

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265532	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/05/2026
NAME OF PROVIDER OR SUPPLIER  Parkway Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  2323 Swope Parkway Kansas City, MO 64130	
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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review, the facility failed to ensure one sampled resident (Resident #1) out of five sampled residents, with known diagnoses of dementia, impulsive disorder, bi-polar disorder, anxiety disorder, cognitive impairment, and who was a known elopement risk received adequate supervision to prevent accidents. On 02/28/26, the magnetic door locks and alarm failed on the secured unit. Staff assigned to supervise the resident, to ensure safety, left the resident unsupervised. The resident went out the door, located off a busy street and major highway, between 7:15 P.M. and 7:20 P.M. The resident remained unaccounted for until 03/01/26 at 2:00 P.M., when he/she was found on the public transit system in a major metropolitan area. The facility census was 69 residents. The Administrator was notified on 03/05/26 at 1:38 P.M., of Past Non-Compliance Immediate Jeopardy which occurred on 02/28/26. All staff were immediately educated on Intensive Monitoring of Residents, When to Notify Management, Abuse and Neglect, and Elopement. New elopement evaluations were completed on all residents to ensure no other residents were at risk. The magnetic locks were repaired. Licensed Practical Nurse (LPN) A was suspended and terminated. The IJ was corrected on 02/28/26. Review of Resident #1's Preadmission Screening and Resident Review (PASRR, DA-124C, a required form to be submitted for any client who requests admission to a Medicaid certified bed regardless of the client's payment source), dated 05/06/20, showed he/she had the following diagnoses:--Schizoaffective disorder bi-polar type (a chronic mental health condition combining schizophrenia symptoms (hallucinations, delusions, disorganized speech) with manic episodes and sometimes major depression);--Bi-polar disorder (a chronic mental health condition characterized by extreme, often debilitating shifts in mood, energy, and activity levels);--Vascular dementia (a cognitive decline caused by reduced blood flow to the brain, which damages or kills brain cells due to lack of oxygen and nutrients);-The resident showed as being only oriented to self and severe memory issues with retention of only 10 to 15 minutes;-He/she showed very slow verbal responses. During an interview on 03/01/26 at 1:36 P.M., the facility Administrator said the resident was transferred to the facility on [DATE] from a sister facility. Review of the resident's Facility admission Record showed he/she was admitted to the facility on [DATE] with additional diagnoses of:-Anxiety disorder (mental health conditions characterized by persistent, excessive, and uncontrollable fear or worry that interferes with daily life); and-Impulse disorder (mental health conditions marked by an inability to resist harmful or disruptive urges, leading to actions taken without forethought). Review of the resident's quarterly Minimum Data Set (MDS-a federally mandated assessment tool completed by facility staff and used for care planning), dated 01/14/26, showed he/she:-Was minimally cognitively intact.-Had a history of behaviors including wandering in and out of other's rooms and throughout the unit.-Was exit seeking. Review of the resident's Nursing Care Plan, dated 01/29/26, showed:-He/she was at risk for wandering and elopement.-The facility staff were to clearly label the resident's room. -The staff were to engage the resident in purposeful activity.-The staff were to attempt to identify times where wandering/elopement was more prevalent.-The staff were to schedule times for regular walks. (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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Review of the Facility Registered Nursing Investigation (RNI), dated 02/28/26 at 7:30 P.M., showed:-At 6:00 P.M. on 02/28/26, the facility Administrator was notified of a malfunction with the magnetic locks on the main floor dementia unit.--It was reported the resident had exited the unit, accessed the stairwell, and reached the sidewalk.--The resident remained on facility property and was returned to the unit by the staff. --The Administrator arrived at 6:30 P.M. and Certified Medication Technician (CMT) A and LPN A were monitoring the doors and the resident who was seated in the unit dining room.-The Administrator attempted to restore the locks without success and contacted the local system repair company. -At 7:20 P.M., LPN A reported the resident was last seen at approximately 7:15 P.M., seated in the unit dining room.-The resident had recently asked about the 7:30 P.M. smoke break and was told it was not yet time.-CMT A had left for the day, while LPN A maintained visual oversight of the doors and residents. -Certified Nurse Assistant (CNA) A was preparing for the next smoke break so he/she not in the vicinity of the resident or the doors.-LPN A stated that he/she went to the restroom for approximately two minutes and upon return, the resident was no longer present on the unit dining room.-911 was called to report a missing person and the facility staff initiated an immediate search of the building and grounds.-The conclusion of the investigation was that there was a failure in the magnetic door locking system and in adherence to established policies and procedures. -The facility was aware of ongoing door lock issues and the resident was exhibiting exit-seeking behaviors, yet the facility failed to provide appropriate protective oversight, which directly contributed to the resident's elopement.-The resident was located on 03/01/26 at 2:00 P.M., returned to the facility, and then transported to the hospital for evaluation, where he/she was found to have no injuries. Review of the resident's Nurse's Notes, dated 02/28/26 at 9:47 P.M., showed:-At around 7:15 P.M., the resident was asking when the next smoke break was going to be.-The staff told the resident the next smoke break was at 7:30 P.M.-The resident was seated in the unit dining room when LPN A went to the bathroom located behind the nurse's station in the unit dining room.-When LPN A returned, the resident was gone.-The staff immediately began looking for the resident. During an interview on 03/01/26 at 1:36 P.M., the facility Administrator said:-The magnetic locks on the unit where the resident resided lost power at some point on 02/28/26.