STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175549	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRATFORD COMMONS REHAB & HEALTH CARE CENTER	**12340 QUIVIRA ROAD , OVERLAND PARK, Kansas, 66213**

(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
F0000	INITIAL COMMENTS The following citations represent the findings of complaint investigation #2646858. The 2567 was sent electronically on 11/18/25.	F0000		
F0689 SS = SQC-J	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 53 residents, with three residents sampled for elopement risk. Based on observation, interview, and record review, the facility failed to provide adequate supervision to prevent newly admitted Resident (R) 1, who had documented intermittent confusion and exit-seeking/wandering behaviors, from leaving the facility on 10/18/25 between 05:20 AM and 05:30 AM, without staff knowledge. R1 remained outside of the facility (whereabouts unknown) for approximately five and a half hours, wearing only a hospital gown and no shoes, in approximately 65 degrees Fahrenheit temperature. Law enforcement located R1 at 10:50 AM, approximately one mile from the facility, wearing a hospital gown and no shoes. The facility discovered the South egress door was not locked and did not alarm when pushed. This deficient practice placed R1 in immediate jeopardy. Findings included: - R1 admitted to the facility on 10/16/25.	F0689	"Past Noncompliance - no plan of correction required"	

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 reverse for further 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.

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

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F0689 SS = SQC-J	Continued from page 1 R1's Electronic Medical Record (EMR) documented a diagnosis of hepatic encephalopathy (a serious brain dysfunction caused by liver failure, leading to the accumulation of toxins in the bloodstream, particularly ammonia and psychiatric changes of varying degree). R1's 10/16/25 "Care Plan" documented R1 had an activity of daily living (ADL) self-care performance deficit and required one staff assistance with transfers. R1's EMR revealed the following: A 10/16/25 "Admission Assessment" documented he was alert and oriented to person and place with intermittent confusion. A 10/16/25 "Elopement Assessment" documented R1 was not at risk for elopement. An "Orders- Administration Note" dated 10/18/25 at 04:12 AM documented R1 eloped most of the shift and went into other residents' rooms. The note documented R1 peed on the floor, staff could not re-orient him, R1 walked unsteadily, and became combative with staff. A "Situation, Background, Assessment, Recommendation (SBAR) Note" dated 10/18/25 at 06:48 AM documented R1 experienced a change in condition of eloping. The note documented Licensed Nurse (LN) G last saw R1 between 05:15 AM and 05:30 AM when a Certified Nurse Aide (CNA) redirected R1. CNA N reported to LN G she could not find R1 and the facility immediately conducted a head count. LN G documented he and the CNAs checked around the facility and parkway. LN G notified Administrative Nurse E of the incident. The oncoming staff, Certified Medication Aide (CMA) R, searched in the neighborhood. The police arrived around 06:10 AM and asked the facility to continue to search inside while they searched the neighborhood. In a "Health Status Note" dated 10/19/25 at 12:36 AM, LN G documented he received shift report that R1 had been wandering and exit seeking. LN G documented earlier in the shift staff found R1 in a nearby room, where R1 unclothed himself. LN G and staff took R1 to the bathroom and redirected R1 to his room. LN G documented R1 could not stay in one place and whenever staff put socks or briefs on R1, R1 took them off. Staff found R1 in different resident rooms and the staff tried various activities to help R1 including walking R1 in the hallway, keeping R1 where the CNA sat, rehydrating R1, and reading bulletins in the activity room; but none were effective. LN G documented he tried to notify the clinical on-call, without	F0689		

