

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/21/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175135	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/12/2023
NAME OF PROVIDER OR SUPPLIER MEDICALODGES POST ACUTE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 6500 GREELEY AVENUE KANSAS CITY, KS 66104		
(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 #KS00180602. On 06/12/23 at 12:452 PM Administrative Staff A received a copy of the "Immediate Jeopardy [IJ] Template" and was notified of the IJ for Resident (R)1. On 06/01/23, Transportation D dropped off R1 at the bus stop, per R1's request, after explicit instructions from Administrative Staff A to take R1 to the bank, but to keep R1 under constant staff supervision. R1 had moderate cognitive impairment, was at risk of falls, and required supervision from staff with activities of daily living (ADLs) and smoking. R1 left the facility via facility transportation to the bank at 01:19 PM on 06/01/23, accompanied by Transportation D. R1 made a statement to Transportation D regarding an idea that R1 might not return to the facility. Transportation D returned to the facility, without R1, at 02:01 PM, as verified on camera. At 03:20 PM, Administrative Staff B approached Administrative Staff A to report Transportation D dropped R1 off at a bus stop after R1 withdrew \$3000.00 in cash. Administrative Staff A called Transportation D who reported he took R1 to the bank and R1 asked for a ride to a friend's house. Transportation D stated he had a personal appointment and could not take R1 to the friend's house so R1 then asked Transportation D to drop him off at the bus stop. Transportation D complied and left R1, with no staff supervision, at the bus stop. At approximately 03:35 PM, three staff members left the facility to look for R1 and found him approximately five miles away, at 03:50 PM. R1 was drinking a pop and smoking a	F 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

06/21/2023

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 000	Continued From page 1 cigarette. R1 arrived back to the facility with staff at 04:17 PM. The facility failed to ensure staff provided the appropriate cares and supervision required for R1, who was cognitively impaired. This neglect placed R1 in immediate jeopardy. The facility completed the following corrections by 06/02/23: Transportation D was terminated on 06/01/23. A Wanderguard (device which alerts staff is resident attempts to leave through guarded doors) was placed on R1's left wrist on 06/01/23. R1's care plan was updated on 06/01/23. An emergency QAPI meeting was completed on 06/01/23. Staff education on ANE and transportation procedures was completed on 06/01/23. Maintenance changed the door codes on 06/02/23. All corrective actions were completed prior to the surveyor entrance, therefore the deficient practice was cited as past non-compliance and existed at a "J" scope and severity.	F 000			
F 600 SS=J	The 2567 was sent electronically on 06/21/23. 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.	F 600			

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F 600	Continued From page 2 §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 44 residents. The sample included three residents with one sampled for abuse and neglect. Based on record review and interviews, the facility failed to ensure Resident (R) 1 remained free from neglect when on 06/01/23, Transportation D dropped off R1 at the bus stop, per R1's request, after explicit instructions from Administrative Staff A to take R1 to the bank, but to keep R1 under constant staff supervision. R1 had moderate cognitive impairment, was at risk of falls, and required supervision from staff with activities of daily living (ADLs) and smoking. R1 left the facility via facility transportation to the bank at 01:19 PM on 06/01/23, accompanied by Transportation D. R1 made a statement to Transportation D regarding an idea that R1 might not return to the facility. Transportation D returned to the facility, without R1, at 02:01 PM, as verified on camera. At 03:20 PM, Administrative Staff B approached Administrative Staff A to report Transportation D dropped R1 off at a bus stop after R1 withdrew \$3000.00 in cash. Administrative Staff A called Transportation D who reported he took R1 to the bank and R1 asked for a ride to a friend's house. Transportation D stated he had a personal appointment and could not take R1 to the friend's house so R1 then asked Transportation D to drop him off at the bus stop. Transportation D complied and left R1, with no staff supervision, at the bus stop. At approximately 03:35 PM, three	F 600	Past noncompliance: no plan of correction required.		

