STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035074	A. Building B. Wing	03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Friendship Village of Tempe	2525 East Southern Avenue Tempe, AZ 85282

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50553 Based on observation, clinical record review, facility documentation, and staff interviews, the facility failed to ensure that one resident (#39) was not physically or sexually abused by another resident (#55). Findings include: Resident #39 was admitted to the facility on [DATE] with diagnoses that included cellulitis of the left upper limb, dementia without behavioral disturbance, and generalized muscle weakness. Review of the Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 11, indicating moderate cognitive impairment. Review of the resident's care plan revealed a focus, initiated on February 16, 2025, that indicated that the resident had memory deficits related to her diagnosis of dementia. Review of Resident #39's progress notes revealed no evidence that any potential abuse situations had occurred on the night of March 2, 2025. There was evidence that a skin assessment was completed, noting bruising on multiple parts of the resident's body, which was documented as present on admission. Additionally, the nursing noted on March 2, 2025 at 11:00PM revealed that Resident #39 was noted to be bleeding from the right elbow, which was then cleaned and dressed appropriately. Resident #55 was admitted to the facility on [DATE] with diagnoses that included dementia without behavioral disturbance, insomnia, and hyperlipidemia. Review of the Quarterly Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 6, indicating severe cognitive impairment. Review of Resident #55's progress notes revealed no evidence that any potential abuse situations had occurred on the night of March 2, 2025. There was a note dated March 3, 2025 at 07:04AM, which revealed that Resident #55 had been moved to a room on the third floor, though no rationale was given as to why the change had occurred. An additional note on March 3, 2025 at 1:14PM revealed that the resident was discharged to memory care, though the note on March 5, 2025 at 15:37 revealed that the resident returned to his room on the third floor from memory care on this date. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility investigation revealed hand-written statements, written on March 2, 2025, from staff members who witnessed the event. In these statements, three Certified Nursing Assistants (Staff #22, Staff #16, and Staff #18) confirmed witnessing Resident #55 inappropriately touch Resident #39, including squeezing her arms and grabbing her breasts. The statements from the CNAs revealed that Resident #55 continued these behaviors despite staff re-direction and Resident #39 telling him to stop. Interview was conducted on March 6, 2025 at 11:49AM with a Certified Nursing Assistant (CNA/ Staff #17), who stated that he would consider inappropriate touching to be abuse, and that if he saw this occur, he would separate the residents immediately and report it to his supervisors. The CNA also explained that he felt there was enough staffing to monitor and care for residents, except when staff call out of work. He stated that management does not help to work the floor when the staffing is short. Interview was conducted on March 6, 2025 at 12:05PM with a Registered Nurse (RN/Staff #25), who stated that she would consider inappropriate touching, such as touching of the breast area, to be potential abuse. She stated that if she witnessed any signs of abuse, she would report this to her supervisor and would document what she saw in the nursing progress notes. Interview was conducted on March 6, 2025 at 1:03PM with a Certified Nursing Assistant (CNA/Staff #22) who confirmed that she was present and clearly witnessed the interaction between Resident #39 and Resident #55 on the night of March 2, 2025. She stated that the two residents were attempting to elope from the facility by entering the elevator. She described that Resident #39 was sitting in her wheelchair, and Resident #55 was standing behind her, holding onto her wheelchair. The CNA described that Resident #39 was being combative, using racial slurs toward the nurse supervisor. She described that as Resident #39 got more agitated, the staff had stepped back to give her space. The CNA explained that Resident #55 appeared to be attempting to comfort Resident #39. She further stated that Resident #55 began to utilize more and more touch with Resident #39. She described that Resident #55 was stroking up and down Resident #39's arms and was touching her hair from behind her. She also stated that Resident #55 had grabbed Resident #39's breasts, describing the interaction as a full grab to both sides of her chest. She stated that Resident #55 had been rubbing up and down on her chest, and had grabbed both breasts in the process. Upon seeing this, the CNA stated that she attempted to intervene, but the residents were difficult to separate. The CNA stated that Resident #55 got more agitated as staff attempted to intervene and that he squeezed Resident #39's arm. She explained that he had grabbed Resident #39's bicep area and squeezed. The CNA stated that this