STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055977	A. Building B. Wing	06/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kennedy Care Center	619 N. Fairfax Ave Los Angeles, CA 90036

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 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. Based on interview and record review, the facility failed to ensure an allegation involving an incident of unknown source resulting in serious bodily injury was reported to the California Department of Public Health (CDPH-state agency who ensures oversight of state and federal regulations to long term care facilities) immediately, but not later than two hours after becoming aware of the incident, for one of four sampled residents (Resident 1) by failing to report that Resident 1 eloped (unauthorized departure of a resident from an around-the-clock care setting) from the facility on on 5/5/2026 at 5:50 PM. Resident 1 remained missing overnight and was returned to the facility by two police officers on 5/6/2026 at 3:35 PM two police officers. On 5/6/2026 at 7:36 PM, Resident 1 was transferred to a general acute care hospital (GACH) where the Resident 1 was diagnosed with fractured (broken) right fifth finger of unknown origin. This deficient practice delayed notification to the state agency responsible for oversight and investigation of incidents involving potential abuse, neglect, or injuries of unknown source, delaying external review of the circumstances surrounding Resident 1's elopement and injury.Findings: During a review of Resident 1's admission Record, dated 4/19/2026, indicated Resident 1 was admitted with diagnoses including dementia (progressive impaired ability to think, remember, or make decisions that interferes with daily activities), diabetes mellitus type II (DM2- A condition that happens because of a problem in the way the body regulates and uses sugar as fuel), and metabolic encephalopathy (a disturbance of brain function that may cause confusion and impaired cognition). During a review of Resident 1's Minimum Data Set (MDS- resident assessment tool), dated 4/22/2026, indicated Resident 1 had severe impaired cognition (ability to think, remember and reason) . Resident 1 required supervision (oversight, encouragement, or cueing) for eating, oral hygiene, and personal hygiene. Resident 1 required partial assistance (Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) for toileting, shower/bathe, upper and lower body dressing, putting on footwear, roll left and right, sit to lying, lying to sitting on side of bed, sit to stand, chair/bed transfer, and walk 10 feet. During a review of Resident 1's Elopement and Wandering Risk Assessment, dated 4/22/2026, indicated Resident 1 was assessed as high risk for elopement due to dementia, metabolic encephalopathy, a history of attempting to leave a previous facility, unsafe wandering behaviors, and verbalizing intent to leave the facility. The assessment indicated Resident 1 required a Wander Guard device. During a review of facility investigation of elopement, Resident 1 eloped from the facility on 5/5/2026 at approximately 6:30 PM and was discovered missing at approximately 6:50 PM. Resident 1 remained missing overnight until located by law enforcement on 5/6/2026 at approximately 3:15 PM and returned to the facility at approximately 3:35 PM. During a review of the May 2026 Medication Administration Record (MAR), Resident 1 missed physician-ordered medications scheduled for 9:00 PM on 5/5/2026 while absent from the facility. The MAR further indicated Resident 1 complained of bilateral hand pain and received Acetaminophen on 5/6/2026 at 7:06 PM. During an interview on 6/23/2026 at 12:08 PM, the Administrator stated he was notified on 5/5/2026 at approximately 6:50 PM that Resident 1 was missing from the facility. The Administrator stated he immediately contacted the local police department, telephoned area hospitals, and, along with the Director of Nursing (DON) and Social (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Services (SS), searched the surrounding community for Resident 1. The Administrator stated Resident 1 was located by law enforcement on 5/6/2026 and returned to the facility. The Administrator further stated he did not report the elopement to the California Department of Public Health because he was more concerned with locating Resident 1. During an interview on 6/23/2026 at 1:17 PM with SS, SS stated that on 5/5/20296 at approximately 6:50 PM, SS was in the facility when SS was notified that Resident 1 could not be located. SS stated that SS reported to the Administrator to that Resident 1 was missing. SS stated staff searched the building and drove around the surrounding areas in search of Resident 1. SS stated that on 5/6/2026,two police officers found Resident 1 sitting on a porch at Resident 1's former house. SS stated that the people living in the house observed Resident 1 sitting outside on the front porch and called the police after they asked Resident 1 to leave but Resident 1 refused. The distance from where the police found Resident 1 was about 15 minutes' drive from the facility, which is not a walking distance. SS stated that Resident 1 must have taken a bus to get to the location where the police located Resident 1. During an interview on 6/23/2026 at 1:45 PM, the Director of Staff Development (DSD) stated DSD assessed Resident 1 upon return to the facility on 5/6/2026 and observed discoloration of Resident 1's right fifth finger. The DSD stated Resident 1 was transferred to the hospital for further evaluation and subsequently returned with a diagnosis of a fractured right fifth finger. During an interview on 6/23/2026 at 3:17 PM, the Director of Nursing (DON) stated Resident 1's elopement was a reportable event. The DON stated the facility is responsible for reporting such incidents to the appropriate agencies within the required timeframes so a timely investigation and implementation of corrective actions can occur. The DON stated failure to report delays external review of the incident and may allow systemic issues affecting resident safety to remain unaddressed. During a review of the facility's policy and procedures (P&P) titled Wandering and Elopement dated 2/2026 indicated, if a resident is missing and not located, notify law enforcement officials and volunteer agencies as necessary. During a review of the facility's P&P titled Unusual Occurrence Reporting dated 2/2026, indicated, the facility will report to appropriate agencies of occurrences that interfere with facility operations and affect the welfare, safety, or health of residents, employees or visitors. Unusual occurrences shall be reported via telephone to appropriate agencies as required by current law and or regulations within 24 hours of such incident or as required by federal and state regulations. A written report detailing the incident and actions taken by the facility shall be sent to the state agency within 48 hours of reporting the event or as required by federal and state regulations.

