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 _____	10/12/2020

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 A Targeted Infection Control Survey/COVID-19 Focused Survey was conducted by KDADS on behalf of the Centers for Medicare & Medicaid Services (CMS) on 10/12/2020. The facility was found to be in compliance with CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID 19. The following citations represent the findings of an abbreviated complaint survey that was also conducted on 10/12/2020 for complaint #KS00156623.	F 000		
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 identified a census of 46 residents. Based on interviews, record reviews, and observations the facility failed to ensure the safety of one Resident (R) 1 of two residents sampled for an elopement (an incident in which a cognitively impaired resident with poor or impaired decision making ability/safety awareness leaves the facility without the knowledge of staff) risk, when she left through the main entrance door. Findings included:	F 689		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 10/19/2020

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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F 689	Continued From page 1	F 689		

- R1's electronic medical record (EMR) documented diagnoses of glaucoma (abnormal condition of elevated pressure within an eye caused by obstruction to the outflow), dementia (progressive mental disorder characterized by failing memory, confusion), muscle weakness, anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), and history of falls.

R1's "Annual Minimum Data Set" (MDS) dated 01/15/20 documented a Brief Interview for Mental Status (BIMS) score of six, which indicated severe cognitive impairment. She required limited assistance with mobility. R1 used a walker and wheelchair for mobility.
She did not show have wandering behaviors.

The "Five Day MDS" dated 09/29/20 documented a BIMS score of three which indicated severely impaired cognition. She required limited assistance with mobility. R1 used a wheelchair for mobility.

The "Cognitive Loss/Dementia Care Area Assessment" dated 01/29/20 documented R1 made her needs known. She wandered through the facility in her wheelchair and was easily redirected.

The comprehensive "Care Plan" dated 05/29/19 documented R1 wandered around the facility in her wheelchair. Staff notified the nurse if she exhibited exit seeking behaviors. The "Care Plan" was revised on 10/07/20 and reflected R1 had an actual elopement related to her cognition and exit seeking behaviors. The facility provided one on one assistance until a safe discharge plan was in place.

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F 689	Continued From page 2	F 689		

Review of the elopement assessments dated 1/7/19, 4/7/19, 7/7/19, 10/7/19, 1/7/20, 4/7/20, and 7/7/20 revealed R1 was at low risk for elopement.

A nursing progress note dated 10/07/20 at 07:16 PM documented the facility's receptionist noticed the front entrance door was open, when she returned to the front desk. The receptionist checked outside and noted R1 had propelled her wheelchair to the corner of the street. R1 was returned to the facility and had no injuries due to the elopement. R1 was immediately placed on one on one supervision.

Review of the "One on One Supervision" logs reviewed from 10/07/20 through 10/12/20 at 11:00 AM revealed one on one supervision was continuing for R1's safety.

On 10/12/20 at 02:40 PM R1 rested in bed she was alert and well groomed. She stated she did not feel well today but, could not specify the reason. A staff member sat outside of her room.

On 10/12/20 at 09:40 AM facility Receptionist GG stated the reception desk, near the front entrance was manned from 08:30 AM until 08:00 PM Monday thru Friday. The front door was always closed and required a code or a staff member's identification badge to enter or exit the facility. She was unsure for the reason R1 was able to exit the building on 10/07/20.

On 10/12/20 at 11:00 AM Maintenance Staff U stated exit doors to the facility were checked for proper functioning and alarms weekly. The front door was used so often it was not checked

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F 689	Continued From page 3	F 689		

weekly since it was known to be operational. The facility did not know there was no alarm attached to the door when it was pushed long enough to open for emergencies.

On 10/12/20 at 01:06 PM Licensed Nurse G stated he was on duty at the time of R1's elopement and immediately went outside to assist in R1's condition. He did not hear an alarm. He stated exit doors required a numerical code or a staff's identification badge to open. He was unsure why an alarm was not triggered. Residents are assessed for their risk for elopement on admission and quarterly.

On 10/12/20 at 03:07 PM Administrative Nursing Staff D stated residents were assessed for elopement risk on admission and quarterly. If a resident was assessed as a high risk for elopement they would be placed on one on one supervision until a satisfactory plan was in place to prevent future elopements. The facility staff had not realized the front door did not have an alarm when it was pushed long enough to activate the emergency opening device.

The facility's "Elopement" policy dated October 2007 documented each resident's level of supervision required was assessed based on observed wandering behaviors. The facility staff ensured all exit alarms were responded to immediately.

The facility failed to ensure the safety of this cognitively impaired resident when the main entrance door opened without sounding an alarm. This failure had the potential to cause injury to R1.