STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175549	A. Building B. Wing	11/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stratford Commons Rehab & Health Care Center	12340 Quivira Road Overland Park, KS 66213

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 to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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
	175549	A. Building B. Wing	11/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stratford Commons Rehab & Health Care Center	12340 Quivira Road Overland Park, KS 66213

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 to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 53 residents, with three residents sampled for elopement risk. Based on observation, interview, and record review, the facility failed to provide adequate supervision to prevent newly admitted Resident (R) 1, who had documented intermittent confusion and exit-seeking/wandering behaviors, from leaving the facility on 10/18/25 between 05:20 AM and 05:30 AM, without staff knowledge. R1 remained outside of the facility (whereabouts unknown) for approximately five and a half hours, wearing only a hospital gown and no shoes, in approximately 65 degrees Fahrenheit temperature. Law enforcement located R1 at 10:50 AM, approximately one mile from the facility, wearing a hospital gown and no shoes. The facility discovered the South egress door was not locked and did not alarm when pushed. This deficient practice placed R1 in immediate jeopardy.Findings included:- R1 admitted to the facility on [DATE].R1's Electronic Medical Record (EMR) documented a diagnosis of hepatic encephalopathy (a serious brain dysfunction caused by liver failure, leading to the accumulation of toxins in the bloodstream, particularly ammonia and psychiatric changes of varying degree).R1's 10/16/25 Care Plan documented R1 had an activity of daily living (ADL) self-care performance deficit and required one staff assistance with transfers.R1's EMR revealed the following:A 10/16/25 admission Assessment documented he was alert and oriented to person and place with intermittent confusion.A 10/16/25 Elopement Assessment documented R1 was not at risk for elopement. An Orders- Administration Note dated 10/18/25 at 04:12 AM documented R1 eloped most of the shift and went into other residents' rooms. The note documented R1 peed on the floor, staff could not re-orient him, R1 walked unsteadily, and became combative with staff.A Situation, Background, Assessment, Recommendation (SBAR) Note dated 10/18/25 at 06:48 AM documented R1 experienced a change in condition of eloping. The note documented Licensed Nurse (LN) G last saw R1 between 05:15 AM and 05:30 AM when a Certified Nurse Aide (CNA) redirected R1. CNA N reported to LN G she could not find R1 and the facility immediately conducted a head count. LN G documented he and the CNAs checked around the facility and parkway. LN G notified Administrative Nurse E of the incident. The oncoming staff, Certified Medication Aide (CMA) R, searched in the neighborhood. The police arrived around 06:10 AM and asked the facility to continue to search inside while they searched the neighborhood.In a Health Status Note dated 10/19/25 at 12:36 AM, LN G documented he received shift report that R1 had been wandering and exit seeking. LN G documented earlier in the shift staff found R1 in a nearby room, where R1 unclothed himself. LN G and staff took R1 to the bathroom and redirected R1 to his room. LN G documented R1 could not stay in one place and whenever staff put socks or briefs on R1, R1 took them off. Staff found R1 in different resident rooms and the staff tried various activities to help R1 including walking R1 in the hallway, keeping R1 where the CNA sat, rehydrating R1, and reading bulletins in the activity room; but none were effective. LN G documented he tried to notify the clinical on-call, without answer. When the routine activity ended around 11:00 PM, LN G administered medication to R1 which helped him sleep for an hour. LN G witnessed R1 exit seeking on two occasions, and LN G redirected R1 and walked with him down the hall. The note revealed R1 was not communicative and became combative on one occasion, as reported by CNA N. LN G documented he notified Administrative Nurse E of the incident and he called the police while LN H called R1's representative around 05:47 AM.The facility's 10/23/25 Investigation documented on 10/18/25 at around 05:20 AM, CNA M last observed R1 in the northwest corner of the facility, sitting in the family area by the breakroom. R1 wore a (hospital) gown, no socks, and no shoes. LN G reported R1 had been wandering the facility throughout the night and staff attempted re-direction with hands-on activities and taking R1 back to his room, without success. The investigation documented the temperature was 67 degrees Fahrenheit and R1 wore a gown at the time of his departure. The investigation documented the following timeline on 10/18/25:Between 05:20 AM to 05:30 AM, CNA N noticed R1 was not sitting in the same area and immediately started a search.At 05:30 AM, LN G, LN H, CNA M, CNA N, and CNA O conducted an interior search of the facility. CNA N checked all of the rooms, bathrooms, doors, courtyard, and therapy rooms.At 05:40 AM, LN G, LN H, and CNA N conducted an exterior search of the facility. CNA N checked the parking lot of the apartments south of the facility.At 05:45 AM, CNA O drove around the neighborhood including the apartment complex south of the facility for about 20 to 25 minutes.At 05:47 AM, LN G notified law enforcement.At 05:50 AM, CNA M searched the perimeter of the community.At 05:56 AM, LN G notified Administrative Staff A and Administrative Nurse D.At 06:00 AM, CNA N did another exterior check of the