STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045280	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Twin Lakes Therapy and Living	6152 Highway 202 East Flippin, AR 72634

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42016 Based on observation, interview, and record review, the facility failed to monitor and supervise a moderately cognitively impaired resident to prevent elopement, for 1 (Resident #1) of 6 sampled residents. The lack of an effective monitoring plan resulted in Resident #1 eloping from the facility and being found approximately .25 miles from the facility on 10/19/2024. The facility staff was not aware that Resident #1 left the facility due to Resident #3 entering a code into the exit panel, disengaging the locking mechanism on the door, and Resident #1 exited without the electronic wander management system alarming. It was determined the facility's non-compliance with one or more requirements of participation had caused, or was likely to cause, serious injury, harm, impairment, or death to the residents. The Immediate Jeopardy (IJ) was related to the State Operations Manual, Appendix PP, S483.25 (Quality of Care) at a scope and severity of J. The IJ began on 10/19/2024 at 11:19 AM, when Resident #1 was let out of the facility by Resident #3. Upon notification by Resident #3 to Housekeeper (HK) #6, a Code [NAME] was called, and the facility staff began searching inside the facility and around the perimeter of the facility. After facility staff were unable to locate Resident #1, the search was expanded off facility property. Resident #1 was located approximately .25 miles from the facility. The resident had exited the facility property without staff knowledge. The Administrator and the Nurse Consultant were notified of the IJ on 10/29/2024 at 12:34 AM. A Removal Plan was requested. The Removal Plan was accepted by the State Survey Agency on 10/30/2024 at 11:09 AM. Findings include: Review of a facility policy titled, Accidents and Incidents - Investigating and Reporting with a revised date of July 2017 revealed, any accident or incident occurring on facility property would be investigated and reported to the Administrator. Review of a facility policy titled, Unusual Occurrence Reporting, with a revised date of December 2007 revealed, the facility would report unusual occurrences or events affecting the health, safety, or welfare of residents. Interpretation and (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

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	implementation indicated the facility would report events that could become life-threatening including, f. inoperable emergency systems, equipment. Review of a facility policy titled, Elopements, with a revised date of 12/2007, indicated staff were to investigate and report missing residents. And outlined implementation of investigation process. Page two of this policy was not provided to surveyors. Review of an undated facility procedure titled, Elopement Procedure Code White, outlined the steps to be taken during an elopement that included appointment of a leader, alerting staff to the even, searching for resident, notification and information to be provided to the responsible party, police, Administrator and Director of Nursing. Review of a facility policy titled, Wandering and Elopements, revealed the facility was to identify residents at risk and would use the least restrictive environment to prevent harm. The care plans of residents identified for wandering, elopement, or other safety issues would be updated with interventions to maintain the residents' safety. Review of a facility policy titled, Wandering, Unsafe Resident, revealed residents at risk for wandering, including elopement, would be identified and assessed for correctable risk factors by staff. The residents' care plan would be updated with interventions and would include a detailed monitoring plan. A review of a facility document titled, Facility Assessment Tool, dated 09/2023, indicated the purpose was to identify resources necessary to provide care and services required by residents residing in the facility. Section titled, Staff training/education and competencies, on page 9 and 10, revealed no training on resident wandering or elopement. Specific to Memory Care Neighborhood, on page 10, indicated the staff training included wandering and egress control. A review of the Admission Record, indicated the facility admitted Resident #1 on 10/01/2024, with diagnoses of altered mental status, the body's inability to effectively use insulin and leads to elevated blood sugar, and a common lung disease that makes it difficult to breathe. The admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 10/14/2024, revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 3 which indicated the resident had severe cognitive impairment. No behavior indicators were present. Resident #1 required partial to moderate assistance bathing; supervision with personal hygiene; set up/clean up assistance for oral hygiene and toileting; and was independent with eating, sitting, standing, walking, transfers, and repositioning in bed. Resident #1 was