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F 600	Continued From page 3 staff members left the facility to look for R1 and found him approximately five miles away, at 03:50 PM. R1 was drinking a pop and smoking a cigarette. R1 arrived back to the facility with staff at 04:17 PM. The facility failed to ensure staff provided the appropriate cares and supervision required for R1, who was cognitively impaired. This neglect placed R1 in immediate jeopardy. Findings included: - R1 admitted to the facility on 03/10/23. The "Diagnoses Tab" of R1's Electronic Medical Record (EMR) documented diagnoses of cognitive communication deficit, difficulty in walking, need for assistance with personal care, shortness of breath, and chronic respiratory failure. The "Admission Minimum Data Set (MDS)" dated 03/16/23, documented R1 had a Brief Interview for Mental Status (BIMS) score of nine, which indicated moderately impaired cognition. R9 was independent with most ADLs but needed supervision with setup help for personal hygiene. He had no falls since admission. The "Quarterly MDS" dated 05/16/23, documented R1 had a BIMS score of nine, which indicated moderately impaired cognition. R1 was independent with setup help for bed mobility, transfers, and walking; supervision with setup help for locomotion and eating; supervision with one staff for toileting; limited assistance with one staff for dressing; and extensive assistance with one staff for personal hygiene. R1 had two or more noninjury falls since last assessment.	F 600			

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F 600	Continued From page 4 The "Cognitive Loss/Dementia Care Area Assessment (CAA)" dated 03/25/23, documented R1 had short- and long-term memory deficits related to a BIMS score of nine. The "ADL Functional/Rehabilitation Potential CAA" dated 03/26/23, documented R1 was at risk for changes in ADL status/needs related to a BIMS score of nine and supervision with cares. The "Care Plan" dated 03/16/23, documented R1 was unable to independently perform ADL and directed he had episodes of urinary incontinence (lack of voluntary control over urination), and staff to check and change, as needed. The "Care Plan" dated 04/25/23, documented R1 was at risk for falls and directed staff encouraged him to change positions slowly. The "Care Plan" dated 05/17/23, documented R1 chose to smoke even though it was an identified health risk. R1 was educated on the policy and regulations regarding smoking. R1 made a choice to keep a travel pack of cigarettes with him and not to turn them into the nurses at the end of the day. The "Assessments" tab of R1's EMR revealed the following: A "Clinical Health Review," dated 03/10/23, documented R1 required supervision with smoking. A "Fall Risk Assessment," dated 04/25/23, documented R1 had a fall risk score of eight, which indicated a moderate risk for falls.	F 600			

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F 600	Continued From page 5 A "Smoking Assessment," dated 05/17/23, documented the facility maintained R1's smoking materials when not in use. In a "Witness Statement" on 06/01/23, Administrative Staff B stated on 06/01/23 at approximately 03:40 PM, she and Social Services X were in Social Services X's office talking about R1 leaving to the bank and asked if he needed to be changed in the system. Administrative Staff B then went to Administrative Nurse D's office to see what she thought should be done with his census. Administrative Staff B overheard LN G tell Administrative Nurse D that R1 went to the bank with Transportation D and Transportation D had dropped R1 off at a bus stop so he could go see some friends. Administrative Staff B then went to Administrative Staff A's office to let her know what was going on. Administrative Staff A made a phone call and told Administrative Staff B and Social Services X what bus stop R1 was dropped off at. At approximately 03:50 PM, Administrative Staff B and Social Services X left the building to find R1. Staff found R1 sitting on a bench, smoking a cigarette, and drinking a pop. Administrative Staff B stated she got out of the car and approached R1, who offered her money to give him a ride to his buddy's house. Social Services X pulled the car around and R1 got into the car, then stated he was tired of living in the facility. Once they returned to the facility, a Wanderguard (bracelet that sets off an alarm when residents wearing one attempt to exit the building without an escort) was placed on R1's left wrist. In a "Witness Statement" on 06/01/23, Social Services X stated she left the facility at 03:50 PM to look for R1. They drove down the street he was	F 600			

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F 600	Continued From page 6 dropped off at and found R1 sitting on a bench, drinking a soda, and smoking a cigarette. Social Services X and Administrative Staff B placed R1 in the car and brought him back to the facility. In a "Witness Statement" on 06/01/23, LN G stated sometime after 01:00 PM, Transportation D asked about R1 wanting to go to the bank and potentially being dropped off at another location. She stated she instructed him to speak with Administrative Staff A for direction. Staff explained the situation to Administrative Staff A as she walked up the hall. She asked what his current BIMS score was, LN G looked it up, and it was nine. Administrative Staff A told Transportation D not to leave him alone or drop him off anywhere under any circumstance. Transportation D said ok and went outside to the van with R1. He returned inside and stated R1 was asking to be dropped off at the bus stop. LN G instructed Transportation A to talk to Administrative Staff A again for guidance. LN G stated at about 02:05 PM, Transportation D returned to the facility and stated he dropped R1 off at the bus stop by a fast-food restaurant and R1 had pulled about \$3,000 out of the bank. LN G sent Transportation D back to Administrative Staff A since LN G was unaware of their prior conversation and the instructions that were given. In a "Witness Statement" on 06/02/23, Administrative Staff A stated at approximately 01:07 PM, Transportation D approached her and informed her R1 wanted to be taken to his local bank, but he had made a statement to Transportation D that he might not come back. She stated she requested LN G to look up his BIMS score which was nine. Administrative Staff A stated she told Transportation D, in front of LN	F 600			