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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** Based on observation, interview, and record review, three of four sampled residents (Residents 1, 2, and 3), who were identified as at high risk for elopement (Refers to an unauthorized departure. It happens when a patient or resident leaves a hospital, clinic, or care facility without notifying the staff or before being officially discharged . This is especially critical when the patient requires supervision for their own safety) and with wandering behaviors (locomotion behavior associated with conditions like dementia or autism. It involves repetitive, aimless, or disoriented pacing, roaming, or leaving a safe area) the facility failed to: Ensure the reception/lobby area is monitored and supervised after 6 PM when the receptionist signs out/leaves for the day to prevent residents at risk for elopement from eloping the facility. Ensure the wander guards (An electronic monitoring device worn on ankle or wrist to help ensure safety by alarm activation if a resident attempts to leave a safe area) and wanderguard alarm doors were functional to alert staff when a resident(s) attempts to elope/leave the facility. Resident 1 and Resident 3 wore a Wander Guard device at all times according the careplan (CP) and medication administration record (MAR) for 5/2026. These deficient practices resulted in Resident 1 eloping from the facility on [DATE] at 5:50 PM without staff awareness, remaining missing overnight for over 20 hours and missed scheduled medications. On [DATE] at 3:35 PM, 2 (two) police officers returned Resident 1 to SNF 1. Resident 1 complained of right phalangeal (finger) to the right pinky (small) pain, had right finger discoloration and left knee abrasions and discoloration. On [DATE] at 7:36 PM, Resident 1 was transferred to a general acute care hospital (GACH) 1 for further evaluation and management where Resident 1 was diagnosed with Phalangeal fracture (break in bone) to the right pinky with splint (brace/immobilizer) and placing Resident 1, Resident 2 and Resident 3 at increased risk for elopement/repeated, fall with injuries, hospitalization and death. Findings 1. During a review of Resident 1's admission Record, dated [DATE], indicated Resident 1 was admitted with diagnoses of dementia, diabetes type 2 (DM2- high blood sugar), and metabolic encephalopathy (disturbance of brain function, it causes confusion, memory loss and coma in severe cases). A review of Resident 1's Minimum Data Setˆ(MDS- resident assessment tool), dated [DATE], indicated Resident 1 had severely impaired cognitionˆ(ability to think, remember and reason). The MDS indicated Resident 1 required supervision (oversight, encouragement, or cueing) for eating, oral hygiene, and personal hygiene. The MDS indicated Resident 1 required partial assistance (Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) for toileting, shower/bathe, upper and lower body dressing, putting on footwear, roll left and right, sit to lying, lying to sitting on side of bed, sit to stand, chair/bed transfer, and walk 10 feet. A review of Resident 1's Nursing Elopement and Wandering Risk Observation/Assessment dated [DATE] at 9:59 AM, indicated Resident 1 was at high risk for elopement due to history of attempting to leave a previous facility, dementia, and metabolic encephalopathy. The Nursing Elopement and Wandering Risk Observation/Assessment indicated that Resident 1 required a Wander Guard due to exhibiting unsafe wandering (moving from place to place without a fixed plan) behavior and that Resident 1 had expressed/verbalized that she planned to leave the facility. A review of Resident 1's Care Plan (CP - (a personalized document that outlines a resident's needs, goals, and the specific services required to achieve them, ensuring consistent and holistic care) Elopement: Resident is at risk for elopement/exit seeking/wandering related to altered cognitive status, dated [DATE], indicated the facility staff will attempt to refocus Resident 1 when the resident is exhibiting elopement/exit seeking/wandering behavior, check exit, stairwell, and door alarms on a routine schedule for operability. The CP indicated that licensed nurses will check the function of the wander guard alarm per manufacturer recommendations, check placement of wander alarm every shift, and equip with a device that alarms when resident wanders. The CP indicated to check for proper (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	functioning of the device and alarms every shift and monitor whereabouts frequently. A review of Resident 1's CP Risk for Falls r/t generalized weakness dated [DATE] indicated Resident 1 needs a safe environment with adequate, glare-free light, a working and