

Missouri Department of Health and Senior Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>31903</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>09/27/2023</b>
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NAME OF PROVIDER OR SUPPLIER  <b>TOWNSHIP SENIOR LIVING THE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>4150 W REPUBLIC ROAD BATTLEFIELD, MO 65619</b>
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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	<p><b>19 CSR 30-86.047(35) Protective Oversight</b></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: <b>Class II</b></p> <p>Based on interview, and record review, the facility failed to provide 24- hour protective oversight to all residents when staff left wandering residents unattended on the hall of the Memory Care Unit resulting in one resident (Resident #1) exiting the building and being returned to the facility approximately 17 minutes later by a person driving by who saw the resident crawling out of a ditch next to a busy street. The memory care unit census was 15 with total facility census of 55.</p> <p>Review of the facility's "Elopement Protocol," dated 05/31/23, showed the following:</p> <ul style="list-style-type: none"> <li>-Only those safe to reside in the community are accepted as resident;</li> <li>-Every resident will be screened prior to admission for severe elopement (when a patient with a known history of altered mental status or intermittent mental status changes, leaves the facility, is missing, and could be at risk for serious harm when not adequately supervised) risk;</li> <li>-Should an elopement occur, an immediate systemic search of property and surrounding neighborhood will take place;</li> <li>-Law enforcement authorities will be notified of elopement within 30 minutes should the resident</li> </ul>	A4776		

Missouri Department of Health and Senior Services  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

*Cheerly Kay RWD, RCAL*

*11.7.23*

Missouri Department of Health and Senior Services

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A4776	<p>Continued From page 1</p> <p>not be located;</p> <ul style="list-style-type: none"> <li>-Once resident is located, resident shall receive a physical examination and the physician notified.</li> <li>-Document elopement;</li> <li>-Re-evaluate if resident is appropriate to remain in the community;</li> <li>-File unusual incident report with licensing agencies as required;</li> <li>-Should the resident be appropriate for retention, service plan adjustments should be immediately undertaken to prevent further elopements.</li> </ul> <p>1. Review of Resident #1's medical record showed an admission date of 07/27/23. .</p> <p>Review of the resident's comprehensive resident evaluation, dated 08/01/23, showed the following:</p> <ul style="list-style-type: none"> <li>-Independent with transfers and mobility and does not require assistive devices;</li> <li>-Low risk for falls;</li> <li>-Depressed or withdrawn, sleep disturbances, comments about death, hallucinations, and delusions, wandering or pacing;</li> <li>-Exit seeking;</li> <li>-Staff assessed resident as a high risk for elopement;</li> <li>-Wander guard (system where residents wear bracelets, sensors that monitor doors and a technology platform that sends safety alerts in real time) due to assessed risk;</li> <li>-Moderately impaired: Has current or history of occasional disorientation to person, place, time, or situation even in familiar surroundings and requires supervision and oversight for safety;</li> <li>-Vision impaired.</li> </ul> <p>Review of the resident's History and Physical, dated 08/08/23, showed the following:</p>	A4776		

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A4776	<p>Continued From page 2</p> <p>-Diagnoses included major depressive disorder, anxiety, Alzheimer's disease (progressive disease that destroys memory and other important mental functions) with late onset, dementia (a set of related symptoms which usually surface when the brain is damaged by injury or disease, non-traumatic intracerebral hemorrhage (a hematoma or blood clot is formed with in the brain without blood extending into the brain ventricles (an interconnected series of cavities filled with cerebrospinal fluid that cushions the brain), traumatic brain injury (brain dysfunction caused by an outside force, usually a violent blow to the head), and cystitis (inflammation of the bladder, usually caused by a bladder infection, not usually serious but a nuisance);</p> <p>-Alert and oriented to him/herself only;</p> <p>-Independent in mobility (walking and moving);</p> <p>-Had recent falls.</p> <p>Review of the resident's progress note dated 09/23/23, at 4:24 P.M., showed at 2:20 P.M., staff notified the Director of Wellness (DOW) that the resident had eloped and was now back safe in the community.</p> <p>Review of the resident's progress note dated 9/23/23, at 6:42 P.M., showed the following:</p> <p>-The DOW had received a call from the receptionist in the independent living (IL- located next to the facility) stating that he/she thought she/she saw a resident exit the memory care unit via the front door;</p> <p>-The DOW went to the memory care unit and walked the hallways. The care partner was in the office and when asked if all the residents were in the unit, he/she said yes. Asked if any door alarms had went off and he/she stated no. Walked with care partner and told him/her that</p>	A4776		