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F 600	Continued From page 7 G, to not let R1 out of his sight, do not even let him out of the van, and to call her if he had any problems with R1. Transportation D acknowledged her direction and left the facility with R1 at approximately 01:19 PM. Administrative Staff A stated at 02:01 PM, Transportation D arrived back to the facility without R1, as verified by camera footage. At approximately 03:20 PM, Administrative Staff B approached Administrative Staff A and said R1 had been dropped off at a bus stop after pulling \$3,000 out in cash from the bank and she asked if Administrative Staff A was aware. Administrative Staff A immediately called Transportation D on his personal cellphone, as he had left the facility. Transportation D stated he was about to call Administrative Staff A and reported he had taken R1 to the bank as requested, but then R1 asked to be dropped off at a friend's house. Transportation D told R1 he had a personal appointment to get to, so he could not do that. R1 then asked Transportation D to drop him off at the bus stop and he complied. Administrative Staff A stated she immediately told Transportation D to get back to the bus stop and find R1 and that she specifically told him not to let R1 out of his sight and asked Transportation D why would he drop R1 off at a bus stop. Transportation D stated R1 was a grown man, and he could see if he left a little kid at a bus stop, but R1 was a grown man. He stated he knew he should not have taken R1 anywhere because he knew he would get in trouble. Administrative Staff A stated at approximately 03:35 PM, three staff members went to locate R1 and found him. R1 reported to Administrative Staff B that he rode the bus and that he was going to see his friends. Administrative Staff A stated at 04:09 PM, she called Transportation D back and terminated him	F 600			

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F 600	Continued From page 8 effective immediately. R1 arrived back to the facility at 04:17 PM, accompanied by staff, and was placed on one-to-one with a Wanderguard placed on his left wrist. According to the "Kansas State University Historical Weather" website, the temperature on 06/01/23 at 01:00 PM was 84.5 degrees Fahrenheit (F), the temperature at 02:00 PM was 85.0 degrees F, the temperature at 03:00 PM was 84.8 degrees F, and the temperature at 04:00 PM was 86.2 degrees F. On 06/12/23 at 09:10 PM, observation of the street where staff dropped R1 off revealed the street was very busy with a posted speed limit of 40 miles per hour (mph). According to "Google Maps," the distance from where staff dropped R1 off at the bus stop to where staff found R1 measured approximately five miles. On 06/12/23 at 12:48 PM, Administrative Staff B stated R1 signed out and went with Transportation D. Administrative Staff B stated she heard LN G, Social Services X, and Administrative Nurse D talking about how R1 went to the bank, withdrew money, then got onto a bus. She asked if Administrative Staff A knew about it and went to notify her. Administrative Staff B stated Administrative Staff A called Transportation D who reported he took R1 to the bank then dropped him off at the bus stop per his wishes. Consultant GG walked into the office at that time and said he was going to look for R1 while Administrative Staff B and Social Services X were going to look the other direction on the street where R1 was dropped off. Administrative	F 600			

