STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056411	A. Building B. Wing	03/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park View Post Acute	3751 Montgomery Dr Santa Rosa, CA 95405

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to store and prepare food under sanitary conditions and in accordance with professional standards for a census of 116 when:Nonstick pans used in food preparation were visibly scratched, compromising the integrity of the cookware and increasing the risk of nonstick coating flaking into food;A manual can opener had missing metal on the tip, creating a potential physical contaminant hazard during food preparation; andItems in the refrigerators were not marked with an open date or delivery date.These failures had the potential to contribute to the spread of foodborne illnesses among a vulnerable resident population.1. During a concurrent interview and observation on 3/2/26 at 8:43 a.m., with the Food & Nutrition Director (FND), two large (12 inch) frying pans were observed hanging on the kitchen rack, indicating they were available and ready for use. Both frying pans had severely worn, non-stick coatings, exposed base metal, and carbonized build up on the food contact surfaces. The damaged surfaces were not smooth or easily cleanable. The FND stated both frying pans were no longer supposed to be used.During an interview on 3/3/26 at 11:05 a.m., with the Dietary Resource Consultant (DRC), when shown photos of the frying pans, the DRC stated, the frying pans showed visible excess carbon and buildup on them which could result in food contamination with shavings from the pan.Review of the U.S. FDA Food Code 2022, section 4-201.11 indicated that equipment and utensils must be durable, retain their original characteristics, and remain easily cleanable throughout their intended lifespan. If surfaces deteriorate . they may become difficult to clean and can harbor pathogenic microorganisms. Additionally, equipment must be constructed to prevent parts from breaking off and becoming physical contaminants or injury hazards.Review of the U.S. FDA Food Code 2022, section 4-101.18 indicated that non-stick coatings (e.g. frying pans) were to be used with utensils and cleaners that prevent scratching or scoring.2. During the initial kitchen tour on 3/2/26 at 8:54 a.m., the can opener blade was observed with significant dark discoloration along the cutting edges, consistent with buildup or corrosion.During a concurrent observation and interview on 3/3/26 at 10:59 a.m., in the kitchen with the FND and DRC, the DRC acknowledged the can opener blade was visibly worn down and the FND stated, if area is worn down, it could not be sanitized properly and could cause contamination.Review of the U.S. FDA Food Code 2022, section 4-501.11 indicated that .(C) Cutting or piercing parts of can openers shall be kept sharp to minimize the creation of metal fragments that can contaminate food when the container is opened. It further indicated that The cutting or piercing parts of can openers may accumulate metal fragments that could lead to food containing foreign objects and, possibly, result in consumer injury.3. During the initial kitchen tour on 3/2/26 at 8:58 a.m., Fridge # 2 contained one partially used pastry bag of whipped topping. The pastry bag was marked with a black ink which was non-legible. There were no other markings on the pastry bag to indicate when it was opened or its use-by date.During the same kitchen tour on 3/2/26 at 9:04 a.m., Fridge # 6 contained a cardboard case of zucchini - the exterior of the box was inspected by surveyor with FND and found no received date.During an interview on 3/3/26 at 11:15 a.m. with the DRC, the DRC stated all foods should be labeled with a received date and labels were used for reference to verify foods were still good to use.A review of the facility's policy and procedure (P&P) titled, Labeling and Dating of Foods, dated (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	2023, the P&P indicated, All food items in the storeroom, refrigerator, and freezer need to be labeled and dated.Food delivered to facility needs to be marked with a delivery or received date.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on observation, interview, and record review, the facility failed to protect resident health information for a census of 116 when dietary tickets were disposed of in the facility's regular trash.This failure decreased the facility's potential to protect and safeguard resident confidentiality and personal privacy.During a concurrent observation and interview on 3/2/26 at 9:17 a.m. with the Food & Nutrition Director (FND), in the kitchen dishwashing area, a dietary aid (DA) was observed removing trays from the soiled tray carts to prepare them to be washed. The DA sorted the tray contents and threw residents' dietary tickets into the garbage can along with scraps of food. The FND stated residents' dietary tickets were thrown into the garbage with food scraps. An observation of the contents of the garbage can included 8 dietary tickets. The FND agreed the residents' name, room number, diet order, allergies, and likes and dislikes were visibly clear to read on the dietary tickets.During an interview on 3/3/26 at 8:58 a.m. with the Director of Nursing (DON), the DON stated any information with residents' identifiers was not to be disposed of in the regular trash. The DON confirmed residents' dietary tickets contained protected health information; therefore, it should have been disposed of in a locked confidential information bin for shredding.During a review of the facility's policy and procedure (P&P) titled, Safeguards for PHI, dated 1/17, the P&P indicated, The covered entity will .When no longer needed or required by law, properly dispose of or destroy PHI, so that it is unrecoverable (shredders or locked shred bins).

