| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 045176 | A. Building<br>B. Wing | 07/03/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| The Woods, A Nightingale Community | 1194 N Chester St<br>Monticello, AR 71655 |

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident receives an accurate assessment.<br><br>Based on record review and interview, it was determined the facility did not ensure the quarterly Minimum Data Set Assessment reflected a behavior that the resident exhibited for one (Resident #20) of one resident reviewed for assessment accuracy.<br><br>The findings include:<br><br>A review of the quarterly Minimum Data Set (MDS) with an Assessment Reference Date of 04/05/25, indicated Resident #20 had a Brief Interview for Mental Status score of 15 which indicated the resident was cognitively intact. The MDS also indicated that Resident #20 had diagnoses which included non-Alzheimer's dementia and did not exhibit wandering behavior.<br><br>A review of a Care Plan Report initiated on 09/24/24, with a revision date of 07/02/25, indicated Resident #20 was an elopement risk and had wandering behaviors related to dementia.<br><br>During a phone interview on 07/03/25 at 10:59 AM, the MDS Coordinator confirmed Resident #20’s quarterly MDS was completed on 04/05/25, which was after Resident #20 was found outside the building on 04/01/25, without staff knowledge. According to the MDS Coordinator, the quarterly MDS did not indicate Resident #20 had wandering behaviors, but it should have, therefore the assessment was inaccurate.<br><br>During an interview on 07/03/25 at 11:11 AM, the Director of Nursing (DON) confirmed there was an incident that occurred on 04/01/25, in which Resident #20 exited the building without staff knowledge. The DON stated she did not do the MDS assessment therefore she could not say if it was accurate or not. |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>Based on observations, interviews, record review, and facility policy review, it was determined the facility did not ensure residents were not provided the code to entrance/exit doors to safeguard residents and prevent residents from eloping from the facility for one (Resident #20) sampled resident.<br><br>The IJ began on 04/01/2025 at approximately 4:30 PM, when Resident #20 used a code for the exit doors provided by facility staff to exit the building without staff knowledge. Resident #20 verified knowledge of codes to the entrance/exit doors of the facility. These findings have been determined to have resulted in Immediate Jeopardy as defined at 42 CFR §483.25.<br><br>The Administrator was informed of the Immediate Jeopardy on 07/02/25 at 5:34 PM, and a Plan of Removal was requested. The facility provided an acceptable Plan of Removal on 07/03/2025 at 12:15 PM, which was verified to be completed by the survey team on 07/03/2025 at 7:45 PM.<br><br>The findings include:<br><br>An “OLTC [Office of Long-Term Care] Incident and Accident Report (I&A)” with a discovery date of 04/01/2025 revealed that on 04/01/2025 at approximately 4:30 PM, Resident #20 exited the facility and walked outside to the north hall end door, where a Certified Nursing Assistant (CNA) observed the resident walking outside a window. The CNA assisted the resident back into the facility. Resident #20 was asked how they had exited the facility, and provided the code to the door, “*234.” A nurse on the hall reported they had last seen the resident at approximately 4:20-4:25 PM, implying the resident was outside unattended and without staff knowledge for 5-10 minutes.<br><br>There were four exit doors on the secure unit on which Resident #20 resided: one that opened to the courtyard, one that opened to a fenced area, and two that opened to the outside. Resident #20 exited on 04/01/25 through one of the two doors that opened to the outside. The door that the resident exited through passed by the laundry room, then to an area near the laundry room that was observed to contain cleaning equipment, a mop bucket, and boxes that could have caused the resident to fall to the concrete.<br><br>On 06/30/25 at 1:26 PM, this surveyor observed Resident #275 enter the code to silence the alarm to the courtyard door after several residents went out unattended by a staff member to await their smoke break.<br><br>On 07/02/25 at 9:57 AM, this surveyor asked several residents sitting near the exit door to the courtyard outside of the main dining room if any knew the code to the exit door. Resident #50 stated “*567. ”<br><br>On 07/02/25 at 10:57 AM, this surveyor asked Registered Nurse (RN) #5 to enter the code to the door at the end of north hall. RN #5 entered code *567 and it unlocked the door. This surveyor asked RN #5 to enter code *234, and this code also unlocked the door. RN #5 stated that code *234 opened the door at the end of the hall, which was three doors from the resident’s room.