STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265861	A. Building B. Wing	06/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carnegie Village Rehabilitation & Health Care Cent	105 Bernard Drive Belton, MO 64012

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 adequate supervision to prevent accidents for one sampled resident (Resident #1). Licensed Practical Nurse (LPN) A failed to visualize the resident when performing the required midnight census safety rounds and Certified Nursing Assistant (CNA) A failed to visualize the resident when doing two-hour nightly rounds. As a result, the resident self exited into the facility courtyard after dark, without staff awareness and fell from his/her wheelchair out of six sampled residents. The facility census was 62 residents. On 6/3/25, the facility Administration was notified of the past noncompliance which occurred on 5/31/25. Facility staff had subsequently been educated on hourly checks to courtyard, abuse, neglect, and two-hour rounding by CNAs. Alarms were ordered for the courtyard doors and additional lighting installed in the courtyard. The deficiency was corrected on 6/1/25. Review of the facility's Midnight Census policy dated 12/24 showed: -It was the policy of the facility to complete an accurate count of all residents in the facility at midnight each night. -This count was known as the Midnight Census. -This manual count was to be completed each night at midnight by the nurse in charge. -A midnight census was essential to the tracking of residents for accountability for clinical and bookkeeping purposes. -All disciplines should be aware of the daily midnight census. -Each resident would be visualized for accuracy of the count and the resident's presence or absence and the changes in the past 24 hours would be noted on the Midnight Census Report. 1. Review of Resident #1's admission Record face sheet showed the resident was admitted to the facility on [DATE] with the following diagnoses: -Parkinson's disease (a progressive disorder that affects movement and coordination). (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	-Alzheimer's disease (a progressive, irreversible brain disorder that slowly affects memory, thinking skills, and the ability to carry out basic tasks). -Difficulty walking. -Reduced mobility. -Insomnia (a sleep disorder which caused difficulty going to sleep, staying asleep and waking early). Review of the resident's Quarterly Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff for care planning), dated 3/7/25, showed he/she was cognitively intact. Review of the resident's Care Plan Report dated 2/28/25 showed: -He/She had activity preferences including taking care of plants/garden; going outside and getting fresh air when the weather was good; being alone and doing things by him/herself. -He/She had decreased mobility. Interventions included staff participation for transfers. -He/She had Parkinson's disease. Interventions included monitoring for risk of falls; mobility as tolerated; monitoring for poor balance, poor coordination and insomnia. Review of the Resident's Fall Incident Report dated 6/1/25 at 4:35 A.M. showed: -The resident was able to make his/her needs known. -He/She had gone out in the courtyard and was found lying face down on the concrete walkway. -He/She was found around 4:30 A.M. according to staff, after they did not find him/her in his/her room during regular room checks by his/her CNA. -He/She initially said he/she had gone outside around 8:00 P.M., but staff said this was not accurate. -He/She stated he/she went outside to find a spot to plant his/her tomato plant, he/she stood up and fell. -He/She did not know why he/she stood up. -He/She didn't remember the time he/she went out to the courtyard. -The staff state he/she was visiting with another resident until around 9:00 P.M. and that resident collaborated the same time. -The CNA stated he/she helped the resident to bed around 9:30 P.M. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The CNA stated when he/she did rounds, the resident was in bed until the 4:00 A.M. check, which occurred between 4:00 A.M. and 4:30 A.M. -When he/she was found by CNA A, the charge nurse was alerted and the resident was checked for injuries. -Staff stated neuro checks were within normal limits; blood pressure was noted to be low. -Ambulance was called per protocol for unwitnessed fall since the resident was on an anticoagulant. -Staff reported the resident was up more during the night, but had only tried to go out on the courtyard a couple times. -Staff stated they had never noticed him/her trying to leave the facility. -New interventions would be added when the resident returned from the hospital. Review of the resident's Progress Notes dated 6/1/25 at 6:58 A.M. showed: -He/She was found outside in the courtyard lying face down on the concrete walkway. -He/She did not tell staff he/she was going outside. -He/She went outside to find a place to plant his/her tomato plant. -He/She stood up and fell, but did not remember why he/she stood up. -He/She moved all extremities and denied any pain. -His/Her