STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175558	A. BUILDING _____ B. WING _____	C 10/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HEALTHCARE RESORT OF LEAWOOD - IRON HORSE HLTH	5401 W 143RD STREET LEAWOOD, KS 66224

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following citations represent the findings of complaint investigations #KS00166602 and #KS00166185.	F 000		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: The facility identified a census of 59 residents. The sample included three residents reviewed for abuse. Based on record review, observation, and interview, the facility failed to prevent an instance of abuse. On 10/21/21 at approximately 2:00 P.M. an Certified Nurse Aid (CNA) N was observed standing over Resident (R) 1 and speaking in a loud and threatening manner. This deficient practice placed R1 at risk for injury and/or impaired psychosocial wellbeing. Findings included: - The electronic medical record (EMR)	F 600		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 11/05/2021

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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documented R1 admitted to the facility on 05/03/2017 with diagnoses that included: Parkinson's disease (a disorder of the central nervous system that affects movement, often including tremors); and dementia (a mental disorder in which a person loses the ability to think, remember, learn, make decisions, and solve problems).

The "Quarterly Minimum Data Set" (MDS) dated 07/29/21 documented the resident had a Brief Interview For Mental Status score of nine which indicated cognitive impairment. The MDS recorded R1 had mild depression, no behaviors and required limited assistance with most activities of daily living (ADL's). R1 ambulated with the use of a rolling walker and wheelchair.

The resident's "Care Plan" revised 10/29/21 documented R1 needed assistance with some ADL's. The "Care Plan" recorded R1 experienced psychosis (any major mental disorder characterized by a gross impairment in reality testing) and delusions (untrue persistent belief or perception held by a person although evidence shows it was untrue) related to R1's diagnoses and directed staff to approach R1 calmly and speak in a calm manner.

Review of the undated "Facility Investigation" revealed on 10/21/21 at approximately 02:00 P.M. Therapy Staff (TS) G witnessed CNA N "hovering over" R1 in an intimidating manor. TS G reported CNA N did not touch and/or harm R1 but the demeanor of CNA N was "not nice." TS G reported CNA N was rude to R1, and TS G felt uncomfortable by the situation. TS G intervened to help R1 and CNA N walked away.

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A "Notarized Witness Statement" by TS G dated 10/21/21 documented R1 was in a wheelchair and tried to stand and walk. CNA N stood over R1, and told R1 to sit down loudly and firmly. CNA N prevented R1 from standing. TS G intervened and CNA N walked away. TS G recorded CNA N did not allow R1 time to express himself.

Interview on 10/26/21 at 02:15 P.M. TS G stated CNA N spoke to R1 forcefully and told R1 "Sit down you are going to fall."

On 10/26/21 at 12:14 P.M R1 sat in a recliner in his room. At this time and, n the presence of Administrative Nurse E, R1 stated there was a nursing assistant the other day that treated him roughly.

Interviewed on 10/26/21 at 2:40 PM. Administrative Nurse C stated all staff were expected to be professional and courteous. The facility had a binder that recorded the direct care needs of residents as well as resources for assistance. Administrative Nurse C stated measures were Nurse C stated the agency CNA had not worked in the facility before and the facility tried to have consistency with agency staff.

Interviewed on 10/26/21 at 2:40 P.M. Administrative Staff A stated the facility worked with the agency to complete their investigation, and that this particular agency CNA was placed on a do not return list . She said the facility would implement daily huddles in response to this situation and continued with abuse and neglect education.

The facility's "Reporting Alleged violations of

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F 600	Continued From page 3 Abuse neglect, Exploitation, or Mistreatment," policy revised November 28/2017 documented: It was the facility's policy that each resident had the right to be free from abuse and neglect and mistreatment. The policy recorded residents must not be subjected to abuse by anyone, including but not limited to facility staff, other residents' consultants, vendors, staff from other agencies serving the resident, resident representative, family, friend, or other individuals. The facility failed to prevent an instance of staff to resident abuse when CNA N spoke in a forceful and intimidating manner to R1. This deficient practice placed R1 at risk for injury or impaired psychosocial wellbeing.	F 600		
F 689 SS=D	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: The facility reported a census of 59 residents. The sample included three residents at risk for elopement (when a cognitively impaired resident leaves the premises or safe area without staff knowledge). Based on record review, observation, and interview, the facility failed to ensure Resident (R) 2, identified at high risk for elopement, received adequate supervision to prevent an elopement when R2 exited through	F 689		

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the facility's double front doors which were unlocked due to activation of the fire alarm. The deficient practice placed R2 at risk for potential accident and/or injury.