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | During an interview on 07/02/25 at 11:19 AM, Certified Nursing Assistant (CNA) #5 stated around mealtime on 04/01/2025 she heard the door alarm sound and observed Resident #20 outside the North door next to the nurse's station, attempting to enter the facility. CNA #5 stated if Resident #20 would not have tried to open the door she would not have seen the resident. CNA #5 stated Resident #20 had exited the door near the laundry room and that the alarm did not work to that door. CNA #5 stated Resident #20 was moved off the secured unit after the incident. CNA #5 stated some of the residents, including Resident #20, knew the code to the doors. CNA #5 stated she observed Resident #20 pushing on the north door since the elopement and she reported it to the Unit Manger. CNA #5 stated Resident #20 has dug in the butt can for cigarettes and that has been reported to the Unit Manger.<br><br>On 07/02/2025 at 11:55 AM, Resident #20 was asked how they had obtained the code to the exit doors, and stated it was provided by an unknown CNA, but added all CNAs will give them the code to the door.<br><br>On 07/02/25 at 12:00 PM, this surveyor asked the Unit Director (UD) if they had been informed that Resident #20 had the codes to the exit doors. The UD stated, yes to the courtyard. The UD was asked for the exit code to the courtyard doors and stated, “*567.” This surveyor asked the UD what other door could be opened with code *567, and the UD stated all of them except the door in the unit. This surveyor asked what was preventing Resident #20 from using the code on another door, to which the UD replied, “We just keep a close eye on [the resident].”<br><br>On 07/02/25 at 12:10 PM, CNA # 6 was asked if they had seen a resident enter the code to any exit door to exit or re-enter the building. CNA #6 stated, “Not through this door on the unit, but I have seen them do it on other halls.” CNA #6 was asked if they had witnessed any resident ever entering the code to exit or re-enter the building to go the courtyard to smoke and stated, “Yes, I have seen them.”<br><br>On 07/02/25 at 12:15 PM, CNA #7 was asked if they had seen a resident enter the code to any exit door to exit or re-enter the building. CNA#7 stated, “Not in the unit, but on the other side of the building I have. ” CNA #7 was asked if they had witnessed any resident ever enter the code to exit or re-enter the building to go to the courtyard to smoke. “On the other side of the building, yes. I have seen them. ”<br><br>On 07/02/25 at 12:27 PM, Resident #48 reported they smoked outside. When asked about the code to the doors, Resident #48 stated, “I know the code to go out, *567.” Resident #48 was asked how they had obtained the door code and stated, “One of the aides gave it to me. Every resident that smokes or wants to go outside has the code. It works on the dining room door and the front door. [Resident #53] will use the code and go out the front door to smoke in the front of the facility. Staff do not go with [the resident]. Staff don't even know [Resident #53] is out there. [Resident #53] went out the back door and no one knew [Resident #53] was out there and hurt their arm bad…I don't have residents asking me for the code because everyone knows the code.”<br><br>On 07/02/25 at 2:00 PM, Resident #53 was asked about injuring their arm outside the facility, and stated, “I wasn’t out front when I fell. I was in the courtyard smoking and I got dizzy so I got up to go in and when I got to the door I fell.” Resident #53 was asked if there were staff present when the fall occurred and stated, “Yes, I can’t remember any of their names but there were staff out there. ” Resident #53 was asked if they knew the code for the exit doors, and stated, “Yes, I do. ”<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | On 07/02/25 at 1:20 PM, Licensed Practical Nurse (LPN) #1 was asked what occurred with the incident where [Resident #20] was found outside, and stated, “We saw [Resident #20] outside by the north hall door and several staff saw [Resident #20] at the time walking.” LPN #1 stated Resident #20 reported they were attempting to find [Resident #53] that smoked to get a cigarette. LPN #1 was asked how Resident #20 was able to exit the facility and stated they did not know how they got the codes.