

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265872	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/06/2024
NAME OF PROVIDER OR SUPPLIER  Ignite Medical Resort Kansas City, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  2100 N W Barry Road Kansas City, MO 64154	

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 - Minimal harm or potential for actual harm</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>46987</p> <p>Based on interview and record review, the facility failed to provide protective oversight to one resident (Resident #1) with a known diagnoses including Alzheimer's disease, Dementia (unspecified), Cognitive Communion Deficit, Difficulty Walking and Falls. The resident eloped from the facility the night of 2/29/24 and was found by a motorist lying in the grass just off a nearby busy roadway. The facility staff were unaware the resident had left the facility. In addition, the staff failed to follow their policy and notify Resident #1's personal representative of the elopement. The facility census was 89.</p> <p>Review of the facility's policy on elopement, revised on 5/2024., included:</p> <ul style="list-style-type: none"> <li>-Elopement is defined as an incident in which a resident who has impaired decision-making ability and is oblivious to his/her own safety needs leaves the facility without knowledge of the facility staff.</li> <li>-Staff will immediately begin a search for the missing resident, once the resident is found notify the resident's responsible party or next of kin, facility staff, and public safety representative, contact the resident's attending physician.</li> <li>-Document relevant information in the clinical record.</li> <li>-Post documentation will be completed for 72 hours.</li> <li>-The Administrator will be responsible for investigating and reporting the elopement in accordance with regulations.</li> </ul> <p>1. Review of the hospital discharge summary, dated 2/26/24 indicated the following:</p> <ul style="list-style-type: none"> <li>- Impaired cognition;</li> <li>- Safety concerns with awareness;</li> <li>- Use of personal alarm to monitor activity;</li> <li>- High fall risk;</li> </ul> <p>(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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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- Requires supervision with frequent reminders/cueing.</p> <p>Review of the initial care plan dated 2/26/24 showed Resident #1 is at risk for elopement. No goals or staff direction regarding interventions were listed in the plan of care.</p> <p>Review of the nursing notes dated 2/29/24 regarding Resident #1 did not include documentation of an elopement.</p> <p>Review of the resident's care plan dated 2/29/24, showed:</p> <ul style="list-style-type: none"> <li>-The resident is at risk for elopement and wandering. Staff are to distract resident from wandering by offering pleasant diversions such as structured activities, food, conversation, television, books.</li> <li>-Staff are to monitor frequent observation of whereabouts of the resident.</li> <li>-The resident is at risk for falls.</li> <li>-The resident required staff assistance with all activities of daily living.</li> <li>-The resident has impaired cognition and staff are to anticipate and meet the needs of the resident.</li> </ul> <p>Review of the resident's clinical record for the month of February 26, 2024 through March 10, 2024 showed the Nurse Practitioner rounding notes dated 2/30/24 included:</p> <ul style="list-style-type: none"> <li>-Resident is seen in the room, sitting at bedside with wife present. Wife reports feeling like not knowing what physical therapy has been doing or what goals of therapy include. Therapy to follow up. Resident is noted to be aphasic (inability to speak), will answer questions with one word. Nursing reports resident got out of facility yesterday and was found walking down the street by bystanders. It is unclear if the resident has a history of wandering. No concerns addressed today about this.</li> </ul> <p>Review of Resident #1's Initial 5 Day Minimum Data Set, (MDS) ( A federally mandated assessment completed by facility staff) completed on 3/1/24., showed:</p> <ul style="list-style-type: none"> <li>- Diagnoses included: Progressive Neurological Conditions such as: Alzheimer's Dementia, Other forms of Dementia, Cognitive Communication Deficit, Seizure disorders, Anxiety and Depression.</li> <li>- BIMS score- Brief Interview for Mental status showed- Moderately impaired cognition- Score of 12.</li> <li>- Requires one person assistance for mobility with use of a walker.</li> </ul> <p>During an interview on 6/6/24 at 11:00 A.M. , Employee A., said:</p> <ul style="list-style-type: none"> <li>- He/she lives near the facility with a family member.</li> </ul> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<ul style="list-style-type: none"> <li>- On the night Resident #1s eloped from the facility his/her family member called him/her to say he/she found an elderly person lying next to the road and wondered if the person could be a resident from the facility.</li> <li>- He/she advised the caller to contact the police.</li> <li>- The family member took a picture of the elderly person and sent it to him/her.</li> <li>- Employee A recognized the person in the photo as Resident #1.</li> <li>- Employee A's said his/her family member told him/her the elderly person was confused, was lying on the ground, and did not know where he/she was.</li> <li>- Employee A's family member told him/her staff must have seen the police outside because they came out of the building to help the resident back up to the facility not long after police arrived.</li> <li>- Approximately 5 days after the incident, he/she was working and Resident #1's family member, Family Member B was visiting the resident in his/her room.</li> <li>- Employee A assumed Resident #1's family member was aware that Resident #1 had eloped and mentioned it however Family Member B said he/she was not aware the resident had eloped.</li> <li>- Family member B asked him/her What are you talking about, that was not my husband. Employee A showed Family Member B the photo that he/she had received and Family Member B confirmed the person in the photo was Resident #1.</li> <li>- Family Member B told Employee A that she had not been notified that Resident #1 had eloped and had been found off the property.</li> </ul> <p>During an interview on 6/6/24 at 12:45 P.M , Family Member B said:</p> <ul style="list-style-type: none"> <li>- He/she is the legal power of attorney for the resident.</li> <li>- The resident has severe Dementia and has had for a long time.</li> <li>- Neither nursing staff or administrator notified him/her that Resident #1 had eloped, he/she heard about it several days after the incident from an employee when she was in the facility visiting Resident #1.</li> </ul> <p>During an interview on 6/6/24 at 1:15 P.M. LPN A., said:</p> <ul style="list-style-type: none"> <li>- When the resident was brought back into the facility around 10:00 P.M. he/she did a head to toe assessment of Resident #1 and found, no injuries.</li> <li>- He/She thought he/she had documented the elopement in the resident's electronic medical record and said that it would be protocol to do so.</li> </ul> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- He/She thought he/she notified the residents physician and family but was not sure if she actually spoke with anyone.</p> <p>- He/She was not sure if the incident was documented in the resident's electronic medical record or if family was notified but it was protocol to do so.</p> <p>During an interview on 6/6/24 at 1:32 P.M. the Director of Nursing said:</p> <p>- She had stopped by to check in on the facility that night and saw the resident outside with police and a pedestrian on the grass by the road. She notified the facility staff of the resident being outside and had staff come to assist the resident back into the building.</p> <p>- She had asked the resident if he/she would like the staff to call his/her family member, and he/she had said no.</p> <p>- That the resident had a BIMS of 14.</p> <p>- The the facility had completed an investigation of the incident and risk management documentation however that information is not part of the residents medical record.</p> <p>During an interview on 6/6/24 at 1:45 P.M the Interim Administrator said:</p> <p>- The facility completed investigation and that documentation is not in the the residents electronic medical record.</p> <p>- The facility followed their elopement policy, the resident was not off the property, was in view of facility cameras, and only gone for 15 minutes.</p> <p>- The Director and Administrator met with the resident's responsible party the following day however he does not have documentation of the conversation.</p> <p>MO 236160</p>		