STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265555	A. BUILDING _____ B. WING _____	C 01/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELDON NURSING & REHAB	1001 EAST NORTH STREET ELDON, MO 65026

(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) COMPLETION DATE
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on interview and record review, facility staff failed to accurately complete elopement assessments for one resident (Resident #1), who staff identified as a resident who wanders daily. The facility census was 63. Review showed the Facility's Elopement Policy, undated, did not direct staff on how to complete an elopement assessment. Review of Resident #1's Minimum Data Set (MDS), a federally mandated assessment tool used to assess resident, dated 10/08/24, showed staff assessed the resident as follows: -Cognitively impaired; -Suffers from delirium (a temporary state of mental confusion and disorientation that can cause significant changes in behavior, thinking, and perception); -Wanders daily; -Inattention and disorganized thinking that comes and goes. Review of the resident's elopement/wandering assessment form, dated 06/26/24, showed staff documented the resident as a one, a low elopement risk. Review of the resident's elopement/wandering assessment form, dated 10/04/24, showed staff	F 658		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 02/14/2024

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.

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F 658	Continued From page 1	F 658		

did not complete the assessment form.

Review of the resident's elopement/wandering assessment form, dated 01/07/25, showed staff did not complete the assessment form.

Review of resident's nurses notes, dated 1/8/25 at 2:12 P.M., showed staff documented the resident wanders about the facility and at times trying to get out the doors.

Review of resident's nurses notes, dated 1/13/25 at 9:44 A.M., showed staff documented the resident up wandering around facility today.

Review of resident's nurses notes, dated 1/14/25 at 12:26 P.M., showed staff documented the resident wandered around door to door and looking out windows.

Review of resident's nurses notes, dated 1/16/25 at 4:02 A.M., showed staff documented the resident wanders the hallways, going to the exit doors, and looks out, and at times will push on the doors.

During an interview on 1/22/25 at 11:30 A.M., the Director of Nursing (DON) said the resident has had three incomplete or incorrect elopement assessments since he/she has been here. The first elopement assessment, dated 6/24/24, showed the resident scored a one, a low elopement risk, which is inaccurate. The DON said he/she expected for an assessment to be redone if it was inaccurate, because from day one the resident showed signs of elopement and exit seeking behavior. The resident has had two more elopement assessments, dated 10/4/24 and 01/07/25, and both were not completed. He/She

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F 658	Continued From page 2 said the MDS/Assessment coordinator is responsible for all elopement assessments and does not know why they were not completed as required. During an interview on 1/29/25 at 9:34 A.M., the MDS/Assessment coordinator said he/she has only been at the facility for five months and was instructed to open the assessments. He/She said the nurses fill out the elopement assessments and then he/she or the DON goes in and completes them. He/She said the resident's elopement assessments must have fallen through the cracks. During an interview on 2/3/25 at 10:53 A.M., the DON said the nurses are only responsible for filling out and completing the resident's first admission elopement assessment, the MDS/Assessment coordinator is responsible for quarterly and annual assessments. He/She said the admission assessment is filled out with the knowledge the facility received upon admission and fourteen days later when the care plan is completed. The admission assessment should be redone if not accurate when there is a clearer picture of the resident's behavior. The DON said he/she does not know why the MDS/ assessment coordinator believed the nurses were in charge of all the elopement assessments. He/She said corporate runs reports and alerts the facility if they are behind on assessments and he/she does not know why they were not alerted for the resident's elopement assessments that were not completed. MO00248228 / MO00248234	F 658		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices	F 689		

