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A4751	19 CSR 30-86.047(28)(F)(1)(C) Community Based Assessment-Significant Change The facility may admit or retain an individual for residency in an assisted living facility only if the individual does not require hospitalization or skilled nursing placement as defined in this rule, and only if the facility: (F) Completes a community based assessment conducted by an appropriately trained and qualified individual as defined in section (4) of this rule: 1. Time frame requirements for assessment shall be: C. Whenever a significant change has occurred in the resident ' s condition, which may require a change in services. II This regulation is not met as evidenced by: Based on interview and record review, the facility failed to update resident community based assessments (CBA) after a change in condition for five of 11 sampled residents. (Residents #1, #2, #3, #4 and #5) The census was 72. 1. Review of Resident #1's face sheet, showed the following: -Admit date 6/17/16; -Diagnoses included memory change, depression, dementia and Alzheimer's disease. Review of the resident's CBA dated 9/21/17, showed the following: -Mental status and behaviors - Socially appropriate behaviors; -Emotional strength - Independent, confident and motivated. Review of the resident's nurse's notes dated 1/3/18 at 9:00 P.M., showed the resident went outside without a coat for about ten minutes and	A4751		

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stated he/she was not cold and refused to come inside. He/she stated, "I don't care if I freeze to death". A family member told staff the resident expressed "This is no way to live and he/she did not want to live and wanted to die so he/she could get out of this. I could just die due to I don't like being here". Staff contacted the resident's physician, who ordered a psychiatric consultation.

Review of the resident's risk of elopement/wandering review dated 1/3/18, showed the following:
-The resident cognitively impaired with poor decision making skills;
-Diagnoses of dementia, depression and Alzheimer's disease;
-No documentation resident walked outside without informing staff;
-Family/responsible party voiced concerns which would indicate the resident might have wandering tendencies or might try to leave;
-The resident at risk for wandering as evidenced by staying near the main exit, outside in the cold without shoes or coat and stated he/she wanted to leave the place because "everyone dies".

Further review of the resident's nurse's notes, showed the following:
-On 1/4/18 at 4:22 P.M., staff called the resident's physician's exchange to report elopement attempts, resident complained he/she wanted to die and walked outside in the cold without coat and shoes;
-On 1/6/18, no time noted, the resident went outside with no coat or shoes and refused to come inside. He/she stated, "I hope this is my lucky day. I can freeze to death". Staff sent the resident to the emergency room.

Further review of the resident's CBA dated

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A4751	Continued From page 2 9/21/17, showed the following: -No updated documentation regarding the resident's wandering behavior; -No updated documentation regarding the resident's depression and suicide ideation. 2. Review of Resident #2's medical record, showed the following: -On 11/16/16 (prior to admission), the resident admitted to the emergency room with a diagnosis of paranoid delusion. He/she reported difficulty remembering things and diminished ability to think or concentrate; -Admit date to the facility 12/23/16; -Diagnoses included diabetes and depression. Review of the resident's CBA dated 5/30/17, showed the following: -Stability/falls: Resident did not fall; -Time and place: Resident aware of time and place. No periods of forgetfulness; -Decision making: Recognized and made own decisions; -Mental status and behaviors: Socially appropriate behaviors; -Emotional strength: Independent, confident and motivated. Review of the resident's nurse's notes, showed the following: -On 12/13/17 at 3:30 A.M., the resident fell out of bed. He/she complained of lower back pain. Staff sent him/her to the hospital; -On 12/14/17 at 12:59 P.M., the hospital sent the resident back to the facility. His/her physician ordered an evaluation with physical therapy; -On 12/27/17 at 12:30 A.M., the resident fell out of bed. Staff found him/her on the floor, behind the door. The resident complained of back pain and staff sent him/her to the hospital;	A4751		

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-On 12/29/17, no time noted, the resident returned to the facility;
-On 12/31/17 at 10:00 P.M., the resident in the dining room earlier for dinner and went to the wrong floor. He/she told staff he/she was a visitor and did not live there;
-On 1/4/18 at 5:45 P.M., the resident went to the third floor nursing staff and told staff he/she could not find his/her room;
-On 1/5/18 at 5:50 P.M., dietary notified nursing staff, the resident needed assistance, in the dining room. The resident told staff he/she was lost and did not know how to get home or to his/her room;
-On 1/16/18 at 9:50 P.M., the resident's physician visited and assessed him/her.

Review of the resident's physician's record dated 1/16/18, no time noted, showed the following;
-Staff reported the resident more confused in the last two weeks;
-Resident not oriented to month or year;
-Diagnoses of increased confusion and dementia.

Further review of the resident's nurse's notes, showed the following:
-On 1/20/18 at 9:20 A.M., the resident got on the elevator dressed in a robe and socks, headed for the lobby. The resident told staff he/she was looking for his/her daughter. The people downstairs could hear his/her family but he/she could not find them. The resident was not easily redirected and appeared to be very confused at the time;
-On 1/24/18 at 4:39 P.M., the resident eloped from the facility. Staff found him/her down the road from the facility. The resident had fallen, his/her pants were wet and he/she did not have a jacket on. At 8:15 P.M., the staff notified the resident's physician. At 8:20 P.M., the resident's

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family member requested staff send the resident to the emergency room for an evaluation.

Further review of the resident's CBA dated 5/30/17, showed the following:
-No updated documentation of the resident's increased fall risk;
-No updated documentation of the resident's increased confusion;
-No updated documentation of the resident's wandering behavior.

3. Review of Resident #3's medical record, showed the following:
-Admit date 8/23/13;
-Diagnoses included high blood pressure, memory lapses and depression.

Review of the resident's CBA dated 5/30/17, showed the following:
-Alert, no impairment or infrequent periods of forgetfulness and memory lapses;
-Decision making - recognizes and makes own decisions.

Review of the resident's nurse's notes, showed the following:
-On 5/6/17 at 6:38 P.M., staff called the resident's family member to report the resident would not comply with care of his/her cat. His/her room smelled of cat urine and feces;
-On 12/30/17 at 7:40 P.M., the resident walked across the street for church. He/she told the pastor he/she thought he/she lived at the facility. The pastor was familiar with the resident and brought him/her back to the facility. Staff placed the resident on elopement precautions.

Review of the resident's physician's note dated 12/30/17, showed the resident walked across the

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A4751	Continued From page 5 street to church without a coat. Further review of the resident's nurse's notes, showed the following: -On 1/3/18 at 2:20 P.M., staff called the resident's family member about the resident's increased confusion, elopement and inability to care for the cat; -On 1/12/18 at 10:50 A.M., staff notified the resident's family member, there was cat urine and feces in the resident's bedding and the resident was unable to keep up maintenance of the cat. At 11:00 A.M., staff notified another family member the cat defecated all over the resident's room, clothing and furniture. Further review of the resident's CBA dated 5/30/17, showed no updated documentation of the resident's confusion and wandering behavior. 4. Review of Resident #4's medical record, showed the following: -Admit date 2/24/17; -Diagnoses included dementia and depression. Review of the resident's CBA dated 8/21/17, showed the following: -Ambulation - Resident independent with use of a walker; -Endurance - Tolerated distance or sustained activity; -Time and place - Occasionally not aware or forgetful; -Mental status and behaviors - Socially appropriate behaviors. Review of the resident's nurse's notes, showed the following: -On 12/21/17 at 5:38 P.M., staff observed the resident walk down the stairs with his/her walker	A4751		