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F0689 SS = SQC-J	Continued from page 2 answer. When the routine activity ended around 11:00 PM, LN G administered medication to R1 which helped him sleep for an hour. LN G witnessed R1 exit seeking on two occasions, and LN G redirected R1 and walked with him down the hall. The note revealed R1 was not communicative and became combative on one occasion, as reported by CNA N. LN G documented he notified Administrative Nurse E of the incident and he called the police while LN H called R1's representative around 05:47 AM. The facility's 10/23/25 "Investigation" documented on 10/18/25 at around 05:20 AM, CNA M last observed R1 in the northwest corner of the facility, sitting in the family area by the breakroom. R1 wore a (hospital) gown, no socks, and no shoes. LN G reported R1 had been wandering the facility throughout the night and staff attempted re-direction with hands-on activities and taking R1 back to his room, without success. The investigation documented the temperature was 67 degrees Fahrenheit and R1 wore a gown at the time of his departure. The investigation documented the following timeline on 10/18/25: Between 05:20 AM to 05:30 AM, CNA N noticed R1 was not sitting in the same area and immediately started a search. At 05:30 AM, LN G, LN H, CNA M, CNA N, and CNA O conducted an interior search of the facility. CNA N checked all of the rooms, bathrooms, doors, courtyard, and therapy rooms. At 05:40 AM, LN G, LN H, and CNA N conducted an exterior search of the facility. CNA N checked the parking lot of the apartments south of the facility. At 05:45 AM, CNA O drove around the neighborhood including the apartment complex south of the facility for about 20 to 25 minutes. At 05:47 AM, LN G notified law enforcement. At 05:50 AM, CNA M searched the perimeter of the community. At 05:56 AM, LN G notified Administrative Staff A and Administrative Nurse D. At 06:00 AM, CNA N did another exterior check of the facility. CMA R checked all bedrooms, bathrooms, under the beds, in closets, and doors. She walked through the laundry room to assisted living (AL) and also checked the AL unit.	F0689		

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F0689 SS = SQC-J	Continued from page 3 At 06:01 AM, LN H notified R1's representative. At 06:11 AM, Administrative Staff A spoke to R1's representative. At 06:30 AM, Administrative Staff A drove around the neighboring housing development to the southwest of the facility and around the nearby gas station. She drove around for 10 to 15 minutes. At 07:00 AM, Administrative Nurse D drove up and down the street in front of the facility for about 20 minutes. Around 08:00 AM, dispatched notified the facility they contacted all hospitals. At 08:30 AM, Administrative Nurse E notified Consultant GG. At 09:00 AM, Administrative Staff A notified R1's other listed representatives. At 09:45 AM, law enforcement notified the facility they had a drone searching for R1 and were dispatching four-wheelers in the search. At 10:50 AM, law enforcement notified Administrative Staff A they located R1 and transported him to the emergency room (ER) for evaluation. The facility notified Consultant GG that law enforcement found R1 and transported him to the ER for evaluation. At 11:11 AM, Administrative Staff A notified R1's representative that law enforcement located R1 and transported him to the ER for evaluation. At 11:14 AM, the facility spoke to the ER for an update on R1. At 04:43 PM, the ER notified the facility they transferred R1 to another hospital for an admission related to gastrointestinal concerns. At 04:54 PM, the facility notified Consultant GG that R1 transferred to another hospital for admission. According to the "Kansas State University Historical Weather" website, the temperature on 10/18/25 between 05:00 AM and 11:00 AM ranged between 63.9 degrees Fahrenheit and 75.3 degrees Fahrenheit. Review of "Google Maps" revealed the distance from the	F0689		

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F0689 SS = SQC-J	Continued from page 4 facility to the intersection law enforcement found R1, was between 0.8 mile to 1.1 miles. CNA M's untitled notarized statement, dated 10/18/25, stated she saw R1 walk up the hall at 05:15 AM and she walked him over to take a seat, since R1 would not stay in his room. CNA M stated he sat down and by 05:30 AM, R1 was missing. She stated they walked through every room and bathroom to search for R1 by 05:46 AM. She stated they searched outside and could not find R1. CNA M stated by 05:50 AM, the facility called the police and R1's representative, while staff continued searching for R1. CNA O's untitled notarized statement, dated 10/18/25, stated when he found out R1 was gone, CNA O stopped doing his rounds and looked for R1. He stated staff went room to room, looked in every bathroom, and all around the building with no signs of R1. CNA N's notarized "Witness Statement," dated 10/18/25, stated she re-entered the facility from taking out the trash around 05:30 AM. She stated she opened up R1's door to his room and did not see R1. CNA N stated she checked all of her rooms and did not find R1. She stated she let the nurse and other staff know, then they conducted a full search inside and outside the building but did not find R1. CNA N stated around 05:45 AM to 05:50 AM, the facility notified R1's representative and police, while staff continued searching for R1. LN H's notarized "Witness Statement," dated 10/18/25, stated she remembered seeing R1 in a gown walking in the hallways. She stated around 05:15 AM, she saw LN G searching for R1 in the building. LN H stated the facility searched in all resident rooms and bathrooms at least five times. She stated the staff checked the courtyard outside, inside the kitchen areas, inside the extra kitchen rooms, resident rooms again, employee bathrooms, the printer room, and the entrance to the memory care unit. LN H stated night and day shift staff drove in their cars around the facility property and to the apartment complexes to look for R1. She stated LN G asked her to call R1's representative while he called Administrative Nurse E. LN H stated she notified R1's representative of the situation, and he understood. LN G's notarized "Witness Statement," dated 10/18/25, stated he last saw R1 around 05:15 AM and 05:20 AM by the back breakroom. He stated after a couple of minutes, one of the CNAs redirected R1 to his seat. LN G stated within five minutes, while he came from another resident's room, the CNA notified him she could	F0689		

