STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265693	A. BUILDING _____ B. WING _____	07/14/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
REDWOOD OF INDEPENDENCE	1800 S SWOPE DRIVE INDEPENDENCE, MO 64057

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0689 **Level of harm -** Immediate jeopardy **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 observation, interview, and record review, the facility failed to provide supervision to prevent elopement for a resident who was identified as a high risk for elopement by the facility for one sampled resident (Resident #1) out of four sampled residents. The resident eloped from the locked dementia unit and went outside the facility on 7/8/20 at 7:40 P.M. and remained outside the facility until 5:00 A.M. on 7/9/20, without the facility staff aware of the resident's whereabouts for nine hours. The resident was found to have swollen legs and bruising on his/her right shoulder, chest, on the back of his/her knees, and the back of his/her right hand and redness to his/her buttocks after being found outside the facility the following morning. The facility census was 105 residents. The Administrator was notified on 7/13/20 at 5:23 P.M. of an Immediate Jeopardy (IJ) which began on 7/8/20. The IJ was removed on 7/13/20, as confirmed by surveyor onsite verification. Record review of the facility's undated Wandering and Elopement Policy showed: -The facility would identify residents at risk for elopement and minimize any possible injury as a result of an elopement. -Nursing and the interdisciplinary team would assess residents upon admission, readmission, quarterly and upon identification of a significant change in condition to determine the resident's risk of wandering and/or elopement. -When a resident was found missing, the charge nurse would call a Code Pink and organize a search. -Facility staff would search areas of the facility, including common areas, bathrooms, showers, and outside areas. -The licensed nurse most familiar with the incident would document in the resident's medical record how the elopement occurred. -The facility would make necessary reports to state agencies. Record review of the facility's undated Elopement Risk Reduction Approaches Policy showed: -Staff were to ensure that residents are able to move about freely while being monitored and remain safe. -Staff were to have a missing resident procedure that included accounting for each resident on a regular basis. -Staff were to accompany wandering residents on their journeys when supervision was required to ensure safety or to encourage a meaningful, alternate activity. Record review of the facility's undated Certified Nursing Assistant (CNA) and Certified Medication Technician (CMT) job descriptions showed the responsibility of checking on residents in their assigned section regularly when working. 1. Record review of Resident #1's hospital Physician's Progress Note, dated 6/5/20, showed: -Had a [DIAGNOSES REDACTED]. -had a history of [REDACTED]. -Was brought to the hospital by the police. -The family requested the resident to be placed at a long-term care facility as they are unable to care for him/her at home. Record review of the resident's Face Sheet, showed he/she admitted to the facility on [DATE] with the following Diagnosis: [REDACTED]. -[MEDICAL CONDITION], malnutrition, low potassium, high blood pressure. -Difficulty in walking. -Need for assistance with personal care. -Cognitive communication deficit. -[MEDICAL CONDITION] disorder (a mental condition that causes loss of contact with reality and mood problems). -Dementia. -Major [MEDICAL CONDITION] (a mental disorder characterized by a feeling of profound and persistent sadness or despair and is frequently accompanied by a loss of interest in things that were once pleasurable). -Anxiety disorder. -Low back pain. Record review of the resident's Admission, History and Physical, dated 6/10/20, showed: -Was admitted to the facility due to wandering, altered mental status, and increased memory loss. -Had a [DIAGNOSES REDACTED]. Record review of the resident's Wandering Risk Scale, dated 6/10/20, showed: -Was at high risk for wandering with a score of 14 (11 or higher was high risk). -Was ambulatory. -had a history of [REDACTED]. -Had wandered within the home without leaving the property grounds. -Had wandered in the past month. Record review of the resident's Behavior Note, dated 6/11/20, showed: -Was combative. -Had blocked the door that goes in and out of the locked dementia unit. -Had slammed another resident's wheelchair into the back exit door and pushed the door to try to get out. -Had told healthcare team to shut