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and reported the incident to all managers;
-On 12/28/17 at 10:30 A.M., staff notified the resident's family member, the resident kept going down the stairs with his/her walker, was very confused and forgot a lot. Staff also called the resident's physician with this information. At 12:59 P.M., the resident's physician called back and told staff, the resident needed to be in a much safer environment and might need memory care;
-On 1/13/18 at 4:00 P.M., the resident in his/her room without clothes. He/she pulled sheets off his/her bed to cover up with and stated, "These are my clothes and I am wearing this. I have to pick my boys up". The resident exhibited exit seeking behavior. He/she thought his/her car was outside. Staff notified the resident's physician who ordered the resident be sent to the emergency room for evaluation. At 7:38 P.M., staff sent the resident to the hospital;
-On 1/14/18 at 4:00 P.M., the hospital sent the resident back to the facility with no discharge paperwork. Staff contacted the hospital and spoke to someone who said, she/he "was calm and cooperative until the last one and a half to two hours when he/she started to wander, became aggressive and would not sit still. They did not do a psychiatric consultation;
-On 1/15/18 at 1:30 P.M., staff contacted the resident's physician to report increased confusion and a decline in his/her mental status;
-On 1/18/18 at 9:16 P.M., staff found the resident going down the third floor stairs with his/her wheeled walker. Staff redirected him/her and escorted him/her to his/her room. Staff notified the health services director and charge nurse;
-On 1/19/18 at 10:30 P.M., staff observed the resident walk up the stairs with his/her walker and told him/her not to do it. The resident was "extremely confused".

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A4751	Continued From page 7 Further review of the resident's CBA dated 8/21/17, showed the following: -No updated documentation of resident's refusal to use elevator when he/she walked with his/her walker; -No updated documentation of the resident's increased confusion. 5. Review of Resident #5's medical record, showed the following: -Admit date 9/19/16; -Diagnoses included depression, high blood pressure, dementia, diabetes and arthritis. Review of the resident's CBA dated 5/25/17, showed the following: -Mental status and behaviors: Socially appropriate behaviors. Resident had a few episodes of saying he/she would kill him/herself when he/she was upset on 3/17 but nothing else reported since then. Review of the resident's nurse's notes, showed the following: -On 11/25/17 at 9:15 P.M., the resident's roommate reported the resident cried and said he/she wished he/she was dead. At 9:20 P.M., staff talked to the resident. He/she cried and said everyone talked about him/her; -On 1/19/18 at 9:58 P.M., the resident became angry when another resident sat at his/her table and wanted him/her removed. When the other resident refused to move, Resident #5, stood up, used foul language and told staff he/she was going to "slit his/her throat". He/she was going to go to his/her room to "commit suicide" and stormed out of the room. Staff notified the resident's physician and put him/her on 15 minute checks.	A4751		

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A4751	Continued From page 8 Further review of the resident's CBA dated 5/25/17, showed no updated documentation regarding the resident's continued threats of suicide. 6. During an interview on 2/2/18 at 3:15 P.M., the health service director (HSD) said it was her responsibility to update the CBAs. She was not aware of the changes in condition, because staff did not tell her. They had a stand up meeting every morning where these issues were supposed to be brought up, but no one did. It was also supposed to be documented in the 24 hour shift report. She did not have time to review every chart and expected staff to inform her at the meeting or put it in the report. 7. During interviews on 1/30/18 at 4:00 P.M. and on 2/2/18 at 3:15 P.M., the former administrator said it was the director of health service's responsibility to update the resident CBAs. They should have been updated with the resident change in condition. She did not know why they were not updated earlier. MO00137889 MO00138174	A4751		
A4776	19 CSR 30-86.047(35) Protective Oversight 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	A4776		

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A4776	Continued From page 9 This regulation is not met as evidenced by: Class I* Based on observation, interview and record review, the facility failed to provide protective oversight for residents who were cognitively impaired and eloped from the building in freezing temperatures for three of 11 sampled residents. (Residents #1, #2 and #3) The census was 72. Review of the facility's procedure for missing resident policy dated 11/10/15, showed the following: -Follow up: Once resident is located, he/she will be placed on 15-30 minute checks until evaluation done by multi-disciplinary team. Staff will be notified of resident's risk for elopement; -A multi-disciplinary team (executive director, health services director, activity director and therapist, when available) meeting will be held with resident and the responsible party within 72 hours of elopement. The team will determine if assisted living is appropriate placement for the resident; -If determined resident is appropriate for assisted living and elopement was due to acute change of conditions as determined by primary care physician, the following steps would be taken: Orders obtained by physician for treatment, 15-20 minute checks while resident received treatment, multi-disciplinary team, resident and responsible party to meet after completion. The executive director would issue a 30 day discharge notice to the resident and responsible party which could be rescinded if the condition improved; -If determined the resident was no longer appropriate for assisted living as evidenced by continued elopement behavior, the following steps would be taken: Executive director would	A4776		

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issue a 30 day discharge notice to the resident and responsible party and a 24 hour sitter would be required until the resident discharged from the facility.

1. Review of Resident #1's face sheet, showed the following:
-Admit date 6/17/16;
-Diagnoses included memory change, depression, dementia and Alzheimer's disease.

Review of the resident's individualized service plan (ISP) dated 9/21/17, showed the following:
-Time and Place: Occasionally not aware, forgetful;
-Decision making: Does not always recognize when to make decisions but follows directions;
-Mental status: Socially appropriate behaviors;
-Emotional status: Independent, confident and motivated.

Review of the resident's nurse's notes dated 1/3/18 at 9:00 P.M., showed the resident went outside without a coat for about ten minutes and stated he/she was not cold and refused to come inside. He/she stated, "I don't care if I freeze to death". A family member told staff the resident expressed "This is no way to live and he/she did not want to live and wanted to die so he/she could get out of this. I could just die due to I don't like being here". Staff contacted the resident's physician who ordered a psychiatric consultation.

Review of the climatological report dated 1/3/18, showed the temperature was 27 degrees Fahrenheit (F) at 12:00 P.M.

Review of the resident's risk of elopement/wandering review dated 1/3/18, showed the following:

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A4776	Continued From page 11 -The resident cognitively impaired with poor decision making skills; -Diagnosis of dementia, depression and Alzheimer's disease; -No documentation resident walked out of the facility without informing staff; -Family/responsible party voiced concerns which would indicate the resident might have wandering tendencies or might try to leave; -The resident at risk for wandering as evidenced by staying near the main exit, outside in the cold without shoes or coat and stated he/she wanted to leave the place because "everyone dies". Review of a physician's fax request for orders dated 1/4/18, showed the resident went outside without a coat and shoes and did not feel the cold. The physician ordered a urine analysis, psychiatric consult and if the problems persisted, to send the resident to the emergency room. Further review of the resident's nurse's notes dated 1/4/18 at 4:22 P.M., showed staff called the resident's physician's exchange to report elopement attempts, resident complained he/she wanted to die and going outside in the cold without coat and shoes. Review of the climatological report dated 1/4/18, showed the temperature was 18 degrees F at 4:33 P.M. Further review of the resident's nurse's notes dated 1/6/18, no time noted, showed the resident went outside with no coat or shoes and refused to come inside. He/she stated, "I hope this is my lucky day. I can freeze to death". Staff sent the resident to the emergency room. Review of the climatological report dated 1/6/18,	A4776		

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showed the temperature was 4 degrees F at 8:00 A.M.

Review of the resident's hospital report dated 1/7/18 at 10:08 A.M., showed hospital staff called the facility and a facility staff member told them they were concerned the resident would try to elope again and were unable to keep him/her safe.