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F 689	Continued From page 3 CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, facility staff failed to provide protective oversight for one cognitively impaired resident (Resident #1) with a history of elopement, when facility staff left the transport van keys in the vehicle and the resident with a history of exit seeking, wandering and elopement attempts eloped from the facility, got into the facility van, and drove nine miles. Facility staff were not aware the resident was missing. The facility census was 63. The administrator was notified on 1/22/25 at 3:17 P.M., of an Immediate Jeopardy (IJ) which began on 1/18/25. The IJ was removed on 1/22/25, as confirmed by surveyor onsite verification. Review of the Facility's Elopement Policy, undated, showed staff are directed as follows: -Determine when resident was last seen and by whom, description of their clothing, and where last seen; -Notify all departments and begin a thorough search of the facility and grounds, including bathroom storage areas, and crawl spaces; -Search streets and neighborhoods adjacent to facility;	F 689		

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F 689	Continued From page 4	F 689		

-Notify Director of Nursing and Administrator;
-Notify attending physician;
-Notify responsible party, and request notification if resident makes contact with them;
-If absence exceeds 30 minutes, notify law enforcement agency and give dispatch all the residents identifying information.

Review of the resident's Minimum Data Set (MDS), a federally mandated assessment tool, dated 10/08/24, showed staff assessed the resident as follows:
-Cognitively impaired;
-Suffers from delirium (a temporary state of mental confusion and disorientation that can cause significant changes in behavior, thinking, and perception);
-Wanders daily;
-Inattention and disorganized thinking that comes and goes.

Review of the resident's elopement/wandering assessment form, dated 06/26/24, showed staff documented the resident as a one, a low elopement risk.

Review of the resident's nurses notes, dated 8/8/24, showed staff documented the resident activated the fire alarm system and exited the dining room door, resident brought back into the facility without incident.

Review of the resident's nurses notes, dated 9/30/24, showed staff documented the resident tried to get out the hall door and did exit the 400 hall door and was returned to the center.

Review of the resident's care plan, dated 12/18/24, showed no interventions were put into

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F 689	Continued From page 5	F 689		

place for the resident's elopement and exit seeking behavior after the 8/8/24 and 9/30/24 incidents.

Review of the resident's elopement/wandering assessment form, dated 10/04/24, showed staff did not complete the assessment form.

Review of the resident's elopement/wandering assessment form, dated 01/07/25, showed staff did not complete the assessment form.

Review of resident's nurses notes, dated 1/8/25 at 2:12 P.M., showed staff documented the resident wanders about the facility and at times trying to get out the doors.

Review of resident's nurses notes, dated 1/13/25 at 9:44 A.M., showed staff documented the resident up wandering around facility today.

Review of resident's nurses notes, dated 1/14/25 at 12:26 P.M., showed staff documented the resident wandered around door to door and looking out windows.

Review of resident's nurses notes, dated 1/16/25 at 4:02 A.M., showed staff documented the resident does wander the hallways, going to the exit doors, and looks out and at times will push on the doors.

Review of the resident's care plan, dated 12/18/24, showed no documented interventions for elopements or the resident's exit seeking behaviors.

Review of the resident's nurses notes, dated 1/18/25, showed staff documented Certified

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F 689	Continued From page 6	F 689		

Nursing Assistant (CNA) B reported the local Sheriff on the phone, the officer reported being at a residential house on Highway 52 and evaluating the safety of Resident #1. Will return call and discuss safety. Spoke with resident's family on the phone about coming to facility for the resident's return. Officer returned call to come get the resident. Sent CNA B and van driver to return resident to facility. He/She arrived safely without injury. Physical and mental assessment within normal limits.

Review of the facility's investigation, dated 1/18/25, showed Resident #1 exited the facility and drove the facility van to a residential area where a homeowner contacted the local Sheriffs office. The resident was picked up by facility staff. Did not have injuries.

During an interview on 1/22/25 at 9:39 A.M., the administrator said the resident was exit seeking and did go to doors often. Staff know to redirect the resident. The resident had eloped once, but did not make it off the property. The resident often talks about going home to be with his/her brother and dog. The administrator said on 1/18/25 he/she did not know how the resident got out of the building, if an alarm was set off, or if the resident was let out by a guest. The administrator said he/she did not know how the resident drove the company van, because he/she had delusions and was not of sound mind. He/She said the keys were left in the van the previous day by the transport driver.