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review the facility failed to ensure Resident Rights were honored when two of two sampled residents (Resident 82 and Resident 5) were not provided with privacy during routine care and while accommodating the resident's expressed preference for minimal coverings.This failure resulted in exposure of both residents in a state of undress to passersˆby, undermining dignity and placing residents at risk for psychosocial harm.A review of Resident 82's admission record indicated she was last admitted on 10/25 with the primary diagnosis of Unspecified sequelae of cerebral infarction (long-term health problems caused by a stroke).A review of Resident 82's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 1/19/26 indicated, an interview could not be conducted with the resident for the resident is rarely/never understood.A review of Resident 5's admission record indicated she was last admitted on 11/22 with the diagnoses of Pneumonia (an infection/inflammation in the lungs), Need for assistance with personal care, and cognitive communication deficit.A review of Resident 5's MDS dated [DATE] indicated, she had no memory impairment and Resident 5's Brief Interview of Mental Status (BIMS - an assessment tool used by facilities to screen and identify memory, orientation, and judgment status of the resident) score was 15 (a score of 12-15 indicates intact cognition).During an observation on 3/2/26 at 4:16 p.m., in Resident 82's room, Resident 82 was lying in bed with no clothing on her upper body. A bath towel draped across her chest had slipped, exposing her breasts. A blanket covered only from the waist down. The privacy curtain was not drawn, allowing Resident 82 to be visible from the hallway.During a concurrent observation and interview on 3/2/26 at 4:26 p.m. in Resident 82's room with Licensed Nurse (LN) C, LN C acknowledged Resident 82's breasts were exposed. LN C stated Resident 82 is nonverbal except for saying one word, Uga. LN C stated the resident typically does not like to wear clothes because she becomes hot easily and usually only agrees to wear a hospital gown before bed.During an observation on 3/3/26 at 3:10 p.m., in Resident 82's room, the resident was again observed lying in bed unclothed, with a white bath towel covering the chest and stomach area and blankets covering the lower body.During an observation on 3/4/26 at 3:00 p.m., in Resident 82's room, the privacy curtain was open and Resident 82 was visible from the hallway. Resident 82 was lying in bed with only a bath towel covering her chest and a blanket covering from the feet to the waist.During an observation on 3/5/26 at 11:54 a.m., in Resident 82's room, the resident was lying in bed unclothed with a white bath towel covering her chest and stomach area and blankets covering the lower body.During an observation on 3/5/26 at 11:55 a.m., from the hallway, Resident 5 was observed receiving routine care as she was getting her brief (an adult undergarment) changed in her bed. The privacy curtain inside the room was not closed, and the glass sliding door curtain was open, making the resident visible from both the hallway and the outside patio area.During a concurrent observation and interview on 3/5/26 at 11:58 a.m. with the Director of Nursing (DON), the DON stated she could confirm from the hallway that Resident 5's bottom half was visible from both the hallway and the outside because neither curtain was closed. The DON immediately entered the room to speak with the Certified Nurse Assistant (CNA) providing care to Resident 5. The DON returned to the hallway and stated she had reˆeducated the CNA on maintaining privacy during care. The DON also stated the facility's expectation are for staff to keep [the resident] covered and close the curtain during care and any stage of undress; if coverings fall, staff must replace them as soon as they can.A review of the facility's policy and procedure (P&P) titled, Resident Rights, Subject: Dignity and Privacy, the P&P indicated, .Residents shall be examined and treated in a manner that maintains the privacy of their bodies. A closed door or drawn curtain shields the Resident from passers-by.

