STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265308	A. Building B. Wing	09/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
New Mark Rehab and Healthcare Center	11221 North Nashua Drive Kansas City, MO 64155

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)
F 0658 Level of Harm - Actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. (continued on next page)

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Actual harm Residents Affected - Few	Based on observation, interview and record review the facility failed to ensure appropriate wound dressing orders were obtained and in place for one resident (Resident #2), when a negative pressure wound dressing (Wound Vac) was left in place from September 9, 2025 until September 19, 2025, causing the wound to open and bleed excessively when the dressing was removed. This effected one of four sampled residents. Facility census was 152.Review of the facility provided policy titled, Wound Management, dated October 24, 2022 showed:-Purpose is to provide a system for treatment and management of residents with wounds including pressure and non-pressure ulcers; -A resident who has a wound will receive necessary treatment and services to promote healing, prevent infection and prevent new pressure ulcers from developing; -A licensed nurse will perform a skin assessment upon admission, readmission, weekly and as needed for each resident, and implement a wound treatment per physician's order;-Per attending physician order the nursing staff will initiate treatment. Review of Resident #2 Quarterly Minimum Data Set (MDS: a federally mandated assessment tool completed by facility staff) dated,9/2/25, showed:-Brief Interview for Mental Stats (BIMS) of 12, indicated very mild cognitive loss; -No refusal of cares;-Moderate to Maximum assistance of staff for Activities of Daily Living (ADLs: tasks completed in a day to care for oneself);-Surgical wound;-Use of pressure reducing devices for the chair and the bed.-Diagnoses included: Left below the knee amputation (BKA), a surgical removal of the left lower leg below the knee, Parkinson's Disease, peripheral vascular disease (PVD, a condition that reduces blood flow to the legs). Review of the Resident's Comprehensive Care Plan updated 9/9/25 showed and order dated 9/9/25 for wound/incision care -Negative Pressure wound therapy to left BKA, cleanse with normal saline, apply granufoam (a special wound dressing to be used with negative pressure wound therapy) to wound beds, attach at 125 millimeters (mm) mercury (HG) secured with gauze.Review of Resident #2's physician orders showed and order dated 9/16/25 as no order for wound vac or wound vac change September 9, 2025 to September 16, 2025.Review of the resident's progress notes showed:-9/10/2025 at 11:15 A.M. wounds to left BKA, wound vac applied, pressure set to 125mm HG. Follow up with Nurse Practitioner to see if the resident is following up with in house wound care or outside wound clinic; -9/14/25 3:59 A.M. Wound vac in place, continuous 125mm HG; -9/19/25 2:05 P.M. Attempted to change wound vac dressing. Wound began bleeding profusely due to sponge adhered to the tissue. The resident had difficulty tolerating pain, asked to take frequent breaks. Pain medication given prior to wound care. Decision was made to send the resident to the emergency department. Excess bandage cut away, dressing applied and wrapped with gauze. Bleeding noted through the bandage after calling 911. Emergency Medical Services (EMS) arrived and the resident was transferred to an area hospital. Review of Physician Assistant (PA) note dated 9/19/25 at 3:05 P.M. showed:-Resident #2 was seen and examined; -Wound vac was changed, unfortunately during the dressing change, the patient experienced a significant amount of bleeding;-Licensed Practical Nurse (LPN) called EMS to have him/her transferred to the hospital;-The resident reported a burning sensation of his/her leg and mild dizziness. During an interview on 9/24/25 at 4:06 P.M. the PA said:-He/She did not see staff remove the dressing from Resident #2; there was a substantial amount of bleeding and staff were wrapping the wound up when he/she arrived; -He/She would not expect a dressing change to cause that kind of bleeding; -He/She would not expect a dressing to be stuck that badly if it was changed regularly; -He/She did not work with wound vacs typically.During an interview on 9/25/25 at 10:32 A.M. Nurse Practitioner A said:-He/She was the primary care provider for Resident #2; -The facility notified him/her of the issue with the dressing being adhered to the wound;-He/She had never known a wound vac dressing to adhere to a wound;-He/She would expect staff to call the primary care physician or wound care physician for wound vac orders. During an interview on 9/25/25 at 11:00 A.M. LPN B said:-Staff notified him/her on 9/19/25 that Resident #2 wound vac did not look right; -He/She assessed the dressing and looked for documentation of when it had been changed; -He/She was unable to find orders for the wound vac dressing change, or when it had been changed;-He/She was only able to find a note that showed the wound vac was in place on 9/10/25; -He/She used saline to soak the dressing to remove it; -There were three sponges and the third sponge was severely adhered to Resident #2's wound;-One area started to bleed significantly;-He/She wrapped the wound with roll gauze, discussed the situation with the Registered Nurse, and decided to call EMS; -He/She cut away the old dressing, applied thick padding, and wrapped the leg with gauze, as the wound was bleeding significantly; -The wound had bled through the thick dressing when EMS arrived;-Typically wound vac dressings should be changed twice