During an interview on 1/22/25 at 10:07 A.M., the transport driver said he/she takes full responsibility for leaving the keys in the van. He/She was in a hurry and did not realize they

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F 689	Continued From page 7	F 689		

were left in there. He/She does not know how the resident drove the van because he/she is not cognitive to do so. He/she does not know how the staff at the facility did not catch the resident leaving, because everyone knows to watch him/her, because he/she was constantly exit seeking and wanting to go home.

During an interview on 1/22/25 at 10:43 A.M., CNA B said he/she gave the resident a shower and took him/her to the dining room for lunch, unsure of the exact time. He/She then left for his/her own lunch break, and was not sure what time it was. He/She came back from his/her lunch break after 25-30 minutes on 1/18/25 through the employee entrance and heard a faint door alarm. CNA B said he/she started to check doors for residents and found the door alarm at the end of the 100 hall was tripped. He/She said Resident #2 was by the door, but he/she checked outside and did not see any other residents. CNA B said CNA C told him/her to check for the resident because he/she is always exit seeking, CNA B said he/she turned off the alarm and went to the nurses station to look for the resident and that is when the sheriff's office called that they had the resident. He/She said the resident was known for trying to leave the building.

During an interview on 1/22/25 at 10:25 A.M., Registered Nurse (RN) A said he/she was on the unit when CNA B came to him/her and said the sheriff's department was on the phone and the resident was missing. RN A said he/she could not say how long the resident was gone or if the alarm went off when he/she left. He/She said the resident was not cognitively intact to operate a vehicle and often had delusions. He/She said the resident had eloped before and had exit seeking

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F 689	Continued From page 8 behaviors and was very fixated about what was outside. NOTE: At the time of the survey, the violation was determined to be at the immediate and serious jeopardy level "J." Based on observation, interview and record review completed during the onsite visit, it was determined the facility had implemented corrective action to remove the IJ violation at the time. A final revisit will be conducted to determine if the facility is in substantial compliance with participation requirements. At the time of exit, the severity of the deficiency was lowered to the "D" level. This statement does not denote the facility has complied with State law (Section 198.026.1 RSMo.) requiring prompt remedial action to be taken to address Class I violation(s). MO00248228 / MO00248234	F 689		

Missouri Department of Health and Senior Services

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	06139	A. BUILDING: _____ B. WING _____	C 01/23/2025

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A4074	19 CSR 30-85.042(65) Protective Oversight, Voluntary Leave Each resident shall receive twenty-four- (24-) hour protective oversight and supervision. 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 This regulation is not met as evidenced by: Class I* See F689. *The higher classification merited due to the effect on the resident. NOTE: At the time of the complaint investigation, the violation was determined to be at an imminent danger class I level. Based on observation, interview and record review completed during the onsite visit, it was determined the facility had implemented corrective action to address and lower the violation at the time. A final revisit will be conducted to determine if the facility is in substantial compliance with participation requirements. At the time of exit, the severity of the deficiency was lowered to the class II level.	A4074		
A4075	19 CSR 30-85.042(66) Nursing Care per Res Condition Each resident shall receive personal attention and nursing care in accordance with his/her condition and consistent with current acceptable	A4075		

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A4075	Continued From page 1 nursing practice. I/II This regulation is not met as evidenced by: Class II See F658.	A4075		

PLAN OF CORRECTION

Provider/Supplier Name:	Eldon Nursing and Rehab
Street Address, City, Zip:	1001 East North Street, Eldon, 65026
Date of Survey:	1/23/2025
PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	265555

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 being submitted as required under State and Federal law. The submission under this plan of correction does not constitute admission on the part of Eldon Nursing and Rehab, as to the accuracy of the surveyor's findings or the conclusion drawn from there. The Facility's submission of this plan of correction does not constitute any admission on the part of the Facility that the findings constitute a deficiency, or that the scope and severity regarding any of the deficiencies cited are correctly applied.	
	The Facility submits the plan of correction with the intention that it be inadmissible by any third party and any civil or criminal action against the Facility or any employee, agent, officer, director, or shareholder of the Facility.	
	Any changes to Facility policies and procedures should be considered to be subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence and should be inadmissible in any proceedings on that basis.	
	Please accept this plan as the Facility's Credible Letter of Allegation that all deficiencies have been corrected by the last day noted in this plan of correction.	