reachable call light, and even floors to prevent falls. A review of Resident 1's Medication Administration Record (MAR) dated [DATE], indicated Resident 1 had a Wander Guard bracelet that expired [DATE] and was last documented wearing the Wander Guard bracelet on [DATE] during the morning shift (7 am to 3 pm). The MAR indicated Resident 1 missed the medications: ˆLantus SoloStar (medication to treat diabetes) on [DATE] that was scheduled for 9 PM. Losartan (medication to treat high blood pressure) on [DATE] that was scheduled for 9 PM. The MAR indicated Resident 1receivedˆ Acetaminophen (pain medication) on [DATE] at 7:06 PM after returning to the facility due to complaints of right and left hand pain. A review of Resident 1's SNF 1 Timeline of Events, the timeline indicated the following: On [DATE] at 3 PM Resident 1 seen by Certified Nursing Assistant (CNA) 1 in her room during initial rounds On [DATE] at 4 PM Resident 1 seen walking around the facility On [DATE] at 5:30 PM Resident observed in her room with the Charge Nurse 1 On [DATE] at 6 PM Resident seen wandering around station 1 in the front lobby while drinking coffee. On [DATE] at 6:30 PM Resident not noted in the facility. On [DATE] at 6:57 PM Administrator informed Resident 1 is missing from the facility. On [DATE] at 7:15 PM Administrator notified Los Angeles Police Department about Resident 1 missing. On [DATE] at 3:15 PM Police called facility to confirm Resident 1 had been located. On [DATE] at approximately 3:35 PM Resident returns to the facility with noted left knee abrasions (superficial injuries), and right-hand discoloration. On [DATE] at 7:36 PM Resident 1 is sent out to the hospital for further evaluation. On [DATE] at approximately 12:15 PM Resident 1 returns to facility from hospital with noted phalangeal (the anatomical term for the individual bones that make up the fingers and toes) fracture (break in the bone) to the right pinky with splint (a rigid or flexible medical device used to protect, support, and immobilize injured body parts like fractured bones) in place. On [DATE] Resident 1 discharged from facility to a lateral skilled nursing facility. A review of Resident 1's Interact Situation Background Assessment Recommendation (SBAR - is a structured communication framework that can help teams share information about the condition of a patient or team member or about another issue your team needs to address.) Summary for Providers dated [DATE] at 6:50 PM, indicated . upon routine rounds (Resident 1) was not in her assigned room. Staff search resident room & surrounding premises. Search expand to nearby streets and surrounding areas. Law enforcement notified at approximately 7:28 PM. A review of Resident 1's 72-hour Charting dated [DATE] at 9:32 PM, indicated Resident 1 refused medication (unspecified) at 5 PM. The 72-hour Charting further indicated that a certified nursing assistant (CNA) 1 reported that Resident 1 was missing from (Resident 1's0 room around 5;50 PM. A review of Resident 1's undated nor timed Note Text Admission/re-admission Summary Note documented by, Director of Staff Development (DSD), indicated Resident 1 noted with right (rt) finger discoloration with no pain. may transfer to GACH 1 for further evaluation and management. A review of Resident 1' Nurse's Note dated [DATE] at 5:53 PM, indicated Resident 1 was safely returned to facility . she (Resident 1) was looking for job. A review of Resident 1's Nurse's Note dated [DATE] at 7:36PM, indicated Resident 1 was transferred to GACH 1 . body check done noted left knee abrasions and right had discoloration . A review of Resident 1's Nurse's Note dated [DATE] at 12:15 PM, indicated Resident 1 was readmitted from the hospital . noted with Phalangeal (finger) to the right pinky (small) with splint (brace/immobilizer) in place A review of Resident 1's Social Service Note dated [DATE] at 2:12 PM, indicated Resident 1 will be discharged today [DATE] at 5 PM going to . A review of Resident 1's Nurse's Note late entry dated [DATE] at 12:37 PM, indicated Resident 1 was brought back by 2 (two) police officers at 3:35 PM yesterday ([DATE]). Corrective time for assessment for elopement assessment. A review of Resident 1's Psychological Note dated [DATE] at 2:46 PM, indicated Resident 1 returned to the facility following hospitalization. Resident 1 had been informed of (Resident 1) transfer to another facility and a family member had approved of the resident's transfer. 2.