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to honor the choices and preferences for two out of two residents (Resident 113, and Resident 111) sampled for choices, when,Resident 113 requested to have her emergency inhaler, Albuterol HFA (an inhaled respiratory medication for shortness of breath), at her bedside on admission for timely use when short of breath and staff did not honor her request.Resident 111 reported stressors related to roommate and requested a room change and staff did not respond.This failure undermined both residents' right to make choices about care and aspects of their life in the facility and contributed to feelings of anxiety and stress.A review of Resident 113's admission record indicated she was admitted on [DATE] with active diagnoses of Chronic Obstructive Pulmonary Disease (COPD-a chronic lung disease causing difficulty in breathing) and Depression. A review of Resident 113's Minimum Data Set (MDS - a resident assessment tool) conducted on 2/25/26 indicated she had a BIMS (Brief Interview for Mental Status-an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score of 11 indicating minimal cognitive impairment, and that it was very important to her to take care of her personal belongings. During an interview on 3/2/26 at 11:14 a.m. with Resident 113 in her room, Resident 113 stated, when she needed her emergency inhaler she needed it now, not in 20 to 30 minutes, and felt anxious when she had to wait. Resident 113 further stated she managed her inhaler at home and had asked multiple times to have it at bedside. A review of Resident 113's physician order summary initiated 2/18/26 indicated her Albuterol HFA was ordered to be at bedside on admission. A review of call light response times for Resident 113 indicated on 2/27/26 she hit the call button at 6:55 a.m. and waited 17.23 minutes for a response. A review of an SBAR worksheet (a documentation tool) completed by a Licensed Nurse on 2/27/26 at 7:00 a.m. indicated the resident felt anxious about her COPD condition and was very worried about getting her inhaler on time and requested to have her emergency inhaler in her room in case an attack occurred. During an interview on 3/4/26 at 9:20 a.m. with Licensed Nurse D (LN D), LN D stated, if a resident requested to have a medication at bedside we should assess for capability and obtain a physician order to do so. LN D further stated she could see why a resident would want to have an emergency inhaler at bedside if they were used to managing it on their own and needed it frequently. During an interview on 3/5/26 at 1:30 p.m. with the Director of Nursing (DON), DON stated resident choices and preferences were important to maintain dignity and independence. A review of a facility policy titled, Self-Administration of Medicines, dated 5/2022, indicated, In order to maintain the residents' high level of independence, residents who desire to self-administer medications are permitted to do so if the facility's interdisciplinary team determined that the practice would be safe for the resident and other residents and there is a prescribers order to self-administer. A review of a facility policy titled, Resident Rights and Preferences & Grievance Policy, reviewed 2/12/25, indicated, Honoring patient preferences is an important part of person-centered care, and efforts are made to support individual choices whenever appropriate. 2. A review of Resident 111's admission record indicated she was admitted on [DATE] with diagnoses of a fracture to her left femur (a break in the bone of her left thigh) , Diabetes type 2 ((DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), and ESRD (End Stage Renal Disease-irreversible kidney failure). A review of Resident 111's MDS dated [DATE] indicated she had a BIMS score of 13, with no cognitive impairment. During an interview on 3/2/26 at 11:11 a.m. with Resident 111 in her room, Resident 111 stated, her problem was her roommate because she was loud and liked to, put up her fists, and this made her anxious at times and rest was difficult. Resident 111 further reported she spoke to the Social Services Assistant (SSA) last Saturday and had not heard back. During an interview on 3/5/26 at 8:30 a.m. with Resident 111 in the physical therapy room, Resident 111 stated, her roommate continued to make her (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	uncomfortable because she was very negative and complained all the time and had become hostile, blaming Resident 111 for the room being cold. Resident 111 further stated the issues with her roommate bring her mood way down and she had yet to hear back from any facility staff. During an interview on 3/5/26 at 9:55 a.m. with the Social Services Director (SSD), SSD stated she had no knowledge of Resident 111's grievance and the SSA would have been the one who spoke to