

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265167	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/27/2025
NAME OF PROVIDER OR SUPPLIER Highland Rehabilitation & Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 904 East 68th Street Kansas City, MO 64131	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide adequate supervision of residents to prevent accidents. Facility staff failed to develop and implement interventions for one resident (Resident #8) who was at risk of elopement and who made statements regarding his/her intent to leave. The facility failed to ensure adequate supervision of residents during the smoke break, resulting in the resident not returning into the building at the end of the break. The resident climbed a fence and pushed him/herself off the ledge from the second floor smoke deck and broke his/her left tibia with a compound fracture which required immediate surgery and will require a second surgery. The facility census was 136.</p> <p>On 3/27/25 the Administrator and Director of Nursing (DON) were notified of past non-compliance Immediate Jeopardy (IJ) which occurred on 3/24/25. On 3/24/25 the facility administrator was notified of the incident and the investigation was started. The resident was sent to the hospital for evaluation and treatment. Staff were reeducated immediately. The IJ was corrected on 3/24/25.</p> <p>Review of the facility's Smoking Policy, dated December 2024, showed all residents will be supervised when they smoke.</p> <p>Review of the facility's Elopement Policy, dated December 2025 showed:</p> <ul style="list-style-type: none"> -It is the policy of the facility that all residents are afforded adequate supervision to provide the safest environment. -All residents identified will have these issues addressed in their individual care plans. -All staff are responsible. -Wandering defined as aimless travel within the facility and enclosed courtyard areas. -Residents who are at risk for elopement shall be provided with at least one of the following safety precautions by the facility. --Door Alarms on facility exits. --A personal safety device that will alert facility staff when the resident had left the building without supervision. <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>--Staff supervision.</p> <p>-Should a resident attempt an elopement, a review of their individualized care plan shall be triggered for possible changes in care practices of safety precautions for that resident.</p> <p>Review of Resident #8's admission Record showed he/she was admitted to the facility on [DATE] with the following diagnoses:</p> <p>-Schizophrenia (a chronic mental illness that interferes with a person's ability to think clearly, to distinguish reality from fantasy, to manage emotions, make decisions and relate to others).</p> <p>-Bipolar disorder (a mental health condition causes extreme mood swings that include emotional highs, called mania and lows, known as depression).</p> <p>-Depression (a mental health condition characterized by persistent feelings of sadness, loss of interest, and low energy levels that can significantly impact daily life).</p> <p>-Attention-deficit/hyperactivity disorder (ADHD - a mental health disorder that includes a combination of persistent problems, such as difficulty paying attention, hyperactivity and impulsive behavior).</p> <p>-Anxiety disorder (a mental health condition characterized by excessive, persistent, and often irrational worry, fear, and nervousness).</p> <p>-Stimulant: Methamphetamine (a highly addictive central nervous system stimulant), cocaine (highly addictive for the nervous system) and ecstasy (a drug that affects the brain's chemistry by releasing a high level of serotonin, which plays a role in regulating mood, energy level and appetite) abuse</p> <p>Review of the resident's Preadmission Screening and Resident Review Level II (PASRR - provides a comprehensive review of the resident's past and current behavioral health conditions and the services needed to ensure their health and safety) evaluation, dated 10/8/24, showed the following Psychiatric diagnoses:</p> <p>-Schizophrenia.</p> <p>-Bipolar disorder.</p> <p>-Anxiety disorder.</p> <p>-ADHD disorder.</p> <p>-Unspecified Psychosis not due to a substance or known physiological condition.</p> <p>-Cannabis use disorder.</p> <p>-Severe methamphetamine use disorder.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>--While outside Resident #8 darted out from the side of the building startling Resident #11.</p> <p>--Resident #8 told Resident #11 that he/she was going to jump the fence.</p> <p>--Resident #11 told Resident #8, you don't want to do that; you will hurt yourself.</p> <p>--Resident #8 took off running and jumped onto the fence.</p> <p>--While out smoking Resident #11 alerted staff the Resident #8 had jumped the fence.</p> <p>--Maintenance worker A alerted the management team of an event occurring in the front outside of the building.</p> <p>--Maintenance worker A reported that while he/she was going to his/her vehicle Certified Nurse Aide (CNA) C who was outside yelled out wait, wait, stop and was pointing up.</p> <p>--Maintenance worker A looked up and saw Resident #8 on the ledge of front of the building, dangling from the fence on the 2nd floor.</p> <p>--Resident #8 then jumped backwards onto the sidewalk of the parking lot.