in condition to determine their risk of wandering/elopement;--The resident's risk for elopement and preventative interventions will be documented in the resident's medical record, and will be reviewed and re-evaluated by the IDT upon admission, readmission, quarterly, and upon change in condition;--Response to Resident Elopement:--The licensed nurse most familiar with the incident will document in the resident's medical record how the elopement occurred. Review of Resident #2's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 9/23/25, showed the following:-Moderate cognitive impairment;-No wandering behavior exhibited;-Mobility with a wheelchair;-Diagnoses included dementia, depression, Wernicke's encephalopathy (acute neurological disorder causing brain injury), heart failure, high blood pressure, and diabetes. Review of the resident's care plan, dated 10/14/25, showed the following:-Focus: The resident is at risk for elopement related to elopement evaluation risk score;-Interventions/tasks included elopement attempts from previous facility or hospital. Wanderguard, check for placement every shift. Supervise closely and make regular compliance rounds. Review of the resident's Elopement Risk Evaluation, dated 10/14/25, showed the following:-Imminent Risk;--Physical: Patient ambulates and propels self, and/or wanders. Patient has intentionally or unintentionally attempted to leave community: Yes;-Action: Implement elopement risk care plan. Interventions: Wanderguard and/or secure environment placement;-Comments: Resident elopement occurred, the resident returned to facility, staff on one to one (1:1) observation with the resident presently, wanderguard placed, notifications to the resident's responsible party and physician. Review of the resident's nurse's note, dated 3/10/26 at 5:04 P.M., showed staff documented the resident eloped outside of facility. The resident was escorted back into facility. A head to toe assessment was completed. The resident had zero bruising and no other changes noted. The resident's emergency contact and physician were made aware and the resident's vital signs were stable. The nurse's note did not specify how the resident eloped from the facility. Review of the second floor staffing sheets, dated 3/10/26, showed one nurse and one Certified Medication Technician (CMT) scheduled for day shift. No other staff (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>scheduled for the second floor on day shift. Observation on 3/19/26 at 1:40 P.M., showed the resident seated in his/her wheelchair with a wanderguard device in the pocket of his/her wheelchair. During an interview, the residentsaid he/she did not remember getting out of the facility. He/She would like to go outside at times. During an interview on 3/20/26 at 10:29 A.M., CNA E said he/she was assigned to the resident on 3/10/26. The last he/she saw the resident was in his/her room at approximately 7:30 A.M. to 8:00 A.M. and he/she was asleep. CNA E thought the resident had eloped before but did not know the date. During an interview on 3/19/26 at 9:42 A.M., Licensed Practical Nurse (LPN) D said on 3/10/26, he/she was the nurse scheduled on the second floor. He/She received a text from the facility that the resident had gotten out. He/She saw the resident being escorted back inside the facility by staff. He/She never heard any alarm sound when the resident left the floor. During an interview on 3/19/26 at 12:35 P.M., the Director of Rehabilitation (DOR) said on 3/10/26, she was in the therapy room second floor working with a resident. She looked out the window and saw Resident #2 across the street, standing with his/her wheelchair. The DOR was the only one working in the therapy room on 3/10/26 and the door was closed and the music was loud. She did not hear any alarms sounding at the facility. If she or any of her staff would have heard any alarms, she would expect them to go and investigate. Observations of the second floor on 3/19/26, showed the following:-At 12:40 P.M., no staff visible on the second floor. During a test for staff responsiveness, conducted with the facility's Administrator, the exit door near room [ROOM NUMBER] was opened and an alarm sounded for approximately three seconds, then stopped, while the door remained open. No staff responded to the alarm. During an interview, the Administrator said from the exit door to where the resident was found outside, it appeared to be a distance of approximately 700 yards;-At 12:50 P.M., Housekeeper A was by the second floor dining room. During an interview, he/she said he/she had been on the second floor for about 10 minutes. He/She did not hear an alarm sound;-At 12:52 P.M., a test for staff responsiveness was conducted with the facility's Administrator at the exit door in the second floor dining room. The exit door was opened and an alarm sounded for approximately 30 seconds. No staff responded to the alarm;-At 12:55 P.M, Physical Therapist (PT) B and PT C were in the therapy room inside the second floor dining room. During an interview, PT B and PT C said they heard an alarm sound a couple minutes ago but they did not go and investigate the alarm. PT B said he/she did not know there was an exit door in the second floor dining room. PT B and PT C said they should have investigated the alarm. During an interview on 3/20/26 at 9:24 A.M, the Maintenance Director said the front door is the only door with a wanderguard sensor. All exit door alarms should sound for 20 to 30 seconds. He was not aware the exit door alarm near room [ROOM NUMBER] was not working properly by sounding for only a few seconds. During an interview on 3/20/26 at 1:02 P.M., the DON said the resident is an imminent risk for elopement, meaning he/she is at high-risk for elopement. The DON did not know how the resident got outside of the building. She expected the elopement policy to be followed as written. During an interview on 3/20/26 at 1:04 P.M., the Administrator there should be at least one staff member on the second floor at all times. The resident got out of the facility through one of the second floor exits. The Administrator did not know how long the second floor exit door near room [ROOM NUMBER] was malfunctioning. He expected staff to respond to any door alarms immediately and for staff to be on the floor as scheduled. He did not know why this did not happen on the day of the resident's elopement. 2801617</p>		