Resident 111 and there should have been a note under progress notes if she had. A review of Social Services Progress notes indicated there was no documentation about Resident 111's report of concerns about her roommate. During an interview on 3/5/26 at 11:51 a.m. with the SSA in the social services office, SSA stated she had spoken to Resident 111 last Sunday when her roommate was loud and agitated and disruptive. SSA further stated she had not made a note and should have so all staff would be, on the same page. During an interview on 3/5/26 at 1:30 p.m. with the DON, DON stated if a Resident had concerns about roommate staff should respect and honor their choices and document what their response was. A review of a facility policy titled, Resident Rights and Preferences & Grievance Policy, reviewed 2/12/25, indicated Grievances are concerns that involve alleged violation of resident rights, unresolved or recurring complaints, or issues that require further review and follow-up by facility leadership. Grievances are formally documented, acknowledged, investigated, and resolved in accordance with facility procedures.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on interview and record review, the facility failed to ensure an appropriate indication for use of an antipsychotic medication for one of five residents sampled for unnecessary medication review (Resident 48). This failure placed Resident 48 at risk for unnecessary psychotropic medication (any drug that affects behavior, mood, thoughts or perception) use.A review of Resident 48's face sheet (demographics) indicated an admission date of 11/1/22, age in her 90s, and medical diagnoses including a fall with multiple fractures of the spine and Unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, among others. A review of Resident 48's physician order, dated 12/24/25, indicated Seroquel (an antipsychotic medication) 12.5 mg (milligrams) by mouth two times a day for dementia with behavioral disturbance. A review of Resident 48's document titled Consent for Treatment: Use of Anti-Psychotic Medication, dated 12/24/25, indicated, Reason for treatment: Agitation/dementia with behavioral disturbance. Review of Resident 48's physician progress notes and psychology progress notes since 12/24/25 revealed no diagnosis of dementia with behavioral disturbance. During a phone interview on 3/5/26 at 1:40 p.m., Pharmacist A reviewed Resident 48's list of medical diagnoses and verified Resident 48 did not have the diagnosis indicated in the physician order for Seroquel of dementia with behavioral disturbance. Review of facility policy Antipsychotic Drugs, last revised 2/2022, indicated, It is the policy of this facility to use antipsychotic drugs based on a comprehensive assessment of a resident, the facility must ensure that: 1. Residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. Based on interview and record review, the facility failed to promptly notify the State Mental Health Authority, Department of Health Care Services (DHCS), for one of two sampled residents (Resident 13), when Resident 13 experienced a significant change in mental health status and received a new diagnosis indicating serious mental illness, requiring referral for Preadmission Screening and Resident Review (PASRR - a federal assessment requirement to help ensure that individuals who have a mental disorder or intellectual disabilities are placed in facilities that can provide the appropriate care).This failure hindered the facility's ability to ensure Resident 13 had an upˆtoˆdate PASRR determination after the new serious mental illness diagnosis, creating the potential for inappropriate placement and delays in identifying and providing necessary specialized behavioral health services.A review of Resident 13's admission record indicated he was last admitted on 1/23 with the diagnoses of Cognitive Communication Deficit, Generalized Muscle Weakness, Need for Assistance with Personal Care, Difficulty in Walking, and Presence of Right Artificial Knee Joint.A review of Resident 13's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 2/10/26, indicated he had no memory impairment and Resident 13's Brief Interview of Mental Status (BIMS - an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score indicated a score of 15 (A score of 12 - 15 indicated a resident was cognitively intact).A review of Resident 13's Face Sheet, (front page of the chart that contains a summary of basic information about the resident), dated 3/5/26, the Face Sheet indicated the onset date of Resident 13's Schizophrenia diagnosis was on 2/18/25, and was classified as During Stay.A review of Resident 13's Psych/Evaluation Progress Note, dated 2/18/25, the Progress Note indicated, the resident was diagnosed with schizophrenia. This Progress Note was the first documentation from the