ˆA review of Resident 2's (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	admission Record, dated [DATE], indicated Resident 2 was admitted with diagnosesˆof dementia and encephalopathy. A review of Resident 2's MDS, dated [DATE], indicated Resident 2 had moderate impaired cognition. Resident 2 was independent (no help or staff oversight at any time) for eating, oral hygiene, personal hygiene, toileting, shower/bathe, upper and lower body dressing, putting on footwear, roll left and right, sit to lying, lying to sitting on side of bed, sit to stand, chair/bed transfer, and walk 150 feet. A review of Resident 2's Elopement and Wandering Risk Assessment dated [DATE] indicated Resident 2 was at risk for elopement and required a Wander Guard due to exhibiting unsafe wandering behavior. A review of Resident 2's CP Resident is at risk for elopement/ wandering, dated [DATE], indicated apply wander guard as ordered, check placement, and function as indicated. 3.ˆ A review of Resident 3's admission Record, dated [DATE], indicated Resident 3 was admitted with diagnosis of chronic obstructive pulmonary disease (COPD- lung disease causing restricted airflow and breathing problems), fractures, and encephalopathy. A review of Resident 3's MDS, dated [DATE], indicated Resident 3 had moderate impaired cognition. Resident 3 required supervision (oversight, encouragement, or cueing) assistance for eating, oral hygiene, personal hygiene, toileting, shower/bathe, upper and lower body dressing, putting on footwear, roll left and right, sit to lying, lying to sitting on side of bed, sit to stand, chair/bed transfer, and walk 150 feet. A review of Resident 3's Elopement and Wandering Risk Assessment dated [DATE] indicated Resident 3 was at risk for elopement due to exhibiting unsafe wandering behavior. A review of Resident 3's CP Resident is at risk for elopement/ wandering, dated [DATE], indicated check exit, stairwell and door alarms on a routine schedule for operability, check function of wander alarm per manufacturer recommendations. Check placement of wander alarm every shift. A review of Resident 3's MAR dated [DATE], indicated Resident 3 had a physician order to wear a Wander Guard bracelet due to wandering/exit seeking behaviors. During an interview on [DATE] at 12:08 PM with the Administrator, the Administrator stated Resident 1 had been discharged from the facility on [DATE] to a more appropriate facility due to her recent elopement from the facility on [DATE]. The Administrator stated on [DATE] at approximately 6:50 PM, Social Services (SS) informed the Administrator that Resident 1 was missing from the facility and that he notified the police department. The Administrator stated that he called around to different hospitals to search for Resident 1.The Administrator stated the SS, Director of Nursing (DON) and himself went to look/search for Resident 1 the evening of [DATE] but were unable to find Resident 1. The Administrator stated that the next day, on [DATE] at approximately 3:15 PM, a police officer called the facility to report Resident 1 was located and would be returning to the facility. The Administrator stated he did not report to California Department of Public Health that Resident 1 had eloped from the facility because he was more concerned with finding Resident 1. The Administrator stated he interviewed the Charge Nurse (CN) 1 who was working on [DATE] and had reported seeing Resident 1 on [DATE] at around 5:15 PM when the CN 1 went to offer Resident 1 medication in Resident 1's room, however Resident 1 refused th medication The Administrator stated that CNA 1 helped translate for Resident 1, and t5hat on [DATE] at around 5:45 PM Resident 1 agreed to take the medication and that was the last time CN 1 saw Resident 1. The Administrator stated that according to the facility's internal investigation, a visitor accidentally held the door open for Resident 1 to leave the facility on [DATE]. During a phone interview on [DATE] at 12:34 PM with CNA1, stated that she had started her shift on [DATE] at 3 PM and noted Resident 1 in Resident 1's room during CNA1's initial rounds. CNA1 stated that on the same day at around 3:30 PM, CNA1 assisted Resident 1 to the restroom. On the same day at around 4 PM, Resident 1 was observed walking around the facility and at around 4:45 PM, CNA1 offered Resident 1 some hot coffee. CNA1 stated around 5 PM, and the charge nurse asked her to talk to Resident 1 because Resident 1 was refusing to take medications. CNA1 stated she talked to Resident 1, who is Spanish speaking, and encouraged Resident 1 to take the medications. CNA1 stated Resident 1 is confused and always talked about wanting to go home to her family/loved one. CNA1 stated that on the same she passed Resident 1's dinner tray around 5:45 PM, and last saw Resident 1 at around 6 PM wandering around Nurses' Station (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1 in the front lobby while drinking coffee. CNA1 stated she did not see Resident 1 in the facility at approximately 6:30 PM and reported to the charge nurse that Resident 1 was not