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Based on interview and record review, the facility failed to protect Resident #1's safety when he/she eloped from the facility and was later found in the facility parking lot with a laceration to the forehead. The facility census was 152.On November 17, 2025 , the Administrator was notified of the past noncompliance incident which occurred on September 7, 2025. On September 7, 2025 facility administration was notified of the incident, an investigation immediately began and corrective actions were implemented to include:-All staff education on wandering/elopement, falls, door alarms, door checks, behaviors/dementia and abuse/neglect, verification that all door alarms were functioning, verification all residents were accounted for on the memory care unit, care plan meeting with family, audit and update of elopement book, and audit and updating of wandering assessments for residents on the memory care unit. The noncompliance was corrected on September 7, 2025. Review of the facility's Wandering & Elopement Policy, dated October 24, 2022, showed: -The purpose of this policy is to enhance the safety of residents of the facility; -The facility will identify residents at risk for elopement and minimize any possible injury as a result of elopement; -If facility staff observes a resident leaving the premises without having followed proper procedures, he/she may: Try to prevent the departure in a courteous manner, get help from other Facility Staff int he immediate vicinity, if necessary, and director another Facility Staff member to inform the Charge Nurse or Director of Nursing Services that a resident is trying to leave the premises;-When an individual who departed without following proper procedures returns to the facility, the Director of Nursing Services or Licensed Nurse should: Examine the resident for any possible injuries, notify the Attending Physician, notify the resident's responsible party. The Licensed Nurse will initiate or update the resident's Care Plan and implement immediate interventions to prevent further wandering/elopement by the resident. The Interdisciplinary Team (IDT), with input from the Licensed Nurse, will conduct a thorough review of the elopement, document its findings in the IDT notes, and update the Care Plan to prevent a recurrence.1.Review of Resident #1's electronic medical record on 9/24/25, showed: -His/Her diagnoses included: Diffuse traumatic brain injury (TBI, brain disfunction caused by an outside source), traumatic subdural hemorrhage (a collection of blood between the dura mater (the outermost layer of the brain's covering) and the brain itself, often caused by head trauma), wedge compression fracture of thoracic (T) 11-T12 vertebra (a type of spinal fracture where the front part of a vertebra collapses, creating a wedge-shaped deformity), dementia with behavioral disturbance, agitation, mood disturbance (a group of thinking and social symptoms that interferes with daily functioning), dysphagia (difficulty swallowing), diabetes mellitus type II (a long-term condition in which the body has trouble controlling blood sugar and using it for energy), pressure-induced deep tissue damage of right and left heels, anxiety disorder, major depressive disorder, congestive heart failure, restlessness and agitation. Review of the resident's quarterly Minimum Data Set (MDS, a federally mandated assessment completed by staff), dated 8/29/25, showed: -He/she scored zero on the Brief Interview for Mental Status (BIMS, a structured evaluation aimed at evaluating aspects of cognition in elderly residents) indicating severely impaired cognition; -The resident requires substantial assistance with all activities of daily living, including dressing, bathing, and personal hygiene;-He/She required the assistance of staff for transfers and bed mobility;-He/She uses a wheelchair for mobility but will walk without it. Review of the resident's comprehensive care plan showed interventions related to history of trauma, behavior problem related to dementia, TBI, risk for elopement (including wandering, door seeking, wandering into other resident's rooms, moves quickly by using a wheelchair and walking), impaired cognitive and communication function related to dementia, TBI, risk for falls.Review of the resident's progress notes showed:-On 9/7/2025 at 1:28 P.M., the nurse documented that after lunch, the resident has agitation, demanding to go home. The resident has been up front with the nurse to maintain the resident's safety. The resident called his/her son, screaming I don't belong here. The son hung up on the conversation. The nursing supervisor was informed of the resident's continued demands to get out; -On 9/7/25 at 2:15 P.M., the nurse documented at 2:00 P.M., he/she was notified by another nurse that there was a resident in the parking lot on the west side of the building parking lot. The nurse arrived to the parking lot with another nurse and the resident was noted to be sitting on the ground with three visitors standing around her. The resident was noted to have a laceration to right side of forehead. The nurse entered the building through the west entrance while the other nurse stayed with the resident to inquire the resident's name. The certified nurses assistant (CNA) stated the resident's name and brought a wheelchair to the parking lot. The resident was brought back inside; -On 9/7/25 at 9:36 P.M., the