STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175548	A. BUILDING _____ B. WING _____	C 12/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HEALTHCARE RESORT OF KANSAS CITY	8900 PARALLEL PARKWAY KANSAS CITY, KS 66112

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F 000	INITIAL COMMENTS The following citations represent the findings of complaint investigation and partial extended survey #KS00167823. On 12/15/21 at 03:51 PM the facility was provided a copy of the "Immediate Jeopardy (IJ) Template" and was notified of the IJ for Resident (R) 1. The facility failed to provide adequate supervision for R1, who was independent with ambulation in a wheelchair. She was at high risk for elopement, had poor safety awareness and a Brief Interview for Mental Status score of two which indicated severely impaired cognition. On 12/12/21 at approximately 05:50 PM R1 exited the facility without staff knowledge or supervision. Facility staff were alerted, by a facility visitor, that R1 was outside the facility, alone, in the parking lot. This deficient practice placed R1 in Immediate Jeopardy. The facility removed the immediacy on 12/15/21 at 05:00 PM and the deficient practice remained at a scope and severity of a "D'. The 2567 was sent electronically to the facility on 12/20/21.	F 000		
F 689 SS=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	F 689		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 12/20/2021

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accidents.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 50 residents. The sample included seven residents identified at risk for elopement (when a cognitively impaired resident leaves the facility without staff knowledge). Based on record review, observation, and interview the facility failed to provide adequate supervision and appropriate interventions to prevent an elopement. Resident (R)1, who mobilized independently in a wheelchair, with poor cognition and identified at high risk for elopement, exited the facility on 12/12/21 at 5:50 PM without staff knowledge or supervision. A facility visitor alerted facility staff that R1 was outside the facility, alone in the parking lot. This deficient practice placed R1 in Immediate Jeopardy.

Findings included:

- R1's electronic medical record (EMR), under the "Diagnosis" tab, listed diagnoses of cognitive communication deficit (problems with communication with an underlying cause in a cognitive deficit rather than a language or speech deficit), asthma (a condition wherein a person's airways become inflamed, narrow and swell, producing extra mucus, which makes it difficult to breathe), arteriosclerotic heart disease (a thickening and hardening of the hearts arterial walls caused by cholesterol deposits, and calcification) and stage three chronic kidney disease (a gradual loss of kidney function and the body's ability to filter blood).

The "Annual Minimum Data Set" (MDS) assessment dated 10/27/21 documented the

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resident had a Brief Interview for Mental Status score of two which indicated R1 had severely impaired cognition. The MDS documented the resident had instances of wandering behavior during the assessment period. R1 ambulated with the use of a wheelchair and received anti-depressant medication.

The 10/27/21 "Cognition Care Area Assessment" (CAA) recorded R1 was hard of hearing, but could hear if the speaker raised their voice volume. The CAA recorded R1 continued to wander at times and could be easily redirected.

The "Elopement Risk Assessment" on admission, dated 10/16/20 documented a score of 16 which indicated R1 was at high risk for elopement.

The "Elopement Risk Assessment" dated 11/11/21 documented a score of 11 which indicated R1 was at high risk for elopement.

The resident's "Care Plan" dated 10/17/21 recorded R1's cognitive status, functional abilities, medication use, nutritional, and other care needs. It identified R1's risk status for falls and skin disruptions. The "Care Plan" lacked documentation to address R1 was at high risk for elopement and lacked interventions to prevent elopement.

Review of the "Nurses Progress Notes" in R1's EMR documented R1 demonstrated exit seeking behavior on the following dates: 10/18/20 at 05:52 AM, 10/21/20 at 01:30 PM, and 08/28/21 at 12:33 AM.

A "Nurses Progress Notes" dated 12/12/21 at 05:50 PM recorded (unidentified) facility staff

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were alerted a resident was "outside in the parking lot." The unidentified staff responded and R1 was brought back into the facility. Staff informed R1's emergency contact person who expressed dissatisfaction and inquired when R1 exited the facility. The staff member informed R1's emergency contact person it was unknown at that time when R1 left the facility.

Review of the "Facility Report" documented on 12/12/21 at approximately 05:50 PM, revealed an unidentified family member called the facility and reported there was a resident out in the front parking lot in a wheelchair and staff responded. The report noted R1 had a dinner plate with food on her lap. Camera footage revealed R1 was outside approximately three minutes. This same report documented the weather outside was between 50 and 55 degrees Fahrenheit (F).