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A4776	<p>Continued From page 3</p> <p>he/she had not seen Resident #1.</p> <ul style="list-style-type: none"> <li>-They inspected the resident rooms and bathrooms and unable to locate the resident;</li> <li>-The Registered Nurse (RN A) went outside of the memory care unit and walked the perimeter of the building to the independent living (IL) and reported to the receptionist that the resident was missing;</li> <li>-The receptionist notified the manager on-call and Registered Nurse (RN) A notified the medication partner who notified the med tech and care partners to assist looking for the resident;</li> <li>-At 2:10 P.M., a van pulled into the driveway and the driver got out and walked to the passenger side and opened the door. The driver said the resident was down the drive way by the road in the grass on his/her hands and knees. He/She assisted the resident into her vehicle and brought the resident to the facility and saw staff outside of the building;</li> <li>-Staff assisted the resident into the facility and did a head to toe examination. There was a small abrasion to the right knee area, but no other scrapes, cuts, bruises or areas of irritation noted;</li> <li>-He/she notified the DOW, the Memory Care Unit Director, and attempted to notify the physician and left message, and then called the nurse practitioner with order to take resident to the emergency room for evaluation for possible unseen injuries;</li> <li>-They called the family and notified them of the resident leaving the facility and need for a visit to the emergency room.</li> </ul> <p>During interviews on 09/23/23, at 5:10 P.M. and at 5:52 P.M., the Executive Director said the following:</p> <ul style="list-style-type: none"> <li>-The alarm for the memory care door went off at 1:53 P.M. today;</li> </ul>	A4776		

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A4776	<p>Continued From page 4</p> <ul style="list-style-type: none"> <li>-The receptionist at the independent living got the alarm and alerted staff per pager due to a wanderguard (a bracelet that a resident wears, sensors that monitor doors and sends safety alerts to caregivers), setting the alarm off;</li> <li>-Memory Care Support Partner E was in a resident's room and Wellness Nurse (RN A) was on the second floor of the Assisted Living (AL) administering medications at the time the resident got out of the building;</li> <li>-From inside the memory care, the first door to go outside is a 15-second release exit door and the camera in the small vestibule showed this unlocked exit door to the outside is where the resident got out. The outside exit door was not locked;</li> <li>-All three residents stood at the inner exit 15-second exit door and another resident pushed on the door until it released;</li> <li>-Resident #1 took advantage of the moment and went on through this door and then out the exit door to the sidewalk. The camera in the vestibule showed Resident #1 leaving. The resident walks very fast;</li> <li>-The resident did wear a wanderguard on his/her wrist and it was on the resident. The alert went off;</li> <li>-A good Samaritan found him/her and brought him/her back to the facility.</li> </ul> <p>During an interview on 09/23/23, at 6:02 P.M., Memory Care Partner B said the following:</p> <ul style="list-style-type: none"> <li>-He/she was agency staff and he/she was not in the memory care at the time the resident left the building;</li> <li>-Memory Care Partner B left the memory care to get lunch. He/she said there was one Memory Care Support Partner E, here and he/she had gone into one resident's room to take the resident</li> </ul>	A4776		

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A4776	<p>Continued From page 5</p> <p>to the bathroom and he/she shut the resident's door because the resident tried to follow them into the resident's room;</p> <p>-Memory Care Partner B had a cell phone that went off and then got a call from the nurse who said the resident was out of the building;</p> <p>-He/she said the resident had tried to get out of the door before by pushing on the door, but had not physically gotten out of the building;</p> <p>-The resident was always talking about leaving and going home and he/she was always doing something;</p> <p>-The resident pushes on the door and then if it doesn't open, he/she walks away;</p> <p>-When the resident returned to the facility, he/she was upset, and apologizing. There was a scrape on his/her left knee.</p> <p>During an interview on 09/27/23, at 9:20 A.M., Memory Care Support Partner E said the following:</p> <p>-He/she took another resident to the restroom and closed the door. This was about 1:45 P.M. after lunch. Memory Care Partner B took a break during that time and left the memory care;</p> <p>-The alarm went off; at 1:53 P.M.;</p> <p>-Resident #1 walks a lot around the memory care. When he/she took another resident to the restroom Resident #1 followed them and he/she closed the door so Resident #1 would not come in when he/she toileted the other resident;</p> <p>-Memory Care Support Partner E wears a little bag to carry a memory care phone and carries a walkie talkie. His/her phone went off as he/she was washing his/her hands in the resident's room after toileting him/her. He/she did not hear the exit door alarm sound until he/she came out of the resident's room after toileting the resident;</p> <p>-The Wellness Nurse told him/her that a resident</p>	A4776		

