

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045300	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/10/2025
NAME OF PROVIDER OR SUPPLIER Paris Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1414 S Elm St Paris, AR 72855	
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)		
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, record review, facility document review, and facility policy review, it was determined that the facility failed to maintain an environment free of hazards and failed to provide supervision for one (Resident #1) of three residents reviewed. Specifically, an electronic locking door known to have issues was not monitored or properly reported for repairs, allowing Resident #1 to elope from the facility and walk down the city street in traffic.</p> <p>The findings include:</p> <p>A review of the Resident Face Sheet, indicated the facility admitted Resident #1 on 07/11/2025 with diagnoses that included dementia, expressive language disorder, cognitive communication deficit following a stroke, muscle weakness, and unsteady on their feet.</p> <p>The admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/17/2025, revealed Resident #1 had a Brief Interview of Mental Status score of 0 which indicated the resident was had severe cognitive impairment. No wandering behaviors were identified.</p> <p>A review Resident #1's Elopement Evaluation recorded 07/13/2025 at 11:56 AM revealed, the resident was ambulatory or independent in wheelchair locomotion, was a new admission who had made statements questioning the need to be in the facility and displayed behaviors which may indicate an attempt to leave like body language, etc. which indicated an elopement may have been forthcoming. The resident was found to be at risk for elopement, but no care plan was initiated at that time per comments, Has not exit-sought.</p> <p>A review of Resident #1's Care Plan, initiated on 07/28/2025, revealed the resident's dementia which effected their decision making and caused cognitive communication issues which greatly impacted their communication and analysis of cognition difficult. Interventions included assistance with decisions as needed, provided cues, prompts, and reminders as needed, and speech therapy to find the best communication method. Resident #1 was at risk for falls related to impulsiveness; the approach was to assist with transfers and ambulation as needed. Behaviors were noted to interfere with care and increase risk for complications, interventions were if the resident refused care to attempt at a later time or with different staff, observe and document behaviors, and the resident calms with her child. On 10/09/2025 the care plan was edited to include elopement behaviors, interventions included an electronic monitoring device applied to the right ankle, listening for door alarms, and one-on-one observations. No elopement plan was initiated prior to Resident #1's 10/07/2025 elopement.</p> <p>(continued on next page)</p>		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 045300
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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of October 2025 General Administration History, revealed Resident #1 had an order placed on 10/08/2025 to check the functioning of the right ankle electronic monitoring device and the surrounding skin's integrity.</p> <p>During a concurrent observation and interview on 10/10/2025 at 11:26 AM, Resident #1 was seen in their room ambulating with a walker. Resident #1's response to all questions was unintelligible, although the resident made eye contact and verbalized a response there was a minimal number of actual words and no communication took place.</p> <p>During an interview on 10/10/2025 at 8:17 AM, the City Police Department [NAME] stated he was in contact with the responding officer to the elopement because there was another incident happening simultaneously. The responding officer worked from noon until midnight and was not available at the time of the interview. The [NAME] reported the officer responded to a 9-1-1 call where a citizen reported an elderly person walking alone down a city street approximately 200 yards away from the nursing facility, going south out of town. A citizen came by and reported to the officers that they were the ones who called it in because they almost hit the person in the street. The [NAME] reported the street had streetlights, but it was dimly lit and did not adequately illuminate the area. The person found walking in the street could not formulate a sentence and was unable to provide their name. The responding officer contacted the dispatch who placed a call to the nursing facility, and they reported they did not have any missing residents. Dispatch contacted the local hospital with the same results. The officer called for Emergency Medical Services (EMS). The [NAME] stated prior to EMS arriving the responding officer was called for emergent backup to a priority situation. The officer asked the citizen to walk with the unidentified person until he could return because the officer was worried the person (Resident #1) would be struck by a car. The other scene was less than a mile away and the officer had to yell from the corner for EMS to come to the 2nd scene before they could assess the person. The [NAME] stated at some point the nursing facility realized they were missing someone and called dispatch back. The nurses arrived with the facility van and took Resident #1 back.