STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265476	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunrise Nursing & Rehabilitation	600 E Sunrise Drive Raymore, MO 64083

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 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give the resident's representative the ability to exercise the resident's rights. Based on interview, and record review, the facility failed to ensure the rights of the one sampled resident's (Resident # 3) Durable Power of Attorney (DPOA) was exercised to maintain the resident safety when the facility allowed a family member who was not the POA to take the resident out of the facility out of 15 sampled residents. The facility census was 139 residents.Review of the facility's policy, Decision Making Capacity, dated 8/2020 showed:-Identifying a Surrogate Decision-maker: A person with legal authority to make medical treatment decisions on behalf of a resident was a person designated under a valid POA, a guardian, a conservator or a next of kin. The facility did not have a policy about an incapacitated resident leaving the facility. 1.Review of Resident #3's face sheet showed the resident had the following diagnoses:-Dementia (a decline in mental ability severe enough to interfere with daily living).-Psychosis (a disconnect from reality).-Altered mental status (a sudden change in a person's baseline awareness, cognition, or consciousness, ranging from mild confusion to unresponsiveness).-Aphasia (a disorder that impairs a person's ability to speak).-The resident's granddaughter was the DPOA.-Special instructions showed:-The resident was an elopement risk.-The resident was deemed incapacitated.-The resident could only be taken out of the facility by the DPOA. Review of the resident's DPOA for Health Care was signed on 2/9/24. Review of the resident's care plan showed:-The resident had impaired cognitive function/dementia or impaired thought processes related to dementia, dated 10/07/24.-The resident is an elopement risk/wanderer, disoriented to place.-History of attempts to leave facility unattended, impaired safety awareness.-Resident wanders aimlessly.-The care plan did not address obtaining permission from the DPOA before allowing relatives to take the resident out of the facility. Review of the resident's Brief Interview for Mental Status dated 4/13/26 showed he/she had a score of 4 indicating he/she was severely cognitively impaired. Review of the resident's DPOA report dated 4/22/26 showed: -On April 18, 2026 at approximately 3:15 P.M. the facility released the resident who was an elderly Dementia patient to a family member without the authorization from the DPOA. -This was not an isolated incident.-The facility has repeatedly failed to protect the resident allowing a relative to remove the resident from the facility on March 2, 2026 and again on April 18, 2026. -Concerns were raised with the facility staff. -The resident is a vulnerable adult with Dementia and documented history of wandering. -The resident required a secure supervised, environment at all times. Review of the Resident's Sign Out Sheet for April 2026 showed:-A family member signed the resident out of the facility on 4/18/26 at 1:59 P.M.-A family member signed the resident back into the facility at 4:11 P.M. on 4/18/26. During an interview on 5/20/26 at 10:30 A.M. the Receptionist said:-Any resident who was leaving the facility would have to sign the Sign Out Sheet.-There was a second book that showed who could take the resident out of the facility.-He/She automatically looks at the book to ensure they can leave the facility.-He/She was trained by the Business Office Manager. Review of the Receptionist's second book on 5/20/26 showed:-The resident was only allowed visitors.-The family member who took the resident out of the building was not on the list. During an interview on 5/20/26 at 10:45 A.M. the Business Office Manager said:-There was a receptionist on duty every day from 8:00 A.M. to 8:00 P.M. every day.-Sometimes they don't catch everyone to have them sign in and out. -The resident's Care Plan did not show he/she was only allowed to leave the facility with the POA, and it should have. -The Nurses (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265476	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunrise Nursing & Rehabilitation	600 E Sunrise Drive Raymore, MO 64083

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 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	on the locked Memory Care unit should have documented if one of the residents left the facility with someone and it was not done. -They do not have a check list for new hires to ensure they know what to do on the job.-The new hires sit with a seasoned employee for two days to learn the job. -The second book at the receptionist desk showed who was allowed to take a resident out of the facility.-The book showed the only person who was permitted to take the resident out of the facility was the DPOA. During an interview on 5/20/26 at 11:00 A.M. the Assistant Director of Nursing (ADON) who was acting Charge Nurse on the locked Memory Care Unit said:-He/She often works on the Memory Care Unit as the Charge Nurse.-Only certain family members were able to take the resident out of the facility.-They were identified on the second book at the receptionist desk or on the face sheet.-There were some family disputes going in with the resident's family. -The Nurse in the Memory care unit writes down when a family member takes a resident out, then throws the paper away when the resident was returned to the unit. -The Nurse should have documented in the Nurses' Notes when a resident left the locked unit for any reason.-There was no documentation either time when the resident had left with a family member.-The Care Plan should have shown the resident had a DPOA and that the resident could only leave the facility with him/her. It did not. -It was the Nurses' responsibility to ensure that only the people on the list were able to take a resident off of the unit. -The Receptionist should ensure every resident who leaves the facility was signed out and if they were from the memory care unit who were they going with.-This had not been done for this resident. During an interview on 5/21/26 at 1:00 P.M. the Social Worker said:-Staff should check with the Nurse as it was their responsibility to ensure if a resident left that they came back safely.-All residents should have signed out if they left the facility and signed back in every time.-She had provided education with the people at the reception desk to ensure everyone signs in and out and who they can leave with. -There should have been documentation in the resident's care plan that showed he/she could only leave the facility with the DPOA. There was not.-Under special instructions it showed who the resident could leave the facility with. -The receptionist has a second book that they should check with every time a resident leaves to ensure that they could leave and who they were leaving with.-The family member who took the resident out of the facility was not on the approved list. During an interview on 5/21/26 at 1:20 P.M. the Director of Nursing(DON) said:-Staff should have looked at the resident's face sheet to have seen who was authorized to take the resident out of the facility.-If there was a question the DPOA should have been called.-If a resident left the building the Nurses should have put a note in the Nurses Notes and the resident should have been signed out. This had not been done.-It should have been documented in the care plan if the DPOA only allowed certain people to take the resident out of the building. This had not been done. 2990695