Review of the resident's hospital report dated 1/11/18 showed the staff assessed the resident at the hospital prior to return to the facility. The resident alert and oriented times three of four: Time, place and person but not the event. Care transferred to licensed practical nurse (LPN) A as the resident not alert and oriented times four.

Further review of the resident's ISP dated 9/21/17, showed the following:
-No updated documentation regarding the resident's suicide ideation or staff direction on how to recognize and respond to it;
-No updated documentation regarding the resident's increased confusion and staff direction on how to recognize and respond to it;
-No updated documentation regarding the resident's elopement risk and staff direction on how to prevent it.

Observation on 2/2/18 at 9:00 A.M., showed no documentation of the resident as an elopement risk. There was no picture posted at the front desk.

During an interview on 2/2/18 at 12:00 P.M., the resident said he/she did not recall going outside on 1/3, 1/4 and 1/6/18, without a coat and shoes or making remarks about wanting to die. He/she did not know the month, day or president and

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A4776	Continued From page 13 appeared to be confused. During an interview on 2/5/18 at 9:50 A.M., the resident's physician said the resident had increased confusion and worsening dementia. Staff notified her about the resident's wandering behavior and sent the resident to the hospital to be stabilized. The resident should not have been allowed to go outside unsupervised. It could be very dangerous if he/she went outside and could not figure out how to get back into the locked building in the evening. She said the resident's depression and wandering behavior could definitely happen again if not monitored. 2. Review of Resident #2's medical record, showed the following: -Admit date 12/23/16; -Diagnoses included diabetes and depression. Review of the resident's risk of elopement/wandering review dated 12/13/17, showed the following: -The resident not cognitively impaired with poor decision making skills such as intermittent confusion or disorientation; -The resident did have a diagnoses of depression but not dementia; -The resident did not express a desire to go home; -The resident did not wander aimlessly or non-goal directed; -The resident was not recently admitted and accepted the situation; -There were no new changes in the resident's status or routine. Review of the resident's nurse's notes, showed the following: -On 12/31/17 at 10:00 P.M., the resident in the	A4776		

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dining room earlier for dinner and went to the wrong floor. He/she told staff he/she was a visitor and did not live there;
-On 1/4/18 at 5:45 P.M., the resident went to the third floor nursing staff and told staff he/she could not find his/her room;
-On 1/5/18 at 5:50 P.M., dietary notified nursing staff, the resident needed assistance, in the dining room. The resident told staff he/she was lost and did not know how to get home or to his/her room;
-On 1/16/18 at 9:50 P.M., the resident's physician visited and assessed him/her.

Review of the resident's physician's record dated 1/16/18, no time noted, showed the following;
-Staff reported the resident more confused in the last two weeks;
-Resident not oriented to month or year;
-Diagnoses of increased confusion and dementia.

Further review of the resident's nurse's notes, showed the following:
-On 1/20/18 at 9:20 A.M., the resident got on the elevator dressed in a robe and socks, headed for the lobby. The resident told staff he/she was looking for his/her daughter. The people downstairs could hear his/her family but he/she could not find them. The resident was not easily redirected and appeared to be very confused at the time;
-On 1/24/18 at 4:39 P.M., the resident eloped from the facility. Staff found him/her down the road from the facility. The resident had fallen, his/her pants were wet and he/she did not have a jacket on. At 8:15 P.M., staff notified the resident's physician. At 8:20 P.M., the resident's family member requested staff send the resident to the emergency room for an evaluation.

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A4776	Continued From page 15 Review of statement written by the health services director (HSD) dated 1/24/18, showed a maintenance assistant told the HSD, someone approached him/her and reported an older person walking down the street. The HSD and LPN A "jumped in" a vehicle and drove down the road. They spotted the resident about two blocks away sitting in the grass, without a coat. Review of the resident's risk of elopement/wandering review, showed it was updated on 1/24/18 (after the incident). Review of a statement written by the former administrator dated 1/29/18, showed a person who drove by the community on 1/24/18, notified the maintenance associate there might be a resident, of the facility down the street. The HSD and LPN A drove down the street where the resident fell and could not get up by him/herself. He/she had an incontinent episode of urine and was not wearing a coat. It was 42 degrees outside. During an interview on 1/30/18 at 10:55 A.M., the HSD said the maintenance associate came to her on 1/24/18, to report a resident walking down the street. The resident was found about one and a half blocks away. He/she was sitting in the grass and asked to be helped up. The resident was allowed to go out of the building unsupervised if he/she signed out. They put elopement precautions in place after this incident. She did not know the resident had increased confusion before the incident, because staff did not notify her about the behaviors observed. During an interview on 1/30/18 at 3:00 P.M., level one medication aide (LIMA) A said the resident showed signs of confusion before the elopement.	A4776		

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Staff notified the resident's physician because it got worse and it would take a long time to redirect him/her. It usually got worse in the evening when there were less staff. When administration left for the evening, they would lock the front doors, but residents could still go out of them. They would have to ring the bell to come back in because the doors locked from the outside. If a resident got confused and did not understand how to ring the bell or if staff were busy assisting another resident, he/she could be outside for a long time. The alarms on the door would ring to the pagers, but if the staff member was busy, they might not go check the door right away. He/she charted his/her concerns and notified the resident's physician.

During an interview on 1/30/18 at 3:30 P.M., certified medication technician (CMT) A said the resident was confused before he/she was sent to the hospital on 1/24/18. He/she would call out for his/her mom and daughter. He/she would forget the location of his/her room and would sit in front of other residents' rooms.

During an interview on 1/30/18 at 3:45 P.M., CMT B said the resident showed signs of aggression and confusion. The resident made complaints about his/her roommate keeping him/her awake at night. He/she would get very upset with the roommate and it was hard to get him/her to calm down. The CMT reported this to administration. He/she said the resident would get lost around the building and would get up in the middle of the night, with his/her bag and say he/she was leaving.

During an interview on 1/31/18 at 2:00 P.M., LIMA C said the resident was definitely confused. He/she would hallucinate and scream out at

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people who were not there. He/ she did not recognize his/her roommate one time and got angry because there was a "stranger" in his/her room. Staff requested a psychiatric consultation. Staff were not told to watch the resident more closely and that the resident might be at risk for elopement.

During an interview on 2/5/18 at 11:30 A.M., the resident's physician said he knew the resident was becoming more confused. He did not know the facility allowed the resident to go outside unsupervised. There should have been something in place to monitor him/her if the staff knew he/she was confused. The situation could have been much worse if they had not found him/her in time. He did not know the front doors locked in the evening from the outside allowing residents to exit, but not reenter without staff assistance. This could be very dangerous if a resident could not get back in due to their confusion.

3. Review of Resident #3's medical record, showed the following:
-Admit date 8/23/13;
-Diagnoses included high blood pressure, memory lapses and depression.

Review of the resident's nurse's notes, showed the following:
-On 5/6/17 at 6:38 P.M., staff called the resident's family member to report the resident would not comply with care for his/her cat;
-On 12/30/17 at 7:40 P.M., the resident walked across the street for church. He/she told the pastor he/she thought he/she lived at the facility. The pastor was familiar with the resident and brought him/her back to the facility. Staff placed the resident on elopement precautions.

