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	265160	A. BUILDING _____ B. WING _____	C 04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEWIS & CLARK GARDENS	1221 BOONES LICK ROAD SAINT CHARLES, MO 63301

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F 689 SS=J	Free of Accident Hazards/Supervision/Devices 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, the facility failed to ensure one resident (Resident #1) out of a sample of eight residents, received adequate supervision to prevent accidents. The facility failed to respond to a door alarm timely after the resident, who was assessed by the facility to be at risk for elopement, exited the facility through an alarmed exit door without staff knowledge. The door alarm volume was not loud enough for staff to hear until they were halfway down the resident's hall. The facility also failed to complete 15 minute checks for the resident who required 15 minute checks for aggressive behavior. The resident fell after he/she left the facility, sustaining multiple facial fractures and a subdural hemorrhage (bleeding in the brain that can put pressure on the brain, leading to a variety of symptoms and potentially life-threatening complications if not treated promptly). The facility census was 76. On 4/24/25 the administrator was notified of the Past Non-Compliance Immediate Jeopardy (IJ) which occurred on 4/17/25. Upon discovery, staff conducted an investigation and notified appropriate parties including the police. In-service education was provided for all facility staff	F 689	Past noncompliance: no plan of correction required.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jamie Conard | TITLE: Admin | (X6) DATE: 5/28/25

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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including elopement policies, 15 minute check policies and door monitoring policies. Staff completed elopement risk assessments for all residents and the elopement risk and code white procedure books were updated with current risk assessments and code white procedures. The alarmed, fire, exit door alarms were adjusted to increase the volume of the alarm for staff to recognize the alarm promptly. Alarmed door audits and 15 minute check audits were performed and ongoing. The IJ was corrected on 4/18/25.

Review of the undated facility policy, Code White Guidelines, showed the following:
-The purpose of the facility is to assure that resident safety and security are maintained. Identification of residents at risk for wandering or elopement is imperative;
-Every resident will be assessed, using the wander and/or Elopement Assessment form, upon admission, readmission, annually and with significant change;
-A nurse will complete the assessment and once completed and the determination has been made, the care plan coordinator will review and incorporate the information with the resident's care plan;
-If the resident is determined to be at risk, the resident will be placed on the "At Risk" list and added to the Code White Program;
-A listing of residents at risk with the resident identification record will be kept at each nursing station and in the front office.

Review of Resident #1's Elopement/Wandering Assessment Form, dated 1/17/25, showed the following:
-The resident was ambulatory or self-mobile in a

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wheelchair;
-The resident had a history of wandering, confusion, disorientation, and was cognitively impaired;
-The resident had a wandering risk score of four which put him/her at risk;
-Interventions were frequent monitoring;
-The resident usually just wandered around the facility and made no attempts to exit and was not exit seeking.

Review of Resident #1's undated Face Sheet showed the following:
-The resident had a power of attorney for health care;
-The resident had diagnoses that included schizophrenia (a serious mental illness that affects how a person thinks, feels, and behaves), bipolar disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs), Alzheimer's disease (a progressive disease that destroys memory and other important mental functions) and vascular dementia (a mental disorder in which a person has problems with reasoning, planning, judgment, memory and other thought processes caused by brain damage from impaired blood flow to the brain).

Review of the resident's Significant Change Minimum Data Set (MDS), a federally mandated assessment instrument required to be completed by facility staff, dated 1/19/25, showed the following:
-The resident's cognition was severely impaired;
-The resident used a wheelchair for ambulation;
-The resident could propel himself/herself in a wheelchair 150 feet independently;
-The resident had no impairments to his/her

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upper or lower extremities;
-Walking 10 feet was not attempted due to the resident's medical conditions;
-The resident wandered less than daily;
-The resident required partial to moderate assistance from staff to get from sitting to lying, lying to sitting, sitting to standing and from a chair to bed positionings;
-The Significant Change MDS showed a decline in communication, increased behaviors, a decrease in cognition, and risk for psychosocial isolation compared to his/her previous MDS, dated 10/19/24.

Review of the resident's Care Plan, dated 4/11/25, showed the following:
-The resident had impaired cognition;
-The resident liked to go all throughout the facility, was easily redirected, and made no attempts to push on the exit doors or speak about leaving;
-The resident was at risk for wandering related to confusion;
-If the resident was exit seeking, redirect him/her from doors and attempt to engage the resident in something that occupied his/her attention;
-Provide the resident with increased supervision during periods of increased wandering and exit seeking behavior;
-The resident had a physical functioning deficit related to dementia and weakness.

Review of the resident's progress notes, dated 4/15/25, showed the following:
-The resident had aggressive behavior toward another resident;
-The resident was placed on 15 minute checks.

Review of Resident #1's 15 minute check log, dated 4/17/25, showed the following:

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-On 4/17/25, the resident was in his/her bedroom from 7:00 P.M. until 8:45 P.M.
-On 4/17/25, staff did not document that a 15-minute check was completed for the resident at 9:00 P.M. or at 9:15 P.M.

Review of the resident's discharge MDS, dated 4/17/25, showed the following:
-The resident wandered daily;
-The resident had short term memory problems;
-The resident was independent to position himself/herself from sitting to lying, lying to sitting, sitting to standing and from a chair to bed positions;
-The resident could walk independently 50 feet;
-The resident could propel himself/herself in a wheelchair 150 feet independently.