around. A phone interview was attempted on [DATE] at 12:35 PM with the Charge Nurse CN1 who was on shift on [DATE] and a voice message was placed. No answer or call back received from CN1. During an interview on [DATE] at 1:17 PM with SS, SS stated that on [DATE] at approximately 6:50 PM, SS was in the facility when SS was notified that Resident 1 could not be located. SS stated that SS reported to the Administrator to that Resident 1 was missing. SS stated staff searched the building and drove around the surrounding areas in search of Resident 1. SS stated that on [DATE], two police officers found Resident 1 sitting on a porch at Resident 1's former house. SS stated that the people living in the house observed Resident 1 sitting outside on the front porch and called the police after they asked Resident 1 to leave but Resident 1 refused. The distance from where the police found Resident 1 was about 15 minutes' drive from the facility, which is not a walking distance. SS stated that Resident 1 must have taken a bus to get to the location where the police located Resident 1.ˆ During an interview on [DATE] at 2 PM with the Receptionist, the Receptionist stated he was working his regular shift on [DATE] and was getting ready to leave/sign out at around 6 PM. The Receptionist stated that on [DATE], he observed Resident 1 walking around the front lobby near the entrance/exit of the facility as Resident 1 usually does. The Receptionist stated he usually sits at a desk in front of the facility entrance/exit and checks in visitors who come in and that he can see people come and go. The Receptionist stated on [DATE] unsure of the time, Resident 1 waved hi to him as she was walking by the lobby like she usually does. The Receptionist stated Resident 1 was not carrying bags and was dressed in her normal clothing. The Receptionist stated no wander guard alarms went off the day of [DATE], even when Resident 1 walked around the front lobby of the facility. The Receptionist stated before leaving his shift, on [DATE] at around 6 PM, he informed Registered Nurse (RN) 1 that he was leaving for the day. During a phone interview on [DATE] at 2:28 PM with RN 1, RN 1 Supervisor stated that on [DATE] she worked from 3-11 PM at the facility. The RN1 supervisor stated that upon arrival to her shift, she began her usual workflow which consists of responding to physician messages, walk around and help other staff with residents, and rounds on residents. The RN1 supervisor stated she had not noticed Resident 1 was not in the facility until about 6:50 PM when one of the CNAs (unable to recall the name), assigned to the same area as Resident 1's room, informed her that Resident 1 was not in the facility nor in Resident 1's room.RN1 stated that CN1 reported to her that Resident 1 was unaccounted for, and that Resident 1's dinner tray was still in her room untouched. RN1 stated she immediately initiated a page code yellow and staff began searching for Resident 1 in other resident rooms, closets, under the bed, restrooms, and the Administrator was notified. The RN1 stated no wander guard alarms went off in the facility the evening of [DATE]. ˆ During an interview on [DATE] at 1:45 PM with the DSD, the DSD stated that on [DATE] she was asked to assess Resident 1 after returned back to the facility at approximately 4 PM. The DSD stated Resident 1 mentioned that she had gone out to look for a job to have some money but could not recall how she ended up at the old address. The DSD stated Resident had a right small finger discoloration and was not wearing the Wander Guard bracelet. The DSD stated Resident 1 was unable to recall how she got the injury to her right hand. The DSD stated on Resident 1's admission assessment, the DSD noted Resident 1's blood sugar (BS) level was elevated/high at 202. The DSD stated that the medical doctor (MD) gave an order to transfer Resident 1 to GACH for further evaluation. The DSD stated GACH diagnosed Resident 1 with a fracture to the right small finger. During a concurrent observation and interview on [DATE] at 2:47 PM with the DSD, in front of the lobby, Resident 2 was asked to approach the exit door to ensure that her Wander Guard thatˆ was on her right wrist was functioning correctly. The DSD acknowledged and stated that the door alarms did not trigger as and when Resident 2 approached the exit door. Resident 2 stood in front of the exit door and no alarm sounded to alert staff Resident 2 was near an exit door. The DSD stated the wander guard bracelet was not working or that the wander guard battery was dead. The DSD stated that (continued on next page)