occasionally incontinent of bowel and bladder; had no indication of pain; no tobacco use; and had no falls. Resident #1 was receiving antianxiety and diuretic medications. Resident #1 had a wander/elopement alarm. A review of care plan, revised 10/20/2024, revealed Resident #1's was an elopement risk, was verbally and physically aggressive, was a fall risk, had suicidal ideation, had altered respiratory status, and had a need for placement on a secured unit. Interventions included assessing fall risk, offering diversions for distraction, addressing unmet emotional /physical needs, intervening when behavioral health consult, administer medications, encourage family visitation, identifying triggers of emotional distress, monitor for fatigue, and providing structured activities. The electronic wander management transmitter device was resolved and was no longer used. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of Resident #1's Order Summary Report, revealed Resident #1 was admitted to the memory unit due to elopement risk on 10/19/2024. A review of the Nsg [Nursing] Admit/Readmit Assessment and Care Plan, dated 10/01/2024 at 3:45 PM documented Resident #1 was at high risk for elopement. No care planning information was entered. A review of the Nsg [Nursing] Elopement Risk with Care Plan, dated 10/01/2024 documented Resident #1 was at high risk to wander. Interventions included placement of an electronic wander management transmitter device. Interventions not put into place included identifying a wandering pattern; documenting wandering behavior and interventions; and identifying escalating triggers and deescalating behaviors of wandering /elopement. A review of the Nsg [Nursing] Elopement Risk with Care Plan, dated 10/19/2024 at 8:59 PM, documented Resident #1 was at high risk for elopement. There was no change in interventions. A review of the treatment administration record (TAR) dated 10/2024 revealed Resident #1 had treatments for a skin tear to the left and right hands; a scratch to the right wrist; and back of neck. A review of the Progress Notes, dated 10/14/2024 at 10:06 AM, revealed Resident #1 expressed aggressive behaviors toward staff and voiced threats about another resident to staff. Medication administered. A review of the Progress Notes, dated 10/15/2024 at 10:08 AM, revealed Resident #1 upset with staff. Medication administered. At 10:59 AM, revealed, Yelling Screaming Monitored, medication calmed resident. A review of the Progress Notes, dated 10/18/2024 at 3:53 PM, revealed Resident #1 was to upset to get weighed. A review of the Progress Notes, dated 10/19/2024 at 12:45 PM, revealed Resident #1 was receiving an antibiotic for a urinary tract infection (UTI), was ambulating, requested coffee, and stated they lost their way. Code [NAME] was announced at 11:32 AM, and a nurse gave instructions to other staff to search for the resident. The nurse went outside and notified the Director of Nursing (DON), the Administrator and the police department. A passerby notified the nurse of someone walking the creek line and took the nurse to the location of Resident #1. A review of the Progress Notes, dated 10/19/2024 at 4:11 PM, revealed Resident #1 had a skin tear to the right hand, a scratch to the left wrist, and a skin tear to the posterior base of the neck. A review of the Progress Notes, dated 10/19/2024 at 5:41 PM, revealed Resident #1 was sent to the emergency room and received a tetanus shot. A review of the Progress Notes, dated 10/20/2024 at 11:18 AM, revealed Resident #1 enjoyed walking outside and sitting at the windows in the dining room, voiced would like to leave. A review of the Progress Notes, dated 10/20/2024 at 1:17 AM, revealed Resident #1's electronic wander management transmitter device was removed on 10/19/2024. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of the Progress Notes, dated 10/23/2024 at 08:27 AM, revealed during a provider assessment, Resident #1 voiced they felt trapped inside and wanted to go outside. A review of the Progress Notes, dated 10/28/2024 at 07:52 AM, revealed Resident #1 wandering hall and asking to leave the facility. A review of Nsg [Nursing] Skin Audit, dated 10/19/2024 at 3:05 PM, revealed Resident #1 had a scratch to the right wrist, the back of the neck and the left hand, post elopement. A review of Nsg [Nursing] Skin Observation Daily for Four Days, dated 10/23/2024 at 10:47 AM, revealed Resident #1 had a skin tear to the left hand. A review of an Admission Record indicated the facility admitted Resident #3 on 07/26/2024 with diagnoses of fracture of the left humerus, muscle wasting and atrophy, and difficulty in walking. A review of the modified admission MDS with an ARD of 08/08/2024 revealed Resident #3 had a BIMS score of 15 which indicated the resident was cognitively intact. A review of Resident #3's, Order Summary Report, for the month of 10/2024 revealed an order dated 08/09/24 indicating Resident #3 was discharged from skilled care services to long term care on 08/11/2024. Review of the care plan, initiated on 07/26/2024, revealed Resident #3 had limited physical mobility related to rheumatoid arthritis, fracture of