up, and that it was their fault, he/she was 'going to sue them for keeping him/her in the memory care unit.' -Was able to be redirected. Record review of the resident's Admission Minimum Data Set (MDS - a federally mandated assessment tool completed by facility staff for care planning), dated 6/16/20, showed: -Was admitted to the facility on [DATE]. -Was severely cognitively impaired. -Displayed verbal behaviors one to three days out of the past seven days. -Displayed no physical or other behaviors. -Displayed behaviors that put the resident and others at risk for physical injury. -Displayed behaviors that significantly interfered with the resident's care and participation in activities and socialization. -Displayed behaviors that significantly intruded on others and disrupted care or the living environment. -Did not wander. -Displayed mood symptoms that indicated moderate depression. -Required supervision for most self-cares. -Was occasionally incontinent of bowel and bladder. -Some of his/her [DIAGNOSES REDACTED]. -Did not use tobacco. Record review of the resident's undated exit seeking care plan with the admitted showed: -He/she admitted [DATE]. -The resident was at risk for exit seeking and wandering related to being disoriented to place and had impaired safety awareness with a history of attempts to leave the facility. -Interventions included: --Assess the resident's fall risk. --Distract the resident from wandering by offering pleasant diversions, structured activities, food, conversation, television or books. --Identify the resident's pattern of wandering and intervene as appropriate. Record review of the resident's undated memory care unit care plan showed: -admitted [DATE]. -Resided on the memory care unit related to a [DIAGNOSES REDACTED]. -Had the following interventions: --Address the resident by name when giving care and involve the resident as much as possible. --Explain all procedures using terms that the resident can understand. --Monitor the resident per protocol to ensure safety. Record review of the resident's Nurse's Note, dated 6/17/20, showed: -Was exit seeking by trying to go out the back door of the locked dementia unit. -Tried to scratch the staff member who was standing by the back door. -Believed he/she was at the facility because of the police. -Had said Jesus wanted him/her to leave now and that was why he/she was trying to exit out the door. Record review of the resident's Behavior Note, dated 6/27/20, showed: -Displayed increased anxiety and agitation towards staff. -Entered other residents' rooms without permission causing other residents to become upset. -Tried to exit both doors on the locked dementia unit and was redirected by staff. Record review of the resident's facility Skin Check, dated 7/3/20, showed he/she did not have any skin abnormalities (no bruising, rashes, wounds, etc.). Record review of the resident's monthly Physician's Progress Note, dated 7/8/20, showed: -Was oriented to self only. -Was anxious and agitated. -Had poor judgment and insight. -Had [MEDICAL CONDITION] (swelling) in his/her extremities. Record review of the resident's July 2020 Medication Administration Record [REDACTED].M. -On 7/8/20, the resident refused [MEDICATION NAME] (dementia medication) 20 milligrams (mg) which was scheduled for 8:00 P.M. Observation of the facility's video footage, dated 7/8/20, showed: -At 7:40 P.M., the resident was seen outside the locked dementia unit at the entrance to the 400 hallway, walked past the nursing station and turned left toward the 500 hall. -At 8:13 P.M., the resident walked by the building from the outside by the end of the 800 hall which is on the opposite end of the building from the locked dementia unit. Record review of Wunderground.com showed the weather on 7/8/20 was: -7:53 P.M. 86 degrees Fahrenheit (F) and 65% humidity. -8:53 P.M. 82 degrees F and 69% humidity. -9:53 P.M. 82 degrees F and 67% humidity. -10:53 P.M. 81 degrees F and 69% humidity. -11:53 P.M. 80 degrees F and 71 % humidity. -There was no precipitation noted. Record review of the facility Midnight Census,