Review of the resident's undated, facility Elopement Timeline, showed the following:
-At 8:13 P.M. on 4/17/25, the resident was in the facility;
-At 8:30 P.M., staff observed the resident in a wheelchair self-propelling in the hallway toward his/her room;
-At 8:45 P.M., Licensed Practical Nurse (LPN) C observed the resident lying in bed;
-At 9:15 P.M., the resident's call light was on, and Nursing Assistant A went to the resident's room. The resident was not in his/her room;
-(no time stated) Code White was activated; the inside and outside of the building was searched and the resident was not found;
-At 9:38 P.M., the Director of Nursing (DON) was notified of the missing resident;
-At 9:55 P.M., the DON arrived at the facility and the search for the resident continued.

Review of Resident #1's Hospital Records, dated

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4/17/25, showed the following:
-Upon arrival to the emergency department the resident's injuries necessitated the activation of a level 2 trauma;
-A Computed Tomography (CT, a diagnostic imaging procedure that uses a combination of x-rays and computer technology to produce detailed images of the inside of the body, including the bones, muscles, fat, organs, and blood vessels) showed a subdural hemorrhage, extensive facial trauma with right and left orbital fractures (eye socket), bilateral upper jaw bone fracture, lower jaw bone fracture, nose fracture, and right cheek bone fracture;
-The resident was placed in the neurological intensive care unit.

During an interview on 4/23/25 at 1:08 P.M. Resident #2 (residing on the same hall), said he/she did not hear an alarm sound on the night Resident #1 went out the alarmed fire exit door.

During an interview on 4/23/25 at 1:11 P.M. Resident #3 (Resident #1's roommate), said he/she did not hear an alarm sound on the night Resident #1 went out the alarmed fire exit door.

During an interview on 4/23/25 at 1:22 P.M., LPN C said the following:
-On 4/17/25 at 8:45 P.M., he/she checked on Resident #1 and the resident was lying in bed;
-Nursing Assistant (NA) A came and told LPN C that he/she went to answer Resident #1's call light, but the resident was not in his/her room;
-LPN C went to the resident's hall and did not hear the alarm until he/she got halfway down the hall;
-Resident #1's wheelchair was parked in front of the alarmed fire door;

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-LPN C went outside and walked the perimeter of the building and did not find the resident. LPN C also went to the building behind the facility and did not see the resident;
-LPN C went back inside and called 911. The 911 dispatcher told LPN C the police had the resident, and the resident was taken to the hospital;
-The resident had never been exit seeking in the past. The resident would wander the halls and go to the dining room;
-The resident could walk but got tired easily and used his/her wheelchair.

During an interview on 4/23/25 at 1:58 P.M., LPN F said the following:
-LPN C went to the A hall where LPN F was working and told him/her that Resident #1 was missing;
-LPN F went to the resident's hall and did not hear the alarm until he/she got to the nurse's station (one quarter of the way down the hall);
-LPN F went to the alarmed fire exit door and shut the alarm off and tested the door to see how hard it was to open. LPN F said it opened pretty easily when you held the door release and the instructions were on the door;
-Resident #1 walked with his/her wheelchair, but he/she did not have a steady gait.

During an interview on 4/23/25 at 2:38 P.M., NA A said the following:
-NA A was making rounds on residents between 9:20 P.M. and 9:30 P.M.;
-NA A saw Resident #1's call light on and went to his/her room. When NA A got to the room Resident #1 was not in his/her bed;
-NA A did not hear the door alarm;
-NA A went and told LPN C that Resident #1 was not in his/her room. NA A and LPN C went looking

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for the resident inside and outside, but did not find the resident.

During an interview on 4/23/25 at 3:46 P.M., Certified Nursing Assistant (CNA) B said the following:
-He/She went on break about 8:40 P.M. and when he/she returned NA A asked if he/she had seen Resident #1 because the resident was missing;
-He/She did not hear an alarm when he/she was on break outside in front of the building.

During an interview on 4/23/25 at 4:09 P.M., CNA E said the following:
-He/She was in a resident room on the B hall assisting with cares. When he/she came out of the room CNA E heard an alarm;
-He/She saw Resident #1 about an hour earlier, but did not see the resident again before he/she went missing.

During an interview on 4/24/25 at 8:46 A.M., the local police department detective said the following:
-Resident #1 was found at the entrance of the driveway of the building behind the facility;
-A call was made to Emergency Medical Services (EMS) at 9:05 P.M. by a local citizen that found the resident on the ground;
-EMS requested police assistance at 9:07 P.M. and the first officer arrived on the scene at 9:10 P.M. (EMS was already there);
-EMS left the scene at 9:33 P.M. and took the resident to the hospital;
-LPN C called the police department to report the resident missing at 10:08 P.M.

Observation on 4/24/25 at 9:43 A.M. showed the

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following:
-The outside of the facility where Resident #1 exited was grass and then turned into an uneven paved parking lot;
-Closer to the front of the other building there was a steep slope to the drive that ended at a heavily traveled four lane road;
-The distance from the facility door the resident exited from and the spot where the resident was found by police was a little over 400 feet.

During an interview on 4/23/25 at 3:00 P.M., a hospital nurse said Resident #1 was stable and would have surgery that afternoon for facial fracture repairs.

During interviews on 4/23/25 at 10:39 A.M. and 4/24/25 at 10:42 A.M., the DON said the following;
-She was notified by LPN C that Resident #1 was missing from the facility and could not be found;
-She told LPN C to call the police to report the resident missing;
-Resident #1 was on 15-minute checks and was supposed to have been monitored throughout the night;
-Staff did not complete the 15 minute check for Resident #1 at 9:00 P.M. on 4/17/25.

During an interview on 4/23/25 at 9:55 A.M., the Administrator said the following:
-Resident #1 went out the B Hall (the hall the resident resided) alarmed, fire, exit door on 4/17/25;
-Resident #1 did wander the halls and would go to the Administrator's office or to the dining room. The resident had not attempted to go out a door.

MO252936

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