</p> <p>-The findings for this event:</p> <p>--There was no supervision of residents during the smoke break.</p> <p>--Resident #8 did not return into the building at the end of the break.</p> <p>--Resident #8 hid on the side of the building out of view as other residents returned into the building.</p> <p>--Once everyone was in the building Resident #8 jumped the fence from the 2nd floor attempting to elope, but was not successful.</p> <p>Review of the resident's Health Status Note, dated 3/24/25 at 12:54 P.M., showed:</p> <p>-Resident #8 went out for smoke break.</p> <p>-Residents came back in the building after smoke break was over.</p> <p>-Resident #8 hid out and waited for everyone to come back in.</p> <p>-Resident #11 had came out a little later due to ear drops.</p> <p>-Resident #11 stated that he/she seen Resident #8 come from the side and climb the fence and jump.</p> <p>-Resident #11 went looking for staff and finally found the Registered Nurse (RN) A and notified RN A.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>-Resident #8 expressed to him/her that he/she was going to jump over the fence several times in the last month.</p> <p>-He/she reported this to his/her charge nurse, LPN B.</p> <p>-Resident #8 did not get any extra monitoring after notifying the charge nurse, LPN B.</p> <p>Review of Resident #11's annual MDS, dated [DATE], showed he/she was cognitively intact.</p> <p>During an interview on 3/26/25 at 3:21 P.M., Resident #11 said:</p> <p>-He/she got out to 9:30 A.M. smoke break late.</p> <p>-When he/she arrived, there was no staff on the second-floor smoke deck monitoring residents.</p> <p>-He/she stayed on the smoke deck after all the other residents went back inside to finish smoking without supervision.</p> <p>-Resident #8 came up to him/her and said that he/she was going to jump over the fence.</p> <p>-He/she tried to talk Resident #8 out of going over the fence, telling Resident #8 he/she would get caught.</p> <p>-Resident #8 ran and jumped over the fence on the second-floor smoke deck anyway.</p> <p>-He/she was traumatized from Resident #8 jumping over the fence, because he/she was unsure if Resident #8 was dead or alive.</p> <p>-He/she ran into the facility to find RN A and tell RN A Resident #8 jumped over the fence.</p> <p>-No staff member was on the smoke deck at the time Resident #8 jumped over the fence.</p> <p>During an interview on 3/27/25 at 11:45 A.M., Certified Medication Technician (CMT) A said:</p> <p>-Resident #11 was the only resident on the smoke deck at the time of the incident.</p> <p>-He/she was passing medications while the residents were on smoke break.</p> <p>-He/she would have expected staff to always be with the residents on the smoke deck.</p> <p>During an interview on 3/27/25 at 12:40 P.M., LPN A said:</p> <p>-He/she was the charge nurse on shift when Resident #8 jumped over the fence on the second-floor smoke deck.</p> <p>-He/she saw the resident when they went out on a smoke break.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>-He/she thought agency CNA B would go out on the smoke deck and monitor the residents while they smoked, since agency CNA B was following him/her when he/she unlocked the door to the smoke deck.</p> <p>-He/she had not told CNA B to monitor the residents on smoke break.</p> <p>-He/she was unsure of the smoking policy.</p> <p>-He/she was doing a treatment on another resident in that resident's room at the time Resident #8 jumped over the fence.</p> <p>-Resident #11 came and found him/her and reported that Resident #8 had jumped over the fence to the ground below.</p> <p>-He/she should have made sure a staff member was out on the smoke deck.</p> <p>-That staff that are responsible for supervising residents during a smoke break is any staff on shift on the floor who were not assigned to the 1 to 1's as they had 2 staff sitting with 2 different residents that day. CMT was passing meds and another CNA were out of the building on an appointment with a resident. That left 2 CNAs and LPN A responsible for watching the residents.</p> <p>During an interview on 3/27/25 at 2:03 P.M., Agency CNA B said:</p> <p>-On 3/24/25 around 9:30 A.M., he/she decided to take his/her morning break and was not watching the residents on the smoke deck.</p> <p>-He/she watched LPN A pass out cigarettes to the residents who smoked, but he/she had not been told to watch the residents during the smoke break.</p> <p>-He/she saw the resident when they went out on a smoke break.</p> <p>-He/she had his/her back to the window overlooking the smoke deck by the door.</p> <p>-He/she did not know a resident had jumped until LPN A said they had.</p> <p>During an interview on 3/27/25 at 2:30 P.M., CNA C said:</p> <p>-He/she was on break in his/her car in the parking lot.</p> <p>-He/she saw Resident #8 on the ledge of the second-floor smoke deck.</p> <p>-He/she yelled at Maintenance worker A, because he/she was closer to the resident.</p> <p>-Resident #8 jumped before either of the staff could get to the resident.</p> <p>-Smoke deck doors are always to be locked unless residents are out smoking with supervision.</p> <p>During an interview on 3/27/25 at 2:47 P.M., Maintenance worker A said:</p> <p>(continued on next page)</p>		

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