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 0689 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 1) dated 7/9/20 1:52 A.M., showed the resident was checked in as present and Registered Nurse (RN) A signed the midnight census for the 300 and 400 locked dementia units. Record review of the facility's Self-Report to the State Agency, dated 7/9/20 at 9:38 P.M., showed the facility reported: -The resident, who resided on the 400 locked dementia unit, was found outside around 5:00 A.M. on 7/9/20. -At the time, it was unknown how the resident got out of the facility. -At the time, it was unknown how long the resident had been outside. Record review of Wunderground.com showed the weather on 7/9/20 was: -12:53 A.M. 79 degrees F and 77% humidity. -1:53 A.M. 76 degrees F and 82% humidity. -2:53 A.M. 77 degrees F and 82% humidity. -3:53 A.M. 78 degrees F and 79% humidity. -4:06 A.M. 77 degrees F and 66% humidity. -4:10 A.M. 76 degrees F and 67% humidity. -4:37 A.M. 70 degrees F and 81% humidity. -4:53 A.M. 70 degrees F and 78% humidity. -There was no precipitation noted. Further review of the resident's undated exit seeking care plan showed: -He/She wandered from the facility on 7/8/20. -There were no new interventions. Record review of the resident's Incident Audit Report, dated 7/10/20, showed: -On 7/9/20 at approximately 5:00 A.M., CNA A asked Assistant Director of Nursing (ADON) A to go with him/her to see if a person sitting outside was one of the facility's residents. -The resident was sitting between the trees. -ADON A notified the Director of Nursing (DON) immediately. -Staff brought a wheelchair out to the resident and returned him/her to the inside of the facility. -Vitals were obtained. -A head to toe assessment was completed. -The family member and nurse practitioner were notified. -The resident reported his/her pain level to be a 4 out of 10 with 10 being the worst pain ever. -The resident had bruises on his/her right shoulder, chest and back of knees and redness to his/her buttocks. -The resident had [MEDICAL CONDITION] 2+ (leaves a slight indentation when a finger is pressed into the skin) his/her left foot and 3+ (5-6 millimeter indentation that takes 10-30 seconds to return to normal after a finger is pressed into the skin) in his/her right foot. During an interview on 7/10/20 at 10:20 A.M., the Administrator said: -The DON called him/her around 5:30 A.M. on 7/9/20 and said the resident was sitting outside. -His/Her understanding was that the resident was smoking. -It wasn't until later in the afternoon of 7/9/20 that he/she realized the resident had been out all night. -The people that lived next door sit in the area where the resident was seen. During an interview on 7/10/20 at 10:20 A.M., the DON said: -They watched the video footage and could see the resident walking at the front of 400 hall, outside the locked area and he/she turned left and headed toward the 500 unit. -There was an alarm sounding on the 400 unit. -An alarm went off in the main dining room at 8:00 P.M. -Staff were looking at the alarm panel. -Staff said they checked out the main dining room door and called maintenance, because they couldn't re-set the main dining room door alarm. -Staff said they checked all residents on the 300, 400 and 500 units and they were all there. -CNA A saw a person outside sitting under a tree near the 900 unit at 11:00 P.M. on 7/8/20 when he/she took his/her lunch break, but it was not uncommon to see people over there. -CNA A then saw the same person sitting outside under a tree near the 900 unit when he/she took out the trash around 5:00 A.M. -CNA A went and got ADON A and they brought the resident in, did an assessment and made sure he/she was alright. -It was 75 degree F outside at the time the resident was found. -Someone had been in earlier on 7/8/20 working on the door alarms. -Staff thought the alarms were not functioning. -He/She notified the Administrator at 5:30 A.M. During an interview on 7/10/20 at 11:15 A.M., the Regional Director of Clinical Services said: -The resident was found with burrs (a seed or dry fruit that has hooks or teeth) on his/her socks. -The resident said he/she was looking for a table near the garage. -The facility staff had found the resident's shoes outside by the 900 hall. -The facility staff found one of the resident's socks to the left of the 900 unit outside the entrance near some bushes. -The facility staff found the resident seated under a tree, far back enough from the front of the building that staff would not be able to see him/her from the front entrance. Observation and interview on 7/10/20 at 11:30 A.M., showed the resident: -Was sitting in the lounge area of the locked dementia unit and a staff member was sitting nearby watching him/her. -Did not remember going outside or anything about the incident. -Had visible bruises of a circular purple bruise on the top of his/her right hand on the 5th finger side and a purple bruise and a lighter purple bruise about 2.5 inches long that wrapped from top side to bottom side of the resident's arm just below his/her wrist. During an interview on 7/10/20 at 3:44 P.M., CMT A said: -He/She worked 7:00 A.M. to 8:00 P.M. on the 400 locked dementia unit on 7/8/20. -He/She left before