STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175281	A. BUILDING _____ B. WING _____	C 07/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF KANSAS CITY	3231 N 61ST STREET KANSAS CITY, KS 66104

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F 000	INITIAL COMMENTS The following citations represent the findings of complaint investigation #KS00189066, KS00189092, and KS00189070. The 2567 was sent electronically on 07/22/24.	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 reported a census of 66 residents. The sample included three residents reviewed for elopement (when a cognitively impaired resident with little or poor safety awareness exited the facility without staff knowledge). Based on observation, record review, and interview, the facility failed to ensure Resident (R)1 received adequate supervision and appropriate interventions to prevent R1 from exiting the facility. This placed R1 at risk for accidents or injuries. Findings include: - R1's Electronic Medical Record (EMR), under the "Diagnosis" tab documented diagnoses of metabolic encephalopathy (condition in which brain function is disturbed either temporarily or permanently due to different diseases or toxins in	F 689		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 07/22/2024

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 body), muscle weakness, abnormalities of gait and mobility, convulsions (involuntary series of contractions of a group of muscles), hypertension (elevated blood pressure), hypotension (low blood pressure), dizziness, and anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear) disorder.

The "Admission Minimum Data Set" (MDS) dated 08/19/23 documented a Brief Interview for Mental Status (BIMS) score of 15 which indicated intact cognition. R1 required partial to moderate assistance from staff for transfers, and toileting. R1 required supervision or touch assistance with propelling in his wheelchair from staff. R1 had no behaviors and had not exhibited wandering.

The "Activities of Daily Living (ADL) Care Area Assessment" (CAA) dated 08/19/23 documented R1 admitted to the facility for therapy for strengthening related to weakness. R1 used a wheelchair for locomotion.

The "Falls CAA" dated 08/19/23 documented R1 used a wheelchair for locomotion. Staff were to encourage R1 to participate in exercises to prevent falls.

The "Quarterly MDS" dated 05/21/24 documented a BIMS score of six which indicated severely impaired cognition. R1 was independent with transfers and required supervision or touching assistance from staff with showering and propelling in his wheelchair. R1 exhibited no behaviors and did not exhibit wandering.

R1's "Care Plan" initiated 10/11/23 documented R1 had a history of attempting to leave the facility

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unattended and R1 had impaired safety awareness. R1 was added to the elopement book. Staff were directed to provide R1 safe wandering as R1 was an elopement risk. R1 had a WanderGuard (a bracelet that sets off an alarm when residents wearing one attempt to exit the building without an escort) in place, and staff were directed to document the resident's wandering behavior and attempted diversional interventions in the behavior log. Staff were directed to observe R1 for behavior episodes and attempt to determine the underlying cause for the behavior; considering location, time of day, persons involved, and situations. Staff were directed to intervene as necessary to protect the rights and safety of others. Staff were to approach and or speak calmly, divert attention, remove R1 from the situation, and take R1 to an alternate location as needed. R1's locomotion intervention revised 02/21/24 documented that R1 was able to propel himself using his wheelchair.

The "Nursing: Elopement Risk Evaluation" dated 05/15/24 documented that R1 was at risk for elopement, had a history of attempts to leave the facility unattended, and had impaired safety awareness.

The "Orders" tab recorded a physician's order on 04/02/24 to check WanderGuard placement, and function, and to check for expiration date and notified Administrative Nurse D if the WanderGuard was expired every shift.

R1's clinical record lacked any documentation of R1's elopement incident.

The "Notarized Witness Statement" dated

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07/09/24 by Licensed Nurse (LN) G documented that LN G was notified that R1 was outside in the courtyard with Certified Medication Aide (CMA) R and the door alarm was sounding. R1 was brought back into the building and taken to the side of the building R1 lived on. LN G stated she notified Administrative Nurse D. Administrative Nurse D requested LN G check R1's Wander Guard to see if it was on and working. LN G observed the Wander Guard on R1's ankle and LN G checked to verify it worked. LN G reported R1 had wandered in his wheelchair around the nurse's desk asking for cigarettes and was redirected.