Findings included:

- R2's electronic medical record (EMR), under the "Diagnosis" tab, listed diagnoses of: dementia without behavioral disturbances ((a mental disorder in which a person loses the ability to think, remember, learn, make decisions, and solve problems), and an anxiety disorder (a mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities).

The "Quarterly Minimum Data Set (MDS)" dated 10/05/21 recorded R2 entered the facility on 01/07/19 and had a Brief Interview for Mental Status score of three, which indicated severely impaired cognition. he MDS recorded the resident had indicators of depressed mood, wandering behaviors during the seven day assessment period. The MDS recorded R2 required only limited assistance with most activities of daily living (ADLs) and could ambulate independently in a wheelchair.

The "Care Area Assessment" (CAA) dated 01/15/21 documented the resident's cognition varied through-out the day. R2 wandered throughout the facility in a wheelchair and eloped in October 2020. The CAA documented R2 had a one -on-one sitter and was easily re-directed.

The "Elopement Risk Assessment" dated 08/02/21 documented a score of 15, which identified R2 at high risk for elopement.

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R2's "Care Plan" initiated on 05/13/21 documented: R2 had a history of attempts to leave the facility unattended, due to impaired safety awareness. The "Care Plan" directed staff to document R2's wandering behavior, attempt diversional interventions and intervene as appropriate. The "Care Plan" advised staff to monitor the WanderGuard (WanderGuard- a signaling bracelet/device that alerts staff of a residents attempts to exit the facility) placement on R2's wheelchair and test its function every shift.

The "Care Plan" recorded R2 received a head to assessment, and one-on- one intervention after an elopement on 10/07/21. Another intervention dated 10/25/21 documented the resident was transitioned from one-on-one monitoring to fifteen-minute checks for seventy-two hours.

A "Nurses Progress Note" dated 09/30/21 at 05:05 P.M. documented R2 had been all over the building setting off WanderGuard alarms on doors and on other units, including the dining hall.

A "Physician's Assistant Progress Note" dated 10/05/21 at 03:03 P.M documented R2 had increased exit seeking behaviors. R2 wandered close to doors causing alarms to go off.

A "Nurses Progress Note" dated 10/07/21 at 05:27 A.M. documented: R2 was up most of the night, slept only about two hours, was restless, exit seeking, and set off alarms several times. R2 pulled the fire alarm, the alarm was reset and R2 was provided one-on-one monitoring doing activities (coloring), and offered a snack.

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A "Physician's Assistant Progress Note" dated 10/07/21 at 11:54 A.M. documented: R2 was seen because R2 was found outside having snuck out during a fire alarm. R2 was outside only minutes and did not appear to have any injuries.

A "Nurses Progress Note" dated 100/7/21 at 05:30 P.M. documented: R2 set off the WanderGuard alarms at least three occasions between 06:00 A.M. and 07:20 A.M. At around 07:20 A.M., alarms went off, staff immediately responded, and looked for the cause. A staff member turned the alarm off, and at that time R2 was found outside in her wheelchair, moving on the sidewalk closest to the building. Staff brought R2 back into the building through the main entrance.

On 10/26/21 at 11:35 A.M. R2 sat in a wheelchair near the entrance to her room and participated in a virtual visitation. R2's wheelchair had a WanderGuard signaling device affixed to it. An interview was not possible due to R2's level of confusion.

Interviewed on 10/26/21 at 02:40 P.M Administrative Staff A stated staff did a good job monitoring the resident and responded timely so R2 was located within 40 seconds,verified by video footage. Administrative Staff A stated it was identified that R2 pulled the fire alarm that morning.

The facility's "Elopement/Unsafe Wandering " policies and procedure revised 06/2021 documented: This facility is committed to promoting resident autonomy by providing and environment that remains as free of accident

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hazards as possible. Each resident is assisted in attaining or maintaining their highest practicable level of function, through providing the resident adequate supervision and diversional programs to prevent unsafe wandering while maintaining the least restrictive environment for those at risk for elopement. The policy documented: Residents capable of ambulation and/or mobility in a wheelchair would have an elopement/wandering evaluation on admission and with observed behavior of wandering or attempting to elope. If an identified risk was present the interventions documented were to be documented on the care plan.

The facility failed to provide adequate supervision to prevent an elopement for R2. This placed R2 at increased risk of accidents and/or injuries.