The Administrator signing and dating the first page of the CMS-2567/State Form is indicating their approval of the plan of correction being submitted on this form.



Administrator 02/14/2025

PLAN OF CORRECTION

Provider/Supplier Name:	Eldon Nursing and Rehab
Street Address, City, Zip:	1001 East North Street, Eldon, 65026
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ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
F658	The facility does and will continue to accurately complete Elopement/Wandering Risk observations on residents.	2/24/2025
1.	**Corrective action will be accomplished for the resident(s) found to be affected by the alleged deficient practice by:**	
	1) Resident # 1 was transferred to a Skilled Nursing Facility with a secured unit January 21st, 2025.	
2.	**The facility recognizes all residents may potentially be affected by this alleged deficient practice.**	
3.	**The corrective action will be accomplished by:**	
	1) Director of Nursing (DON)/Designee completed Elopement/Wandering Risk observations on current residents January 22nd and 23rd, 2025.	
	2) Residents admitted on or after January 23rd, 2025, will have a licensed nurse accurately complete an Elopement/Wandering Risk observation within 24 hours of admission.	
	3) Current and future admitted residents will have a licensed nurse accurately complete an Elopement/Wandering Risk observation with each due Minimum Data Set (MDS) Assessment beginning February 24th, 2025.	
	4) Inservice education for licensed nurses was conducted by the DON/Designee beginning February 13th, 2025, on the following: 1) Residents admitted on or after January 23rd, 2025, will have a licensed nurse accurately complete an Elopement/Wandering Risk observation within 24 hours of admission. 2) Current and future admitted residents will have a licensed nurse accurately complete an Elopement/Wandering Risk observation	

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F658	with each due MDS Assessment beginning February 24th, 2025.	2/24/2025
4.	**The measures put in place and the systemic changes made to ensure the alleged deficient practice does not recur were:**	
	1) The above documented inservice education will be reviewed annually and with the orientation of newly hired licensed nurses.	
	2) DON/Designee will monitor for compliance to the following daily beginning February 24th, 2025, x 4 weeks or as determined by QAPI committee if substantial compliance is achieved prior: 1) Residents admitted on or after January 23rd, 2025, will have a licensed nurse accurately complete an Elopement/Wandering Risk observation within 24 hours of admission. 2) Current and future admitted residents will have a licensed nurse accurately complete an Elopement/Wandering Risk observation with each due MDS Assessment beginning February 24th, 2025.	
	3) Administrator/Designee will monitor for compliance to the following quarterly during the QAA committee meeting report reviews beginning February 24th, 2025: 1) Residents admitted on or after January 23rd, 2025, will have a licensed nurse accurately complete an Elopement/Wandering Risk observation within 24 hours of admission. 2) Current and future admitted residents will have a licensed nurse accurately complete an Elopement/Wandering Risk observation with each due MDS Assessment beginning February 24th, 2025.	
5.	**The facility plans to monitor its performance to ensure that solutions are sustained. This plan will be implemented and**	

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PLAN OF CORRECTION

Provider/Supplier Name:	Eldon Nursing and Rehab
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F658	**the corrective action will be evaluated for its effectiveness. The plan of correction will be integrated into the Quality Assurance System.**	2/24/2025
	All negative findings of the Quality Assurance checks as related to compliance to the following will be documented and submitted to the monthly Facility Quality Improvement Committee for review and additional interventions will be made as needed: 1) Residents admitted on or after January 23rd, 2025, will have a licensed nurse accurately complete an Elopement/Wandering Risk observation within 24 hours of admission. 2) Current and future admitted residents will have a licensed nurse accurately complete an Elopement/Wandering Risk observation with each due MDS Assessment beginning February 24th, 2025.	