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A4776	Continued From page 18 Review of the resident's physician's note dated 12/30/17, showed the resident walked across the street to church without a coat. Further review of the resident's nurse's notes, showed on 1/3/18 at 2:20 P.M., staff called the resident's family member about the resident's increased confusion, elopement and inability to care for the cat. During an interview on 1/26/18 at 11:45 A.M., the resident said he/she did not know the month, date or year. He/she thought he/she prepared his/her own food and did not remember leaving the facility without a coat on 12/30/17. During an interview on 1/30/18 at 12:30 P.M., LIMA D said there were times when the resident was confused. He/she did not know where he/she was and would forget his/her room number. LIMA D did not know if they put precautions in place to prevent the resident from leaving the building, because he/she was still allowed to go to church after the 12/30/17 incident. Observation on 1/30/18 at 12:40 P.M., showed the resident's room door approximately 50 feet from a side exit door which exited to the facility parking lot. This investigator opened the door at 12:41 P.M. and no staff responded to the alarm. During an interview on 1/30/18 at 3:00 P.M., LIMA A said on 12/30/17, someone from the church brought the resident back to the facility when they noticed him/her outside with no coat or socks. The LIMA noticed his/her confusion was getting progressively worse. He/she would not be able to find his/her room. They were supposed to watch	A4776		

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A4776	Continued From page 19 the resident if he/she went outside, but they did not always see him/her go if they got busy. During an interview on 1/30/18 at 3:30 P.M., CMT D said the resident showed signs of confusion off and on a week or two before he/she went over to the church on 12/30/17. He/she would forget where he/she lived and would wear the same clothes day after day. Staff would have to help him/her change his/her clothes. During an interview on 1/30/18 at 3:45 P.M., CMT B said the resident showed signs of confusion for awhile. He/she stopped taking care of his/her cat and it would go to the bathroom all over his/her room. The cat would soil the room and he/she would not let staff clean it. The cat would go to the bathroom on his/her bed and clothes and he/she would wear them. The resident would refuse to shower insisting he/she already had one and would not dress appropriately for the weather. The pastor from the church would pick residents up and take them over, but would not check in with the staff about who he/she took. The resident was more confused in the evening and staff would try to redirect him/her away from the front door. After the elopement, staff were supposed to make sure the resident was escorted to the church and they would watch to make sure he/she made it back okay, but did not know when he/she would return and would not always see him/her come back into the building. He/she continued to go to church unassisted after the elopement. The front door and side exit doors send an alarm to the pagers when they are opened, but staff did not always have time to check the doors if they were busy assisting other residents. He/she let administration know the resident was becoming more confused before the elopement on 12/30/17.	A4776		

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A4776	Continued From page 20 During an interview on 1/31/18 at 2:10 P.M., LIMA C said the resident showed signs of confusion before the elopement. He/she would forget where his/her room was located. He/she stopped taking care of his/her cat and it would defecate all over his/her room and clothes. He/she was allowed to walk over with a group of residents to church. The resident who was "most coherent" would call back over and let staff know they were returning. The only thing the facility put in place after the elopement was a red stop sign at the front door to remind them to stop at the front desk and sign out. There was no one at the front desk in the evening and staff would get busy with medications or helping residents in their rooms and did not always know when residents left. Confused residents might not pay attention to the sign. He/she brought these concerns to management. They are supposed to be assisted living, but cannot check on everyone, assist with activities of daily living, pass medications and supervise residents when there are only two or three of them on duty. During an interview on 2/1/18 at 7:30 A.M., the business manager said she sat at the front desk during the day. She tried to watch all the residents and make sure they signed out, but sometimes they would get by her. Observation on 2/2/18 at 9:00 A.M., showed no staff at the front desk. A resident walked outside without signing out. No staff responded to the door after the resident exited. Observation on 2/2/18 between 9:05 A.M. and 12:00 P.M., showed the investigator opened several exit doors on the second and third floors. There were no audible alarms which sounded	A4776		

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A4776	Continued From page 21 and no staff responded to the doors. During an interview on 1/30/18 at 12:00 P.M., the health services director said they did not put a system in place to prevent the resident from leaving after the 12/30/17 incident, because she did not think the resident eloped. He/she regularly walked across the street to go to church. The issue was not the elopement, but the fact the resident was not dressed appropriately for the weather. A staff member tried to get the resident to put a coat on, but he/she refused. She did not realize the resident had increased confusion. Staff did not tell her about the resident's behaviors and did not document them in the 24 hour shift report. During an interview on 2/2/18 at 9:30 A.M., a church member said he/she knew the resident who would walk over from the facility when the weather was warmer. The church staff tried to make sure someone picked residents up when the weather got colder. Facility staff did not always come outside to ensure residents were picked up or returned. Sometimes residents would get confused and wander over to the church when they saw the lights on in another part of the building. On 12/30/17, the resident came over before church services started. He/she did not have a coat or socks on and it was very cold outside. He/she appeared to be very confused when questioned by the church staff. This was not the first time the resident appeared to be confused at the church. During an interview on 2/5/18 at 8:00 A.M., the resident's physician said she knew the resident was sick a few days before she went over to the church, but did not know the resident had increased confusion. She would have expected	A4776		

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them to tell her this because she would have consulted with the family about finding a different level of care if needed. The resident had dementia and short term memory loss. She was not aware the facility allowed the resident to go over to the church unsupervised and if the resident was showing signs of confusion, they should not have allowed it. The resident should not have been going outside unsupervised after the 12/30/17 incident. She did not know the facility allowed the residents to exit through doors that would lock behind them. This could be a concern for confused residents.

4. During interviews on 1/30/18 at 4:00 P.M. and on 2/2/18 at 12:30 P.M., the administrator said Resident #3 was allowed to go to church, because this is what he/she had always done. She did not know the resident showed increased confusion therefore did not put elopement precautions in place. It was the HSD's responsibility to assess the residents once the behaviors were brought to her attention. If residents were showing signs of confusion, they should have been reassessed as a elopement risk. She did not know the staff were not responding to the door alarms on their pagers. Only the health services staff received door alarm notifications on their pagers, but they should have been checking them when they went off.

*The higher classification merited due to the extent of the violation.

*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

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A4776	Continued From page 23 lower the violation at the time. During the onsite visit, the facility inserviced the staff on duty regarding the updated facility policies, including wearing beepers and responding to all door alarms. The administrator developed policies and procedures to ensure safeguards would be put in place to recognize and prevent future potential elopements. This included documentation of all behavior and reporting of all incidents. The facility inserviced staff as they came on duty, regarding the facility's updated policies and procedures, until all staff were inserviced. A final revisit will be conducted to determine if the facility is in substantial compliance with participation requirement. At the time of exit, the severity of the deficiency was lowered to the class II level. MO00137889 MO00138174	A4776		
A4777	19 CSR 30-86.047(36) Proper Care Per Individual Service Plan Residents shall receive proper care as defined in the individualized service plan. I/II This regulation is not met as evidenced by: Class II Based on observation, interview and record review, the facility failed to provide proper care per the resident's individualized service plan (ISP) for residents who were confused, ambulated unsafely and eloped from the building for four of 11 sampled residents. (Residents #1, #2, #3 and #4) The census was 72.	A4777		

