

Missouri Department of Health and Senior Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30722	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/31/2023
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NAME OF PROVIDER OR SUPPLIER CASTLEWOOD SENIOR LIVING, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 1538 N OLD CASTLE ROAD NIXA, MO 65714
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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A4776	<p>19 CSR 30-86.047(35) Protective Oversight</p> <p>Protective oversight shall be provided twenty-four (24) hours a day. For residents departing the premises on voluntary leave, the facility shall have, at a minimum, a procedure to inquire of the resident or resident ' s guardian of the resident ' s departure, of the resident ' s estimated length of absence from the facility, and of the resident ' s whereabouts while on voluntary leave. I/II</p> <p>This regulation is not met as evidenced by: Based observation, record review, and interviews the facility failed to provide 24-hour a day protective oversight for all residents when facility staff failed to initiate elopement protocol when one resident (Resident #1), with a diagnosis of dementia, exited the building alone setting off a door alarm. The facility census was 48.</p> <p>Review of the facility's policy titled, "Elopement Prevention & Elopement Actions - Assisted Living & Memory Care," dated 05/31/23, showed the following:</p> <ul style="list-style-type: none"> -The following protocol is in place in the event of a missing resident; -All available staff are to immediately search apartments, common areas and grounds; -In the event that the resident is not located within an approximate 10 minute timeframe, 911 must be notified immediately, along with the Executive Director who will notify the responsible party or designate an individual to do so; -During this time other staff will continue searching for the resident; -Locate the resident's emergency information folder and attain the resident's picture. Make copies and notes as many details as possible; -Hand off picture to responding emergency personnel; 	A4776		
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Missouri Department of Health and Senior Services

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

County Darby, LNHA Executive Director

11-17-2023

Missouri Department of Health and Senior Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30722	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/31/2023
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A4776	<p>Continued From page 1</p> <p>-All of those involved must complete an incident report.</p> <p>1. Review of Resident #1's medical records showed the following:</p> <p>-Admission date of 11/20/20; -Diagnoses included Alzheimer's disease (a form of dementia).</p> <p>Review of the resident nurses' notes showed the following:</p> <p>-The Executive Director reviewed the camera footage and observed on 10/07/23, at 4:55 P.M., the resident exited the building by holding the front door entrance door until it released; -Resident observed walking back into the community, escorted by another resident's family member, on 10/07/23, at 5:12 P.M.</p> <p>Review of the facility's investigation of the resident's elopement on 10/07/23 showed the following:</p> <p>-Care Partner A shut off the front door alarm and did not start elopement protocol; -Initiation of the process did not start until Care Partner B came back from helping a resident and Care Partner A asked her what that alarm meant; -At that time staff Care Partner B called the Executive Director and started elopement protocol; -The Executive Director called 911 and all other notifiable parties; -A family member of another resident brought the resident back into the community. He/she had found the resident outside when he/she arrived; -All involved staff filled out the witness interview forms on 10/07/23.</p>	A4776		

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A4776	<p>Continued From page 2</p> <p>During an interview on 10/31/23, at 12:00 P.M., Care Partner A said the following:</p> <ul style="list-style-type: none"> -After dinner he/she heard an alarm go off, and did not know what it was. So he/she searched for it, and saw it was the front door. He/she entered the code so it stopped alarming. He/She then went back to washing dinner dishes; -He/She stated that about 10 minutes had passed when Care Partner B came back into the kitchen area, so he/she asked Care Partner B what that alarm was for; -He/She stated that is when Care Partner B called the Administrator; -He/She said they were about to start searching apartments to make sure all residents were accounted for, when a family member of another resident brought the resident back into the community. <p>During an interview on 10/31/23, at 1:30 P.M., Care Partner C said the following:</p> <ul style="list-style-type: none"> -He/She said staff do elopement drills monthly; -Protocol is to go directly to the door, and look outside. If no one is seen, staff do head count of residents. <p>During an interview on 10/31/23, at 1:40 P.M., Level One Medication Aide (LIMA) D said the following:</p> <ul style="list-style-type: none"> -Staff do monthly elopement drills with a training paper; -If door alarm goes off one staff goes to the door and the other staff starts a head count of residents in the facility. <p>During an interview on 10/31/23, at 11:00 A.M.,</p>	A4776		
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A4776	<p>Continued From page 3</p> <p>the Administrator said the following:</p> <ul style="list-style-type: none"> -Care Partner A was a newer employee; -Once Care Partner B came back they started searching for her inside when a family member of another resident brought the resident back into the community. <p>MO00225571</p>	A4776		