appeared to cause Resident #39 pain, explaining that Resident #39 had an injured wrist, which was wrapped, and Resident #55 had squeezed the injured arm. The CNA explained that at one point, Resident #39 had pointed at Resident #55 and had told him to stop touching her, but Resident #55 did not let go. The CNA stated that the residents were finally separated with the help of Resident #55's spouse. When asked if she felt this was a potential abuse situation, the CNA stated yes and no. She elaborated that Resident #55 appeared to be enjoying himself in the moment, but she also knew that he was not a completely alert and oriented resident. Additionally, the CNA explained that she felt that the facility did not provide adequate training on how to manage their residents with behaviors. She stated that she was trained to separate the residents, but was later told by her supervisors that the residents should have been left alone. The CNA expressed frustration at not having the training of knowing how to manage residents in situations like these. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview was conducted with Resident #55 on March 6, 2025 at 2:00PM. The resident's speech was difficult to follow, as the responses given were disorganized. However, the resident denied recalling any interactions with a female resident by the elevator recently. An interview was conducted on March 6, 2025 at 2:37PM with the Director of Nursing (DON). The DON stated that facility offers annual abuse training, which includes training on the types of abuse, reporting, and prevention. The DON confirmed that inappropriate touching would be a sign of potential abuse. She explained that any concerns for abuse should be reported to facility management immediately. She also stated that nursing documentation would consist of whatever the nurses are instructed to complete by their supervisors, which she states most likely would be paper statements for the facility investigation. She stated she would not expect documentation in the clinical record unless injury occurred. The DON explained that on March 2, 2025 at 8:32PM, she was notified by the night shift nurse manager by phone call of an incident between Resident #39 and Resident #55. She stated that she was informed that during the incident, Resident #55 had touched Resident #39's breasts. The nurse manager had contacted the family for both residents. The DON stated that the next day, she had reviewed the camera footage from the event. She described that she had seen in the footage that Resident #55 was petting Resident #39's hand because she was upset. The DON stated that Resident #55 was petting up and down Resident #39's arms, and stated that he may have been touching the sides of her breasts in the process. She also stated that when Resident #55 went to hug Resident #39, his hands were on her breast area. She stated that the whole event lasted approximately 25 minutes. The DON explained that the two residents seemed to like each other. She elaborated that Resident #55's spouse had previously expressed that she did not want the two residents together, so staff were trying to keep them apart. The DON stated that Resident #55 had since been moved to a new room on a different floor until he discharges to memory care. She stated that he was sent to memory care for a short time on March 3, 2025, but had returned to the facility. She stated she could not speak to what happened, but stated that the memory care section could not meet his needs there. The DON explained that the plan was to have Resident #55 be in his new room on the new floor with family or a sitter present. A review of the camera footage was conducted with the DON on March 6, 2025 at 3:33PM. The DON explained that the footage was for March 2, 2025 at 7:59PM. The footage revealed one female resident sitting in her wheelchair near the elevator, with another male resident pushing the wheelchair from behind. The female resident appeared irate. The camera footage also revealed that the female resident had her left arm/wrist area wrapped in what appeared to be a gauze wrap. The DON identified these residents as Resident #39 and Resident #55. The footage also showed three staff members standing around the two residents, and another staff member could be seen at the nursing station, talking on the phone. The DON identified all of the staff members, which included three Nursing Assistants, including Staff #22, Staff #16, and Staff #18, around the residents and the nurse manager, who was at the desk. All three of the Nursing Assistants had clear view of the residents. However, one of the Nursing Assistants was standing in front of the residents so that the camera did not capture most of the interaction between the two residents. In parts of the footage, it could be seen that Resident #55 was rubbing his hands down the arms and on the head of Resident #39. The DON stated that in what she could see in the footage, it appeared that Resident #55 was attempting to comfort Resident #39 by stroking her arms and patting her head. She stated that she believed that the resident may have unconsciously put his hands on her chest or sides of her chest in the process. Due to an obscured view, the camera footage could not confirm much about the physical contact made by the residents. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled, Abuse Prevention Program, revealed that it is the facility's policy to provide each resident with an environment that is free from verbal, sexual, physical, and mental abuse. The policy defines sexual abuse as non-consensual contact of any kind with a resident. Physical abuse is defined in this policy as hitting, slapping, pinching, kicking, etc. The policy indicated that residents who allegedly mistreat another resident will be removed from contact with other residents during the course of the investigation. The policy revealed that all incidents will be documented, whether or not abuse occurred, was alleged or suspected. This policy indicated that all suspected crimes, including physical or sexual abuse, will be reported to the Administrator immediately and to the State Department of Health as soon as possible within 24 hours. The policy indicated that allegations involving serious bodily injury should be reported within 2 hours, while all others should be reported not later than 24 hours after forming the suspicion.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50553 Based on clinical record review, staff interviews, facility documentation and policy review, the facility failed to develop and implement policies and procedures for documenting and reporting alleged violations involving abuse, in accordance with federal and state laws and regulations. The deficient practice resulted in an alleged violation concerning abuse not being documented in the residents' (#39 and #55) clinical records, and the allegation not being reported within the mandatory two-hour timeframe to Adult Protective Services (APS) and the State Agency. This deficient practice could result in further allegations not being documented or reported in a timely manner, which could impact residents' quality of life and care. Findings include: Resident #39 was admitted to the facility on [DATE] with diagnoses that included cellulitis of the left upper limb, dementia without behavioral disturbance, and generalized muscle weakness. Review of Resident #39's progress notes revealed no evidence that any potential abuse situations had occurred on the night of March 2, 2025. Resident #55 was admitted to the facility on [DATE] with diagnoses that included dementia without behavioral disturbance, insomnia, and hyperlipidemia. Review of Resident #55's progress notes revealed no evidence that any potential abuse situations had occurred on the night of March 2, 2025. There was a note dated March 3, 2025 at 07:04AM, which revealed that Resident #55 had been moved to a room on the third floor, though no rationale was given in the clinical record as to why the change had occurred. Review of the facility's investigative report dated March 4, 2025 revealed the following: - In an interaction on March 2, 2025 at approximately 8:30PM, two residents (#39 and #55) were observed together, attempting to exit the unit via an elevator. While staff attempted to intervene, Resident #55 was observed by multiple staff to touch Resident #39 on the head, arms, and breasts. - The facility conducted an investigation and collected statements from the staff involved, who confirmed the allegations. - The event was reported to the Arizona Department of Health Services on March 3, 2025 at 4:33PM, and to APS on March 3, 2025 at 4:54PM. There was no evidence found that the abuse situation was reported to the State Agency or APS within the required two-hour timeframe. Interview was conducted on March 6, 2025 at 12:05PM with a Registered Nurse (RN/Staff #25), who stated that she would consider inappropriate touching, such as touching of the breast area, to be potential abuse. She stated that if she witnessed any signs of abuse, she would report this to her supervisor and would document what she saw in the nursing progress notes. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview was conducted on March 6, 2025 at 12:13PM with a nurse manager (Staff #28), who stated that all abuse allegations or concerns should be reported to the Director of Nursing (DON) or Administrator. She also stated that the facility has two hours to report allegations of abuse. She also stated that she would expect details about what was witnessed to be documented, most likely in incident notes in the Electronic Health Record (EHR). An interview was conducted on March 6, 2025 at 2:37PM with the Director of Nursing (DON). The DON stated that her understanding of reporting requirements for potential abuse was that if the allegation resulted in any type of injury, the facility had 2 hours to report the incident. She stated that all other allegations could be reported within 24 hours. She also stated that nursing documentation regarding an abuse allegation would consist of whatever the nurses are instructed to complete by their supervisors, which she states most likely would be paper statements for the facility investigation. She stated she would not expect documentation in the clinical record unless injury occurred. Review of the facility policy titled, Abuse Prevention Program, revealed that it is the facility's policy to provide each resident with an environment that is free from