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A4777	Continued From page 24 1. Review of Resident #1's face sheet, showed the following: -Admit date 6/17/16; -Diagnoses included memory change, depression, dementia and Alzheimer's disease. Review of the resident's service plan dated 9/21/17, showed the following: -Time and Place: Occasionally not aware, forgetful; -Decision making: Does not always recognize when to make decisions but follows directions; -Mental status: Socially appropriate behaviors; -Emotional status: Independent, confident and motivated. Review of the resident's nurse's notes dated 1/3/18 at 9:00 P.M., showed the resident went outside without a coat for about ten minutes and stated he/she was not cold and refused to come inside. He/she stated, "I don't care if I freeze to death". A family member told staff the resident expressed "This is no way to live and he/she did not want to live and wanted to die so he/she could get out of this. I could just die due to I don't like being here". Staff contacted the resident's physician, who ordered a psychiatric consultation. Review of the resident's risk of elopement/wandering review dated 1/3/18, showed the following: -The resident cognitively impaired with poor decision making skills; -Diagnoses of dementia, depression and Alzheimer's disease; -No documentation resident walked out of the facility without informing staff; -Family/responsible party voiced concerns which indicated the resident might have wandering tendencies or might try to leave;	A4777		

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A4777	Continued From page 25 -The resident at risk for wandering as evidenced by staying near the main exit, outside in the cold without shoes or coat and stated he/she wanted to leave the place because "everyone dies". Further review of the resident's nurse's notes dated 1/6/18, no time noted, showed the resident went outside with no coat or shoes and refused to come inside. He/she stated, "I hope this is my lucky day. I can freeze to death". Staff sent the resident to the emergency room. Review of the resident's hospital report dated 1/7/18 at 10:08 A.M., showed hospital staff called the facility and a facility staff member told them they were concerned the resident would try to elope again and were unable to keep him/her safe. Review of the resident's nurse's notes on 1/11/18 at 3:30 P.M., showed the resident readmitted to the facility. Further review of the resident's ISP dated 9/21/17, showed the following: -No updated documentation regarding the resident suicide ideation or staff direction on how to recognize and respond to it; -No updated documentation regarding the resident's increased confusion and staff direction on how to recognize and respond to it; -No updated documentation regarding the resident's elopement risk and staff direction on how to prevent it. Observation on 2/2/18 at 9:00 A.M., showed no documentation of the resident as an elopement risk. There was no picture posted at the front desk.	A4777		

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A4777	Continued From page 26 During an interview on 2/2/18 at 12:00 P.M., the resident said he/she did not recall going outside on 1/3, 1/4 and 1/16/18, without a coat and shoes or making remarks about wanting to die. He/she did not know the month, day or president and appeared to be confused. 2. Review of Resident #2's medical record, showed the following: -Admit date 12/23/16; -Diagnoses included diabetes and depression. Review of the resident's nurse's notes, showed the following: -On 12/13/17 at 3:30 A.M., the resident fell out of bed. He/she complained of lower back pain. Staff sent him/her to the hospital; -On 12/14/17 at 12:59 P.M., the hospital sent the resident back to the facility. His/her physician ordered an evaluation with physical therapy. Review of the resident's ISP dated 12/25/17, showed the following: -Stability/falls - Initiated skilled physical therapy for fall prevention. No direction for staff services to prevent falls; -Time and place - Aware of time and place; -Mental status - Socially appropriate behavior. Further review of the resident's nurse's notes, showed the following: -On 12/27/17 at 12:30 A.M., the resident fell out of bed. Staff found him/her on the floor, behind the door. The resident complained of back pain and staff sent him/her to the hospital; -On 12/29/17, no time noted, the resident returned to the facility; -On 12/31/17 at 10:00 P.M., the resident in the dining room earlier for dinner and went to the wrong floor. He/she told staff he/she was a visitor	A4777		

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A4777	Continued From page 27	A4777		

and did not live there;
-On 1/4/18 at 5:45 P.M., the resident went to the third floor nursing staff and told staff he/she could not find his/her room;
-On 1/5/18 at 5:50 P.M., dietary notified nursing staff, the resident needed assistance, in the dining room. The resident told staff he/she was lost and did not know how to get home or to his/her room;
-On 1/16/18 at 9:50 P.M., the resident's physician visited and assessed him/her.

Review of the resident's physician's progress notes dated 1/16/18, no time noted, showed the following;
-Staff reported the resident more confused in the last two weeks;
-Resident not oriented to month or year;
-Diagnoses of increased confusion and dementia.

Further review of the resident's nurse's notes, showed the following:
-On 1/20/18 at 9:20 A.M., the resident got on the elevator dressed in a robe and socks, headed for the lobby. The resident told staff he/she was looking for his/her daughter. The people downstairs could hear his/her family but he/she could not find them. The resident was not easily redirected and appeared to be very confused at the time;
-On 1/24/18 at 4:39 P.M., the resident eloped from the facility. Staff found him/her down the road from the facility. The resident had fallen, his/her pants were wet and he/she did not have a jacket on. At 8:15 P.M., staff notified the resident's physician. At 8:20 P.M., the resident's family member requested staff send the resident to the emergency room for an evaluation.

Review of the resident's ISP dated 1/24/18 (after

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A4777	Continued From page 28	A4777		

the resident eloped), showed it was updated to include:
-Stability/falls -The resident fell on 1/24/18 with no injury. Physical therapy initiated after the 1/10/18 fall. No staff direction on how to prevent future falls;
-Time and place - Infrequent periods of forgetfulness;
-Decision making - Does not always recognize when to make appropriate decisions, but follows directions;
-Mental status - Impaired judgement, elopement risk.

During an interview on 1/31/18 at 2:00 P.M., level one medication aide (LIMA) C said the resident was definitely confused. He/she would hallucinate and scream out at people who were not there. He/she did not recognize his/her roommate one time and got angry because there was a "stranger" in his/her room. It was hard to redirect him/her when he/she got agitated. Staff requested a psychiatric consultation. They were not told to watch the resident more closely and the resident might be at risk for elopement.

3. Review of Resident #3's medical record, showed the following:
-Admit date 8/23/13;
-Diagnoses included high blood pressure, memory lapses and depression.

Review of the resident's nurse's notes dated 5/6/17 at 6:38 P.M., showed staff called the resident's family member to report the resident would not comply with care of his/her cat. His/her room smelled of cat urine and feces.

Review of the resident's ISP dated 6/7/17, showed the following:

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A4777	Continued From page 29 -Time and place - Alert, no impairment or infrequent periods of forgetfulness; -Decision making - Recognizes and makes own decisions; -Mental status - Socially appropriate behaviors; -No documentation of a cat or care for the cat. Further review of the resident's nurse's notes, showed the following: -On 12/30/17 at 7:40 P.M., the resident walked across the street for church. He/she told the pastor he/she thought he/she lived at the facility. The pastor was familiar with the resident and brought him/her back to the facility. Staff placed the resident on elopement precautions; -On 1/3/18 at 2:20 P.M., staff called the resident's family member about the resident's increased confusion, elopement and inability to care for the cat; -On 1/12/18 at 10:50 A.M., staff notified the resident's family member, there was cat urine and feces in the resident's bedding and the resident was unable to keep up maintenance of the cat. At 11:00 A.M., staff notified another family member the cat defecated all over the resident's room, clothing and furniture. Review of the resident's ISP updated on 1/6/18 (seven days after the elopement), showed the following: -Time and place - Occasionally not aware, forgetful. Resident displayed periods of forgetfulness and staff would check on him/her periodically during each shift to ensure he/she was safe; -Decision making - Does not always recognize when to make decisions but follows directions; -Mental status - Socially appropriate behaviors; -No updated documentation regarding the cat and care of the cat;	A4777		

