Printed: 06/05/2026
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
	265727	A. Building B. Wing	03/31/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carmel Hills Wellness & Rehabilitation	810 East Walnut Independence, MO 64050

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 interview and record review, the facility failed to provide supervision for one sampled resident (Resident #3), out of three sampled residents, when on 3/19/26 Floor Tech (FT) A did not secure the door to the secured unit resulting in the resident exiting the facility and later being found in the community and sent to the Emergency Room. The facility census was 154 residents.On 3/31/26 the Administrator and Director of Nursing (DON) were notified of past non-compliance which occurred on 3/19/26. All staff received education prior to working their next shift. The deficiency was corrected on 3/20/26. Review of the facility's Wandering and Elopement Policy, dated August 2020, showed:-The facility identified residents at risk for elopement and minimized any possible injury because of the elopement.-A licensed nurse assessed each resident for elopement risk and implemented preventative interventions were documented in the resident's medical record. 1. Review of Resident #3's face sheet, undated, showed the resident was admitted to the facility on [DATE].-His/Her diagnoses included: --Alzheimer's Disease (a progressive brain disorder that gradually destroys memory, thinking skills, and eventually the ability to perform simple daily tasks).--Anxiety disorder (a mental health condition characterized by excessive, persistent, and uncontrollable fear or worry that interferes with daily life).--Hearing loss. Review of the resident's initial Minimum Data Set (MDS- a health status screening and assessment tool used for all residents of long-term care nursing facilities) dated 1/29/26, showed the resident was severely cognitively impaired. Review of the resident's Elopement Risk Evaluation, dated 1/29/26, showed:-The resident was able to walk.-The resident wandered aimlessly.-The resident did not verbalize plans to elope.-The resident was at risk for elopement. Review of the resident's care plan, dated 1/30/26, showed:-The resident was at risk for elopement related to the Elopement Evaluation risk score.-The resident was on the secured unit. -The resident had impaired cognitive function (impaired thought processes). Review of Weather Underground dated 3/19/26 at 8 P.M. showed the outside temperature was 72 degrees. Review of the Police Report, dated 3/19/26, showed:-At 8:18 P.M., an unidentified caller reported a disoriented older person walking on the street wearing camo pants and blue or black sweater. The older person had tried to walk in the caller's home.-At 9:58 P.M. Emergency Medical Services (EMS) located the resident about 1.5 miles from the facility and transported him/her to the local hospital. Review of the resident's hospital discharge paper work, dated 3/19/26, showed:-The resident was found wandering and was only alert to self.-The resident had no injuries. Review of the facility's investigation, dated 3/20/26 showed:-Investigation determined that the entry door to the facility was not securely closed after staff exited the unit.-This condition was likely associated with staff use of the door and created a window of opportunity for unauthorized egress.-The facility provided education to all employees regarding elopement.-The facility had the door between the rehab unit and the secured unit serviced and adjusted it to have the alarm sound whenever the door was opened.-The timeline was complete and thorough, showing the times of the incident. During an interview on 3/30/26 at 12:11 P.M., Certified Medication Technician (CMT) A said:-He/She was working the night the resident eloped.-He/She saw the resident around 8:00 PM standing at 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265727	A. Building B. Wing	03/31/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carmel Hills Wellness & Rehabilitation	810 East Walnut Independence, MO 64050

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	nurses station.-At approximately 8:30 P.M., he/she was passing meds and when he/she went to give the resident their meds the resident was not in his/her room.-He/She called a Code Pink (code to inform all staff there was a missing resident) over the intercom and searched every room and closet on the unit.-At that time each staff member swept their assigned area.-The resident was not found and the search started on the outside of the facility.-He/She notified the Administrator, and they contacted the police and corporate.-The resident was not exit-seeking.-The resident was not noted to be staring at the door or watching codes.-The resident did not usually wander, he/she went back and forth between his/her room, the dining room and the nurses station.-The Administrative Team did an investigation, and it was determined the resident went out through the door between the rehab and the secure unit.-He/She received training after the elopement regarding the door alarms and resident elopements.-At the time the doors were alarmed, the alarm went off if anyone pushed on the handle for 20 seconds. -The alarm did not go off when the resident exited.-Doors can be opened with a code and the alarm would not go off. During an interview on 3/30/26 at 12:11 P.M., the DON said:-Prior to the elopement the door would alarm after pushing on the release bar 20 seconds.-The administrative staff were notified, and contacted the police department and the hospitals.-He/She and the Regional Nurse Consultant (RNC) and did the sweep of the outside grounds and drove up and down the streets trying to find the resident. -The Administrator remained at the facility.-Staff continued to actively look for the resident. -The resident was found a local hospital without injury.-The hospital called the facility and Licensed Vocational Nurse (LVN) C took the call.-All staff were educated about the elopement and door alarms before coming back to the next shift. During an interview on 3/30/36 at 2:36 P.M., the Administrator said:-Prior to the elopement the doors were set up to push and hold for 15 seconds then it will open, and alarm would sound. -Staff did not hear the alarm.-When FT A used the code to get off the unit the door did not sound.-FT A received education and a corrective action plan. -FT A was newer to working on that unit. During an interview on 3/30/26 at 6:21 P.M., FT A said:-He/She was working on the secured unit.-He/She left the unit using the code and didn't check to see if anyone was following him/her.-He/She did not listen for the door to click shut once he/she passed through it. -Prior to the incident he/she had received training to watch the door for anyone trying to leave behind him/her.-Now, he/she made sure the door was closed correctly, and no one was following him/her.-He/She reported he/she was not paying attention and did not intentionally let the resident off the unit.-He/She was unsure of what time he/she came through the door, maybe around 8:15 and 8:30 P.M. During an interview on 3/30/26 at 6:26 P.M., LVN C said:-The door used to sound about 15-20 seconds after pushing on it. -It was enough time for the person to go through the door if no one was paying attention.-To his/her knowledge the door alarm was working correctly.-Staff were trained not to allow residents out to make sure the door closes behind you. During an interview on 3/30/26 at 6:59 P.M., Certified Nurses Aide (CNA) A said:-He/She was working the night of the elopement.-He/She remembered seeing the resident around 8:00 P.M. to 8:10 P.M -The resident was following him/her around and the last place the resident was seen was in the dining room.-The alarm did not go off the night the resident eloped.-If staff pushed on the door for a few seconds the door would open. During an interview on 3/31/26 at 9:14 A.M., the facility's Nurse Practitioner said:-The resident was fairly new to the facility.-He/She was aware the resident had eloped.-The facility physician was in the building the next day and saw the resident.-He/She adjusted one of the resident's medications that caused restlessness.-The resident had no recollection of eloping.-He/She expected the staff to check on the resident every hour to two hours.-The resident was not exit-seeking but liked to wander.-He/She expected the staff to know he was a wanderer as that was the reason the resident was on the secure unit. 2978949