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PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	265555

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F689	The facility does and will continue to provide protective oversight to residents.	2/24/2025
1.	**Corrective action will be accomplished for the resident found to be affected by the alleged deficient practice by:**	
	1) Resident # 1 was transferred to a Skilled Nursing Facility with a secured unit January 21st, 2025.	
2.	**The facility recognizes all cognitively impaired residents may potentially be affected by this alleged deficient practice.**	
3.	**The corrective action will be accomplished by:**	
	1) The Director of Nursing (DON)/Designee immediately inserviced nursing staff and transporters beginning January 22nd, 2025, (utilizing the Elopement Risk Policy) regarding actions to ensure other residents remain free from accidents; that staff are knowledgeable of what to do if a resident elopes; and that staff will assure residents remain free from accidents. This inservice material was continued until education was completed for all nursing staff and transporters by January 24th, 2025. Education included, but was not limited to, the following: need to monitor door alarms timely, residents at risk for elopement including those that are cognitively impaired, and the need to remove keys from facility vehicles upon exiting the vehicle.	
	2) DON/Designee had each nursing staff member and transporter verbalize what should take place if a resident elopes and measures to reduce the incidence of elopement following the education. Any identified concerns were addressed immediately.	
	3) DON/Designee educated other recently hired staff regarding the above items pertinent to their responsibilities before they were allowed to begin their	

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PLAN OF CORRECTION

Provider/Supplier Name:	Eldon Nursing and Rehab
Street Address, City, Zip:	1001 East North Street, Eldon, 65026
Date of Survey:	1/23/2025

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	265555

ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
F689	first shift (education was completed January 24th, 2025).	2/24/2025
4.	**The measures put in place and the systemic changes made to ensure the alleged deficient practice does not recur were:**	
	1) The above documented inservice education will be reviewed annually and with the orientation of newly hired nursing staff, transporters, and other staff.	
	2) Newly hired nursing staff members, transporters and other staff will verbalize to the DON/Designee what should take place if a resident elopes and measures to reduce the incidence of elopement following the education. Any identified concerns will be addressed immediately./	
	3) DON/Designee and Administrator will monitor for compliance to the following 5 times weekly beginning February 24th, 2025, x 4 weeks or as determined by QAPI committee if substantial compliance is achieved prior: 1) Keys are removed from facility vehicles upon exiting the vehicle.	
5.	**The facility plans to monitor its performance to ensure that solutions are sustained. This plan will be implemented and the corrective action will be evaluated for its effectiveness. The plan of correction will be integrated into the Quality Assurance System.**	
	All negative findings of the Quality Assurance checks as related to compliance to the following will be documented and submitted to the monthly Facility Quality Improvement Committee for review and additional interventions will be made as needed: 1) Nursing staff, transporters, and other staff are educated (utilizing the Elopement Risk Policy) regarding actions to ensure other residents remain free from accidents; that staff are knowledgeable of what to do if a resident elopes; and that staff	

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PLAN OF CORRECTION

Provider/Supplier Name:	Eldon Nursing and Rehab
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F689	will assure residents remain free from accidents. 2) Education includes, but is not limited to, the following: need to monitor door alarms timely, residents at risk for elopement including those that are cognitively impaired, and the need to remove keys from facility vehicles upon exiting the vehicle. 3) Nursing staff members, transporters, and other staff will verbalize to the DON/Designee what should take place if a resident elopes and measures to reduce the incidence of elopement following the education. Any identified concerns will be addressed immediately. 4) Keys are removed from facility vehicles upon exiting the vehicle.	2/24/2025

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A4074	Refer to F689	2/24/2025
A4075	Refer to F4075	2/24/2025

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		2/24/2025

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