</p> <p>A review of the police report from Resident #1's elopement revealed the responding officer located a person walking down the city street with a walker. A motorist stopped and stated they had placed the 9-1-1 call because they had almost hit the person. The responding officer was unable to understand the person's verbal communications. After the nursing facility and the hospital denied any missing residents, the responding officer asked for EMS. Prior to EMS' arrival the officer had to respond to another incident and when EMS arrived to the first scene, the officer also instructed EMS to move further south to the second incident leaving the person walking down the road. While the responding officer was at the local hospital a second 911 call came in reporting the person again walking in the same road. Dispatch was instructed to contact the County Sherriff's Office for further assistance. By this point the facility was aware Resident #1 had eloped and was the person walking in the street through traffic. The staff utilized the facility's transport van to return Resident #1 to the facility. Resident #1's identity was not known to the police department until Wednesday 10/08/2025 when the responding officer did his follow-up with the facility.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of the City Police Departments redacted radio log from 10/07/2025 3PM-11PM shift revealed, at 8:07 PM a citizen called in and reported a person with a walker walking on a public street by the facility. An officer made contact with the person at 8:11 PM. Dispatch contacted the facility at 8:13 PM to inquire about any missing residents. At 8:16 PM it was reported to the officer that the facility was not missing any residents. At 8:28 PM the local hospital was contacted and reported back at 8:28 PM they had no missing patients. At 8:32 PM the officer requested dispatch to send EMS. At 9:28 PM two different citizens called in and reported the person with the walker was further down the road and was now blocking traffic. At 9:32 PM dispatch was instructed to contact the County Sheriff's office for assistance to remove the person from the road. EMS reported the person was alert and oriented and known to walk every night around that time.</p> <p>A review of a progress note from 10/08/2025 at 11:10 AM LPN #4 notified Resident #1's family/representative of the elopement. The representative stated it was only a matter of time, the resident was an escape artist and did this at their last facility.</p> <p>During an interview on 10/10/2025 at 12:42 PM, Resident #1's family stated they were not sure how the resident got out of the facility's secure unit. To their knowledge, someone found the resident two blocks away and the paramedics brought the resident back to the facility. The family reported that while in another facility, Resident #1 got out and was found across the highway at the movie theater. The family reported the resident was not in a locked unit previously and believed the resident was secure because at the current facility every door seemed to have a different code on it. A nurse reported to the representative that maybe the door was faulty, and the resident followed someone out who was not paying attention. The family did not believe Resident #1 was in any danger now, since the application of the electronic monitoring ankle bracelet. The family stated they believed the staff were doing what they could, but they must be more careful with residents.</p> <p>During an interview on 10/10/2025 at 9:24 AM, the Maintenance Director (Maintenance) stated he checked the doors including the electronic monitoring system and the electronic door locks every Tuesday. Maintenance stated his wife worked here in therapy and sometimes she took one of the residents outside and let the alarm go off so they could do a mock elopement with a resident. Maintenance reported after Resident #1's elopement he came in and checked the door on the 500-Hall secure unit where the resident got out. He said he tried it three times then a buzzing noise started. He stated the keypad showed red like it was locked but it opened right up. Maintenance called a repair business, and they came and changed out the keypad. Maintenance believed it was shorting out since it was not doing it every time and took 3 times to recreate the scenario. Maintenance stated he had worked here about 26 years and had checked the doors weekly. Maintenance stated he gets handwritten work orders and after he addresses it, he signs, dates the bottom with the resolution and sticks it in his desk drawer.</p> <p>A review of hand-written maintenance work orders from 06/01/2025-10/10/2025 provided by the facility revealed no work orders for the 500-Hall secure exit doors.</p> <p>A review of the computerized maintenance tracking system for six months from 10/10/2025 provided by the facility revealed on 10/03/2025 the Maintenance Director completed a test operation of doors, locks, gates, and alarms as well as a facility inspection of secure doors and mag door check. There were no notations made.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of a witness statement dated 10/07/2025 at 10:00 PM revealed Medication Assistant Certified (MAC) #9 was assisting Resident #1, who asked for some underwear, which was provided. At around 7:00 PM snacks were provided, Resident #1 retrieved some snacks and went and sat by the back door. MAC #9's second statement from 10/08/2025 revealed the resident always had a change of clothes on their walker.