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A4777	Continued From page 30 -No updated documentation regarding elopement precautions. During an interview on 1/31/18 at 2:10 P.M., LIMA C said the resident showed signs of confusion before the elopement on 12/30/17. He/she would forget where his/her room was located. He/she stopped taking care of his/her cat and it would defecate all over his/her room and clothes. He/she would not allow staff to clean up after the cat. 4. Review of Resident #4's medical record, showed the following: -Admit date 2/24/17; -Diagnoses included dementia and depression. Review of the resident's nurse's notes, showed the following: -On 12/21/17 at 5:38 P.M., staff observed the resident walk down the stairs with his/her walker and reported the incident to all managers; -On 12/28/17 at 10:30 A.M., staff notified the resident's family member, the resident kept going down the stairs with his/her walker, was very confused and forgot a lot. Staff also called the resident's physician with this information. At 12:59 P.M., the resident's physician called back and told staff, the resident needed to be in a much safer environment and might need memory care. Review of the resident's ISP dated 1/10/18, showed the following: -Stability/falls - Skilled physical therapy services for dementia management and safety in motion to decrease fall risk; -Time and place - Occasionally not aware, forgetful. Note placed on resident's walker to remind him/her of room number and to avoid	A4777		

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A4777	Continued From page 31 using stairs; -Decision making - Does not always recognize when to make decisions but follows directions. Staff to provide resident with reminders to use his/her walker when he/she ambulated and to use the elevator to go from one floor to another due to confusion; -Mental status - Socially appropriate behaviors. Further review of the resident's nurse's notes, showed the following: -On 1/13/18 at 4:00 P.M., the resident in his/her room without clothes. He/she pulled sheets off his/her bed to cover up with and stated, "These are my clothes and I am wearing this. I have to pick my boys up". The resident exhibited exit seeking behavior. He/she thought his/her car was outside. Staff notified the resident's physician who ordered the resident be sent to the emergency room for evaluation. At 7:38 P.M., staff sent the resident to the hospital; -On 1/14/18 at 4:00 P.M., the hospital sent the resident back to the facility with no discharge paperwork. Staff contacted the hospital and spoke to someone who said, she/he "was calm and cooperative until the last one and a half to two hours when he/she started to wander, became aggressive and would not sit still. They did not do a psychiatric consultation; -On 1/15/18 at 1:30 P.M., staff contacted the resident's physician to report increased confusion and a decline in his/her mental status; -On 1/18/18 at 9:16 P.M., staff found the resident going down the third floor stairs with his/her wheeled walker. Staff redirected him/her and escorted him/her to his/her room. Staff notified the health services director and charge nurse; -On 1/19/18 at 10:30 P.M., staff observed the resident walk up the stairs with his/her walker and told him/her not to do it. The resident was	A4777		

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A4777	Continued From page 32 "extremely confused". During an interview on 1/30/18 at 3:10 P.M., LIMA A said the resident had increased confusion. He/she would come down from the third floor using his/her walker even after staff would remind him/her to use the elevators. The resident was very unsteady on his/her feet and the LIMA was afraid he/she would fall. During an interview on 2/2/18 at 11:00 A.M., the resident said he/she did not know the month, day or year. He/she did not know how to go from one floor to another due to confusion and to where the elevators were or how they worked. 5. During interviews on 1/30/18 at 10:55 A.M. and on 2/2/18 at 3:15 P.M., the director of health services (HDS) said she did not know the residents had a changes in cognition or she would have reassessed them and updated the ISPs. The information should have been placed in the 24 hour shift report or brought to her attention by staff. 6. During an interview on 1/30/18 at 4:35 P.M., the former administrator said the HDS was responsible to update the resident ISPs. They should have been updated when the residents showed signs of confusion and wandering behavior. She did not know why they had not been updated. MO00137889 MO00138174	A4777		
A4798	19 CSR 30-86.047(47)(A) Physicians Orders Followed	A4798		

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A4798	Continued From page 33 Medication Orders. (A) No medication, treatment or diet shall be administered without an order from an individual lawfully authorized to prescribe such and the order shall be followed. II/III This regulation is not met as evidenced by: Class II* Based on interview and record review, the facility failed to follow physician's orders, when staff failed to administer medication for five of 11 sampled residents. (Residents #5, #6, #7, #8 and #9) The census was 72. Review of the facility's policy on medication administration errors dated 1/1/13, showed the following: -If staff made a medication error, the charge staff/supervisor would be notified immediately, the error would be documented and the resident's physician would be notified; -A medication error included: a drug not dispensed in the right amount, strength, at right time, by correct route, to the correct resident and omission of a drug for which the reason and the justification not documented; -Procedure: In the event of a medication error, immediate action would be taken to protect the resident's safety and welfare. Staff would call 911 if the resident in severe distress. Staff would promptly notify the attending physician of the error. The physician's orders would be implemented and the resident monitored closely. The following would be documented in the resident's medical record: Factual description of the error, name of the physician and the time notified and the resident's condition for 24 hours as directed. The charge staff/supervisor would be notified promptly of the error and an unusual	A4798		

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A4798	Continued From page 34	A4798		

occurrence report and medication error form would be completed. Staff would notify the resident's family or legal representative.

1. Review of Resident #5's medical record, showed the following:
-Admit date 9/9/16;
-Diagnoses included depression, high blood pressure, dementia, diabetes and arthritis.

Review of the resident's physician's orders dated 12/1/17 through 12/31/17, showed the following:
-Aspirin (used to treat pain) 81 micrograms (mcg), one tab by mouth, daily at 8:00 A.M.;
-Glipizide (used to treat diabetes) 5 milligrams (mg), one tablet (tab) by mouth, daily at 8:00 A.M.
-Memantine (used to treat dementia) 10 mg, 1.5 tab (15 mg), by mouth, daily at 8:00 A.M.;
-Metformin hydrochloride (HCL - used to treat diabetes) 500 mg, by mouth, twice daily at 8:00 A.M. and 4:00 P.M.;
-Metoprolol tartrate (used to treat high blood pressure) 100 mg, by mouth, twice daily at 8:00 A.M. and 4:00 P.M. Staff should check the resident's blood pressure and hold if less than 110 systolic (the maximum arterial pressure during contraction of the left ventricle of the heart);
-Oxybutynin (used to treat overactive bladder) 5 mg, one tab by mouth, daily at 8:00 A.M.;
-Fish oil 1000 mg, one cap by mouth, three times daily at 8:00 A.M., 12:00 P.M. and 4:00 P.M.;
-Vitamin D3 1000 units, one tab by mouth daily, at 8:00 A.M.;
-Vitamin B-12 100 mcg, one tab by mouth daily, at 8:00 A.M.;
-Lisinopril (used to treat high blood pressure) 10 mg, one tab by mouth daily, at 8:00 A.M. Check blood pressure and hold if under 110 systolic.