verbal, sexual, physical, and mental abuse. The policy defines sexual abuse as non-consensual contact of any kind with a resident. Physical abuse is defined in this policy as hitting, slapping, pinching, kicking, etc. The policy revealed that all incidents will be documented, whether or not abuse occurred, was alleged or suspected. This policy indicated that all suspected crimes, including physical or sexual abuse, will be reported to the Administrator immediately and to the State Department of Health as soon as possible within 24 hours. The policy indicated that allegations involving serious bodily injury should be reported within 2 hours, while all others should be reported not later than 24 hours after forming the suspicion. Review of the Code of Federal Regulations (CFR), 42 CFR S 483.12 (2016), indicated that in response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 50553 Based on clinical record reviews, facility documentation, and staff interviews, the facility failed to ensure that an alleged violation involving abuse (involving Resident #39 and Resident #55) was reported to the State Agency and Adult Protective Services (APS) within the required timeframe of two hours. Findings include: Review of the facility's reportable event record/report revealed that on March 2, 2025, a female resident (#39) had asked a male resident (#55) to push her wheelchair into the elevator to go to the second floor. When staff attempted to intervene, Resident #39 became very upset, and Resident #55 attempted to console her. In the process, Resident #55 touched Resident #39's arms, head, and sides of her breasts. The dates and times listed in the reportable event record were inconsistent, with one section listing the time of this event as March 2, 2025 at 1:30PM. Another section listed the event as occurring on March 2, 2025 at 08:30PM. Another section listed that it occurred on 3/3/3035 with no specified time. Review of the complete investigation revealed that the event most likely occurred on March 2, 2025 at approximately 8:30PM, as staff statements supplied supported this time and date. This event was reported to the Arizona Department of Health Services on March 3, 2025 at 4:33PM, and to APS on March 3, 2025 at 4:54PM. Review of the facility investigation revealed hand-written statements, written on March 2, 2025, from staff members who witnessed the event. In these statements, three Certified Nursing Assistants (Staff #22, Staff #16, and Staff #18) confirmed witnessing Resident #55 inappropriately touch Resident #39, including squeezing her arms and grabbing her breasts. The statements from the CNAs revealed that Resident #55 continued these behaviors despite staff re-direction and Resident #39 telling him to stop. The facility investigation also included an email statement, dated March 2, 2025 at 10:03PM, from the nurse manager who was on shift and witnessed the event. In this statement, the nurse manager described that he had called the Director of Nursing while the staff attempted to separate Resident #39 and Resident #55. Interview was conducted on March 6, 2025 at 12:13PM with a nurse manager (Staff #28), who stated that all abuse allegations or concerns should be reported to the Director of Nursing (DON) or Administrator. She also stated that the facility has two hours to report allegations of abuse. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on March 6, 2025 at 2:37PM with the Director of Nursing (DON). The DON stated that facility offers annual abuse training, which includes training on the types of abuse, reporting, and prevention. The DON confirmed that inappropriate touching would be a sign of potential abuse. She explained that any concerns for abuse should be reported to facility management immediately. The DON stated that her understanding of reporting requirements for potential abuse was that if the allegation resulted in any type of injury, the facility had 2 hours to report the incident. She stated that all other allegations could be reported within 24 hours. The DON explained that on March 2, 2025 at 8:32PM, she was notified by the night shift nurse manager by phone call of an incident between Resident #39 and Resident #55. She stated that she was informed that during the incident, Resident #55 had touched Resident #39's breasts. When discussing reporting timeframes, the DON stated that she believed that only allegations regarding injury had to be reported within 2 hours, and that she had been doing it this way for a long time. Review of the facility policy titled, Abuse Prevention Program, revealed that it is the facility's policy to provide each resident with an environment that is free from verbal, sexual, physical, and mental abuse. This policy indicated that all suspected crimes, including physical or sexual abuse, will be reported to the Administrator immediately and to the State Department of Health as soon as possible within 24 hours. The policy indicated that allegations involving serious bodily injury should be reported within 2 hours, while all others should be reported not later than 24 hours after forming the suspicion. Review of the Code of Federal Regulations (CFR), 42 CFR S 483.12 (2016), indicated that in response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.