According to https://www.wunderground.com/history/daily/us/mo/kansas-city/KMCI/date/2021-12-12 the temperature on 12/12/21 at 05:53 PM was 45 degrees F.

Review of the facility's video surveillance from 12/12/21 revealed the following timeline:
05:44 PM: a car pulled up or past the facility entrance.
05:45.54 PM Certified Medication Aid (CMA) P used a key card and entered the building.
05:46.10 PM R1 appeared in a wheelchair, moving slowly through the inner door to the outside foyer.
05:46.50 PM R1 passed thru the inner door, foyer, and outer door and was completely outside the facility.
05:49.15 PM an unidentified male entered the

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building.
05:50.02 PM facility staff exit the facility through the front door.
05:50.44 PM facility staff return withR1 to inside the facility.
R1 was outside the facility without supervision for at least three minutes and 52 seconds.

In an undated "Witness Statement" CNA N documented at 05:30 PM R1 sat by the door, like always.

In an undated "Witness Statement" CNA O documented at 05:50 PM staff observed R1 leaving the dining room with her plate of food. R1 headed toward the front of the building.

In an undated "Witness Statement" Licensed Nurse (LN) M documented at 05:50 PM staff were "notified by a family member a wheelchair resident was in the parking lot. Staff immediately went outside and brought the resident back in." LN M spoke with R1's emergency contact, who was very upset. Further inquiry revealed a different (unidentified) staff member noted R1 by the receptionist desk at approximately 05:30 PM. R1 had been out of the facility, with her family, and had returned at 05:00 PM. Shortly after R1's family member left, R1 self-propelled her wheelchair in the hallway toward the facility dining room.

On 12/15/21 at 08:30 AM observation of the facility parking lot, where R1 traveled, revealed numerous hazards such as changing slopes, concrete curbs, asphalt, shrubbery, landscape rock, and a drive-up entrance to the facility. There is also close proximity to a busy four lane roadway where traffic moved at 35 miles per

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hour.

On 12/15/21 at 02:10 PM R1 sat in the dining room seated with another resident. Staff encouraged R1 to participate in a bingo game.

On 12/15/21 CMA P was unavailable for interview.

Interviewed on 12/15/21 at 12:54 PM Administrative Nurse D stated R1's main objective was not to exit the facility, but acknowledged that R1 did wander about the facility and liked to sit in the lobby near the reception desk. Administrative Nurse D could not say why R1's "Care Plan "did not have interventions for exit seeking behaviors prior to 12/15/21. She further stated preventative measures included photographs of elopement at risk residents placed at the nurse's desks and receptionists' desk and speaking to the families to develop alternate activities. Nurse D noted there was an "agency nurse" assigned to R1 at the time of elopement.

Interviewed on 12/15/21 at 01:03 PM Administrative Staff A stated she expected staff to use the elopement risk assessment located in the computer software and develop a plan of care to address elopement risk, documented on the "Care Plan." Administrative Staff A said she expected all staff on duty to be cognizant of, and accountable for, residents at risk for elopement.

Review of the facilities "Safety Program For Wandering Dementia Resident's" policy dated December 2021 recorded: Each resident was to be assessed immediately upon admission for potential wandering or elopement. The elopement

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wandering UDA was to be completed and it was to be determined if the resident was a wandering/elopement risk .

The facility failed to provide adequate supervision and appropriate interventions to prevent R1, who was identified at high risk for elopement and diagnosed with impaired cognition, from exiting the facility in the evening of 12/12/21. At approximately 05:50 PM R1 exited the facility, alone and without the knowledge of facility staff, through the front door. This deficient practice placed R1 in immediate jeopardy for potential accidents and/or life threating injury.

The deficient practice was abated on 12/15/21 at 05:00 PM when the facility implemented the following corrective actions:
R1 was placed on 15-minute checks. Facility staff had to verify and ensure R1 was safe. This practice would continue for an undetermined amount of time.
All residents were evaluated to ensure potential elopement risks were identified.
Elopement books at each nurse's station and front desk were updated with all current information regarding residents at risk for elopement in the facility.
The "OWL Program" was initiated. This ensured that all residents at risk for elopement were monitored for safety and wellbeing. An owl picture was placed on the back of the wheelchair, front of walkers and outside of resident's rooms who were identified as elopement risks so all staff would be constantly aware of residents at risk for elopement.
All staff were in serviced on 12/15/21 on elopement risk, and processes in place to ensure resident safety.

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F 689	Continued From page 7 The deficient practice remained at a scope and severity of a "D"	F 689		