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A4798	Continued From page 35 Review of the resident's medication administration record (MAR) dated 12/1/17 through 12/31/17, showed the following medications due at 8:00 A.M. on 12/17/17, circled to indicate not given, and documented as "See paper chart" as the reason: -Aspirin; -Glipizide; -Memantine; -Metformin; -Metoprolol tartrate - Staff initialed and circled the dated box to show the medication not given and blood pressure not taken at 8:00 A.M. Blood pressure documented at 4:00 P.M. was 145/88, (normal is 120/80); -Oxybutynin; -Fish oil; -Vitamin D3; -Vitamin B-12; -Lisinopril. Review of the resident's nurse's notes dated 12/17/17, showed no documentation of the medication error, physician and family notification or if staff monitored the resident. 2. Review of Resident #6's medical record, showed the following: -Admit date 4/29/11; -Diagnoses included diabetes, high blood pressure, schizophrenia, diabetic neuropathy (nerve damage) and tremors. Review of the resident's physician's orders dated 12/1/17 through 12/31/17, showed the following: -Accuchecks: Check and record twice daily at 11:00 A.M. and 4:00 P.M.; -Amlodipine (used to treat high blood pressure) 5 mg, 1.5 tab, by mouth, daily at 8:00 A.M.; -Bupropion HCL (used to treat depression) 150	A4798		

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A4798	Continued From page 36 mg, one tab, twice daily at 8:00 A.M. and 4:00 P.M.; -Gabapentin (used to treat nerve pain), 100 mg, twice daily at 8:00 A.M. and 4:00 P.M.; -Invega sustenna injection (used to treat schizophrenia), 156 mg/milliliters (ml) suspension, inject one ml intramuscularly (IM), on the 14th, of each month; -Januvia (used to treat diabetes) 100 mg, every morning, with breakfast, at 8:00 A.M.; -Levemir (used to treat diabetes) 100 units, inject 16 units, subcutaneous (SQ - shot given between the fat layer between the skin and muscle) every morning, at 8:00 A.M.; -Novolin R (used to treat diabetes) 100 units, inject 4 units SQ, twice daily at 8:00 A.M. and at 12:00 P.M., with meals; -Propranolol (used to treat high blood pressure) 80 mg, one tab by mouth, twice daily at 8:00 A.M. and 4:00 P.M.; -Rosuvastatin (used to treat high cholesterol) 10 mg, one tab, by mouth daily at 8:00 A.M.; -Vitamin B-12 1000 micrograms, one tab by mouth daily, at 8:00 A.M.; -Vitamin D3 1000 units, one tab by mouth daily, at 8:00 A.M. Review of the resident's MAR dated 12/1/17 through 12/31/17, showed the following: -On 12/14/17 at 8:00 A.M., no documentation the invega injection administered. Staff did not initial the box, circle it, or record a reason the medication not administered; -On 12/17/17 showed the following medications due at 8:00 A.M., circled to indicate not given, and documented as "See paper chart" as the reason: -Amlodipine; -Bupropion; -Gabapentin;	A4798		

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A4798	Continued From page 37 -Levemir injection; -Novolin injection; -Propranolol; -Rosuvastatin; -Vitamin B-12; -Vitamin D-3; -At 11:00 A.M. on 12/17/17, no documentation staff administered or recorded the resident's accucheck. Staff initialed and circled the dated box to show the medication not given. Documentation of the back of the MAR, showed, "See paper chart"; -At 12:00 P.M. on 12/17/17, no documentation staff administered the resident's novolin injection. Staff initialed and circled the dated box to show the medication not given. Documentation of the back of the MAR, showed, "See paper chart"; -At 4:00 P.M. on 12/17/17, staff administered the next ordered accucheck, the resident's blood sugar recorded as 264. Review of the resident's nurse's notes dated 12/17/17, showed no documentation of the medication error, physician and family notification or if staff monitored the resident. 3. Review of Resident #7's medical record, showed the following: -Admit date 1/14/16; -Diagnoses included diabetes, high blood pressure, anxiety, congestive heart failure, chronic obstructive pulmonary disease (COPD - lung disease) and chronic lymphedema (swelling due to excess fluid). Review of the resident's physician's orders dated 12/1/17 through 12/31/17, showed the following: -Allopurinol (used to treat gout) 100 mg, two tab by mouth, daily at 8:00 A.M.; -Amlodipine 10 mg, one tab by mouth, daily at	A4798		

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	22909C	A. BUILDING: _____ B. WING _____	C 02/08/2018

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AUTUMN VIEW GARDENS AT SCHUETZ ROAD	11210 SCHUETZ ROAD SAINT LOUIS, MO 63146

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A4798	Continued From page 38 8:00 A.M.; -Aspirin 81 mg, one tab by mouth, daily at 8:00 A.M.; -Bumetanide (used to treat edema) 2 mg, one tab by mouth, twice daily at 8:00 A.M. and 4:00 P.M.; -Carvedilol (used to treat heart failure) 6.25 mg, one tab by mouth, twice daily with meals at 8:00 A.M. and 4:00 P.M.; -Citalopram (used to treat depression) 20 mg, one tab by mouth, daily at 8:00 A.M.; -Cranberry 500 mg, one tab by mouth, daily at 8:00 A.M.; -Glyburide (used to treat diabetes) 2.5 mg, one tab by mouth, twice daily at 8:00 A.M. and 4:00 P.M.; -Glucosamine/chondroitin (used to treat arthritis), one capsule (cap) by mouth, twice daily at 8:00 A.M. and 4:00 P.M.; -Fish oil 1000 mg, one cap by mouth, three times daily at 8:00 A.M., 12:00 P.M. and 4:00 P.M.; -Accuchecks - staff to obtain accuchecks twice daily and record at 8:00 A.M. and 4:00 P.M. Review of the resident's MAR dated 12/1/17 through 12/31/17, showed the following medications due at 8:00 A.M. on 12/17/17, circled to indicate not given, and documented as "See paper chart" as the reason: -No documentation of accucheck at 8:00 A.M.; -Allopurinol; -Amlodipine; -Aspirin; -Bumetanide; -Carvedilol; -Citalopram; -Cranberry; -Glyburide; -Glucosamine/chondroitin; -Fish oil 1000 mg.	A4798		

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A4798	Continued From page 39 Review of the resident's nurse's notes dated 12/17/17, showed no documentation of the medication error, physician and family notification or if staff monitored the resident. 4. Review of Resident #8's medical record, showed the following: -Admit date 6/25/16; -Diagnoses included high blood pressure, diabetes, COPD and anemia. Review of the resident's physician's orders dated 12/1/17 through 12/31/17, showed the following: -Accuchecks, check and record at noon; -Acetaminophen (used to treat pain) 325 mg, two tabs by mouth daily, at 8:00 A.M.; -Bupropion 150 mg, one tab by mouth daily, at 8:00 A.M.; -Cartia (used to treat high blood pressure) 180/24HR, one cap by mouth daily, at 8:00 A.M.; -Eliquis (used to prevent strokes) 5 mg, one tab by mouth twice daily, at 8:00 A.M. and 4:00 P.M.; -Hydroxychloroquine sulfate (used to treat arthritis) 200 mg, one tab by mouth twice daily, at 8:00 A.M. and 4:00 P.M.; -Levemir injection (used to treat diabetes) 22 units, SQ daily at 8:00 A.M.; -Lyrica (used to treat neuropathy) 100 mg, one cap by mouth twice daily, at 8:00 A.M. and 4:00 P.M.; -Metformin 1000 mg, one tab by mouth twice daily, at 8:00 A.M. and 4:00 P.M.; -Mi-acid gas chewable 80 mg, one tab by mouth twice daily, at 8:00 A.M. and 4:00 P.M.; -Potassium chloride (used to treat low potassium), 10 milliequivalent (meq), two tab by mouth daily at 8:00 A.M.; -Spiriva (used to treat respiratory issues) inhaler, one cap per device daily at 8:00 A.M.; -Blood pressure: Staff to obtain blood pressure	A4798		