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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** 50553 Based on observation, clinical record review, facility documentation, and staff interviews, the facility failed to ensure that adequate supervision was provided to one resident (#14) to prevent elopement from the facility. The deficient practice resulted in one resident leaving the building without notice, and could result in other residents going missing and/or getting injured. Findings include: Resident #14 was admitted to the facility on [DATE] with diagnoses that included Alzheimer's disease, unspecified hearing loss, and influenza. Review of the Admission / Medicare 5-day Minimum Data Set (MDS), dated [DATE], revealed that the resident had a Brief Interview for Mental Status (BIMS) score of 9, indicating moderate cognitive impairment. Review of the elopement evaluation completed on February 11, 2025 revealed that the resident scored a 6, indicating the resident was at risk for elopement. Review of the resident's careplan revealed a focus, initiated on February 11, 2025, that indicated that the resident was an elopement risk, with interventions in place including to keep an identification bracelet on the resident at all times, using distractions to prevent wandering, and having staff or family to accompany the resident outside of the neighborhood. The goal in place was that the resident would not leave the neighborhood unattended. Review of the facility five-day investigative report regarding Resident #14's elopement revealed a statement from a security guard (Staff #24). The statement revealed that at 11:28AM on February 14, 2025, security noticed Resident #14 at the gate near the independent living area, across the street from the facility. The security noted that the resident seemed unaware of her surroundings. The security assisted the resident back to the second floor of the facility and into the care of the nurses. The staff member could not be reached for further interview. Further review of the facility five-day investigative report revealed a brief statement from the nurse supervisor (Staff #28), stating that the resident had made it out of the building and was found and returned unharmed. There was no evidence of statements from any additional staff working that day or statements from the resident or her representative. There was also no evidence in the report that camera footage had been reviewed or if any information had been obtained from the camera footage. A review of the progress notes revealed a general note dated February 14, 2025 at 12:11PM, which indicated that Resident #14 had made it out of the building and was found across the street. The note revealed that security had brought her back to the facility, and the resident's family was notified. There was no evidence that staff had noticed the resident to be missing or that action had been taken to locate the missing resident. (continued on next page)

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(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	Further review of the progress notes revealed another general note dated February 14, 2025 at 2:50PM, which revealed that Resident #14's family was asked to provide a caregiver to keep the resident safe. The note detailed that the family member was upset, stating that it is the facility's responsibility to watch the resident and keep her safe. An additional general note was added on February 14, 2025 at 3:39PM, which revealed that the resident would have a sitter from 8:00AM to 8:00PM for safety until she discharged to memory care services. Interview was conducted on March 6, 2025 at 12:29PM with Resident #14, who seemed to have poor recollection of her elopement on February 14, 2025. The resident repeatedly spoke of wishing to go to where she had lived before, stating that she had tried to go to where she had lived before coming to the facility. Interview was conducted on March 6, 2025 at 11:49AM with a Certified Nursing Assistant (CNA/Staff #17), who stated he did not recall receiving training on elopement from the facility, but he was familiar with what it was. The CNA explained that he felt there was enough staffing to monitor and care for residents, except when staff call out of work. He stated that management does not help to work the floor when the staffing is short. Additionally, the CNA stated that residents are allowed to leave the unit or building, but only with staff accompanying them. He explained that if a resident could not be found, staff would walkie-talkie to the other staff and begin searching for the resident. The CNA stated he was not aware of any recent elopement incidents in the facility. Interview was conducted on March 6, 2025 at 12:05PM with a Registered Nurse (RN/Staff #25), who stated that residents are allowed to leave the unit or building, but she would expect either staff or family to accompany them if they have dementia or confusion. The RN also stated that residents who are