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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	Resident 1, Resident 2, and Resident 3required a Wander Guard bracelets due to the residents being at high risk for elopement. The DSD stated that Resident 1 was discharged from the facility on [DATE]. The DSD stated any resident with an elopement assessment score of 10 or higher is required to wear a wander guard bracelet. The DSD did not know when the Wander Guard alarm system was last checked per manufacturer instructions. During a concurrent observation and interview on [DATE] at 2:59 PM with Licensed Vocational Nurse (LVN)1, during the facility Resident Council meeting, Resident 3 was asked to show the LVN1 her Wander Guard bracelet to ensure it was on correctly. Resident 3 stated I don't even know what a Wander Guard is. LVN1 checked both wrists and ankles on Resident 3 and stated no Wander Guard was on as required per physician's order. LVN1 stated she thought she saw Resident 3's wander guard bracelet on the morning of [DATE] atˆ 8 AM, even though she could not remember the location of where Resident 3 had it on. LVN1 stated Resident 3 has a history of taking her Wander Guard off. During an interview on [DATE] at 3:17 PM with the DON, the DON stated Resident 1 had eloped on [DATE] and believes Resident 1 took the bus to go to the resident's old house/address where the resident and family member used to live, and that' s where the police found (Resident 1) on [DATE]. ˆThe DON stated, it is the facility's responsibility to redirect residents who are at risk for elopement and demonstrating wandering behavior in the facility. The DON stated Resident 1 who has dementia, is fall risk, and has chronic health conditions like diabetes is at risk of serious injury or death, such as traffic related injuries, dehydration, malnutrition, falls, becoming lost and unable to find way back, exploitation or abuse. DON stated delay in receiving necessary medications or medical treatment could worsen confusion, anxiety, or behavioral symptoms. The DON stated the wander guard is a critical component of the facility's elopement prevention program, it provides staff with immediate notification when an at-risk resident attempts to exit through a protected door. The system should be tested routinely to ensure it is functioning properly. If the system is not working properly, residents are at risk for leaving the facility unnoticed, delayed staff response to attempted exits, elopement resulting in injury of death, increased risk of falls or accidents outside the supervised environment, exposure to environmental hazards and unsafe conditions, inability of staff to implement timely interventions to prevent an unsafe exit. The DON verified the alarms failed to sound when Resident 2 approached the door, which placed Resident 2 at risk for elopement. The DON stated that elopement is a reportable event, and the facility is responsible for reporting to appropriate agencies withing the required timeframes so that a timely investigation and implementation of corrective actions to prevent recurrence. The DON stated failure to report delays external review and may allow systemic issues to go unaddressed, impacting resident safety. During a review of the Resident Wristband Transmitter (Wander Guard) manufacturer instructions, undated, indicated, it is very important to test your Resident Wristband Transmitters on a regular basis. It is the facility's responsibility to implement a regular testing procedure. The manufacturer recommends testing Resident Wristband Transmitters Daily. To test Resident Wristband Transmitter: Take door system tester and pass tester withing proximity of resident wearing Resident Wristband Transmitter. Door system tester will display whether the Resident Wristband Transmitter is transmitting correctly and will give warning in case of low battery. ˆ A review of the facility's investigation, the facility was unable to determine why the Wander Guard system failed to activate when Resident 1 exited the facility. A review of the facility's policy and procedures (P&P) titled Wandering and Elopement dated 2/2026 indicated, if a resident is missing and not located, notify law enforcement officials and volunteer agencies as necessary. During a review of the facility's P&P titled Unusual Occurrence Reporting dated 2/2026, indicated, the facility will report to appropriate agencies of occurrences that interfere with facility operations and affect the welfare, safety, or health of residents, employees or visitors. Unusual occurrences shall be reported via telephone to appropriate agencies as required by current law and or regulations within 24 hours of such incident or as required by federal and state regulations. A written report detailing the incident and actions taken by the facility shall be sent to the state agency within 48 hours of reporting the event or as required by federal and state regulations.