STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265339	A. Building B. Wing	05/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alpine Breeze Health and Wellness	6124 Raytown Road Raytown, MO 64133

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure adequate supervision and implement effective measures to prevent resident elopement for one sampled resident (Resident #1) of 8 sampled residents who resided on the facility's secured memory care unit. On 4/29/26, the main door out of the memory care unit did not fully latch after use. As a result, the resident was able to exit the secured unit unsupervised, access the facility elevator and make his/her way out of the facility through a door where the alarm had been temporarily disabled, without staff awareness, and was later located by law enforcement at a local barbershop without injury. The facility census was 146 residents.The Administrator was notified on 5/7/26 of the past noncompliance which began on 4/29/26. The facility immediately completed education for wandering and elopement risk, alarm response and missing persons. An elopement drill with staff was completed on 4/30/26. All resident elopement assessments were updated on 4/30/26. A Quality Assurance Performance Improvement (QAPI) was put in place on 4/30/26 to review and interpret all audit findings. The deficiency was corrected on 5/1/26. Review of the facility's Elopements and Wandering Residents policy Dated 8/1/25 and reviewed 4/20/26 showed:-This facility ensured that residents who exhibited wandering behavior and/or are at risk for elopement receive adequate supervision to prevent accidents and receive care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering or elopement risk.- Elopement occurred when a resident left the premises or a safe area without authorization, such as an order for discharge or leave of absence, and/or any necessary supervision to do so.-The facility was equipped with door locks/alarms to help avoid elopements.-Alarms were not a replacement for necessary supervision. 1. Review of Resident #1's admission Record face sheet showed he/she was admitted to the facility on [DATE] with a diagnosis of mild cognitive impairment of unknown origin. Review of the resident's admission assessment dated [DATE] showed:-He/She was at high risk for elopement.-He/She could ambulate and propel him/herself and/or wandered.-He/She had intentionally or unintentionally attempted to leave the community. Review of the resident's Care Plan Report dated 4/22/26 and revised on 4/29/26 showed:-He/She was admitted to the Garden Unit (memory care) due to his/her elopement risk.-Interventions include documenting behavior patterns and triggers; offering companionship, reassurance and redirection when exit-seeking began; monitoring for possible contributing factors that might lead to potential elopement risk, including restlessness in late afternoon, increase in anxiety or packing belongings, providing structured, meaningful activities during high-risk times such as late afternoon Review of the Facility Incident Report dated 4/29/26 showed:-On 4/29/26 at approximately 8:20 P.M., staff reported that law enforcement officers came to the facility to confirm that the resident lived at the facility.-The facility did a head count of the memory care unit and verified the resident was not in the facility.-The Director of Nursing (DON) was notified that law enforcement was returning the resident to the facility.-Police reported the resident had been located at a barbershop nearby the facility.-The barbershop owner contacted law enforcement after observing the resident state, I'm not sure where to go.-Law enforcement transported the resident back to the (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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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	facility.-The resident returned at approximately 8:27 P.M. and was assessed for injuries or visible marks.-No notable injuries were observed.-The resident was wearing weather appropriate clothing and weather conditions were clear with no precipitation or visibility concerns during the time of the incident.-The resident was interviewed and reported that he/she exited the building via the memory care unit entry door, accessed the elevator, traveled to another floor and exited the building via the 400 hall exit door, which the stop sign alarm did not activate due to routine maintenance from the alarm company. He/She did not recall hearing an alarm at the time.-Review of the door identified that the memory care unit entry door was not fully latched at the time, allowing the resident to open the door and leave the unit.-It was then identified that the resident exited the elevator, and the 500 and 600 halls had a stop sign barrier across the door, which acted as a visual deterrent and the 400 hall did not have the banner.-The door alarm did not alarm due to routine maintenance activity completed on this hall by an outside vendor.-The outside vendor left at approximately 5:15 P.M.-The staff reported the last known visual of the resident prior to returning at approximately 7:45 P.M. Review of the resident's Progress Notes dated 4/29/26 at 8:25 P.M. showed:-Law enforcement arrived at the facility at 8:20 P.M. stating that a resident was at the barber shop down the street.-The resident was unable to tell the officers where he/she lived.-A head count was done at 8:20 P.M. and noted that the resident was not in the facility.-Law enforcement stated they were bringing the resident back.-At approximately 8:35 P.M. the resident arrived at the facility.-The resident was taken to his/her room. -Vital signs were completed and noted, water offered, and vital signs repeated again.-The resident denied pain or discomfort.-Skin assessment was done and no injury noted.-The resident was resting in bed.-The resident was placed on 15-minute checks. Review of the resident's Skin Check dated 4/29/26 showed he/she did not have any new wounds. Observation and interview on 5/7/26 at 11:30 A.M. showed the resident used a walker when ambulating. He/she said: -He/She did not remember going off of the unit.-He/She did not think he/she had been outside.-He/She did not remember leaving the facility.-He/She would not know how to get out.-He/She was hoping his/her son would come take him/her home, but they did not want him/her there.-He/She guessed the staff were taking good care of him/her at the facility.-He/She did not like being in a place when he/she did not know why he/she was there. Observation of memory care unit doors on 5/7/26 at 11:50 A.M. showed:-The doors had codes to open and would not open without a code. -The door closest to the resident's room led outside to an area that is fenced. -The door where the resident went out had a working alarm. -The doors to the outside had alarms, but not the interior doors. During an interview on 5/7/26 at 3:30 P.M., the Administrator said:-The resident was able to get off the memory care unit because another resident's family member left the unit door unlatched. -The resident took his/her walker with him/her. -The unit door was flush so it could not be determined by looking if it was latched or not. -The doors to the outside had alarms, but the interior doors did not. -There were staff were present, but they were busy with other residents since it was after dinner time.-Nobody missed the resident because he/she was not gone very long. -The resident showed them how he/she pushed the button at the elevator door to go up. - When the resident got off the elevator, he/she turned right and walked down the hall.-The resident showed them how he/she exited the facility. -The staff would not necessarily have noticed if he/she was gone right away.-The upstairs staff would not have necessarily known who he/she was.-The door alarm was not on that day because there was a company at the facility working on the alarm system. Incident 3000358