the left humerus, osteoarthritis, obesity, muscle wasting and atrophy, and muscle weakness. Resident #3 required the use of a motorized wheelchair for ambulation. On 10/19/2024, Resident #3 required education regarding safety and letting other residents out of the exit door. Interventions included changing the security code to doors monthly and documenting the change; Resident #3 would not have a roommate with an electronic wander management transmitter device; and Resident #3 was educated on the purpose of keypads/alarms/safety of all residents. A review of the Employee Memorandum Witness Statement, with a date of 10/19/2024, revealed Resident #3 admitted to entering the code allowing Resident #1 to exit, and the alarm did not sound when the door opened. A review of the Employee Memorandum Witness Statement, with a date of 10/19/2024, revealed Certified Nursing Assistant (CNA) #8 received notification of a missing resident while on lunch. CNA #8 took a vehicle, turned left from the facility, and began a search. A review of the Employee Memorandum Witness Statement, with a date of 10/19/2024, revealed Registered Nurse (RN) #9 began looking for Resident #1 after the Code [NAME] (missing person) was called. A lady stopped and notified RN #9 of (Resident #1) walking the creek line toward (a boat manufacturing company). The driver took RN #9 to the location of Resident #1. RN #9 got Resident #1 from the creek and up to the barbwire fence when the police and the DON arrived. A review of the Employee Memorandum Witness Statement, with a date of 10/19/2024, revealed Housekeeper (HK) #6 was in the breakroom and heard a knock on the door and was told by Resident #3 that Resident #1 went out the B-Hall door. HK #6 called code white and notified Laundry #7. HK #6 did not hear the alarm sounding. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of the Employee Memorandum Witness Statement, with a date of 10/21/2024, revealed the Maintenance Director was notified of the elopement, arrived at the facility at 12:06 PM and checked the door on B-Hall. The alarm functioned properly on all doors. 11 (electronic wander management transmitter devices), on residents, were checked and worked. Alarm history was reviewed and revealed Resident #1's electronic wander management transmitter device alarmed multiple times, and the system was in good working condition. During a concurrent interview and observation on 10/28/2024 at 08:40 AM, Certified Nursing Assistant (CNA) #8 stated Resident #1 was wandering daily, and residents are taken outside to a fenced area at least twice daily. Resident #1 exited the dining room into the hallway to the exit door. CNA #8 redirected Resident #1 back to the dining room and offered an activity. Resident #1 refused. During an observation on 10/28/2024 at 08:50 AM, the Maintenance Director was testing door alarms. The Maintenance Director stated there were no residents on D-Hall with electronic wander management transmitter devices. The Maintenance Director stated all doors were tested weekly, on Monday, and the transmitters on the electronic wander management transmitter devices were tested daily to ensure they were working. During an interview on 10/28/2024 at 09:21 AM, the Director of Nursing (DON) did not know the residents that were at risk for elopement, and did not have a list of residents that wandered or had exit seeking behaviors. The DON asked the Maintenance Director if he had a list of residents that had an electronic wander management transmitter device, the Maintenance Director stated 4 residents currently had an electronic wander management transmitter device. During an interview and observation on 10/28/2024 at 9:35 AM, the Maintenance Director stated since the last elopement, the electronic wander management system was part of the action plan, and the electronic wander management transmitter devices were placed on residents, after notifications were made. The Maintenance Director stated he would be notified by staff, (Administrator and DON), during the morning meeting of the residents identified as requiring a transmitter device. The Maintenance Director would then take an electronic wander management transmitter device to the computer and link the number on the electronic wander management transmitter device to the resident's name in the computer. The electronic wander management transmitter device was then taken to the door and checked for operation. The Maintenance Director took an electronic wander management transmitter device into the hallway, from Administrators Office, and stood 15 feet from the front entrance of the facility. The Maintenance Director approached the front entry, entered the exit code (1 symbol and 3 numbers) on the exit panel and a low alarm sounded with a moderate tone and decreased to no sound (decrescendo). The panel was reset by moving the electronic wander management transmitter device away from the door. The Maintenance Director approached the door and set the transmitter device on the arm of the furniture near the door. After 20 seconds an audible alarm sounded and continued to sound until the transmitter device was moved away from the door. The Maintenance Director stated the distance from the monitor varies from 10 to 15 feet, and this one is closer, 6 feet. The Maintenance Director stated the handheld tester was used to check the 4 electronic wander management transmitter devices, currently being used, daily. The Maintenance Director demonstrated with the transmitter, a digital readout on the handheld tester displayed with the transmitter number and OK. The Maintenance Director stated OK meant the transmitter was functioning, the expiration date was located on each transmitter and must be replaced in March of 2025, batteries were no longer accessible, and the transmitter device must be replaced. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 10/28/2024 at 10:15 AM, the Director of Nursing (DON) stated Resident #3 had a BIMS of 15 and let Resident #1 out of facility using keypad at the end of the 200 Hall. The DON does not know how Resident #3 was aware of the door code. The DON state Resident #3 told housekeeping they let someone out the door. The DON stated she brought Resident #1 back to the facility in her personal vehicle, about noon on Saturday, after Resident #1 was found. During an interview on 10/28/2024 at 10:33 AM, Resident #3 stated they did let someone out the door because they wanted to go out. Resident #3 would not state how the code to the door was obtained. Resident #3 laughed when asked to demonstrate buttons pushed to open the exit door and stated, I just pushed any button. During a concurrent interview and observation on 10/28/2024 at 11:07 AM, the Maintenance Director demonstrated how the electronic wander management system was tested on B Hall the day of the elopement, by placing the electronic wander management transmitter device in their left boot, walked to the exit panel and entered the code. The panel made a decrescendo sound and did not deactivate the exit door. Maintenance Director stood at the exit door for 20 seconds and the alarm sounded. The Maintenance Director walked away from the exit door, past laundry and past room [ROOM NUMBER], left the transmitter device on the handrail and reset the panel, obtained the transmitter device, exited through the door and the alarm continued to sound. The Maintenance Director stated he was notified of the elopement by the Administrator on 10/19/2024 between 11:45 AM and 12:00 PM, and arrived at the facility about 12:30 PM, and changed the code on all of the exit panels. The Surveyors and the Maintenance Director viewed a video of elopement involving Resident #1 and Resident #3 on the B Hall. The following is a timeline of the video, from the facility's video system, shown to surveyors by the Maintenance Director. -Video view from the indoor camera located on B-Hall, faced the exit door, identified by the Maintenance Director as 1 B Hall. -On 10/19/2024 at 11:13 AM, Resident #1 was walking on the B Hall near room [ROOM NUMBER], away from the nurses' station toward the exit door. At 11:14 AM, Resident #1 entered Resident #1's room at the time), on left side of the hallway. At 11:16:46 AM, Resident #1 exited the room and turned left onto the B hall and walked toward the exit door. At 11:17:16 AM, Resident #1 arrived at the back exit door, a laundry aide was walking down the hallway at 11:17:36 AM and spoke with the resident. The Maintenance Director identified the laundry aide as Laundry #7. At 11:17:50 AM, Resident #1 walked from the back door toward nurses' station, and entered room [ROOM NUMBER]. At 11:18:30 AM, Resident #1 and Resident #3 exited room [ROOM NUMBER], turned left toward the exit door. Resident #3 was in an electric wheelchair. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	At 11:19:10 AM, Resident #3 positioned wheelchair, so it faced the exit panel and pressed 4 buttons on the exit panel, Resident #1 pressed on the door and exited the facility. Resident #3 immediately turned and moved away from the exit door. At 11:19:50 AM, Resident #3 entered room [ROOM NUMBER]. At 11:20:39, Resident #3 exited room [ROOM NUMBER] turned right onto B-Hall, toward the nurses' station. At 11:27:48 AM, Resident #3 pressed numerous buttons on the keypad then knocked on the Employees Breakroom door. The door was opened by a staff member identified by the Maintenance Director as Housekeeper (HK) #6. At 11:28:36 AM, HK #6 exited the employee breakroom, turned right toward the exit door. HK #6 entered the code on the exit panel and exited B-Hall through the doorway. At 11:28:40 AM, HK #6 reentered the door and moved towards the nurses' station out of view of the camera. Video view from the outdoor camera, located outside the B Hall exit, faced the garage/shed. The Maintenance Director stated the designation of the camera was 14 Big Shed. At 11:19:07 AM, Resident #1 exited the B Hall, turned right and followed the gravel road. At 11:28:40 AM, HK #6 exited the B Hall and went out of view. The Maintenance Director stated Resident #1 followed the creek and somebody should have gone outside and looked for the resident when the Code [NAME] was called. During an interview on 10/28/2024 at 11:39 AM, the DON stated Registered Nurse (RN) #9 found Resident #1 after