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A4798	Continued From page 40 daily at 8:00 A.M. and 4:00 P.M. Review of the resident's MAR dated 12/1/17 through 12/31/17, showed the following medications due at 8:00 A.M. on 12/17/17, circled to indicate not given, and documented as "See paper chart" as the reason: -Acetaminophen; -Bupropion; -Cartia; -Carvedilol; -Eliquis; -Hydroxychloroquine sulfate; -Levemir injection; -Lyrica; -Metformin; -Mi-acid; -Potassium chloride; -Spiriva inhaler; -No documentation of an accucheck done at 12:00 P.M. on 12/17/17. Staff initialed and circled the dated box to show the accucheck not completed. Documentation on the back of the MAR, showed, "See paper chart"; -No documentation of blood pressure taken at 8:00 A.M. on 12/17/17. Documented blood pressure at 4:00 P.M. on 12/17/17, was 142/78. Review of the resident's nurse's notes dated 12/17/17, showed no documentation of the medication error, physician and family notification or if staff monitored the resident. 5. Review of Resident #9's medical record, showed the following: -Admit date 8/1/17; -Diagnoses included gout, diabetes and Alzheimer's disease. Review of the resident's physician's orders dated	A4798		

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A4798	Continued From page 41 12/1/17 through 12/31/17, showed the following: -Accuchecks, three times daily, at 11:00 A.M., 4:00 P.M. and 9:00 P.M.; -Aspirin 81 mg, one tab by mouth daily, at 8:00 A.M.; -Bumetanide 0.5 mg, one tab by mouth daily, at 8:00 A.M.; -Escitalopram (used to treat depression) 5 mc, one tab by mouth daily, at 8:00 A.M.; -Icaps multivitamin, one tab by mouth daily, at 8:00 A.M.; -Lisinopril 20 mg, one tab, by mouth daily, at 8:00 A.M.; -Metoprolol Tartre 25 mg, one tab by mouth twice daily, at 8:00 A.M. and 4:00 P.M.; -Vitamin B-12 1000 mcg, one tab by mouth daily, at 8:00 A.M.; -Vitamin D 5000 units, one tab by mouth, daily at 8:00 A.M. Review of the resident's MAR dated 12/1/17 through 12/31/17, showed the following medications due at 8:00 A.M. on 12/17/17, circled to indicate not given, and documented as "See paper chart" as the reason: -Aspirin; -Bumetanide; -Escitalopram; -Icaps multivitamin; -Lisinopril; -Metroprol Tartrate; -Vitamin B-12; -Vitamin D; -No documentation of an accucheck done at 11:00 P.M. on 12/17/17. Staff initialed and circled the dated box to show the accucheck not completed. Documentation on the back of the MAR, showed, "See paper chart." Review of the resident's nurse's notes dated	A4798		

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A4798	Continued From page 42 12/17/17, showed no documentation of the medication error, physician and family notification or if staff monitored the resident. 6. During an interview on 1/30/18 at 1:00 P.M., licensed practical nurse (LPN) A said the MARS would only have reflected "see paper chart" if the resident or medication was new and the orders were entered into the electronic MAR. He/she did not know the residents did not get their medications administered on 12/17/17; therefore, did not notify the residents' physicians or family members. He/she did not work the morning shift on 12/17/17, and did not enter the information into the electronic MAR; even though, his/her initials were electronically signed for residents who missed medications on that date. 7. During an interview on 1/31/18 at 2:00 P.M., level one medication aide (LIMA) C said the facility was short of staff on the morning of 12/17/17, after someone called in and was not replaced. Each nursing staff member had their own cart of medication to administer. They were not told what to do for the additional cart of medication belonging to the staff member who called in. He/she took it upon him/herself to start administering the medication once he/she realized the medication had not been given to the residents. The medications were late, because he/she did not start until after all of his/her medications were administered. The former administrator saw him/her passing the medications around 10:00 A.M., and asked what time the medications were supposed to be administered. The administrator told him/her a medication error report would have to be written for everyone who got their medication late. He/she stopped passing medication at that time as he/she would not have enough time to write all	A4798		

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A4798	Continued From page 43 the reports and continue administering medication. He/she was not directed to call the residents' physicians or family members to report the incident. He/she knew the procedure was to call each residents' physician, report the missed medication and follow the orders given to them by the physician, but thought the charge nurse would do this. The former administrator and LPN A both knew the medication did not get administered and did not call the residents' physicians or family members. He/she did not know who entered LPN A's initials on the residents' MARs. 8. On 1/30/18 at 4:00 P.M., the former administrator said she did not know staff did not administer medication to all of the residents the morning of 12/17/17. If a resident missed a dose of medication, staff were supposed to call the physician and responsible party and document the error. She did not know who made the error or why it was not documented. MO00136703	A4798		
A8015	19 CSR 30-88.010(15) 30 Day Notice-Transfer/Discharge No resident shall be transferred or discharged except in the case of an emergency discharge unless the resident, and the next of kin, or a legally authorized representative or designee, and the resident's attending physician and the responsible agency, if any, are notified at least thirty (30) days in advance of the transfer or discharge, and casework services or other means are utilized to assure that adequate arrangements exist for meeting the resident's needs. In the event that there is no next of kin, legally authorized representative or designee	A8015		

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A8015	Continued From page 44	A8015		

known to the facility, the facility shall notify the appropriate regional coordinator of the Missouri State Ombudsman's office. II

This regulation is not met as evidenced by:
Based on interview and record review, the facility failed to provide a written discharge notice for residents who the facility informed could no longer live at the facility for one of 11 sampled residents. (Resident #3) The census was 72.

1. Review of Resident #3's medical record, showed the following:
-Admit date 8/23/13;
-Diagnoses included high blood pressure, memory lapses and depression.

Review of the resident's nurse's notes, showed the following:
-On 12/30/17 at 7:40 P.M., the resident walked across the street for church. He/she told the pastor he/she thought he/she lived at the facility. The pastor was familiar with the resident and brought him/her back to the facility. Staff placed the resident on elopement precautions;
-On 1/3/18 at 2:20 P.M., staff called the resident's family member about the resident's increased confusion, elopement and inability to care for the cat;
-On 1/12/18 at 10:50 A.M., staff notified the resident's family member, there was cat urine and feces in the resident's bedding and the resident was unable to keep up maintenance of the cat. At 11:00 A.M., staff notified another family member the cat defecated all over the resident's room, clothing and furniture;
-On 1/13/18, no time noted, the resident fell out of his/her chair. Staff assessed him/her and got him/her to stand but he/she was not stable. He/she initially responded to questions but then

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A8015	Continued From page 45 became incoherent. Staff called 911 and sent the resident to the hospital. 2. During an interview on 1/17/18 at 12:43 P.M., the resident's family member said the facility would not take the resident back due to his/her memory issues. The facility had not issued the resident or responsible party a discharge notice. The resident was in good physical health and nothing with his/her overall condition had changed, so the family did not understand why the facility was saying they can't take him/her back. The family was looking to move the resident and asked the facility for some paperwork to provide to a potential new facility. The resident's memory issues, which the facility was citing as the reason for not taking him/her back, were not mentioned in the paperwork provided to the family. 3. During an interview on 1/30/18 at 12:30 P.M., the health services director (HSD) said the resident was discharged from their facility after his/her hospital stay. The facility decided to discharge the resident, because he/she was making poor choices like going out without a coat and they could not continually monitor him/her when he/she left the building. She talked to the family and they were already planning to move the resident to a different facility in the state where they lived. It was the former administrator's responsibility to issue a discharge notice, so she did not send one to the family. 4. During an interview on 1/30/18 at 4:15 P.M., the former administrator said she did not issue a discharge notice because the HSD talked to the family and it was her understanding the resident's family chose to discharge him/her.	A8015		

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A8015	Continued From page 46 *The higher classification merited due to the violation's effect on the residents. MO00137889	A8015		