PLAN OF CORRECTION

Provider/Supplier Name:	The Castlewood Senior Living	
Street Address, City, Zip:	1534 N Old Castle Road Nixa Mo 65714	
Date of Survey:	October 31, 2023	
PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		
ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
	This plan of correction is submitted as required under State and/or Federal law. The submission of this Plan of Correction does not constitute an admission on the part of the community as to the accuracy of the surveyors' findings or the conclusions drawn therefrom. Submission of this Plan of Correction also does not constitute an admission that the findings constitute a deficiency cited are correctly applied. Any changes to the community policies and procedures should be considered subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence, corresponding state rules of civil procedure and should be inadmissible in any proceeding on that basis. The community submits this plan of correction with the intention that it be inadmissible by any third party in any civil or criminal action against the community or any employee, agent, officer, director, attorney, or shareholder of the community or affiliated companies.	11/17/2023
MO-00225571	Correction of Cited Deficiency: The door alarm sounds when its being opened by holding down the emergency release bar for 15 seconds. Netwatch updated our system so the alarming door will now send an alert to the paging system. This will alert the Charge Nurse or designee of the door being opened and the need to initiate protocol.	11/17/23
MO-00225571	Assessment to Identify other Residents that may be affected: The Executive Director and Director of Wellness provided staff education of our elopement protocol and the importance of checking wanderguard placement and functioning every shift for residents who have one in place.	11/17/23
MO-00225571	Procedure to ensure on-going compliance: Continue monthly elopement drills by Director of Wellness or designee.	11/17/23

Conty Darby, LNHA
12-1-2023

	<p>Continue weekly door checks by the Plant Operations Director or designee. Wanderguard placement and function every shift by charge nurse or designee. This information obtained will be reviewed in monthly risk management/QA meeting.</p>	<p>11/17/23</p>
<p>MO-00225571</p>	<p>Monitoring for on-going compliance:</p> <p>Continue monthly elopement drills by Director of Wellness or designee. Continue weekly door checks by the Plant Operations Director or designee. Wanderguard placement and function every shift by charge nurse or designee. This information obtained will be reviewed in monthly risk management/QA meeting.</p>	<p>11/17/23</p>

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{A4776}	<p>19 CSR 30-86.047(35) Protective Oversight</p> <p>Protective oversight shall be provided twenty-four (24) hours a day. For residents departing the premises on voluntary leave, the facility shall have, at a minimum, a procedure to inquire of the resident or resident ' s guardian of the resident ' s departure, of the resident ' s estimated length of absence from the facility, and of the resident ' s whereabouts while on voluntary leave. I/II</p> <p>This regulation is not met as evidenced by: This deficiency is uncorrected. For previous example, please refer to the prior Statement of Deficiencies dated 10/31/23.</p> <p>Class II</p> <p>Based on observation, interview, and record review, the facility failed to provide protective oversight for all residents when the facility failed to ensure staff routinely monitored residents' electronic monitoring system (a device worn on a resident's ankle or wrist that will set off alarms and alerts the staffs' pagers and phones when a resident wearing the device exits the locked Memory Care area) to ensure they worked properly for five residents (Resident #1, # 2, # 3, # 4, and # 5), of 13 residents who resided on the facility's Memory Care Unit, that staff had identified as needing them as an intervention. The facility census was 55.</p> <p>Review of the facility policy "Elopement Prevention & Elopement Actions - Assisted Living & Memory Care," dated 05/31/23, showed the following: -For communities that are secured with locked doors requiring keypad code access (Memory Care), residents identified at moderate to high risk may reside with electronic monitoring system</p>	{A4776}		
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Missouri Department of Health and Senior Services
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Court Darby, LNHA Executive Director
TITLE
DATE
2-26-2024