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A4776	<p>Continued From page 6</p> <p>went out of the memory care and he/she went around to each resident's room to check if all residents were there. The Wellness Nurse went out to do a property search. He/she and Memory Care Partner B looked around and counted to see if everyone was there;</p> <p>-Before the resident left there were three residents at the door and Resident #1 was in the middle and one resident held down the door and it released. There was a 15 second release sign on the door. The other resident helps everybody and assists others. The Wellness Nurse began perimeter search when about that time, a van pulled up with Resident #1.</p> <p>During an interview on 09/23/23, at 5:43 P.M., the Wellness Nurse, RN A, said he/she had worked some with the resident and said he/she was more difficult to take care of. The resident was always looking for home. The resident was always on the move and liked to talk to other residents and tries to "supervise" them. RN A received a call from the receptionist about 1:55 P.M. that a resident exited the door.</p> <p>During an interview on 09/27/23, at 10:25 A.M., Memory Care Lead Partner C said the following:</p> <p>-The resident was wandering agitated and wanted to go home this last week on Thursday, but did not attempt to exit the door. The resident likes to check all the door including residents' room doors and tries to open them. He/she wiggles the door knobs;</p> <p>-The resident will go to the memory care exit door, but never pushes on the door that he/she was aware of. The resident thinks he/she lives across the street and knows his/her address and says it to them;</p> <p>-On breaks, staff were to wait until all residents</p>	A4776		

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A4776	<p>Continued From page 7</p> <p>eat their lunch and then assist to toilet all of the residents or ask them or check their incontinent briefs or pull-ups. One staff was to walk the floor and be with the residents and not in a resident's room if another care partner was out on a break. They do carry a walkie talkie and do call someone like the assisted living partner to come and assist them if or when needed. He/she carries a memory care phone to call the nurse if need to. Most all of the residents are toileted before a break. They were to redirect residents by having an activity, singing and do have activities at 10:30 A.M. and 2:00 P.M.;</p> <p>-If the care partners hear an alarm, they were to go check the door, look through the little strip on the inner door and check if anyone in the foyer who could go outside the exit door;</p> <p>-They do hear alarms all day. Visitors do come in the memory care door. If anyone pushes on the inner door, it will sound;</p> <p>-They were to make sure no resident is in the hallway, and do check their whereabouts by do a head count of the residents.</p> <p>During interview on 09/27/23, at 9:47 A.M., the Memory Care Director said the following:</p> <p>-When staff go on a break, they were to talk to the other care partner if they need to do personal care, and direct the residents to have snacks, do puzzles and activities. They were the call a nurse to come and assist in the memory care when they would do cares or when they needed someone to watch the residents while the other care partner was on a meal break;</p> <p>-On the weekends, he/she expected Memory Care Support Partner E to call for assistance, a backup, when he/she needed to toilet a resident and Resident #1 and other residents were wandering around in the memory care. During the</p>	A4776		

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A4776	<p>Continued From page 8</p> <p>week, there were more staff here and available.</p> <p>During an interview on 09/27/23, at 3:19 P.M., the Administrator said the following:</p> <p>-He/she would expect staff to keep an eye on the residents out in the common areas. When staff hear an alarm, they were to go and investigate this. Staff were to do a head count and make sure all resident were accounted for. The staff were to silence the alarm, but they need to check the doors and get on their walkie talkies to call staff when there was a concern;</p> <p>-On weekends, when staff go on a break, typically someone was to go cover for the break. They need to keep two staff in the memory care at all times and never want to leave one person in the memory care.</p> <p>MO00224874 and MO00224882</p>	A4776		

## PLAN OF CORRECTION

<b>Provider/Supplier Name:</b>	The Township Senior Living	
<b>Street Address, City, Zip:</b>	4150 W Republic Rd., Brookline MO 65619	
<b>Date of Survey:</b>	9-27-2023	
<b>PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER</b>		
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A4776	<p><b>Correction of Cited Deficiency:</b>                      Inservice of Elopement policy and procedure. Elopement drills completed on 9/25, 10/6 &amp; 10/13.</p> <p>Resident #1 was transferred and admitted to _____ on 10.20.23, returned to the community on 10.26.23 with a medication change. _____ is tolerating the medication change well and no further concerns. Resident #1 has had no further elopements or attempts to elope.</p> <p>The weekend Manager on Duty covers breaks in Memory Care to ensure there's always two staff in the Memory Care Neighborhood at all times.</p>	10/6/23
	<p><b>Assessment to Identify other Residents that may be affected:</b>                      BOD or designee will Inservice all staff of Elopement policy and procedure at time of hire, quarterly and as needed. Elopement drills completed on 9/25, 10/6 &amp; 10/13.</p> <p>Director of Wellness or designee will confirm all residents with wander guards are working properly with placement checks twice daily.</p>	10/6/23 & Ongoing
	<p><b>Procedure to ensure on-going compliance:</b>                      Director of Wellness, Plant Ops Director or designee will check operation of door monitors and wander guard system weekly. Elopement drills will be conducted every six months and as needed.</p> <p>Community to hold monthly elopement drills to ensure understanding of elopement policy and procedure.</p>	Ongoing

Christy Kay RCAL, RWD

11.7.23

