Printed: 06/27/2024
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265425	A. Building B. Wing	02/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Edgewood Manor Health Care Center	11900 Jessica Lane Raytown, MO 64138

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** 33409 Based on observation, interview and record review, the facility failed to ensure the safety and protective oversight for one sampled resident (Resident #5) who left the faciity on [DATE] around 5:02 P.M., without the knowledge of the facility staff and was gone overnight from the facility out of 10 sampled residents. The facility resident census of 62 residents. On 2/27/24, the Administrator were notified of the past noncompliance (PNC) for an incident that occurred on 2/15/24. The facility administration was notified on 2/16/24 of the resident's elopement and facility investigation of the resident elopement immediately begun on 2/16/24. In-services were provided to staff who were involved and to all staff related to resident's visual monitoring (Face checks) every hour or at least every two hours to ensure the safety and protective oversight supervision for all resident at the facility on 2/16/24 and 2/17/24. The deficiency was corrected on 2/17/24. Review of the facility's Elopement Protocol revised on 1/19/22 showed: -An elopement will be defied as anytime a resident is missing for the facility or there is a possibility that the resident has left the facility without appropriate supervision and their whereabouts are unknown. -The first person aware of an elopement will call a Code [NAME] to the area of the believed elopement, if known. -Page all units to search room to room for the resident. All rooms, closets, bathrooms, and work areas are to be searched. -The administrator is to be called immediately. Review of the facility's Intensive Monitoring/Visual Checks revised on 6/30/23 showed: -Face checks for all resident on each unit will be monitored by visual checks at least every two hours or may be provided more intensive monitoring every hour. -Special units will not be left unattended at any time. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265425	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/27/2024
NAME OF PROVIDER OR SUPPLIER Edgewood Manor Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 11900 Jessica Lane Raytown, MO 64138	

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	-Upon hire, Licensed and registered Nurse (RN) will require to review, agree and sign the nurse census call-in protocol, signed form should be placed in employee fill. -Certified Nursing Assistant (CNA) can provided direction to monitor the resident in a timely manner at the discretion of administration for medical or behavioral decomposition. -Document of face checks monitoring will be done in electronic medical record under task. 1. Review of Resident #5's Admission Face Sheet showed he/she had the following diagnoses: -Paranoid Schizophrenia (a long-term mental health condition where you may see, hear or believe things that are not real and person experiences paranoia that feeds into delusions and hallucinations, it's common for them to feel afraid and unable to trust others) -Disorganized schizophrenia (is associated with symptoms like disorganized speech, thinking, and behavior). -Seizures (is sudden uncontrolled body movement). -Has a Public Administrator (PA) as a guardian. Review of the resident's Annual Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff for care planning) dated 12/2/23, showed he/she was cognitively intact. Review of the resident's Care Plan revised on 12/10/23 showed: -He/she was at risk for elopement: --Complete elopement assessment on admission, readmission and quarterly. --Face checks/intensive monitoring will be completed per facility protocol revised on 9/22/22. -The resident was independent with activities of daily living. --Facility staff to provided protective oversight and assist where needed. Review of the resident's Certified Medication Technician (CMT) Medication Administration Record (MAR) date 2/15/24 showed the last dose of medication was given to the resident was at 4:00 P.M. Observation/review of the facility's Video Surveillance dated 2/15/24 showed: -On the 300 hallway at 5:02.39 P.M. below the video time stamp had written live and a person detected. -The resident was wearing a red sweatshirt or jacket, black pants and shoes was seen walking toward the end of 300 hall to the exit door. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265425	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/27/2024
NAME OF PROVIDER OR SUPPLIER Edgewood Manor Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 11900 Jessica Lane Raytown, MO 64138	