Missouri Department of Health and Senior Services

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{A4776}	<p>Continued From page 1</p> <p>utilization and care planning to minimize their risk.</p> <p>Review showed the facility did not provide a policy regarding the use and monitoring of electronic monitoring system.</p> <p>Review of the form titled "Documentation," and provided by the Administrator regarding the electronic monitoring system devices showed the following:</p> <ul style="list-style-type: none"> -Visual pulse LED indicates the tag's (device) current mode; -No LED indicates the tag is off; -Flashing LED indicates tag is active, but not in a monitored zone; -Solid LED indicates tag is active and in a monitored zone. <p>1. Review of Resident #1's face sheet (basic and medical information shown at a glance) showed the following:</p> <ul style="list-style-type: none"> -Admission date of 11/10/23; -Diagnoses included Alzheimer's disease (a form of dementia). <p>Review of the resident's Community Based Assessment (CBA - assessment completed by trained and qualified staff describing a resident's abilities and needs), dated 11/16/23, showed the the facility will utilize a electronic monitoring system for the safety of the resident.</p> <p>Review of resident's Individualized Service Plan (ISP - the planning document prepared by the facility which outlines a resident's needs and preferences, services to be provided, and goals expected by the resident or the resident's legal representative in partnership with the facility), dated 11/26/23, showed the staff to utilize a electronic monitoring system for the safety of the</p>	{A4776}		

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{A4776}	<p>Continued From page 2</p> <p>resident.</p> <p>Review of the resident's record and facility records showed staff did not document monitoring of the electronic monitoring device to ensure the device was functioning properly.</p> <p>Interview and observation on 02/08/24, beginning at at 11:30 A.M., with the Administrator, showed the following:</p> <ul style="list-style-type: none"> -The resident was sitting at the dining room table in the Memory Care Unit (MCU). The resident's electronic monitoring system device placed on his/her left wrist. The device showed no flashing red light; -The Administrator confirmed there was no flashing red light to indicate proper functioning of the electronic monitoring system device. <p>2. Review of Resident #2's face sheet showed the following:</p> <ul style="list-style-type: none"> -Admission date of 11/10/23; -Diagnoses included Alzheimer's disease. <p>Review of the resident's CBA, dated 11/16/23, showed the following:</p> <ul style="list-style-type: none"> -Staff will utilize a electronic monitoring system for the safety of the resident; -Staff to check wander tag placement and function once each shift and specify location of electronic monitoring system device; -Report if device is missing or malfunctioning. <p>Review of the resident's ISP, dated 11/16/23, showed the staff will utilize a electronic monitoring system for the safety of the resident.</p> <p>Review of the resident's record and facility records showed staff did not document monitoring of the electronic monitoring device to</p>	{A4776}		

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{A4776}	<p>Continued From page 3</p> <p>ensure the device was functioning properly.</p> <p>Interview and observation on 02/08/24, beginning at 11:30 A.M., with the Administrator, showed the following:</p> <ul style="list-style-type: none"> -The resident had a electronic monitoring system device on his/her right ankle. The electronic monitoring system device did not display a flashing red light; -The Administrator confirmed there was no flashing red light to indicate proper functioning of the electronic monitoring system device. <p>3. Review of Resident #3's face sheet showed the following:</p> <ul style="list-style-type: none"> -Admission date of 07/25/23; -Diagnoses included unspecified dementia. <p>Review of the resident's current active physician orders showed an order, dated 11/09/23, for placement, use, and monitoring of the electronic monitoring system device.</p> <p>Review of the resident's CBA, dated 01/10/24, showed the following:</p> <ul style="list-style-type: none"> -Staff will utilize a wander management system for the safety of the resident; -Staff to check electronic monitoring system device placement and function once each shift and specify location of electronic monitoring system device; -Report if electronic monitoring system device is missing or malfunctioning. <p>Review of the resident's ISP, dated 01/10/24, showed the staff will utilize a electronic monitoring system for the safety of the resident.</p> <p>Review of the resident's MAR, dated November 2023 to February 2024, showed the placement of</p>	{A4776}		