the resident eloped. -The resident was always trying to get out and would say he/she wanted to see his/her family. -He/She tried to distract him/her when the resident was anxious. -When he/she left on 7/8/20, the resident was sitting near another CNA and the resident was saying he/she was going to get out of here. -Sometimes the doors on the 400 hall got stuck and maintenance would fix them. Record review of CMT A's time sheet showed he/she clocked out at 7:38 P.M. on 7/8/20. During an interview on 7/10/20 at 3:50 P.M., the Maintenance Director said: -To enter the 400 locked dementia unit, one needed to push the button on the wall to the right of the door to deactivate the alarm and unlock the door. -To exit the unit, one entered the numeric code on the keypad panel to the right of the door inside the unit to deactivate the alarm and release the door. -The secured door (magnetically locked) onto the 400 hall could be opened if the push bar on the door was depressed for 15 seconds or more. -The door could be opened, but the door alarm would be activated. -Someone would need to silence the door alarm for it to stop sounding. -If the door was opened and held in place with the door magnets attached to the walls (such as when someone was taking in large objects into the unit like dietary and/or laundry carts, etc.), the alarm would sound the entire time the door was held open. -There were no records of activation of any door alarms as those alarms were not connected to the computer system/alarm company. -If a door alarm sounded, staff would get on the overhead intercom system and ask staff to address the alarm that was sounding. -Staff were to go to the area involved and assess the situation, and were to try to determine why the alarm was sounding. -If unable to determine why the alarm had sounded, staff would be expected to verify the presence of each resident within the building to ensure no resident had eloped (left the facility without letting staff know). -Two staff were expected to walk the perimeter of the building (one going right, the other going left) to determine if any residents had exited the building. -Staff would come back inside, findings were to be documented and the facility management notified. -If a resident was missing from the facility and hadn't been found, staff were supposed to notify the police. During an interview on 7/10/20 at 4:08 P.M., CNA E said he/she: -Worked 2:00 P.M. to 10:00 P.M. on 7/8/20 on the 300 unit. -Heard a door alarm sounding. -Found it was the alarm on the main dining room door that was going off. -Called the Maintenance Director at 8:05 P.M. to see if he/she could shut the door alarm off and he/she told him/her how to re-set it. -Was told a perimeter search was done but doesn't know who did it. -Waited further instructions from the charge nurse but was not given any. -The 400 doors to the facility locked unit had been malfunctioning. -On 7/8/20, when he/she pushed the 400 door, the alarm sounded but opened without a 15 second delay, he/she had reported this to the charge nurse. Record review of the resident's Incident Note, dated 7/10/20 at 4:55 P.M., showed: -DON, Administrator, family member/responsible party notified. -The incident was not described. -A head to toe assessment was completed on the resident and the resident was assessed for any injury. -Injuries were not identified on assessment. -A skin check was completed. -The results of the skin check were not identified. -The resident returned to the unit under constant observation or one-on-one. -The investigation continued. -The resident's family member was kept up to date on the investigation. -The resident's spouse was also in a skilled facility, the family chose to move the resident to the facility where the spouse was located. During an interview on 7/10/20 at 5:03 P.M., CMT B said: -The door alarms kept going off on 7/3/20 and it was getting annoying. -He/She reported the door problem to the Maintenance Manager then. -The door alarm was messing up on 7/7/20. -The 400 door wouldn't stick on 7/7/20 and wasn't closing. -He/She was passing medications on the 300 hall around 8:00 P.M. on 7/8/20. -At 8:17 P.M., CNA D from 500 hall said the door in the dining room was going off, so he/she did a head count on 300 hall and they were all there. -He/She asked CNA I to count the residents on the 400 unit. -He/She was not instructed to do a perimeter sweep. -He/She went on the 400 unit at some time after the alarm was sounding and no staff were on the 400 unit. -He/She asked RN B where CNA I was and RN B said he/she was on a break. -400 unit cannot be left unattended by staff. -CNA I was in and out of 400 unit and no one