</p> <p>A review of a witness statement dated 10/07/2025 at 11:00 PM revealed, MAC #8 last saw Resident #1 at 7:30 PM and thought the resident had gone to bed. MAC #8 reported no door alarms went off.</p> <p>A review of a witness statement dated 10/08/2025 revealed MAC #3 last saw the resident between 7:30 PM- 8:00 PM, the resident had clothes on their walker and was sitting in a chair at the end of the hallway. Resident #1 put clothes on the floor beside the chair. This was not new or unusual behavior for the resident. The resident was not trying the doors or pacing.</p> <p>During an interview on 10/11/2025 at 11:40 AM, Certified Nursing Assistant (CNA) #1 was at the 500-Hall secure exit door past the dining room were Resident #1 went out and stated, the staff had issues with door prior to the elopement. CNA #1 stated, sometimes it would not open from the inside and when it closed you had to make sure it closed behind you or it left a gap. The problem had been reported to nurses over the last two to four weeks. CNA #1 stated she did rounds on evening shift every two hours at 4PM, 6PM, 8PM, and 10PM. She gathered briefs for everyone needed and went to each room starting at the end of the hall. She saw everyone she changed and checked the roommate as she went. The check for residents was more of a mental thing no documentation was done. CNA #1 reported that since the secure doors keypad had been changed there had been no other issues. Tuesday, 10/07/2025, the evening of the elopement, CNA #1 left the facility prior to dinner and was not in the building at the time of the elopement.</p> <p>During an interview on 10/10/2025 at 11:57 AM, Central Supply Tech (CST) #2 stated it had been at least a month since the 500-Hall door had issues with not working. CST #2 stated he did not report the issues but knew it had been mentioned before. CST #2 stated the facility did not have an active Administrator and some things get forgotten, we are all just helping each other out. CST #2 reported before the door was fixed you could hear it making a mechanical winding sound. When he heard the winding sound, he would pull it until it stopped. You can tell people that, but they don't listen. I just think some employees get too comfortable.</p> <p>During an interview on 10/10/2025 at 12:04 PM, MAC #3 stated she worked Tuesday night 10/07/2025 the night Resident #1 eloped. MAC #3 reported Resident #1 had no issues at dinner and later they were roaming in the hallway, but it was not unusual behavior. MAC #3 reported, sometimes Resident #1 packed clothes up but after they walked around, they put them away. MAC #3 was unaware when Resident #1 left the facility stating she goes to another hall to pass medications from 8PM-9PM, about 15-20 mins before she left the 500-Hall Resident #1 was sitting in the hallway on their walker. MAC #3 was vaguely aware of the door locking issues but had not thought about it in a while and thought it had been fixed.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/10/2025 at 12:31 PM, Licensed Practical Nurse (LPN) #4 stated she had worked on the secure unit for two weeks during the day. She stated there was a situation where the 500-hall secure exit door would open but it would not catch back with the magnet. LPN #4 stated, You had to push it again and make sure it closed. LPN #4 stated CNA #7 told her to be careful with the door and CNA #7 said she made a report of it. LPN #4 reported no issues with the door now that the keypad had been replaced. LPN #4 stated the CNAs round every two hours looking at the census and each room at the resident. LPN #4 stated she also will go around with the med pass and lay eyes on them.</p> <p>During an interview on 10/10/2025 at 12:54 PM CNA #7 stated, the door 500-Hall secure exit door shuts but it does not lock tight, and you must push it again or it will open. CNA #7 reported the door had been that way a couple months and she reported it to Maintenance. I told him when he came back a couple of months ago and they did look at it. Not sure if they did anything or replaced anything at that time. I haven't noticed it for a while. I work back there and make sure the door shuts and locks when I am back there, It's my habit. CNA#7 stated she was not on duty when Resident #1 eloped.</p> <p>During an interview on 10/10/2025 at 1:01 PM, LPN #5 stated the last time she saw Resident #1 on 10/7/2025 at 7:50 PM. I was in the room across the hall, and [pronoun] told me good night. LPN #5 stated after the encounter she took a break and left the facility. At about 8:20 PM the facility staff got a call, and the police asked if they were missing a resident, dispatch said they had a person and described them. LPN #5 stated, she looked up and asked a few staff if we were missing a resident. Since everyone told her no, she told dispatch no. LPN #5 stated nothing else was done at that time. At 9:40 PM, Floor Tech (FT) #6 called and reported seeing Resident #1 on the street while driving to the facility. Staff were sent down there. LPN #5 stated an alarm never went off and she thought the 500-Hall side door by the dining room because it has been known to be faulty. Resident #1 had put clothes under a chair by the door. LPN #5 reported after Resident #1 had returned to the facility they pointed to the 500-Hall door and said, I got out. LPN #5 stated the staff tested the door several times at about 11, and it opened. They facility put one on one staff to the 500-Hall exit door at that time.