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F0689 SS = SQC-J	Continued from page 5 not find R1. LN G documented staff immediately checked for R1 in all the residents' rooms since they had found R1 in other resident rooms before. LN G stated staff checked outside for R1, switched halls, then rechecked rooms but they could not find R1. LN G documented he notified Administrative Nurse E and called the police around 05:47 AM. LN G stated that other CNAs drove in the neighborhood to look for R1. He stated the police and administration arrived at the facility in about 20 to 30 minutes. During an observation on 10/23/25 at 12:50 PM, the South egress door had a solid red light on the handle. Administrative Staff A stood beside the South egress door, while the door was pressed, and the door immediately sounded with short beeps. After approximately 15 seconds, the door alarm changed to a sustained tone and the door opened when pushed. Administrative Staff A put a key into the door and unlocked it, and the light changed to green; and when she locked the door, it returned to a solid red light. During an observational drive on 10/23/25 at 01:22 PM, revealed two possible paths R1 traversed when he left the facility. In the first possible route, R1 could have walked on the sidewalk beside the busy street in front of the facility, which had a posted speed limit of 45 miles per hour (mph) and two lanes of traffic for each direction. The other possible route R1 could have walked had a couple of streets with posted speed limits of 25 mph to 30 mph. Observation of the street in which law enforcement found R1 revealed a posted speed limit of 25 mph and had multiple areas of missing sidewalk and construction equipment/supplies noted in the street. On 10/23/25 at 03:28 PM, R1's representative stated R1 remained in the hospital and had no injuries from the elopement. R1's representative stated he had difficulty judging R1's cognition, because one moment R1 made sense and the next moment he said something out of left field. On 10/23/25 at 03:15 PM, CNA P stated she found elopement risk residents in the Kardex (a nursing tool that gives a brief overview of the care needs of each resident), and if a resident had dementia (a progressive mental disorder characterized by failing memory and confusion), she kept an extra eye on them. CNA P stated she asked the nurse about elopement risks for newly admitted residents. CNA P stated if a resident started exit seeking or wandering, she tried to remove them from the exit and reassured them of their safety in the facility. She stated she notified	F0689		

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F0689 SS = SQC-J	Continued from page 6 the nurse of exit-seeking or wandering behaviors; and at nighttime, she let any staff know to have an extra set of eyes on the resident. CNA P stated she worked with R1 one day during his admission, and she could tell he had some wandering behaviors. She stated she encouraged him to sit in an open area for staff to keep tabs on him, and at the nurses' station to distract him with a snack. CNA P stated R1 never went to any of the doors or tried to open any doors, but he walked around the dining room, then back and forth to the nurses' station. She stated she let R1 walk around, since he maintained his independence, but she kept an eye on him. CNA P stated if R1 had gone to a door, she would have attempted to redirect him away from the exit and reassured him he was safe and warm in the facility. She stated staff distracted R1 with a football game, a snack, a drink, or a word puzzle. She stated if she heard a door alarm go off, she would radio and ask what happened, then check the doors. CNA P stated if she could not find a resident, she immediately searched the whole hallway and accounted for all her residents, while looking for the missing resident. She stated she notified the nurse, called a code yellow (which stood for missing resident) and initiated a head count of all residents. She stated that if staff did not find the missing resident, then the facility notified the police. On 10/23/25 at 03:32 PM, LN I stated the elopement book contained residents at risk for elopement and the residents' charts listed elopement risks. LN I stated management notified staff of elopement risks for new admission residents, or he received report from the hospital prior to their admission. LN I stated if a resident started wandering around without being in the elopement book, the facility put the resident in the elopement book. LN I stated he saw R1 one time last week, and R1 engaged in activities without any exit-seeking behaviors at that time. LN I stated if he could not find a resident, he would notify all staff to drop what they were doing and search for the resident. He stated if staff could not find the missing resident, the charge nurse delegated a staff member to check around the building. He stated if they did not find the resident, the facility would notify the police, the resident's family, and administration. LN I stated if he heard a door alarm go off, staff checked the surrounding areas and hopefully found whoever went out the door. He stated the nurses used to have a key to turn off the alarm and immediately re-engage the alarm. LN I stated the process to unlock the door to reset the alarm, now included calling Administrative Staff A to get the code to get the key out of the lock box in the medication room. He stated if a resident started having	F0689		

