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 07/20/2021

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 investigation #KS00163989 and partial extended survey. On 07/19/21 at 03:45 PM the facility was provided a copy of the "Immediate Jeopardy (IJ) Template" and was notified of the IJ for Resident (R) 1. On 07/13/21 R1 exited the facility via an alarmed fire exit door at the end of Bridgewood hallway. She self-propelled her wheelchair down the sidewalk, next to the street, and into a parking lot. R1 was outside, unsupervised, for approximately 15-30 minutes before staff found her and returned her to the facility. The street had four lanes of traffic moving north and south at 35 miles per hour. The temperature was 87 degrees Fahrenheit (F). The facility failed to ensure the door alarms were audible from all care areas including the dining room and nurse station. The facility also failed to ensure R1, who had a history of wandering and a previous elopement, was adequately supervised by staff. This deficient practice placed R1 and four other residents at risk for elopement in immediate jeopardy. The IJ was abated on 07/20/21 at 04:50 PM when it was verified the facility had placed louder alarms on the doors and had assigned supervision to the at-risk residents. The deficient practice remained at a scope and severity of an "E"	F 000		
F 689 SS=K	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents.	F 689		

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

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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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 52 residents. The sample included three residents reviewed for elopement (when a cognitive impaired resident with little or poor safety awareness exits the facility without staff knowledge). Based on observation, record review, and interview, the facility failed to ensure Resident (R)1 received adequate supervision with audible door and Wander Guard alarms to prevent elopement. R1, who was on the West unit, exited the facility without staff knowledge and supervision on 07/14/21 between approximately 04:30 PM and 04:40 PM. R1 exited through the fire exit door on the South side of the building. R1 pushed on the door for approximately 15 seconds and then exited the facility. R1 then wheeled her wheelchair approximately a half block to a nonsecure, unsupervised location. R1 was then found by staff seated in her wheelchair in the parking lot of another facility. R1 was found in an urban metropolitan area with four lanes of traffic, changing speeds up to 35 miles per hour, and significant hazards, such as changing elevations and cross streets. The temperature was 87 degrees Fahrenheit (F) and R1 wore light blue pants, a short-sleeved shirt, socks, and shoes. This deficient practice placed this resident and four other residents at risk for elopement in immediate jeopardy .

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Findings included:

- R1's electronic medical record (EMR), under the "Diagnoses" tab recorded diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion), anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear) disorder, and muscle weakness.

The "Annual Minimum Data Set" (MDS) dated 01/15/21 documented a Brief Interview for Mental Status (BIMS) score of three which indicated severely impaired cognition. R1 had no behaviors of wandering exhibited during the look back period. R1 self-propelled in a wheelchair with supervision and set up help only.

The "Cognitive Loss/Dementia Care Area Assessment" (CAA) dated 01/15/21 documented R1 as pleasantly confused and she liked to wander throughout the facility in her wheelchair that she self-propelled.

The "Behavioral Symptoms CAA" dated 01/15/21 did not trigger.

The "Quarterly MDS" dated 04/05/21 documented R1 had short- and long-term memory problems with no behaviors of wandering exhibited during the look back period. R1 required supervision of one staff member for locomotion on the unit, and supervision with set up help only off the unit.

The "Elopement/Wandering Evaluation" dated 05/02/21 documented R1 had a score of 12 which indicated high risk for elopement.

The "Care Plan" revised 05/29/19 for cognitive

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issues related to dementia directed staff if R1 wandered around the facility in her wheelchair staff were to notify the nurse if exit seeking behaviors occurred.

The "Care Plan" created 05/13/21 for elopement risk/wandering related to history of attempts to leave the facility unattended directed staff to document wandering behaviors, attempt diversional interventions, and monitor Wander Guard placement and function every shift.

Review of the "Progress Note" dated 07/13/21 at 06:30 PM documented the following: "the door alarm was sounding and when the nurse entered the hallway another resident stated that someone had went out the door. [R1] had exited the facility out of the long hall exit door on Hallbrock and staff immediately responded. The charge nurse assessed [R1] with no injuries noted, when [R1] was asked how she was she stated hot and accepted water to drink. The Primary Care Physician and family were notified. The Primary Care Physician ordered urinary analysis and blood work related to elopement. [R1] was placed on one on one with a staff member."

Review of the progress note dated 07/14/21 at 10:57 AM documented "[R1] had normally been seeking exits and the behavior continued over the past months but had never actually exited and the severity was done under radar."

The "Facility Investigation" documented "staff assisted residents in the dining room and did not hear the door alarm. The Certified Nurse Aid went to the door and looked outside to the parking lot and saw no one. [R1] was located half a block away in the parking lot of an independent living

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facility south of the facility."

Certified Nurse Aid (CNA) M's 07/13/21 "Witness Statement" documented after helping another resident, she and CNA N exited that resident's room and heard both the Wander Guard alarm and the door alarm going off. CNA M documented CNA N went to the road but could not see R1. Staff then dispersed throughout the facility to look for R1. CNA M's statement lacked a timeline of events.