contracted psychological services provider indicating Resident 13's schizophrenia diagnosis.During a concurrent interview and record review on 3/4/26 at 11:23 a.m., with Minimum Data Set Coordinator (MDSC), Resident 13's most recently scanned PASRR Level I Screening dated 6/17/24 was reviewed. The PASRR Level I screening indicated, Resident 13 had a serious diagnosed mental disorder of Depression. The MDSC stated, there is no record in the chart for a new PASRR screening after 6/24. The MDSC agreed despite the new schizophrenia diagnosis on 2/18/25, no new PASRR Level I screening was submitted to DHCS.A review of the facility's policy and procedure (P&P) titled, Resident Assessment, revised 11/2019, the P&P indicated, It is the policy of this facility to ensure that each resident is properly screened using the PASSR specified by the state.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure ongoing accurate clinical assessment and documentation for one resident (Resident 78) when no wound assessments for a head wound were documented. This failure made it difficult to determine the wounds progression, response to treatment, and healing trajectory, when there were no assessments available for comparison. This failure had the potential for poor wound response and non- healing to go unnoticed and untreated.A review of Resident 78's admission record indicated he was admitted on [DATE] with diagnoses of Vascular (having to do with the blood vessels and circulation) Dementia (a progressive state of decline in mental abilities), and Dysphagia (difficulty swallowing). A review of Resident 78's Minimum Data Set (MDS-a resident assessment tool) dated 11/27/25 indicated he had a BIMS Score of 14 with no cognitive impairment. During an interview on 3/4/26 at 2:24 p.m. with Resident 78 in his room, Resident 78 stated, the nurses changed his dressing every other day and that he had pain and tenderness with dressing changes. Resident 78 further stated he was concerned because the wound was not healing. A review of Resident 78's Care Plan dated 5/9/25 indicated Resident 78 had a chronic wound to the top of his scalp with orders to monitor/document location, size, and treatment of skin injury and to report any abnormalities, failure to heal, signs or symptoms of infection, or maceration, to the physician. A review of Progress Notes from 2/5/26 through 3/5/26 indicated no documented head wound assessments and no skin issues noted. A review of Resident 78's most recent Interdisciplinary Team notes dated 2/25/26 indicated to continue wound care with no documented discussion of wound assessment or progress towards healing. During an interview on 3/4/26 at 3:24 p.m. with Licensed Nurse E (LN E) and the Director of Nursing (DON), LN E stated she did not document wound assessments when dressing changes were done or periodically. LN E further stated if the wound looked bad they would refer Resident 78 to the Kaiser wound care nurse. The DON confirmed there were no wound assessments documented in the medical record or on paper and the Kaiser wound care nurse had not assessed Resident 78. During an interview on 3/5/26 at 7:55 a.m. with the Assistant Director of Nursing (ADON), ADON stated she could not provide any wound assessments for Resident 78. During an interview on 3/5/26 at 1:30 p.m. with the DON, DON stated, there were no documented wound assessments for Resident 78's head wound and she would be unable to report the current size or characteristics of the wound, and it would be difficult to determine if there was a change in condition. A review of a facility policy titled, Medical Records & Documentation Policy, revised 9/19/25, indicated, Documentation should reflect resident status, care provided, physician orders, and relevant observations. A review of a facility document titled, Licensed Vocational Nurse Job Description, dated 12/17/21, indicated, Chart nurses' notes in a professional and appropriate manner that timely, accurately, and thoroughly reflects the care provided to the resident as well as the resident's response to care. A review of a published article through the Wound Care Education Institute (A NAWCO-National Alliance of Wound Care and Ostomy, accredited organization for nursing wound care certification and evidenced based standards of care) dated 4/17/2025, titled, Best Practices for Wound Assessment and Documentation, indicated, Wound Documentation is more than record keeping, it is a clinical tool that informs care planning, tracks healing trajectories, and supports regulatory compliance. and lists the foundational elements of wound assessment and documentation as precise anatomical location, wound classification or etiology, accurate measurements, wound bed characteristics, wound edges and margins, exudate characteristics, peri-wound skin status and pain and symptoms reporting.