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F0689 SS = SQC-J	Continued from page 7 exit seeking or wandering behaviors, he would notify management and update the chart. LN I stated facility staff provided redirection with activities, a snack or drink, or had the resident work on something next to the nurse. He stated staff increased supervision of the residents who wandered and had CNAs look in their rooms every time they walked by. On 10/27/25 at 11:42 AM, CNA M was not available for an interview. On 10/27/25 at 12:37 PM, LN G was not available for an interview. On 10/23/25 at 04:30 PM, Maintenance Staff U stated he checked the doors every week and had checked the South egress door on 10/17/25. He stated the South egress door remained active, and staff typically did not use that door. On 10/23/25 at 03:51 PM, Administrative Nurse D stated staff knew the elopement risk residents by the elopement risk binder and the Kardex. Administrative Nurse D stated if a resident had wandering or exit-seeking behaviors, the administration talked about the residents in the morning meetings and put interventions into their care plans. She stated staff offered R1 activities, puzzle find books, cards, television, music, taking him back to his room, a quiet and calm environment, and talking with R1. Administrative Nurse D stated if staff could not find a resident, she expected staff to notify the charge nurse, and the charge nurse immediately started a facility head count, then searched inside the facility. She stated if the staff could not find the resident, they checked every door, bathroom, cubby or crevice, courtyard, and outside the facility. Administrative Nurse D stated staff kept a timeline of events and notified Administrative Staff A and Administrative Nurse D, and if they did not find the resident, staff notified police. Administrative Nurse D stated she believed the facility staff handled R1's situation and notified her when he eloped. On 10/23/25 at 12:52 PM, Administrative Staff A stated on 10/18/25 around 06:00 AM, she received a call that staff could not find R1, and they continued their search for him. She stated she and Administrative Nurse E arrived at the facility and immediately searched inside and outside of the building. Administrative Staff A stated she looked at the doors to see which door he would have exited from and found the South egress door unlocked. She stated she removed all of the keys from the nurse's station and locked a key in a	F0689		

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F0689 SS = SQC-J	Continued from page 8 lock box in the medication room that required a code to open it. Administrative Staff A stated only three people had the code, and the nurse had to call one of them to get the code. Then the code changed each time staff accessed the box. She stated on 10/18/25, the facility continued to search for R1 and maintained constant communication with the police. Administrative Staff A stated multiple staff members drove around and kept searching for R1. She stated she received report R1 had wandered in the facility during the two days he was admitted to the facility. She stated R1 was alert and oriented with mild confusion. The facility's "Elopement" policy, approved September 2025, directed the facility to provide residents at risk for elopement with at least one of the following: door alarms on facility exits, a personal safety device to alert staff when the resident left the building, or staff supervision. The policy directed at no time shall a personal safety alarm or door alarm be turned off without the continual supervision of the exit. On 10/23/25 at 04:30 PM, Administrative Staff A was presented with the Immediate Jeopardy (IJ) Template and notified the facility failure to provide adequate supervision to prevent the elopement of newly admitted R1 on 10/18/25, constituted immediate jeopardy at F689. The immediate jeopardy at F689 also constituted Substandard Quality of Care at 42 CFR 483.25. The facility identified, implemented, and completed the following corrective measures: 1. Administrative Staff A audited all egress doors and found the South egress door unsecured on 10/18/25. 2. The facility conducted an "Ad Hoc- Quality Assurance and Performance Improvement (QAPI) meeting" on 10/18/25. 3. The facility audited all residents for elopement evaluations on 10/18/25. 4. The facility educated staff on elopements, abuse, neglect, and exploitation (ANE), and egress doors on 10/18/25. 5. Maintenance evaluated and assessed all facility egress doors on 10/18/25. 6. Administrative Staff A removed all alarm door keys and placed them in a lock box in the medication room that required a code from designated staff to open it on 10/18/25.	F0689		

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F0689 SS = SQC-J	Continued from page 9 7. The facility started door audits on 10/18/25 and continued them two to three times daily. 8. The facility conducted an elopement drill on 10/20/25 and scheduled additional elopement drills through January 2026. Due to the facility completion of all corrective actions prior to the onsite visit, the deficient practice was deemed past noncompliance at a scope and severity of a “J” (isolated, immediate jeopardy).	F0689		