Licensed Nurse (LN) G's 07/13/21 "Witness Statement" documented LN G returned to the hall after R2 stated she saw R1 exit the building. LN G ran down the hall and then heard the door alarm as she got further down the hall. LN G exited the facility. R1 was not in sight at that time. R1 was found at 05:06 PM after exiting the facility at 04:45 PM. R1 returned to the facility and assessed with no injuries, her only complaint was that she was hot. LN G had not witnessed R1 attempting to elope that day, but she was found seated by the door earlier that day and the alarm had sounded.

Certified Medication Aide (CMA) R's 07/13/21 "Witness Statement" documented CMA R and LN H walked outside to "take a breath before dinner began." When CMA R and LN H returned to the back doors they ran into R1 as she tried to get out the golf course doors. CMA R turned off the alarm and redirected R1.

CNA N's 07/13/21 "Witness Statement" documented at about 04:45 PM she heard the Wander Guard and door alarm sounding. CNA N looked outside for R1 and did not see her. Upon coming in the facility CNA N and CNA M checked

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rooms, dining room, and R1's room and could not locate R1. CNA N documented everyone went outside to look for R1, who was eventually located by management staff all the way down a busy street, at another building.

CNA O's 07/13/21 "Witness Statement" documented CNA O walked towards the busy four lane road adjacent to the facility grounds , noted co-workers at the intersection, so CNA O headed south. CNA O turned into the parking lot south of the facility. CNA O noted two unidentified older women looking to their right, looking at something in the distance. CNA O saw R1 in her wheelchair to the right of the building sitting straight ahead of the turn into the parking lot. CNA O approached R1 and asked if R1 needed help. R1 reported she was looking for her house. CNA O stated she could help, and wheeled R1 back to the facility.

On 07/19/21 at 10:40 AM R1 laid in her bed on her right side with blankets pulled up over her shoulder. Staff sat in a chair in R1's room for one on one observation.

Observation on 07/19/21 at 11:40 AM revealed the locked door on the back of Brickwood hallway was noted to alarm after pressure was applied for 15 seconds. After 15 seconds, the door opened, and the alarm shut off while the door was open. When the door was pulled shut, the door alarm began to sound, no staff responded. Housekeeper U, located three rooms away from the door, stated it took a badge to shut the alarm off. Upon recognition that it was not a staff member at the door, Housekeeper U came to shut the alarm off.

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On 07/19/21 at 11:42 AM Housekeeper U stated she thought the alarm did not always work. She stated there were people in to work on the alarms last week because something did not work right.

On 07/19/21 at 12:00 PM Maintenance Staff C stated staff from the alarm company came to look at the alarm because it was not "working right" and Administrative Staff C felt a technician should look at it. The door alarms only sound at the door that has been opened and not anywhere else in the building.

On 07/19/21 at 12:40 PM an unidentified staff member stated the alarms could not be heard in the dining room when staff were serving the residents. She further stated staff could "hardly" hear the alarm at the nurse's station located in the middle of the hallway.

On 07/19/21 at 12:41 PM LN H stated the alarm was very hard to hear at the nurse's station. LN H further revealed that the elopement occurred during meal time.

On 07/19/21 at 01:35 PM Administrative Nurse D stated she felt that once R1 was missing, the staff responded appropriately. Administrative Nurse D revealed that she felt that R1 should have been handled differently prior to the elopement and it may have been prevented. She further stated when R1 was found attempting to exit the building, staff should have kept her in eyesight.

On 07/19/21 at 01:45 PM Administrative Staff B stated that when the elopement first happened, R2 stated R1 went "that way" and pointed to the door at the back of the hallway. She further revealed that when a response team comes out

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the facility to investigate the incident, the facility will look at getting a louder door alarm. Administrative Staff B revealed when staff were interviewed, it was found they reported they could not hear the door alarm until they were further down on the hallway .

The facility's policy "Quality of Care: Elopement/Unsafe Wandering" reviewed 02/2021 documented staff assisted each resident 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 facility failed to ensure Resident (R)1 received adequate supervision and failed to ensure audible door and Wander Guard alarms to prevent elopement. This placed all five residents at risk for elopement, including R1, in immediate jeopardy.

The facility abated the immediate jeopardy on 07/20/2021 at 04:50 PM by implementing the following:
One to one observation of R1
15-minute checks on the four other residents who were at risk for elopement. One staff member designated only to those four residents. Staff member move from resident to resident and document activity and location. Activities will be involved with the residents to keep them busy and engaged.
Louder alarms have been ordered for all eight exits with an expected completion date of Wednesday, July 21, 2021.Temporary alarms with very shrill sounds will be placed until the

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F 689	Continued From page 8 permanent door alarms are received. The scope and severity of the deficient practice remained at the level of an "E" to represent the risk to all five residents known to wander and at risk for elopement.	F 689		