else was on the unit. During an interview on 7/10/20 at 5:25 P.M., RN B said: -Worked the day and evening shift on the 300 unit and half of the 400 unit on 7/8/20. -There was an electrical issue that resulted in the fire doors remaining shut. -Had passed medications on the 300 unit behind the closed fire doors when he/she heard some type of alarm. -Sent CNA E to find out what the alarm was. -CNA E found the dining room alarm was going off. -CNA E called the Maintenance Director to find out how to turn the alarm off. -CNA D did a head count on the 500 unit and all of the residents were there. -Had thought CMT B did the head count on the 400 locked dementia unit, because CMT B walked back onto the 400 unit. -Asked CNA D if a perimeter sweep was done and CNA D said it was, but did not say who did it. -Did not know who did the perimeter sweep. -CNA I came off of the 400 unit after the alarm went off and went for his/her break. -Assumed the 400 unit staff did their rounds on the unit. -He/She would expect the staff to do their rounds and physically see the residents. -The resident was aggressive, combative and is constantly trying to push the 400 unit doors open. -The resident tried to go out a window once. -Did not know how the resident got out off of the 400 locked dementia unit and out of the building. During an interview on 7/10/20 at 5:50 P.M., the DON said he/she was told that CNA

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F 0689 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 2) D, CNA E and CMT B did a perimeter sweep. During an interview on 7/10/20 at 6:00 P.M., CNA A said he/she: -Worked on the rehab side of the facility on the night shift of 7/8/20 into the morning of 7/9/20. -Left for his/her lunch break around 11:00 P.M. -Saw a person wearing a mask who was sitting between a tree and a bush on the ground between the facility and the housing next door. -There were always people from the housing area next door outside on the lawn or outside smoking. -The person seemed fine and he/she had not seen the person before. -Had left the property. -Had turned in a different entrance when he/she returned to the facility. -At about 5:00 A.M., he/she was taking the trash out and he/she saw the same person in the same clothes, sitting in the same place and sitting in the same position. -The person had one sock on his/her left foot and none on his/her right foot and no shoes. -Asked the person his/her name and he/she responded that he/she was taking a break. -Asked the person his/her name again and he/she said it was none of his/her business. -Went inside the facility and asked ADON A to come with him/her to see if the person was one of their residents. -ADON A identified the person as Resident #1 who resided on the 400 locked dementia unit. -Reached his/her hand out and the resident was able to pull himself/herself up, the resident was able to stand fairly well with swollen legs. -ADON A had brought a wheelchair to the resident and took him/her inside. -Took the resident's vitals, wrote them down and gave them to ADON A, while the nurses assessed the resident. -Had not heard any door alarms sounding during his/her shift. During an interview on 7/12/20 at 11:27 A.M., CNA G said: -He/She worked the evening shift on 7/8/20 on the 500 unit with CNA D. -He/She usually worked on the other side of the building on the rehab unit. -The fire doors wouldn't attach to the magnets to keep them open. -He/She didn't hear any alarms go off on that evening. -He/She heard one of the 400 unit CNAs tell RN B about something after dinner, but he/she didn't hear what it was. -Then RN B asked him/her and CNA C and one other staff member (didn't know their name) to look around outside for any residents. -They walked around the whole building after dinner and no residents were found outside. -He/She was not familiar with the resident. -He/She rounds on the residents who are incontinent and need to be checked. -The other residents use their call lights if they need something. During an interview on 7/12/20 at 11:48 A.M. Licensed Practical Nurse (LPN) A said: -He/She worked the evening shift on the 500 hall on 7/8/20. -CNA D said the main dining room alarm went off that evening. -CNA D said he/she checked his/her hall, which was the 500 hall to see if all the residents were there and they were. -He/She was new there and didn't know how often rounds were usually done. During an interview on 7/13/20 at 1:00 P.M., the DON said he/she could not provide orientation paperwork on LPN A as he/she had not turned it in yet. During an interview on 7/12/20 at 11:57 A.M., CNA J said: -He/She worked on the 400 locked dementia unit from