</p> <p>During an interview on 10/10/2025 at 1:14 PM, FT #6 stated he was driving to work down the city street when he met a car with their flashers on and got in behind them. Resident #1 had their walker with dining cups with stuff in them and was booking it. He knew it was Resident #1 right away. A county officer and EMS arrived, and I called the facility. The nurse came down and called the girls to bring the transport van down there. It took 5 staff to get Resident #1 in the van. A couple in the car behind Resident #1 said they called it in. The staff had to calm down Resident #1, then they loaded up and brought them back. The Regional Administrator told me the next day Resident #1 walked them to the exit door past the dining room on 500-hall. The resident took her walker and pushed the door open. The resident would have had to walk along the side of the facility by the therapy room. The other side had creek and was muddy. Resident #1 was scared to death. It was at least a half a mile down the highway.</p> <p>During an interview on 10/10/2025 at 1:53 PM the Medical Director (MD) stated the facility had a policy and procedure on elopement, but he did not know the specifics. The MD stated Resident #1 eloped and walked about 3/4 of a mile then was picked up and brought back to the facility unharmed. He stated he saw Resident #1 Wednesday and assessed no harm to the resident. The MD stated he was aware the facility had a plan to fix the door the resident went out, but had no idea what happened stating, It just came open.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/10/2025 at 2:02 PM the Director of Nursing (DON) stated a resident saying they wanted to go home, packing a bag, or door checking were all considered resident exits seeking behaviors. The DON stated she would have to check but she believed Resident #1 was care planned as an elopement risk. Resident #1 resided on the secure unit, but the electronic monitoring system had not been initiated prior to the 10/07/2025 elopement. There were 2 CNAs and a MAC working the Secure unit the night of the elopement. The DON stated she was notified by the charge nurse that Resident #1 had an elopement. The facility staff took the transport van to pick Resident #1 up and returned to the facility. The DON stated she in-serviced LPN #5 about elopements and doing the census for a room-by-room search. The staff did a facility census, body audits, and notifications. They notified Resident #1's family, The MD, Myself and she notified the Regional Administrator. After Resident #1 was returned they checked the door. LPN #5 checked the 500-Hall secure exit door and said it was not locking. Once they figured out the door was malfunctioning a staff member was assigned to sit and monitor it. The DON stated she was unaware of any issues with the 500-Hall exit door and maintenance request are put in through a computerized tracking program which the charge nurses have access to but did not know if the CNAs did. Maintenance then got alerted to it, but Maintenance was known to check the system on a regular basis. The system had been in place for at least 7 years since she had been employed there and stated the staff should know about it. The DON stated the staff also wrote down maintenance work orders, but the computerized tracking system was the official system. The DON stated there were no work orders that were in the computerized system for any locking doors issues.</p> <p>During an interview on 10/10/2025 at 2:41 PM the Regional Administrator stated anytime a resident gets out of the facility, off the property, and out of line of sight, it is an elopement. She stated she was notified by the DON when Resident #1 eloped on 10/07/2025 somewhere around 9:45PM-9:50PM. They made sure the resident was on route back to the facility. Resident #1 was placed one-on-one and was assessed for the electronic monitoring system. She stated Resident #1 was not care planned for an elopement risk prior to the 10/07/2025 event because Resident #1 had been in the facility since July 2025 and there has been no exiting seeking or door checking behaviors. The Regional Administrator stated she was not aware of Resident #1's elopement from another facility. The Regional Administrator stated the facility did not know 100% for sure how Resident #1 got out but stated one of the MAC asked and Resident #1 rolled to the door and pointed to it. The staff checked it 3 times and it was not working. A staff member was stationed there, and the repair company came out the next day, a keypad had to be replaced. They thought it might have gone bad during the rainstorm. Everything has been working since then. The next day the DON and Regional Administrator asked Resident #1 again how they got out, Resident #1 walked right to the same door. The staff have been checking all the doors and keypads to see if any have issues. The Regional Administrator stated some maintenance work orders are made in the computerized tracking system and some are handwritten. The written ones were given directly to the Maintenance Director unless they were emergent than he was called. The Regional Administrator stated the computerized tracking system was just being implemented for maintenance work orders this week but had no knowledge of any issues with that door prior to the event. The Regional Administrator stated she told the Maintenance Director to give her the computerized tracking system in-service, and she would personally go around to everyone. The slips of papers and sticky notes we have are not a system. It's just not going to cut it.</p> <p>(continued on next page)</p>		

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