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{A4776}	<p>Continued From page 4</p> <p>the electronic monitoring system device and monitoring of the electronic monitoring system device present on the MARs and initialed as completed by staff.</p> <p>During an interview and observation on 02/08/24, beginning at 11:30 A.M., with the Administrator, showed the following:</p> <ul style="list-style-type: none"> -The resident had a electronic monitoring system device in place on his/her left ankle. The electronic monitoring system device did not display a flashing red light; -The Administrator confirmed there was no flashing red light to indicate proper functioning of the electronic monitoring system device. <p>4. Review of Resident #4's face sheet showed the following:</p> <ul style="list-style-type: none"> -Admission date of 09/01/21; -Diagnoses included Alzheimer's disease. <p>Review of the resident's current active physician orders showed an order, dated 11/09/23, in place for placement, use, and monitoring of the electronic monitoring system device.</p> <p>Review of the resident's CBA, dated 12/12/23, showed the following:</p> <ul style="list-style-type: none"> -Staff will utilize a electronic monitoring system for the safety of the resident; -Staff to check electronic monitoring system device placement and function once each shift and specify location of electronic monitoring system device; -Report if tag is missing or malfunctioning. <p>Review of the resident's ISP, dated 12/12/23, showed the staff will utilize a electronic monitoring system for the safety of the resident.</p>	{A4776}		

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{A4776}	<p>Continued From page 5</p> <p>Review of the resident's MAR, dated November 2023 to February 2024, showed the placement of the electronic monitoring system device and monitoring of the electronic monitoring system device present on the MARs and initialed as completed by staff.</p> <p>During an interview and observation on 02/08/24, beginning at 11:30 A.M., with the Administrator, showed the following:</p> <ul style="list-style-type: none"> -The resident had a electronic monitoring system device in place on his/her left ankle. The electronic monitoring system device did not display a flashing red light; -The Administrator confirmed there was no flashing red light to indicate proper functioning of the electronic monitoring system device. <p>5. Review of Resident #5's face sheet showed the following:</p> <ul style="list-style-type: none"> -Admission date of 02/14/20; -Diagnoses included Alzheimer's disease. <p>Review of the resident's current active physician order, dated 11/09/23, showed an order in place for placement, use, and monitoring of the electronic monitoring system device.</p> <p>Review of the resident's CBA, dated 01/10/24, showed the following:</p> <ul style="list-style-type: none"> -Staff will utilize a electronic monitoring system for the safety of the resident; -Staff to check electronic monitoring system device placement and function once each shift and specify location of electronic monitoring system device; -Report if electronic monitoring system device is missing or malfunctioning. <p>Review of the resident's ISP, dated 01/10/24,</p>	{A4776}		

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{A4776}	<p>Continued From page 6</p> <p>showed the staff will utilize a electronic monitoring system for the safety of the resident.</p> <p>Review of the resident's MAR, dated November 2023 to February 2024, showed the placement of the electronic monitoring system device and monitoring of the electronic monitoring system device present on the MARs and initialed as completed by staff.</p> <p>During an interview and observation on 02/08/24, beginning at 11:30 A.M., with the Administrator, showed the following:</p> <ul style="list-style-type: none"> -The resident had a electronic monitoring system device in place on his/her left ankle. The electronic monitoring system device did not display a flashing red light; -The administrator confirmed there was no flashing red light to indicate proper functioning of the electronic monitoring system device. <p>6. During an interview on 02/08/24, at 9:28 A.M., Level One Medication Aide (LIMA) A said the following:</p> <ul style="list-style-type: none"> -Staff do electronic monitoring system device checks daily on each shift on each resident; -If the flashing red light is going on the electronic monitoring system device, it is functioning correctly; -Staff replace it with a new one if the red light is not flashing. <p>During an interview on 02/08/24, at 1:45 P.M., Licensed Practical Nurse (LPN) B said the following:</p> <ul style="list-style-type: none"> -He/she was the nurse that did the admission paperwork for Resident # 1 and Resident # 2; -He/she would not be responsible to put the electronic monitoring system device checks in the MAR (where the home documents monitoring of 	{A4776}		