a passerby told her someone was down the road. The DON does not know why they stopped to tell RN #9. During an interview on 10/28/2024 at 12:45 PM, the Administrator stated, Resident #1 was never signed out of the facility, and did not have a sign out sheet in the sign out logbook. During an interview on 10/28/2024 at 2:42 PM, the Resident Representative stated, Resident #1 had never left the facility before, when at home, the resident would have cabin fever and asked to go somewhere and family would take Resident #1 out for a drive. The Resident Representative stated they were informed Resident #1 was found one quarter of a mile from the facility in a creek, clothing was wet and muddy, had burs, and went under barbed wire fence and was cut. The Resident Representative stated Resident #1 was following the creek because Resident #1 knew it would lead to the Resident Representative's home. During an interview on 10/28/2024 at 9:15 PM, Certified Nursing Assistant (CNA) #2 stated they were familiar with Resident #1 and did not work the day of the elopement. CNA #2 stated, Resident #3 was bragging today, about the elopement, about opening the door and letting another resident out and stated I'm gonna use the code and let them (other residents) out. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 10/28/2024 at 9:30 PM, Licensed Practical Nurse (LPN) #1 stated they were familiar with Resident #1 who had an electronic wander management transmitter device in place and wandered constantly. LPN #1 stated a couple of weeks before the elopement, there were issues with the alarm system, and that the alarm would randomly go off, and indicated Resident #1 was at one of the doors when the resident was in the dining room, or in their room, and not close to the exit door. LPN #1 stated that on 10/04/2024 at 5:33 AM, Resident #1 was in bed and the electronic wander management system showed resident was at the door on the 200 Hall. LPN #1 stated the Maintenance Director was notified and was trying to figure it out. LPN #1 did not know if the Maintenance Director was able to find a problem with the unit. LPN #1 stated the electronic wander management transmitter device was not removed from Resident #1 to be repaired or replaced, and she did not believe it was ever removed from Resident #1. LPN #1 stated Resident #3 told other residents, on first shift, that Resident #3 was going to let all the residents out if given the chance because Resident #3 did not want other residents to come into the resident's room. A review of the Incident Report, number 24-00268, dated 10/28/2024 at 3:39 PM, revealed Law Enforcement (LE) #3 was dispatched on 10/19/2024 at 11:10 AM to an Agency/Officer Assist at the facility address, at the request of LE #10. LE #3 responded to a call at the nursing facility for a missing resident, Resident #1. LE #3 arrived at the dispatched location and observed vehicles on the side of the road and people in the field next to the road. LE #3 spoke with individuals identified as employees of the nursing facility, and Resident #1. During an interview on 10/29/2024 at 08:05 AM, LE #3 stated a call was sent out over the radio for a missing person at the facility. The officer responding was from the Sheriff's Department and LE #3 offered to respond for assistance as they were closer. LE #3 stated the call was located on a local highway and when turning onto the highway, three vehicles were located on the side of the roadway facing West. LE #3 stated he exited the patrol vehicle and entered the field where several people were gathered. LE #3 stated a nurse was present with three other individuals, one was identified as Resident #1 and another as a nurse and one as the Director (LE #3 did not have names of nurse or Director). LE #3 stated Resident #1 had blood on both hands, and the back of the shirt, and the clothing was not wet. LE #3 stated the creek bed was dry, and the concern was the 20-plus black angus [NAME], ranging in age from 3 to 6 years old, in the field facing the resident. LE #3 stated there was a hole in the barbed wire fence and Resident #1 was brought from the area of the creek through the open fence area with the barbed wire being held open so Resident #1 could get through without being caught in the fence. Resident #1 was placed in the Directors vehicle and returned to the facility. LE #3 stated Resident #1 repeated, I don't want to be here. During an interview on 10/29/2024 at 08:58 AM, the (Wander Management System Provider) office staff (WMSOS) #5 stated the wander management system was installed in the facility in March of 2024 and was not aware of any onsite service since that time. WMSOS stated the facility called last week and asked for a guide/manual that outlined testing. WMSOS stated testing should be done weekly on the doors and daily on the transmitters. WMSOS stated that when a resident, with an electronic wander management transmitter device in place, exited the door regardless of an electric wheelchair being present at the door, and a code being put in, the alarm should have sounded as soon as the resident crossed the threshold. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 10/29/2024 at 09:08 AM, the (Wander Management System Provider) owner (WMSO) #4 stated electrical interference could affect the functioning of the system and the facility should have called if there was a problem. The facility was not contacted about any issues with the transmitter devices. A technician was sent to the facility, regarding the alarm not sounding on Monday (10/21/2024). During an interview on 10/29/2024 at 10:20 AM, the Administrator was asked if a root cause analysis was done for the elopement and the Administrator stated, A Quality Assurance and Performance Improvement (QAPI) was not created for this elopement. Resident #1 was placed on the unit and an electronic wander management transmitter device was removed. The Administrator stated Resident #1 had exit seeking behaviors on 10/18/2024 and was walking the halls. The Administrator stated the electronic wander management system was installed as part of a Plan of Correction for a prior elopement. The Administrator stated he was not aware of issues or malfunctions of the system because the Maintenance Director checked the system. The Administrator stated the Maintenance Director did recreate the incident three times with Resident #3's wheelchair and received the same results. During an interview on 10/29/2024 at 11:15 AM, the Administrator stated there was no specific policy on Elopements, only unusual occurrences, accidents, and incidents. The procedure used for elopements outlined what was done in the event of a missing resident. During an interview on 10/29/2024 at 2:46 PM, the Nurse Consultant provided a copy of the electronic wander management system company's call for service dated 10/21/2024. Review of the document indicated the system was functioning properly, It was picking up 5 to 6 feet, when tested by the technician with the maintenance director. During a telephone interview on 10/30/2024 at 08:28 AM, Licensed Practical Nurse (LPN) #1 stated residents who wandered are assessed for elopement during the shift by observation on rounds every 2 hours, during medication pass and when walking the halls. Interventions would be used if needed, based on observations. If a resident had an electronic wander management transmitter device, it would be checked for each shift for placement and documented on the Treatment Administration Record (TAR). LPN#1 stated a there was a testing device in the medication cart for use to ensure the sensor was working properly but she had not received training on how it was used. LPN #1 stated Resident #1's sensor was activating the system on 10/4/2024 between 05:00 AM and 05:30 AM, and Resident #1 was in bed. LPN #1 stated the Maintenance Director was informed of the issue that morning. LPN #1 stated Certified Nursing Assistant (CNA) #2 reported that Resident #3 was going to let other residents out of the building. LPN #1 did not immediately notify anyone and did not believe it was important, and after some thought, notified the Minimum Data Set (MDS) Coordinator and Registered Nurse (RN) #9. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045280	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/01/2024
NAME OF PROVIDER OR SUPPLIER Twin Lakes Therapy and Living		STREET ADDRESS, CITY, STATE, ZIP CODE 6152 Highway 202 East Flippin, AR 72634	

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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 - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 10/30/2024 at 12:17 PM, LPN #11 stated residents at risk for elopement were identified by an assessment, upon admission, and if a resident had increased confusion, were antsy, wanting to leave seeking exit, verbalized they wanted to leave, or had a BIMS showing low cognition. An (electronic wander management transmitter device) would be put on, if the resident was ambulatory, and had exit seeking behaviors, and no comprehension. The device would be placed by (Maintenance Director), or another staff member. LPN #11 stated nurses used to check to confirm placement of the device and documented placement on the TAR, and the Maintenance Director checked functioning. Functioning is checked on the weekend by the nurses. LPN #11 stated the tester was located in the medication cart for use when the Maintenance Director was not available. At 12:18 PM, during interview, the door alarm sounded, LPN #11 observed control panel and left the nurses station, viewed the end doors of A, B and C halls, opened the door and observed the exit on the secured unit, and visualized the entry door and returned to nurse station, no doors were opened. The Administrator walked to the nurse's station, looked at the alarm panel, and returned to the front entry hall, no further action was taken by staff. LPN #11 stated an employee must have left the door open too long. During an interview on 10/30/2024 at 12:25 PM, the DON stated residents at risk for elopement were identified by the admission assessment. The DON stated the decision for placement of an (electronic wander management transmitter device) would be made after reviewing the residents. If a resident is at risk or high risk for wandering, had behaviors, BIMS