<br><br>On 07/02/25 at 2:40 PM, Resident #275 was asked if they smoked and confirmed they did, four times a day. Resident #275 was asked about the door codes and if residents used them without staff present, and stated, “Sometimes I just go outside to sit. We go out through the dining room. The code is *567 and use the same coming back in. One of the nurses gave it to me. I can go out anytime I want without staff. There is a gate, but I haven't tried to go out. There is a door that goes into that locked unit. Those residents come out at the same time as us. We can go out anytime we want, at any hour we want.”<br><br>On 07/02/25 at 02:48 PM, the Administrator was asked to elaborate on the incident with Resident #20 eloping from the facility, and stated, “I received a call that [Resident #20] entered the key code to walk around the building to [Resident #53] to get a cigarette.” The Administrator was asked about Resident #20 residing on the secure unit, and stated, “Yes, [Resident #20’s] sister felt [Resident #20] needed to be on the secured unit. We moved [Resident #20] out because [Resident #20] was doing so well and [the resident’s] BIMS was high enough and did not need to be there.” The Administrator reported Resident #20 was moved off the secure unit the day following the elopement. The Administrator was asked how the facility ensured there was not a reoccurrence, and responded stating staff supervise the residents up front, because Resident #20 was not an elopement risk. The Administrator reported no changes were made to the key pads for the exit doors. “[Resident #20] is not an elopement risk, because [Resident #20] has a high BIMS and can tell me if [Resident #20] wants to go or stay.” When asked if Resident #20 currently knew the code to unlock the exit doors, the Administrator stated, “Not that I am aware of.”<br><br>On 07/02/25 at 03:35 PM, the Director of Nursing stated that the courtyard was the designated smoke area, and Resident #53 continues to try to smoke out front. Resident #53 has the code for the exit doors and lets [the resident] out of the facility.<br><br>During an interview on 07/02/25 at 05:15 PM, Resident #20 stated they promised the Director of Nursing they would not go outside again, because the resident did not want to get in trouble.<br><br>A review of the quarterly Minimum Data Set (MDS) with an Assessment Reference Date of 04/05/25 revealed Resident #20 had a Brief Interview of Mental Status (BIMS) score of 15 indicating the resident was cognitively intact. Resident #20 had a diagnosis of non-Alzheimer's dementia.<br><br>A review of the Care Plan Report (revision date 06/28/25) revealed Resident #20 was a smoker. Resident #20 often attempted to hoard cigarette butts, lighters and other smoking materials rather than giving them to the nurse. The resident's family would bring smoking materials and give to the resident despite staff education that this is against the rules.<br><br>The Immediate Jeopardy was removed on 07/03/2025 at 12:15 PM when the following plan of removal was implemented by the facility:<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | 1. Identification of Residents Affected or Likely to be Affected:<br><br>On 07/02/2025 the Director of Nursing (DON)/designee identified all residents at risk or high risk with exit seeking and/or wandering behaviors that scored a 9 or above (33 were identified).<br><br>2. Actions to Prevent Occurrence/Recurrence:<br><br>3. On 07/2/2025 the DON/designee educated all staff on shift and ongoing as staff reported to work prior to their shift to monitor and supervise residents to prevent elopement. The in-service materials included to only provide the door code to authorized personnel.<br><br>4. On 07/2/2025 Resident #20 was directly involved in this deficient practice and had [Resident #20] care plan reviewed and updated by the DON/designee and updated to reflect current wandering and elopement risk.<br><br>5. By 07/2/2025 the Minimum Data Set (MDS) Coordinator reviewed section E of the MDS and associated CAA [Care Area Assessments] for all residents. Care plans were reviewed and updated to ensure they reflect audit findings. Concerns were not identified.<br><br>6. On 07/2/2025 the DON, designee(s) and /or MDS Coordinator(s) re-evaluated residents at risk for wandering/elopement using an elopement wandering risk scale. (33 residents were reassessed and care plans reviewed updated).<br><br>7. All staff received education on wandering, elopement, and resident safety from the Director of Nursing (DON) or designee(s) prior to reporting to their shift.<br><br>8. MDS/designee will ensure all residents receive a wandering risk assessment upon admission, quarterly, and with significant change of condition to ensure appropriate monitoring and supervision.<br><br>Date facility asserts likelihood for serious harm no longer exists: 07/02/2025.