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F 600	Continued From page 9 Staff B stated she and Social Services X found R1 sitting on a bench, and she got out of the car and approached R1. R1 told Administrative Staff B he would give her money to give him a ride. R1 got into the car and realized who they were and stated he was not going back to the facility. Administrative Staff B stated she told R1 to go back to the facility so they could complete the proper documentation for him to leave. On 06/12/23 at 12:57 PM, Social Services X stated she was in Administrative Staff A's office discussing where to look for R1 at and Consultant GG stated he would go to the area of the bus stop. Social Services X and Administrative Staff B drove in the opposite direction of Consultant GG on the street where R1 was dropped off at. She stated while they were driving, she looked over and saw R1 sitting on a bench. Administrative Staff B ran across the street while Social Services X pulled the car around. She stated R1 was not happy when he found out they were with the facility. On 06/12/23 at 01:40 PM, Administrative Staff A stated around 01:00 PM, Transportation D approached her and stated R1 wanted to go to the bank and had mentioned he did not know if he was going to come back to the facility. She stated she asked LN G what R1's BIMS was, and it was nine. Administrative Staff A stated she directed Transportation D to not let R1 out of his sight, take him to the bank, and call her if he had any issues to which he said ok. She stated at approximately 03:20 PM, Administrative Staff B asked her if she knew Transportation D dropped R1 off at a bus stop. She stated she immediately called Transportation D who reported that R1 wanted to be dropped off at a bus stop by the	F 600			

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F 600	Continued From page 10 fast-food restaurant. Administrative Staff A stated she told Transportation D he needed to go back and pick R1 up. She stated Consultant GG drove one direction while Social Services X and Administrative Staff B drove the other direction. Social Services X called Administrative Nurse D to report they found R1. Administrative Staff A terminated Transportation D. R1 returned to the facility and a Wanderguard was placed on R1, which he was not happy about. She stated he was placed on one-to-one supervision and his care plan was updated. Administrative Staff A stated staff were educated on abuse, neglect, and exploitation (ANE) and transportation procedures, an emergency Quality Assurance and Performance Improvement (QAPI) meeting was held, and the door codes were changed. On 06/15/23 at 10:03 PM, Transportation D stated he was taking R1 outside in a wheelchair when R1 stood up and stated he was leaving. He stated he told R1 if he left then Transportation D would get into trouble. Transportation D went inside to talk to Administrative Staff A and told her R1 was getting ready to leave and he did not want to take R1 anywhere. Transportation D stated he went back outside and R1 continued to state he was leaving so he went back inside to tell Administrative Staff A to talk to R1. He stated Administrative Staff A told him to take R1 through the drive through at the bank and he told her R1 had to go inside the bank and was able to walk so he could not stop him from getting out of the van. Transportation D stated he took him to the bank and when they got to the stop light by the fast-food restaurant, R1 got out of the van. He stated he asked R1 if he was going to come back and R1 stated he would call at 06:00 PM. Transportation D stated he did not call the facility	F 600			

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F 600	Continued From page 11 when R1 got out of the van because he was running late for his doctor's appointment and was frustrated and did not know what to do. He stated he had told the facility R1 was trying to leave, but nobody did anything and/or the facility failed to send extra staff with him to the bank. The facility's "Abuse, Neglect, and Exploitation" policy, last revised October 2022, directed neglect was defined as the failure to provide the goods and services necessary to avoid physical harm and occurred on an individual basis when a resident received lack of care in one or more areas. The "policy" defined willful as the individual acted deliberately. The "policy" directed it was the policy of the facility to treat each resident with respect, kindness, dignity, and care, and to keep them free from abuse and neglect. The facility failed to ensure R1 remained free from neglect when on 06/01/23, Transportation D dropped R1 at the bus stop per R1's request, after explicit instructions from Administrative Staff A to take R1 to the bank but to keep him under constant staff supervision. R1 had moderate cognitive impairment, was at risk for falls, and required supervision with ADLs and smoking. R1 was found by staff five miles away, sitting on a bench, drinking a soda, and smoking a cigarette. The facility failed to ensure staff provided the appropriate care and supervision required for R1, who was cognitively impaired. This neglect placed R1 in immediate jeopardy. The facility completed the following corrections by 06/02/23: Transportation D was terminated on 06/01/23. A Wanderguard (device which alerts staff is resident attempts to leave through guarded	F 600			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175135	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/12/2023
NAME OF PROVIDER OR SUPPLIER MEDICALODGES POST ACUTE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 6500 GREELEY AVENUE KANSAS CITY, KS 66104		
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F 600	Continued From page 12 doors) was placed on R1's left wrist on 06/01/23. R1's care plan was updated on 06/01/23. An emergency QAPI meeting was completed on 06/01/23. Staff education on ANE and transportation procedures was completed on 06/01/23. Maintenance changed the door codes on 06/02/23. All corrective actions were completed prior to the surveyor entrance, therefore the deficient practice was cited as past non-compliance and existed at a "J" scope and severity.	F 600			