score, and dignity, were used to determine placement of the device. The DON stated maintenance was responsible for placement of the (electronic wander management transmitter device) on the resident after he received notification. Maintenance would be notified during the morning staff meeting and the DON would follow up to ensure placement. The DON stated Resident #1's device was removed when the resident was placed on the secured unit, because there was no need for the device due to having closer supervision by staff. The DON stated wandering did not constitute placement of an (electronic wander management transmitter device), residents would be observed by staff who would report exit seeking behaviors and a device would be placed. During an interview on 10/30/2024 at 4:08 PM, LE #10 stated he was dispatched to a call for a resident that ran away from the nursing facility. The resident was described as (gender) wearing blue jeans and t-shirt with a beard and white hair. LE #10 responded from the Sheriff's Office to the scene. LE #3 with local police department radioed he was on scene just East of the nursing facility, in a field. Upon arrival there were pedestrians and vehicles off the side of the road, nurses and aides were walking Resident #1 back to the road. LE #10 was notified by LE #3 that the resident was walking in the creek bed toward cows. LR #10 recalled seeing cows that were facing the resident, and stated he was not sure what would have happened if the resident walked further up on the cows. LE #10 estimated the creek bank was approximately 4 feet high and was about 10 feet wide in that area. LE #10 stated there was always water running in the creek, but it was minimal at that time, and the resident did not appear to be wet, but did have skin injuries to arms, believed to be from the barbed wire. LE #10 stated he asked the resident why the resident left the facility and Resident #1 stated (family member)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045280	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/01/2024
NAME OF PROVIDER OR SUPPLIER: Twin Lakes Therapy and Living		STREET ADDRESS, CITY, STATE, ZIP CODE: 6152 Highway 202 East Flippin, AR 72634	

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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 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. 42016 Based on facility document review, and interviews, the facility failed to review and update the facility assessment at least annually and failed to ensure the facility assessment included pertinent information to assure the necessary care and resources were allocated to meet the needs of the residents. This deficient practice had the potential to affect all residents of the facility. The total census was 46 residents. Findings include: A review of a facility document titled, Facility Assessment Tool, dated 09/2023, indicated the purpose was to identify resources necessary to provide care and services required by residents residing in the facility. Section titled, Staff training/education and competencies, on page 9 and 10, revealed no training on resident wandering or elopement. Specific to Memory Care Neighborhood, on page 10, indicated the staff training included wandering and egress control. The section titled, Physical Environment and building/plant needs, revealed a table with headings that included Physical Resource Category and Resources. The first category listed was Building and/or other structures, and the Resources described the resource as Building description and did not indicate specific information about a secure unit; physical equipment included ventilators, a dialysis chair and station. Review of a facility policy titled, Wandering and Elopements, revealed the facility was to identify residents at risk and would use the least restrictive environment to prevent harm. The care plans of residents identified for wandering, elopement, or other safety issues would be updated with interventions to maintain the residents' safety. A review of Resident #1's medical record revealed Resident #1 exited the facility on 10/19/2024 without the knowledge of the facility staff. The Facility Assessment Tool did not identify or address wandering or elopement within the resident population and did not include the electronic wander management system installed by the facility in March of 2024. During an interview on 10/29/2024 at 08:58 AM, the (Wander Management System Provider) office staff (WMSOS) #5 stated the wander management system was installed in the facility in March of 2024. During an interview on 11/01/2024 at 09:35 AM, the Nurse Consultant stated the facility assessment was dated September 2023 and should accurately reflect the current status and needs of the facility, should be updated annually and when changes occur. The Nurse Consultant stated the facility did not have a dialysis chair or station, did not have ventilators, and was not updated to reflect the electronic wander management system. The Nurse Consultant stated the previous Administrator was responsible for the facility assessment accuracy and updates, but the assessment was not current.