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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	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview, and record review, the facility failed to implement supervision and monitoring interventions for one of one sampled resident (Resident 6) when the facility did not prevent the resident from exiting beyond the secured patio on 3/2/26 despite her severe cognitive impairment, documented history of exitˆseeking, and careˆplanned interventions such as door alarms and frequent checks.This failure resulted in Resident 6's elopement beyond the secured patio and exposed Resident 6 to significant hazards with potential for serious injury.A review of Resident 6's admission record indicated she was last admitted 4/25 with the diagnoses of Unspecified Intrascapular Fracture of Left Femur (broken hip on the left side), generalized muscle weakness, unsteadiness on feet, and Alzheimer's Disease with Late Onset.A review of Resident 6's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 2/4/26 indicated she had significant deficits in orientation and Resident 6's Brief Interview of Mental Status (BIMS - an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score indicated a score of 4 (A score of 0-7 indicates severe cognitive impairment).During an observation on 3/2/26 at 9:24 a.m., in the exterior service area near the dumpsters, while with the Food and Nutrition Director (FND), Resident 6 was observed outside the facility's gated patio, walking alone with her walker. During the observation, the resident stated she was running away and expressed a desire to leave the facility.During an interview on 3/4/26 at 8:57 a.m. with the Staffing Coordinator (SC), the SC stated she was aware Resident 6 was an elopement risk and stated any staff member was responsible to check when the resident's slidingˆdoor alarm sounded.During an interview on 3/4/26 at 9:39 a.m. with Licensed Nurse (LN) B, LN B stated Resident 6 had previously attempted to leave the facility on several occasions. LN B stated approximately one month earlier, Resident 6 reached the same exterior patio gate. LN B further stated the Resident 6 slipped through the first set of double doors into the lobby after a visitor entered. LN B stated the resident frequently verbalizes wanting to go home, and her exitˆseeking behavior varies from day to day.During an interview on 3/5/26 at 12:01 p.m. with the Director of Nursing (DON), the DON acknowledged that on 3/2/26 Resident 6 was outside the gate and was no longer in the patio. The DON stated Resident 6 had experienced two or three elopement incidents and described the 3/2/26 incident as a oneˆoff, stating it just so happened the surveyor was present when it occurred.During a review of Resident 6's Licensed Nurse (LN) Elopement/Wandering Evaluations, dated 3/11/25, 6/5/25, 7/5/25, and 8/25/25, the evaluations indicated the LN tool uses a scoring system in which 0-8 indicates low risk and 10-99 indicates high risk. The evaluation dated 8/25/25 showed a score of 17, indicating the resident was assessed as high risk for elopement.During a review of Resident 6's Nurse Advanced (N Adv) Elopement Evaluations, dated 10/25/25, 1/8/26, 2/5/26, and 3/2/26, the evaluations indicated this tool identifies any score of 1 or higher as a positive indication of elopement risk. The evaluation dated 3/2/26 showed a score of 2.0, indicating the resident continued to demonstrate behaviors associated with elopement risk.During a review of the facility's policy and procedure titled Elopement, dated 7/25, the policy indicated the facility is committed to maintaining a safe environment and implementing reasonable measures to minimize the risk of resident elopement.