daughter stated his/her symptoms of Parkinson's, memory and cognition had worsened greatly. -He/She was encouraged to leave the door to his/her room open for more frequent monitoring and to not go to the courtyard late at night without staff knowledge. Review of the resident's Progress Notes dated 6/1/25 at 5:30 P.M. showed: -The resident was alert and able to have a conversation. -He/She was asked if he/she remembered when he/she had gone out in the courtyard and he/she could not remember the exact time he/she went out. -He/She did recall being in another resident's room crocheting prior to going to his/her room. -The other resident he/she was visiting thought he/she had left his/her room around 9:00 P.M. -He/She voiced that he/she was going out in the courtyard to see where he/she could plant the tomato plants he/she had gotten while out of the facility with his/her daughter the day before. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/She said he/she didn't yell for help and did not have his/her cell phone with him/her. -He/She did attempt to get him/herself up and was unable to do so. -He/She could not give a time frame for how long he/she was outside. During an interview on 6/2/25 at 9:30 A.M. the resident said: -He/She went out to the courtyard to see where he/she was going to plant his/her tomato plant. -He/She did not tell anyone he/she was going outside. -He/She did not call out for help because he/she didn't think anyone would hear him/her. -He/She fell because he/she stood up from his/her wheelchair. He/She probably should not have stood up. -He/She did not remember telling staff not to wake him/her during the night. During an interview at 11:43 A.M. CNA A said: -He/She found the resident in the courtyard. -The staff would do rounds every two hours, but did not typically check the courtyard. -He/She did not remember what time he/she last saw the resident up and around. -When rounding, he/she would stop near the resident's bathroom to check him/her, since he/she was continent, so he/she would not wake the resident up. -The resident had said not to bother him/her unless he/she needed something. -He/She could see the resident's feet in his/her bed from by the bathroom. -He/She came to work around 10:00 P.M. -The resident was very active at night sometimes, but usually stayed in his/her room. Sometimes he/she would be laying down or sometimes stay up knitting. -There was a light in the courtyard, but not very bright. -The resident was far enough back from the exit door in the courtyard that he/she would not have been seen if someone had glanced out. -The resident used his/her wheelchair to get around, but thought he/she could do more than he/she actually could. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/She went in the resident's room at 4:30 A.M., because something just told him/her to check and see if the resident was there. -He/She swore he/she saw the resident's feet in bed during the previous rounds. -He/She went to the nurse and the nurse had not seen the resident. -He/She got another CNA to assist him/her looking for the resident. -He/She decided to check the courtyard because the resident liked to go out there. -He/She found the resident face down and his/her wheelchair was behind him/her. -The resident was awake. -The resident said he/she had a tomato plant and was trying to find a spot to plant it. -The staff did rounds to check the residents every two hours, which is what they are trained to do. During an interview at on 6/2/25 at 12:00 P.M. Physician A said: -He/She was advised of the situation with the resident that morning. -The resident would sometimes go around in the facility during the evenings. -He/She had been working with the resident due to his/her difficulty sleeping, trying different medications. -He/She was not sure how mobile the resident was at night. -He/She had been having very thorough conversations with the resident about his/her sleep concerns; he/she was able to make his/her needs known. -The expectation would be that the resident was checked per the facility protocol during the night. During an interview on 6/2/25 at 1:10 P.M. CNA B said: -He/She assisted CNA A with the resident. -He/She started his/her round around 4:00 A.M. and CNA A came to him/her and said the resident was not in his/her room. -He/She checked all of the rooms in his/her hall and the resident was not in any of the other rooms. -He/She asked CNA A if he/she had checked the staff bathroom and it had been checked by the nurse. -They rechecked all of the resident rooms. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The previous week he/she had stopped the resident from going out to the courtyard around midnight because he/she was looking for his/her knitting bag, which was on the back of his/her chair. -The resident was a little forgetful. -They found the resident in the courtyard, face down on the ground, with his/her wheelchair to the side of him/her and folded on the ground. -The resident said he/she was out there trying to figure out where he/she was going to put his/her tomato plant. -Rounding was done every two hours and that meant laying eyes on the residents to make sure they were breathing. -The staff had not been checking the courtyard at night. During an interview on 6/2/25 at 1:30 P.M. Licensed Practical Nurse (LPN) A said: -When he/she was doing rounds at around 8:00 P.M. the resident was awake and laying in his/her bed. -The resident liked to go visit the other residents throughout the facility. -CNA A made rounds every two hours and said he/she walked in the resident's room and saw his/her feet. -The resident did not want to be awakened during the night, and did not want the light turned on. -During 4:00 A.M. rounds CNA A went further in the resident's room and found him/her missing. -The staff began looking for the resident; they checked all of the resident rooms and the bathrooms. -The resident was found in the courtyard. -He/She had no idea the resident had been going outside at night without staff knowledge. -The staff had never had anyone go out to the courtyard at night and and never thought of checking the courtyard. -If all the residents were in their beds, there would be no need. -The resident was awake when he/she was found, and denied pain. -The resident was sent to the hospital due to being on a blood thinner. -Rounding to check residents should be done every two hours. During an interview on 6/3/25 at 11:00 A.M. Resident #3 said: (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/She knew the resident and there were times the resident would try to get him/her to go with him/her to the courtyard. -The resident had been in the courtyard the night before he/she fell. -The resident was a night person; sometimes he/she would go to bed in the early morning hours. -He/She knew the resident went out at night, but did not think the staff were aware. During an interview on 6/3/25 at 11:10 A.M. Resident #2 said: -The resident had come to see him/her the night he/she fell, and left his/her room around 10:00 P.M. or a little before. -The resident did not ask him/her to accompany him/her to the courtyard that night, but had asked him/her earlier in the day. -The resident was a night owl and sometime would come visit him/her at 8:00-9:00 P.M. -He/She did not know if the staff knew the resident had been going out in the courtyard. During an interview on 6/3/25 at 12:30 P.M. the Director of Nursing (DON) said: -There was not an assignment for staff to check the courtyard. -He/She did not think the resident could have been out there long or he/she would have developed hypothermia (low body temperatures), since he/she was not a big person. -He/She was used to it being the standard that the charge nurse physically counted the residents at midnight and that was his/her expectation. -CNA A should have gone in and visualized the resident. -The resident did not wish to be awakened during the night because he/she didn't sleep well. -The resident stayed up later than people were used to. -The resident typically stayed in his/her room and staff had to encourage him/her to come out. He/She was just settling in to the facility. -The resident was excited about his/her plant as this was an activity he/she could do with the other residents. -The resident was starting to have more issues with his/her memory. During an interview on 6/3/25 at 1:00 P.M. the Administrator said: -The facility did not have a specific policy on rounding. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-CNA A said he/she rounded every two hours and he/she saw the resident's feet in his/her bed at 2:00 A.M. -CNA A peeked at the resident in his/her room at 10:00 P.M., 12:00 A.M. and 2:00 A.M. At 4:30 A.M. he/she was not in his/her bed. -The resident had asked not to be bothered at night. -They had caught the resident trying to go out late at night before but it was not unusual for him/her to be up late at night. -If the resident had gone through the dining room exit to the courtyard, the staff would have seen him/her. He/She went out the other exit to access the courtyard. -There had been some changes in the resident's cognition, but he/she was not an elopement risk. -The resident would go outside and sit in the courtyard for hours taking pictures of flowers. -He/She had been excited he/she could have his/her own tomato plant. -The facility did not lock the doors to the courtyards because another facility had gotten in trouble for doing so. -The courtyard had lighting. -The expectation was that rounding was done every two hours and maybe more if needed. -The charge nurse did not check residents' room-to-room at midnight. It was his/her expectation that this would be done. -It had not previously been a practice to check the courtyard at night, so they never did it. -CNA A should have gone into the room to check the resident. -The staff had seen the resident go outside before; it was a known thing. -It was his/her expectation that staff would follow the midnight census policy. -The resident's vital signs were within normal limits, when he/she was found. He/She did not say he/she was upset or cold. -The resident denied calling for help even though there were windows surrounding the courtyard. MO00255085 MO00255111 1