-At around 6:00 P.M., the resident went down the back stairway while the magnetic locks were not functioning and left the facility.-The resident was seen quickly and returned to the unit and the Administrator arrived and started to work on the door locks.-He/she thought the issue was a fuse and he/she called the magnetic lock company emergency repair person.-He/she instructed LPN A to ensure the resident was watched by staff at all times and remain in within the line sight until the magnetic locks were repaired.-When LPN A was seated at the nurse's station, he/she had a clear view of the resident and both doors to prevent the resident from leaving the facility. -While he/she was waiting for the door lock repair person in the facility lobby, LPN A called him/her saying that he/she had to use the restroom, and when LPN A came out, the resident was missing. -Prior to LPN A going to the restroom, the resident had been seated in the lobby.-The Administrator said LPN A should have notified someone before going to the restroom as he/she knew the magnetic door locks were not working, and the other staff member was getting residents ready for the next smoke break. During an interview on 03/04/26 at 10:10 A.M., LPN A said:-The resident had only been a resident in the facility for six hours before he/she eloped for the first time.-He/She was notified of the new admission at 10:36 A.M. The resident arrived at noon and he/she had no time to review the resident's admission packet. -The resident eloped for the first time around 6:00 P.M.-He/She was unaware the resident was exit seeking prior to the resident leaving the first time. -He/She was not aware the magnetic (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>locks were not functioning until after the resident eloped.-Staff who went out on the smoking patio with residents alerted him/her the resident must have gotten out around 6:00 P.M., so he/she was able to go get the resident.-Once the resident got out the first time, the staff began checking on him/her every few minutes to make sure he/she didn't leave again. -He/she was instructed to keep the resident within the line of eyesight by the Administrator until the mag locks on the door were repaired. -The shift ended at 7:00 P.M., but the night shift LPN was running late so he/she stayed over.-CMT A left around 7:05 P.M. and CNA A was setting up for the next smoke break when around 7:15 P.M., the resident came and asked him/her when the next smoke break was.-LPN A told the resident the next smoke break was at 7:30 P.M. and told him/her to sit in the dining area and wait.-The resident sat down at a table with his/her drink and some noodles.-At around 7:20 P.M., LPN A had to use the restroom, so he/she went to the restroom behind the nurse's station, closed the restroom door and used the restroom. -He/She returned in about two minutes and when he/she came out of the bathroom, the resident was missing from the unit.-He/She did not think the resident could get out that quickly and felt there was no one to ask to relieve him/her for a restroom break as it was just him/her and CNA A on the unit and CNA A was busy.-He/She immediately called the Administrator and began to search for the resident. -He/She did not think about getting anyone to watch the resident while he/she went to the restroom as the resident seemed to listen and sit to wait for the smoke break. During an interview on 03/04/26 at 11:44 A.M., CMT A said:-He/she was outside on the smoking patio assisting residents at 6:00 P.M., when he/she saw the resident walking down the sidewalk in the back of the facility.-He/she called LPN A, and the resident was brought back inside.-After the resident came back inside, the staff began checking on him/her every few minutes.-They tried to make sure someone always had eyes on the resident. -The Administrator instructed LPN A what the plan was. -LPN A told him/her they would all just need to keep an eye on the resident until the locks were fixed. -He/she got off at 7:00 P.M., so he/she left around 7:05 P.M., and was not there when the resident eloped the second time. During an interview on 3/4/26 at 4:10 P.M., CNA A said:-He/She was not aware the magnetic door locks were not working.-He/She was out on the smoke deck with residents when the resident eloped the first time. -He/She and CMT A saw the resident walking down the sidewalk around 6:00 P.M. and called LPN A to go get him/her.-He/She had not seen the resident try to get out of the facility prior to 6:00 P.M.-The second time the resident eloped, he/she was on another hall preparing things for the resident's next smoke break.-He/She stayed until about 7:45 P.M., helping to look for the resident.-He/She and LPN A had been making sure the resident was always in eyesight of a staff member until the magnetic locks were repaired.-LPN A did not ask him/her for help to watch the resident when LPN A went to the bathroom, he/she continued his/her tasks. During an interview on 03/01/26 at 3:19 P.M., the Administrator said:-The resident had been found and was at the hospital for evaluation.-There were no known injuries as the assessment found no abrasions, scratches, or redness.-The resident was found on the metro bus transit system.-The corporate Chief Nursing Officer's (CNO) spouse works for the transit system and saw the resident on the bus.-The resident was identified and the facility was contacted.-The resident was found with a hoodie on, but the facility was unable to determine where he/she got it as when he/she left, he/she had on a black jacket.-The Administrator felt the event was preventable as the resident had two elopements within an hour of each other.- Facility staff knew the mag locks were not working properly and LPN A knew the magnetic lock company was to be onsite for repairs and the doors and the resident needed oversight until the doors were verified working. -LPN A knew he/she was assigned to ensure the resident remained in the line of sight until the mag locks were fixed. -LPN A assigned CNA A to take residents out to smoke. -LPN A went to the bathroom and did not ask anyone to take over watching the resident. -The Administrator was in the building and could have taken over watching the resident while LPN A went to the restroom.-The resident had been admitted from a sister facility within the corporation because of the facility's new locked dementia unit.-At the time, the resident was the only known exit seeking resident on the locked dementia unit. During an (continued on next page)</p>		

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