<br><br>Onsite Verification: The IJ was removed on 07/03/2025 at 7:45 PM after the survey team completed an onsite verification that the removal plan had been implemented as follows:<br><br>1. A review of a document titled Residents at Risk for Wandering provided by the DON revealed (Score of 9 or higher on Wandering Risk Scale) and 33 resident names were listed.<br><br>2. (No corresponding validation to item 2 in the facility’s POR)<br><br>3. A review of an in-service conducted by the DON dated 7/02/2025 with a subject of elopement procedures/practices included multiple staff names, signatures and different titles.<br><br>4. A review of Resident #20's care plan revealed a focus of [Resident #20] is an elopement risk/wandered related to dementia. [Resident #20] went outside looking for cigarettes. Code to door changed. Revision on: 7/02/2025; interventions included identify pattern of wandering: Is wandering purposeful, aimless, or escapist? Is resident looking for something with a date initiated of 07/02/2025.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | 5. A review of care plans located in the residents' electronic health record (EHR) for 5 randomly selected residents on the list provided by the DON revealed the following:<br><br>a. Resident #34's care plan indicated the resident is at risk for falls related to weakness, wanders.<br><br>b. Resident #327's care plan revealed the resident is an elopement risk/wanderer related to wandering risk assessment score 9.<br><br>c. Resident #64's care plan revealed the resident is an elopement risk/wanderer related to impaired safety awareness related to wandering assessment score 9.<br><br>d. Resident #4's care plan revealed the resident is at risk for wandering related to dementia, poor sense of self safety.<br><br>e. Review of Resident #63's care plan revealed the resident is an elopement risk/wanderer related to impaired safety awareness, exit seeking admitted to secure memory unit; wandering risk score 11.<br><br>6. A review of wandering risk scales located in the residents' electronic health record (EHR) for five randomly selected residents on the list provided by the DON revealed the following:<br><br>a. Resident #34's wandering risk scale indicated at risk to wander with a score of 9.0.<br><br>b. Resident #327's wandering risk scale indicated at risk to wander with a score of 9.0<br><br>c. Resident #64's wandering risk scale indicated at risk to wander with a score of 9.0.<br><br>d. Resident #4's wandering risk scale indicated at risk to wander with a score of 9.0.<br><br>e. Resident #63's wandering risk scale indicated high risk to wander with a score of 11.0.<br><br>7. On 07/03/2025, interviews with different staff either in person or by telephone revealed the following:<br><br>One Registered Nurse indicated they were trained on and verbalized understanding on how to identify exit seeking behaviors in residents, what to do if a resident elopes, hiding the door code from residents and who to notify if a resident elopes.<br><br>Three Licensed Practical Nurses from different shifts indicated they were trained on and verbalized understanding on how to identify exit seeking behaviors in residents, what to do if a resident elopes, hiding the door code from residents and who to notify if a resident elopes.<br><br>Nine Certified Nursing Assistants covering different shifts indicated they were trained on and verbalized understanding on how to identify exit seeking behaviors in residents, what to do if a resident elopes, hiding the door code from residents and who to notify if a resident elopes.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | One housekeeper and one dietary aide covering different shifts indicated they were trained on and verbalized understanding on how to identify exit seeking behaviors in residents, what to do if a resident elopes, hiding the door code from residents and who to notify if a resident elopes.<br><br>8. A review of the EHR for five randomly selected residents (Resident #4, #34, #63, #64 and #327) from the list of 33 residents identified by the DON as at risk for wandering revealed the MDS Coordinator had completed wandering risk assessments for the residents and the care plans were updated to reflect the residents were at risk to wander and interventions were in place.<br><br>Observation of the facility residents on 07/03/2025 between 1:30 PM and 6:00 PM revealed some residents in their rooms, some residents were in a common area with a television on, and some residents were in the dining area and no residents were observed attempting to exit the facility or pushing or shaking on doors. Residents on the secured unit were observed sitting in either their wheelchairs in a common area with the television on, at the dining room table or ambulating or propelling themselves in a wheelchair on the unit. No residents were observed trying to exit the area or pushing or shaking on the doors. |