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	-At 5:02.54 P.M., the resident in the red sweatshirt was at the end of hallway and turned toward right then was out of site (that was location of the keypad, which required a code to be enter before anyone could exit the out that door). -The video time showed 5:02.58 P.M. and then the video skips to 5:03.35 P.M. -At 5:03.35 P.M., the exit door was opened and closed and can be slightly heard on the video. Review of the resident's guardian email to the facility dated on 2/16/24 at 8:24 A.M. showed: -The Deputy PA had received a phone call from the resident's family member the morning of 2/16/24 around 7:42 A.M., explaining that the resident had showed up to his/her house on the evening of 2/15/24 around 10:00 P.M. and the resident was asleep at their home. Family member was hoping to have the resident picked up to go back to the facility before he/she left his/her house. -He/she had not received any phone calls from the facility that the resident had eloped. -He/she was just double checking with the facility that in fact the resident had eloped the night before and how to get the resident back to the nursing home. -Phone calls were attempted to contact the facility with no answer and the PA office was unable to leave voice mail at 8:02 A.M., 8:12 A.M. and 8:15 A.M. Review of the resident's Transfer to Hospital Note dated 2/16/24 at 10:35 A.M., showed the resident arrived back to the facility with the Administrator and Activities Director at approximately 10:31 A.M. on 2/16/24. Review of the resident's Incident Note written by the Regional Facility Advisor Nurse dated 2/16/24 at 3:41 P. M. showed: -The facility received a call from resident's guardian around 9:17 A.M., that he/she had received a call from the resident's family member that the resident had showed up at the family members' house between 10:30 P.M. and 10:45 P.M. on 2/15/24. -The immediate response from staff was to check the resident's room for verification of the missing resident, and the resident's room was checked, and the resident was not found. Review of the facility Investigation dated 2/16/24 at 12:53 P.M. showed: -On 2/15/24 the resident had eloped. -The facility staff were notified of the resident elopement on 2/16/24 at 9:17 A.M. -At 9:17 A.M. the resident's guardian had notified the MDS's Coordinator that, the resident's family member had called the guardian to inform him/her the resident had showed up on his/her doorstep at around 10:00 P. M. on the evening of 2/15/24. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265425	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Edgewood Manor Health Care Center	11900 Jessica Lane Raytown, MO 64138

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	-Resident noted on facility camera system at 5:00 P.M. to 5:10 P.M. walking back and forth to exit door on the 300 halls where the resident had resided on. -Resident noted to wear a red jacket on with dark colored trouser and his/her gloves in his/her hands. The resident then noted what it looks like to be trying to enter door code in the keypad. -Resident was eventually able to enter code and exit out the door. -Conclusion of the investigation documented that the resident eloped form facility by entering a code into the exit door on 300 halls. During the facility investigation the following findings were noted: --CMT A who was scheduled to complete face check form 5:00 P.M. to 7:00 P.M. during 7:00 A.M. to 7:00 P. M. day shift, did not notify the charge nurse that the resident was not in the facility. -Off going/oncoming charge nurse did not make facility rounds to ensure all residents were in the building at change of shift. -CMT B who was scheduled for 7:00 P.M. to 7:00 A.M. shift to administer medication and document facility face check, did in fact noted that the resident was not in the facility because he/she was unable to administer the resident's medications that was due at bedtime. The CMT was unable to locate the resident to complete face checks. -The evening/night CMT did not notify the charge nurse that the resident could not be located. -Charge nurse on duty 7:00 P.M. to 7:00 A.M. shift, did not complete midnight census round checks to see if resident was in the facility to be counted on the resident census. -Maintenance supervisor did not ensure facility door codes were changed weekly per policy. Review of the Activities Director's written Witness Statement dated 2/16/24 showed he/she had talked to the resident near the 100,200, and 300 nursing station, right around 4:45 P.M. to 5:00 P.M., before Activities Director had left for the day on 2/15/24. During an interview on 2/26/24 at 3:23 P.M., Activities Director said the last time he/she saw the resident on 2/15/24 was around 4:45 P.M. to 5:00 P.M. around the 300-nursing station area. Review of CMT C's written Witness Statement dated 2/16/24 showed the resident told him/her the resident decided to leave the facility to go somewhere. The resident had walked to the store then got on a bus. During an interview on 2/26/24 at 3:38 P.M., CMT C said: -On 2/16/24 he/she arrived at the facility for day shift and made round on assigned resident. He/she notice the resident was not in his/her room at that time. -Later he/she had went to give the resident his/her morning medication and he/she was not in his/her room. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265425	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Edgewood Manor Health Care Center	11900 Jessica Lane Raytown, MO 64138