around 2:00 P.M. and left around 7:00 P.M. on 7/8/20. -The doors were fine and were not alarming when he/she left. -The resident was asking if he/she could go home. -He/She explained to the resident why he/she could not go home. -He/She re-directed the resident when he/she says he/she wants to go home. -He/She gave the resident some gloves and towels before he/she left, so the resident could wipe off the tables to keep the resident busy and distract him/her. -He/She told CNA I the resident would mess with the doors and told him/her to re-direct the resident and keep him/her busy with things like folding clothes. Record review of the facility timeclock, dated 7/28, showed CNA J left at 6:56 P.M. During an interview on 7/12/20 at 12:38 P.M., CNA I said: -He/She worked 2:00 P.M. to 10:05 P.M. on 7/8/20. -He/She did not initially have an assigned hall. -He/She floated between halls for about the first hour and then ended up staying on the 400 locked dementia unit for the rest of his/her shift. -He/She doesn't usually work on the 400 locked dementia unit. -He/She heard a bath aide say to CMT A that the 400 door was messing up again. -The last time the 400 door was messing up, the door wouldn't latch so the alarm would sound even if it was shut and the door alarm would just keep going off. -He/She heard something about the main dining room door going off that night, but the nurse took care of it so he/she didn't really know anything about it. -CNA J and CMT A were on the 400 locked dementia unit with him/her earlier in the shift. -CNA J left around 7:30 P.M. -They are supposed to do rounds every two hours. -He/She did rounds. -He/She talked to the DON and knows the resident was seen on video off of the 400 locked dementia unit around 8:00 P.M. -He/She remembers he/she had just put another resident to bed before leaving and the resident was trying to walk with him/her. -He/She thought he/she saw the resident sitting at the table in front of the fan on the 400 unit messing with plastic wrap on a cookie when he/she left the facility. -He/She could not explain why the facility video showed the resident outside at 8 :00 P.M. -The resident does wander. -The resident tried to go into other resident's rooms. -The resident thinks he/she was going to California. -The resident asked how to get out and tried to push on the door and they would have to try to distract him/her. -He/She gets most of the residents in bed on the 400 unit before leaving for the evening. -CMT A left around 9:00 P.M. Record review of the facility time clock, dated 7/8/20, showed CNA I clocked out at 10:00 P.M. During an interview on 7/12/20 at 12:59 P.M., RN A said: -He/She worked at the facility two shifts per week and had only worked at the facility for two weeks. -He/She was trained on the rehab unit and on the 500 unit. -He/She was not trained on the 300 or 400 unit. -He/She didn't know the residents on the 300 or 400 unit. -He/She worked the night shift and was responsible for the 300 unit and the even rooms on 400 unit, which was about 40 residents (this included Resident #1). -He/She came in at 10:00 P.M. -He/She was told the fire alarm went off that morning, so all the magnets were not working resulting in all of the fire doors remaining closed. -He/She didn't hear any alarms go off that night. -He/She spent most of the night on 300 unit and went on 400 unit once to give a resident a pill. -He/She didn't look to see what staff were on the 400 unit. -There was a CMT scheduled on the 400 unit, so he/she stayed on the 300 unit. -He/She relied on the 400 unit being a locked unit with two scheduled staff working on the unit. -He/She expected the staff to round every two hours and check on all residents. -LPN B gave him/her the resident roster and told him/her to do census on his/her side. -He/She had not seen other staff go room to room looking to see if the residents were there when marking midnight census. -He/She thought checking the midnight census was a billing thing and that it meant checking to see if there were any residents on the list that went out to the hospital or were discharged . -He/She did not think doing the midnight census was an actual head count. -He/She completed the midnight census that night, but not by doing an actual head count. -No one on the night shift that night said anything about a door alarming. -There was a resident on the 300 unit who was trying to get out the door at the end of the hall that he/she had to keep re-directing. During an interview on 7/12/20 at 1:49 P.M., LPN B said: -He/She worked from 10:00 P.M. on 7/8/20 to 6:00 A.M. on 7/9/20 and was assigned to the 500 unit and to the odd number rooms on 400. -The