assessed to be an elopement risk have their careplans updated to reflect this, their photograph is placed at the nurses' stations and front desk, and staff know to re-direct them as needed. The RN stated that if a resident cannot be found, staff would look for the resident. If not found, the staff would call security and notify the supervisor and Director of Nursing (DON). The nurse explained that she was not working the day that Resident #14 had eloped from the facility, but had heard that she had left. She could not provide any details about the event. The RN identified that the risk of a resident leaving the building without notifying anyone to be that the resident could be run over by a vehicle. Interview was conducted on March 6, 2025 at 12:13PM with a nurse manager (Staff #28), who explained that she was working on the date that Resident #14 had eloped from the facility. She explained that on February 14, 2025, Resident #14 made it across the street, where security had found her and brought her back to the facility. The nurse manager stated that she was brought back to the facility on [DATE] at 12:11PM. The nurse manager was unable to give the last time that the resident was seen, but stated that no one had noticed that the resident was gone. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035074	A. Building B. Wing	03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Friendship Village of Tempe	2525 East Southern Avenue Tempe, AZ 85282

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	Interview was conducted on March 6, 2025 at 1:21PM with the Health Services Manager (Staff #33), who confirmed that she manages the front reception desk staff. She explained that residents are not required to check in and out at the reception desk when leaving or entering the facility, as the nursing staff does this. She explained that the front desk staff are made aware of the elopement risk residents by being provided a folder with pictures of the elopement risk residents, and the front desk staff are expected to watch out for those residents. She stated that the front desk has staff present everyday from 7:00AM to 7:00PM, and the doors automatically lock after hours, requiring security to open the doors for access. The manager reviewed the notes from the staff working on February 14, 2025, and stated that security had brought the resident back into the facility at 11:42AM. The front desk staff had not noticed that the resident had left the building. The manager also stated that the staff can not leave the front desk unattended. She confirmed that there were only two entrances to the building, the front entrance and an employee entrance, which requires a key card to access. Interview was conducted on March 6, 2025 at 2:37PM with the Director of Nursing (DON/ Staff #51), who stated that if a resident can not be found, staff will search the building for them and if they are not found, security is called. She stated that camera footage is also pulled to see if the resident went out of the door. Staff are expected to call the DON and the Administrator. If the resident is still not found, the police are called. The DON stated that on the day that Resident #14 eloped from the facility, the CNA had seen her 5 minutes prior to the resident going missing. When asked if there was documentation that this interaction had occurred, the DON stated that she had not obtained a statement from the CNA when conducting her investigation. The DON also stated that she was unsure if the resident had left the floor by taking the stairs or the elevator. When asked about camera footage, the DON explained that the camera system does not store footage from that far back, so the footage cannot be reviewed. The DON stated she was first informed of the situation when the nurse manager on shift called her, stating that Resident #14 was found at the gates and had crossed the street on her own, and was brought back by security. The nurse manager informed the DON that no one had seen her go, and that the resident's family would be notified. When asked if the resident had shown any wandering behaviors prior to the elopement, the DON confirmed that a few days prior, the resident had touched the door to the stairwell, which was located close to her room. She explained that this is when the resident's care plan and elopement assessments were updated. Review of the facility policy titled, Elopement/ Missing Resident, revealed that it is facility policy to attempt to prevent any elopement occurrence with any resident. The policy indicated that if a resident is identified to have elopement risk, a plan of care should be developed and strategies implement to keep the resident safe. The policy also detailed that once the resident is returned to the facility, the incident should be documented in a clinical note, which should include details such as when the resident was last seen, staff actions taken, when and where the resident was found, and condition of the resident and their clothing upon return.