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	-CMT C did not report that resident was not in his/her room at that time to anyone. During an interview on 2/27/24 at 9:18 A.M., CMT A said: -He/she last saw the resident around 4:00 P.M. for his/her last dose of afternoon medication. -He/she had saw the resident in passing after the medication pass. -He/she did not remember seeing the resident prior to leaving the facility at end of his/her shift change. -He/she was not aware of the resident having history of wandering or exit seeking behaviors. The resident would have the ability to enter a code to door if he/she knew the code. -He/she was assigned to pass medication on the 100, 200, 300 and 400 unit. -After he/she had completed medication pass, he/she would be station himself/herself back onto the 100, 200 and 300 unit nursing station area. -He/she tries to make walking rounds on the resident every one to two hours. -The facility does not have assigned staff member to remain or station continuous supervision or monitoring of the 100, 200, and 300-unit residents at all times. -If he/she were not able to locate the resident, he/she should had notified the charge nurse immediately. -For CMT shift change, if oncoming staff on time would complete a walk through and give report. -He/she did not complete shift change walk-through or report with on coming staff member on 2/15/24. Review of CMT B's written Witness Statement dated 2/16/24 showed when he/she went to the resident's room to pass medication, he/she noticed the resident was not in his/her room. During an interview on 2/27/24 at 9:39 A.M., CMT B said: -He/she was not aware the resident had left the building. -He/she had not seen the resident during his/her shift. -He/she did not get shift change report and had to obtain the keys for medication cart from the secured keypad medication room. -He/she began medication administration for all residents in the facility. -Did not have CNA coverage for 100, 200, 300 unit when he/she had to pass medication on the skilled unit. The unit was left without a staff member station on that unit. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265425	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/27/2024
NAME OF PROVIDER OR SUPPLIER Edgewood Manor Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 11900 Jessica Lane Raytown, MO 64138	

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	-The resident was not in his/her room when tried give the resident his/her medication. -CMT B thought the resident was out smoking or visiting with peers. -He/she looked for the resident again and did not find him/her and then look in computer record to see if the resident was out of the building. Sometime the resident's electronic chart does not have most current/correct information about the resident. -CMT B had completed medication administration between 10:00 P.M. and 11:00 P.M. -He/she went completed the night shift sitting at nursing station on the 100, 200 and 300 unit. During an interview on 2/27/24 at 9:58 A.M., LPN B said: -The CMT was responsible for provided or assisting resident with any cares, passing medication and face checks on assigned resident for 100, 200 and 300 units. -He/she went back to the 200, 300 unit around 5:00 P.M. to obtain blood sugars and did not see the resident at that time. Review of LPN A's written Witness statement dated 2/16/24 showed: -He/she had arrived at the facility on 2/15/24 (evening) at approximately during the resident smoke break time. -At no time did he/she recall seeing the resident. During an interview on 2/27/24 at 10:38 A.M., LPN A said: -100, 200 and 300 hallways were all independent residents that were able to provide their own cares and transfer themselves without staff assistance. -When he/she arrived at the facility the day shift nurse was busy with family members. And waited for nurse to give shift change report. -He/she did not receive any report of any resident missing or not in the building. -Night nursing staff were responsible for completing the midnight resident census. -He/she would normally complete around 2:00 A.M. -He/she did not complete a walk-through of all residents during night shift. -All night staff were supposed to check on assigned resident to include face checks and report if they were not able to locate a resident. During an interview on 2/27/24 at 2:23 P.M., the Administrator said: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265425	A. Building B. Wing	02/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Edgewood Manor Health Care Center	11900 Jessica Lane Raytown, MO 64138

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	-He/she had completed the elopement investigation and found: -The facility staff had not been changing the door code per facility policy of every week. -Facility staff did not complete resident face checks per facility policy to ensure the safety of the resident and protective oversight. -He/she would expect facility staff to notify the charge nurse and the Administrator of any resident not found during rounds. During an interview on 2/28/24 at 1:55 P.M., Deputy PA said: -Their office had received a phone call from the resident family member on the morning of 2/16/24 who said the resident had arrived at his/her door step on the evening of 2/15/24 around 10:00 P.M The resident had slept the night at the family member's home. -On 2/16/24 the PA office had emailed the facility to ask if the resident was at the facility or was missing. -Later that morning he/she had received a phone call from the facility saying the resident had left the facility and the facility administration would make contact with the family member to transport back to the facility. -The PA office would expect the facility to ensure the protective oversight of the resident safety and know where the resident was while a the facility. -He/she would expect the facility to notify the PA office if the resident was not able to be located or if there was a change of condition. Complaint# MO 00231972