main dining door alarm happened before he/she got there. -The facility tested the alarms and they were working. -The fire doors were closed. -CNA K and CNA L were the CNAs on night shift on the 500 unit. -CNA C and someone else (he/she didn't know who) were the CNAs on the 400 locked dementia unit. -The resident who left the building was not on his/her side of the 400 hall. -The CNAs were supposed to do rounds every two hours. -He/She did his/her side of the midnight census (500 and 400 odd numbered rooms) and RN A did his/her side (300 and 400 even numbered rooms). -For the midnight census, he/she went back and checked to see if everyone was there and looked for anything different from what was on the census sheet, like if a resident changed rooms or was in the hospital. -All the residents in his/her area were present that night. -RN A was on the 300 unit most of the shift. -He saw RN A go on the 400 locked dementia unit once, possibly to give a resident medication. -No alarms went off while he/she was there that night. -There's a panel at the nurses' station and it did not indicate any doors were open. -It was a quiet night. -The resident had followed people off of the locked unit before. -The resident would say he/she wanted to go home and staff re-directed him/her. During an interview on 7/12/20 at 2:18 P.M., Dietary Aide A said: -He/She heard an alarm going off in the dining room around 7:00 P.M. -He/She didn't know why the alarm was sounding. -The alarm was still going off around 8:00 P.M. -Dietary staff closed the kitchen doors around 8:00 P.M. and he/she could no longer hear the alarm after the doors were closed. -No one announced any type of code to indicate the reason the alarm went off. During an interview on 7/12/20 2:24 P.M., the Cook said: -He/She heard alarms while he/she was in the kitchen when cleaning up after dinner. -He/She looked at the door in the dining room and the door in the hall by the dining room and they were closed. -A code was not announced overhead to indicate any type of alert they needed to respond to and no one asked them any questions about the alarm. -The alarm was going off for a long time. During an interview on 7/12/20 at 6:23 P.M., ADON A (ADON of the Express Recovery Unit (rehab) ERU) said: -He/She worked as the charge nurse on the rehab side of the facility from 6:00 P.M. on 7/8/20 to 6:00 A.M. on 7/9/20. -He/She didn't hear any alarms all night. -He/She was at the front of the building when CNA A came and asked him/her to see if the person he/she saw outside on the curb was one of their residents. -CNA A said he/she saw this person earlier when he/she left for his/her break around 11:00 P.M. and this person was in the same place as he/she was earlier. -He/She saw the person outside and knew it was one of their residents. -He/She asked the resident his/her name and the resident did not want to tell him/her his/her name. -He/She knew the resident lived on the 400 locked dementia unit. -He/She did not know the resident's elopement history. -He/She called the DON. -He/She and CNA A helped the resident stand up. -The resident's feet were swollen. -He/She went into the building and asked a staff member to get a wheelchair. -They brought the resident into the building in the wheelchair. -He/She notified the nurse practitioner, the charge nurse, and the family. -They checked the resident's vital signs and they were all within

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265693	A. BUILDING _____ B. WING _____	**07/14/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
REDWOOD OF INDEPENDENCE	**1800 S SWOPE DRIVE INDEPENDENCE, MO 64057**

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 -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 3) normal range. -They assessed the resident. -The resident had some bruises on his/her shoulder, chest, and knees. -The bruises looked like they could have been new bruises. -The resident's bottom was a little red. -They had checked to make sure all other residents were present in the building. -They had someone sit with the resident one-on-one from then on. -He/She would expect that staff are seeing what's going on with their residents such as where they are, what they are doing, etcetera. -He/She would expect staff to print off the census and check to make sure every resident was present. -There were two staff on the 400 locked dementia unit. -He/She was not aware of a time when no staff were on the 400 locked dementia unit. During an interview on 7/13/20 at 1:00 A.M., CNA L said: -He/She worked on the 500 unit on the night shift on 7/8/20 into the morning of 7/9/20. -He/She wasn't aware the resident was missing that night