STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046083	A. BUILDING: _____ B. WING _____	C 08/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNINGSIDE PLACE	6921 W 81ST STREET OVERLAND PARK, KS 66204

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S 000	INITIAL COMMENTS The following citations represent the findings of an abbreviated survey for complaints # 173638, 173558, 171950, 171467, 170831, 170385 and 170331 of the above named facility conducted on 8/1, 8/2 and 8/3/2022.	S 000		
S3026 SS=J	26-41-101 (f) (1) Staff Treatment of Residents ANE (f)The administrator or operator shall ensure that all of the following requirements are met: (1) No resident shall be subjected to any of the following: (A) Verbal, mental, sexual, or physical abuse, including corporal punishment and involuntary seclusion; (B) neglect; or (C) exploitation. This REQUIREMENT is not met as evidenced by: 26-41-101 (f) (1) (B) The facility reported a census of 65 residents. The sample included four residents (R) and one closed record review. Based on observation, interview, and record review, the administrator failed to protect R2 and R4 from neglect when the facility staff failed to follow the facility policies, which required "Resident Safety Checks", following the "Resident Elopement /Missing Residents'" policy, and documenting all incidents and injuries. This failure allowed cognitively impaired R2 to leave the facility without staff knowledge on 07/28/22. R2 required transport to the hospital for assessment for a laceration he received to his chin and abrasions to both knees from a fall during the time he was out of the	S3026		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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facility without staff supervision. This failure further allowed cognitively impaired R4 to leave the facility without staff knowledge on 07/30/22. In both cases local law enforcement contacted the facility to tell them the resident(s) were not in the building.

Findings included:

- Record review for R2 on 08/01/22 revealed an admission date of 07/01/22 and diagnoses of hypertension, psychosis, vascular dementia with behaviors, and self-care deficit.

Review of the "Functional Capacity Screen" (FCS) dated 07/01/22 identified R2 required supervision with bathing, dressing and eating. He was independent with toileting, transfers, and walking. He lacked the ability to manage his own medications and was marked with impaired short-term memory, impaired long-term memory, memory recall, and impaired decision making.

Review of the "Negotiated Service Agreement" (NSA) dated 07/01/22 identified the facility would provide supervision and oversight for bathing and eating, he could understand verbal communication and demonstrated this by his actions, words and behavior. He could be understood and could clearly express his wants and needs. He had impaired decision making and had difficulty making decisions and made decisions which were harmful or potentially harmful to himself. He was independent with transferring, walking, toileting and used no mobility device.

Review of the "Healthcare Service Plan" (HSP) dated 07/01/22 stated the resident had impaired decision making and had difficulty making

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decisions. The HSP documented R2 made decisions which were harmful or potentially harmful to self. The HSP lacked an interventions for R2 leaving the facility unsupervised.

Review of the facility "Elopement Risk" assessment dated 07/01/22 revealed the resident scored a nine, which indicated the resident had a risk for elopement. The prevention of elopement protocols defined on the document stated the resident agreed not to leave the facility without staff or a family member.

Review of the facility assessment titled "Mini Mental Exam" scored the resident with a score of 21, which indicated the resident had mild confusion maximum amount of points is thirty-one.
The resident total score was twenty-one. The definition provided by the document is the resident was mildly confused.

Review of the "Progress Notes" for R2 dated 07/02/22 thru 08/01/22 revealed the following entries:

On 07/02/22 at 03:28PM revealed the resident admitted to the facility with no concerns.

On 07/05/22 at 09:26PM revealed the resident had a lot of forgetfulness and redirected several times. No concerns voiced.

On 07/28/22 at 06:01PM and signed by LN B revealed resident returned from hospital.

The note lacked documentation stating why and when the resident went to the hospital.

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On 07/29/22 at 07:02PM and signed by LN B revealed the resident's stitches were dry and intact. R2 has not been exit seeking.

On 08/01/22 at 03:30PM and signed by LN A revealed resident was seen by the "Advanced Practice Registered Nurse" (APRN) this morning. New order received to cleanse the abrasions to bilateral knees, apply triple antibiotic ointment and cover daily. The resident continued on fall/elopement follow up. Stitches to the laceration to the chin were documented as intact with no signs of infection noted. Resident was calm today with no exit seeking noted.

On 08/01/22 at 09:21PM and signed by LN A revealed the resident continued on alert charting for high elopement risk and caregivers to check on him and document every hour.

The "Electronic Progress Notes" lacked documentation of the resident leaving the facility without staff knowledge on 07/28/22, the note lacked documentation of injuries acquired from a fall while the resident was out of the facility, and the notes further lacked interventions to protect/prevent the resident from trying to leave the facility in the future.