The "Notarized Witness Statement" dated 07/09/24 by CMA R documented CMA R heard the door alarm sounding for about a minute or two when CMA R went to check the doors. CMA R documented she went to the front door of the building before realizing it was not that door, but the door to the back patio. CMA R turned to go to the back patio door when R2 yelled that R1 was outside the gate, and R1 was opening the gate. CMA R proceeded to go out the back patio door to and retrieved R1 from the back parking lot. CMA R stated LN G came to assist with taking R1 back into the building. LN G asked CMA R if CMA R was outside with R1, to which CMA R stated no, she was responding to the alarm.

On 07/09/24 at 04:55 PM the other gate in the courtyard, located roughly 18 steps from the back patio door, had no locking mechanism on the gate. When the gate was pushed from the inside of the courtyard the gate swung freely and revealed the back parking lot behind the building. The ground leading up to the gate was level concrete and the gate opened up to level

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pavement meeting up with the concrete.

On 07/09/24 at 01:22 PM, R1 sat in his wheelchair facing the back patio door. R1 was dressed in clean clothes and had a nasal cannula on receiving oxygen. R1 had a WanderGuard on his right ankle. R1 responded when greeted and R1 stated it was a nice day but nothing further was said when questioned. R1 continued to look out the back patio door while speaking.

On 07/09/24 at 01:53 PM LN G stated that she was called and told that R1 was in the courtyard. LN G stated that she was informed R1 had been outside the fence around the courtyard. LN G brought R1 back into the building and checked to make sure R1 was ok. LN G stated she told Administrative Nurse D that R1 was outside. Administrative Nurse D asked LN G to check if R1's Wander Guard worked. LN G called R1's family representative but did not call the physician related to LN G was waiting for further instructions from Administrative Nurse D.

On 07/09/24 at 03:45 PM Certified Nurse Aide (CNA) M stated that she recalled R1 getting out to the courtyard and going through the gate but could not recall the day it occurred. CNA M stated that CMA R had responded to the door alarm before CNA M got there. CNA M revealed this was not the only time R1 had pushed through the back patio door without staff. CNA M further revealed he had done it another day, but CNA M was outside taking a smoke break, and met R1 at the door.

On 07/09/24 at 04:35 PM Administrative Staff B stated that the door alarms go off all the time. Administrative Staff B stated R1 went out thru the

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door and R1 did go out to the parking lot. Administrative Staff B recalled CMA R going out to get R1 and the gate was open to the parking lot.

On 07/09/24 at 04:44 PM, Housekeeper U stated that anyone could open the gate leading out of the courtyard to the parking lot. Housekeeper U revealed you just grabbed the silver thing, and it would open easily.

On 07/09/24 at 04:55 PM the other gate in the courtyard, located roughly 18 steps from the back patio door, had no locking mechanism on the gate. When the gate was pushed from the inside of the courtyard the gate swung freely and revealed the back parking lot behind the building. The ground leading up to the gate was level concrete and the gate opened up to level pavement meeting up with the concrete.

The facility "Area of Focus: Elopement" policy reviewed 11/28/23 documented an elopement occurred when the resident leaves the premises or a sage area without authorization and or any necessary supervision to do so. A resident who leaves a sage area may be at risk of (or has the potential to experience) heat or cold exposure, dehydration and or other medical complications, drowning, or being struck by a motor vehicle. The facility must ensure that each resident receives adequate supervision and assistance devices to prevent accidents. When the resident is found, the charge nurse or designee will assess the resident's physical, mental, emotional, and cognitive state and notify the physician and responsible party. The resident will be monitored as deemed necessary by the interdisciplinary team. An incident (event) report will be completed

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F 689	Continued From page 6 by the charge nurse or designee to include witness statements. The facility failed to ensure R1 received adequate supervision and appropriate interventions to prevent R1 from exiting the building without staff. This placed R1 at risk for accidents or injuries.	F 689		