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{A4776}	<p>Continued From page 7</p> <p>the devices). He/she thought that would be the Director of Nursing (DON).</p> <p>During an interview on 02/09/24, at 12:10 P.M., LPN C said the following: -When checking the electronic monitoring system device for proper functioning staff ensure the red light is blinking; -If the device is not functioning staff would call the Memory Care Director; -He/she did not notice that Resident #1 and Resident #2 electronic monitoring system device checks were not on the MAR's as he/she just checks everybody back there.</p> <p>During an interview on 02/08/24, at 10:05 A.M., the Memory Care Director said the following: -Staff do electronic monitoring system device checks daily on each shift on each resident; -There is a red flashing light on the electronic monitoring system device if it is working correctly; -If the device is not flashing staff change it out with a new device.</p> <p>During an interview on 02/08/24, at 11:15 A.M., the DON said the following: -Staff do electronic monitoring system device checks daily on each shift; -If the device had a flashing red light it is functioning correctly; -Staff would replace a device with a new one if the red light was not flashing.</p> <p>During interviews on 02/08/24, at 9:13 A.M., 10:55 A.M., and 11:30 A.M., with the Administrator said the following: -The battery lasts in the electronic monitoring system devices for a long time, but she was not sure of the duration; -Each memory care resident has electronic</p>	{A4776}		

Missouri Department of Health and Senior Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30722	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 02/08/2024
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NAME OF PROVIDER OR SUPPLIER CASTLEWOOD SENIOR LIVING, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 1538 N OLD CASTLE ROAD NIXA, MO 65714
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{A4776}	Continued From page 8 monitoring system device checks every shift on their MAR; -The facility failed to put the electronic monitoring system device checks on the MAR (where the home documents monitoring of the device) at the time of admission for Resident #1 and Resident #2; -The electronic monitoring system device was functioning correctly if the red light in the corner of the electronic monitoring system device flashes; -If the electronic monitoring system device does not have a flashing red light on, they change it out with a new electronic monitoring system device.	{A4776}		

PLAN OF CORRECTION

Provider/Supplier Name:	The Castlewood Senior Living	
Street Address, City, Zip:	1534 N Old Castle Road Nixa Mo 65714	
Date of Survey:	February 8, 2024	
PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		
ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
A4776	This plan of correction is submitted as required under State and/or Federal law. The submission of this Plan of Correction does not constitute an admission on the part of the community as to the accuracy of the surveyors' findings or the conclusions drawn therefrom. Submission of this Plan of Correction also does not constitute an admission that the findings constitute a deficiency cited are correctly applied. Any changes to the community policies and procedures should be considered subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence, corresponding state rules of civil procedure and should be inadmissible in any proceeding on that basis. The community submits this plan of correction with the intention that it be inadmissible by any third party in any civil or criminal action against the community or any employee, agent, officer, director, attorney, or shareholder of the community or affiliated companies.	2/26/2024
A4776	<p>Correction of Cited Deficiency: All residents, indicated to have a wanderguard in place, had their wanderguard placement and functioning verified. 2/8/2024</p> <p>All staff will be educated on the expectation to check all wanderguards on the indicated residents each shift. The staff will be educated on the proper steps to ensure each wanderguard on the indicated resident, is in proper working function.</p>	2/26/2024
A4776	<p>Assessment to Identify other Residents that may be affected:</p> <p>The Executive Director, Director of Wellness and Memory Care Director will provide staff education on the expectation of checking each wanderguard each shift and the proper steps to ensure the wanderguard is in working function.</p>	2/26/2024

CDanby, LNHA
7554
2-29-2024