The resident "Electronic Progress Notes" lacked documentation regarding resident leaving the facility without staff knowledge, safety checks upon return until the resident was determined to be safe from another attempt to leave the facility without staff knowledge and interventions to prevent/protect the resident from attempting to leave the facility again without staff knowledge.

Review of the facility provided investigation

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revealed at approximately 07:00 AM on 07/28/22 LN C was contacted by R 2's "Durable Power of Attorney" (DPOA) stating that R 2 was at a local hospital for evaluation. The DPOA informed LN C that R2 left the facility and walked to his home. R2's DPOA stated R2's spouse called the local law enforcement agency. The DPOA stated R2 told her that he walked out an open door. The investigative note stated all doors to the facility were checked and all were secured and alarmed. Doors to the dining area were all locked. The police arrived at approximately 07:15 AM and they also walked the building and to R 2's room to see that all was secure. At approximately 07:40 AM LN C stated the night nurse and the Certified Medication Aide (CMA), were standing at the medication cart with her and saw that the door by the breakroom had a blinking light showing it was unsecure, they went to the door and it was open and they "rescued" the door. R2 returned from the hospital via ambulance and was taken to his room. Interview with the resident at the time of his return to the facility revealed he wanted to see his wife and the door was not locked, he went out the two hundred hall, climbed the wall, and went to see her.

Interview with R 2 on 08/03/22 revealed he confirmed he left the facility to go see his wife. He stated he fell in the street and that is how he skinned his shins, hurt his chin, and bruised his lip.

Observation on 08/03/22 at 12:10 PM revealed the resident walked with steady gait in the back hallway of the facility.

Observation of 8/2/22 revealed the area outside the door the resident exited had a rock wall approximately 5-foot-high and a locked gate to

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the immediate left out the door. The area to the right outside the door was all grass with a rock wall on the edge of the lawn. There were shrubs and a narrow walkway to the back of the building. The back of the building was a lacked a sidewalk until the first exterior door located on the southeast corner of the building. The facility set on 81st street, and approximately 75 yards from the facility is Metcalf Avenue. Metcalf is a major street and the posted speed limit is 40 miles per hour in this area.

Interview on 08/03/22 at 09:06AM with Administrator D and LN C confirmed the facility did not start performing the hourly checks per the facility policy until 08/01/22.

Review of the facility provided policy titled "Resident Safety Checks" and updated on 08/2020 stated the staff would ensure resident safety with awareness of where their assigned residents were throughout the day. Additionally, a systematic approach for resident monitoring would be provided with routine safety checks. Safety checks would be made every hour per staff assignments and residents must be checked to visually confirm the resident was safe. All residents would be physically visited to account for whereabouts.

Record Review of the facility provided policy titled "Resident Elopement / Missing Resident" updated 08/2020 stated routine safety checks were made by staff to account for resident whereabouts once during each shift and at each change of shift. Staff were to immediately respond to door alarms or other monitoring /alert systems and if no resident was found near any monitored door (in or out), all resident residing in the secured area would be accounted for starting with residents on

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wandering risk list immediately. Staff would then notify the legal representative and complete documentation including an incident report.

The administrator failed to ensure facility staff followed the facility's policies on Resident Safety Checks and Resident Elopement/Missing Resident. This failure allowed R 2 to leave the facility without staff knowledge on 07/28/22. R 2 required transport to the hospital for assessment for a laceration received to his chin and abrasions to both knees from a fall during the time he was out of the facility without staff knowledge.

- Record review on 08/01/2022 for R 4 revealed an admission date of 06/24/21 with diagnoses of seizure disorder, traumatic brain injury, depression and bipolar affective disorder.

Review of the FCS dated 04/01/22 identified the resident required physical assistance with bathing, dressing, toileting, transfers, walking and eating. He lacked the ability to manage his own medications, was incontinent of bladder and had impaired short term, long term, memory recall and decision making. He could sometimes understand and could be sometimes understood. He was marked with falls, socially inappropriate behaviors and impaired decision making. He used a wheelchair for mobility.

Review of the NSA dated 04/01/22 identified the facility would provide assistance with bathing three times a week. Staff were to encourage activities for socialization, know the resident required extra support for understanding and staff would clarify when needed. Staff would encourage the resident to make

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choices/decisions on day to day needs. The resident was able to feed himself, and staff were to assist with opening packages. The facility would provide one on one assistance for dressing needs. Staff would walk with resident while R 4 used his walker using two staff and a gait belt. Staff would provide stand by assist with walking and peri- care after toileting.

Review of the HSP dated 04/01/22 instructed staff to assist the resident with bathing three times a week and to wash his hair each time. The staff were instructed to speak simply and directly and assist him in making choices and dressing due to R 4 being a fall risk.

Review of the facility "Elopement Risk" assessment dated 04/01/22 revealed the resident had a risk of elopement. The assessment noted the resident had a traumatic brain injury, had impaired decision making, and agreed not to leave the facility without staff or a family member.

Record review of the facility assessment titled "Mini Mental Exam" scored the resident with a score of 17, which indicated the resident had confusion.

Record review of the "Electronic Progress Notes" revealed on 08/01/22 at 08:50 PM and signed by LN A the resident was calm with no behaviors of exit seeking. The resident was on alert charting for high elopement risk and caregivers were to check on him and document hourly.

The resident's "Electronic Progress Notes" lacked the required entries per the facility policies for the resident leaving the facility without staff knowledge, safety checks upon return until the resident was determined to be safe from another

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attempt to leave the facility without staff knowledge and interventions to prevent/protect the resident from attempting to leave the facility again without staff knowledge.

Record review on 08/01/22 of the security video footage with Administrator A and Maintence Director E revealed the following events of R 4 exiting the facility without facility staff knowledge.

The date stamp is 07/30/22 and the events are time stamped as follows:

At 05:15 PM R4 stood without aid at the front door of the unit, and he pressed the egress bar on the front door of the unit and continued to hold it until the door opened.

At 05:16 PM the door released so R4 pushed the door open and walked through the door.

At 05:17 PM Certified Nurse Aide(CNA) F approached the door ,inserted her key, and reset the alarm on the door. There was not a resident present at the door, CNA F did not open the door and go through the door to check for any residents.

At 05:46 PM LN G and CNA F opened the door and R4 was escorted in by the local law enforcement agency.

At 05:47 PM R4 walked back into the memory care unit.

Interview on 08/01/22 Administrator A confirmed staff did not follow facility policy and look to see if a resident had exited the facility. He confirmed CNA F only reset the door alarm.

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S3026	Continued From page 9 Interview on 8/2/22 at 11:11AMwith Maintenance Director E revealed the doors functioned as follows; 1. When door is armed with the alarm on the light in the egress bar is a solid red. 2. When the egress bar is depressed the door beeps twice. 3. When the egress bar is depressed and held down for the 30 seconds the alarm tone changes to a solid tone and the light in the egress bar turns green. This means the door is opened. 4. To reset the door; you must insert the key, turn it to the left and the door light will turn a solid red. Interview on 08/03/22 at 09:06 am with Administrator D and LN C confirmed the facility did not start performing the hourly checks per the facility policy until 08/01/22. Interview on 08/03/22 with R4 revealed he denied any concerns or complaints, he further had forgotten the time of day, and did not remember consuming breakfast or lunch. Review of the facility provided policy titled "Resident Safety Checks" and updated on 08/2020 stated the staff would ensure resident safety with awareness of where their assigned residents were throughout the day. Additionally, a systematic approach for resident monitoring would be provided with routine safety checks. Safety checks would be made every hour per staff assignments and residents must be checked to visually confirm the resident was safe. All residents would be physically visited to account for whereabouts. Record Review of the facility provided policy titled "Resident Elopement / Missing Resident" updated	S3026		

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S3026	Continued From page 10 08/2020 stated routine safety checks were made by staff to account for resident whereabouts once during each shift and at each change of shift. Staff were to immediately respond to door alarms or other monitoring /alert systems and if no resident was found near any monitored door (in or out), all resident residing in the secured area would be accounted for starting with residents on wandering risk list immediately. Staff would then notify the legal representative and complete documentation including an incident report. The administrator failed to protect R4 when he left the facility without staff knowledge on 07/30/22. In both cases the facility was unaware until the local law enforcement agency notified the facility of the resident's absences. This system failure placed all residents in immediate jeopardy. On 08/01/22 at 04:57PM the facility provided an abatement plan which removed the jeopardy status, the plan included the following: Immediate hourly checks for R2 and R4 until it was determined they no longer at risk of elopement. Immediate one on one staff training on the Resident Safety Checks and Missing Resident Policies for all staff in the building every shift until 08/09/22 when the facility will provide a formal Inservice and training, this training includes the functions of the alarms on the exterior doors. Immediate implementation for the next weeks all exterior doors will be checked three times daily to ensure they are functioning appropriately after the installation of the new fire panel that was placed on 07/25/22.	S3026		