STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056488	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunnyside Nursing Center	22617 So. Vermont Ave Torrance, CA 90502

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** 47092 Based on interview, and record review, the facility failed to ensure a resident, who was assessed at risk for wandering (moving around inside the facility without awareness of personal safety, potentially putting themselves in harm's way), did not elope (the act of leaving a facility unsupervised and without prior authorization) from the facility for one of nine sampled residents (Resident 1). The facility failed to: 1. Have a system in place to supervise and monitor Resident 1's whereabouts to prevent him from eloping from the facility. 2. Develop a care plan with interventions addressing Resident 1's risk for wandering, to ensure the resident's safety, and prevent him from eloping from the facility. 3. Ensure staff followed the facility's policy and procedure (P&P), titled Wandering Residents - No Facility Wide Wandering Notification System dated 11/2016, that indicated residents at risk for wandering shall have a care plan implemented with interventions appropriate to the resident to help prevent wandering out of the facility during the day. These deficient practices resulted in Resident 1 eloping from the facility on 10/30/2024 and was missing for over two hours before staff noticed he was gone. Resident 1 was placed at risk for exposure to harsh environmental conditions, including extremes in heat and/or cold, possible motor vehicle accidents, medical complications related to his diagnoses of diabetes mellitus ([DM] a disorder characterized by difficulty in blood sugar [b/s] control and poor wound healing), such as hyperglycemia (when b/s levels are too high [normal b/s levels range from 70 milligrams [mg]/deciliter [dl] a unit of measurement), hypoglycemia (when b/s levels are too low), and possible death. Resident 1 was eventually located on 11/6/2024 (eight days after he was found missing from the facility), in a towing yard, living in a van. On 11/6/2024 at 4:10 p.m. an Immediate Jeopardy ([IJ] a situation in which the facility's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident) was called in the presence of the facility's Executive Director (ED), Chief Clinical Officer (CCO), and RCN (RCN) due to the facility's failures to have a system in place to prevent Resident 1 from eloping from the facility and placing nine other residents, who were assessed at risk for elopement, to go missing. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056488	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/06/2024
NAME OF PROVIDER OR SUPPLIER Sunnyside Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 22617 So. Vermont Ave Torrance, CA 90502	

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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	On 11/7/2024, the facility submitted an acceptable IJ Removal Plan ([IJRP] interventions to immediately correct the deficient practices). After onsite verification of the facility's IJRP's implementation through observation, interview, and record review, the IJ was removed on 11/7/2024 at 6:23 p.m. in the presence of the facility's ED, and the CCO. The facility's IJPR included the following immediate actions: 1. Corrective and appropriate actions to be implemented for the affected residents identified in the deficiencies. a. Immediate Action: On 10/30/2024 at approximately 4:30 p.m., the Certified Nursing Assistant (CNA) assigned to Resident 1 reported to the CCO and ED that Resident 1 was missing. Immediately a Code Orange (a message usually sent out via intercom to notify and prompt staff to search for a missing resident) was called, which initiated facility staff to conduct a thorough search within the premises of the facility and surrounding neighborhoods, but staff were unable to locate the resident. The facility also alerted local hospitals and shelters. The incident was reported to the local sheriff's office via telephone on 10/30/24 at 5:40 p.m., and notification was faxed to the California Department of Public Health (CDPH) on 10/31/24 at 3:00 p.m. The resident's roommate was interviewed and queried after staff were unable to locate Resident 1. The resident's roommate indicated that Resident 1 said he wanted to go to Pacific Coast Highway. A facility staff drove down Pacific Coast Highway to assist with locating Resident 1. An in-service for staff regarding Elopement Policy was completed on 11/1/2024. b. A door monitor (a person assigned to monitor the facility's entrance/exit doors) was assigned for the back door entrance initiated 10/30/24. The local Sheriff's office was also informed and assisted in looking for Resident 1. The local Sheriff's Office made multiple postings to social media and to other missing person's outreach. The Department of Motor Vehicle (DMV) was called to request if the facility could avail itself of any vehicle registered under Resident 1 to locate the resident and inform the sheriff's department. The DMV informed the facility that they were not allowed to disclose any vehicle information that was registered to Resident 1. The final investigation report was sent to CDPH on 11/5/2024 at 5:00 p.m. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	c. Immediate action: On November 6, 2024, at 2:00 p.m., the facility admission coordinator worked with the insurance case manager to locate information on a responsible party. The insurance case manager found details about Resident 1's daughter and her phone number from an entry made six months prior in their portal, related to a previous admission and discharge, which had not been relayed to the facility or included in Resident 1's current admission records. The RCN called the daughter at around 2.30 p.m. on 11/6/2024. The daughter stated she called the sheriff's office and the sheriff posted information on the patient on social media. Resident 1's daughter indicated Resident 1 did not want to stay with her but currently had a van that was parked in the lot of a towing company. On November 6, 2024, at 5:40 p.m., Resident 1 was located by the facility's RCN. The resident expressed a desire not to return to the facility, preferring to stay in his van, where he had been residing when not hospitalized or in a nursing home over the past year. Resident 1 mentioned that he had visited his doctor for an appointment earlier in the day and received his prescription. His van was parked at a towing company lot, where the owner of the towing company keeps an eye on him (Resident 1). Resident 1 reported having his own supply of food and medication and confirmed a recent visit to the social security office. Resident 1 also signed a discharge against medical advice (A.M.A) on 11/6/2024 since he insisted on not wanting to return to the facility. The Sheriff's department was notified on 11/6/24 that Resident 1 had been located and where Resident 1, they (the Sheriff's department) and also completed a wellness check on 11/7/24 and Resident 1 continued to not want to return to the facility. d. Immediate action: All exit doors are equipped with an alarm 24 hours and 7 days a week. Door monitors have been assigned to monitor two exit doors beginning 11/6/24 with the front door being monitored from 8 a.m. to 8 p.m. and the back door and back patio from 6:30 a.m. to 8 p.m. The alarms are activated after the door monitors leave for the day. 2. Governing Body (responsible for ensuring that the facility's Quality Assessment [QAPI] and Performance Improvement program is effective and ongoing) - QAPI committee a. Immediate Action: The Interdisciplinary Team ([IDT] a group of healthcare professionals with diverse specialties who collaborate closely to develop and implement a comprehensive care plan for each patient) convened on 11/6/24 to revise the wandering and elopement policy. The updated policy includes assessment updates, risk scoring with targeted interventions based on risk levels, elopement drills, and procedures to follow if a resident goes missing. Following the review and update of the policy, an ad hoc meeting of the Quality Assurance Performance Improvement (QAPI) Committee was held on 11/6/24 to review, update and approve the new wandering and elopement policy, including the wandering and elopement assessment. b. Immediate Action: During the ad hoc QAPI Committee meeting on 11/6/24, a root cause analysis (RCA) revealed key issues in the wandering and elopement process, including communication breakdowns, inconsistent documentation, and training gaps in high-risk monitoring protocols/interventions. Staff were found to lack clear guidance on monitoring frequency, specific elopement prevention protocols, and proper documentation of care plans for high-risk residents. These findings underscore the need for improved communication, consistent documentation, and targeted training to enhance care quality for residents at risk of elopement. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	c. The ED will oversee corrective actions initiated on 11/6/2024 and monthly thereafter during QAPI meetings which are based on the results of the RCA and plan of corrections for the findings during the survey. Any corrective actions not meeting the 100% compliance benchmark, as determined by medical records audits, wandering and elopement system audit will be reviewed and revised with the QAPI Committee for revision, further evaluation, and recommendations, with a designated person IDT member assigned to each corrective action. d. Any new issues found during medical record audits and wandering, and elopement system audit will be presented to the Wandering/Elopement IDT members for immediate action. The CCO will monitor the immediate actions for implementation of monitoring/audit needs at least monthly for the next 3 months or until compliance is 100% or is achieved. 3. Specific staff involved in implementing the corrective actions. a. Team. Members: Medical Director, ED, CCO, Director of Staff Education, and RCN. Each member will perform as follows: i. Medical Director: Through the QAPI committee, the Medical Director will monitor the system, recommend changes, and oversee corrective action plans. This role includes identifying and implementing medical interventions to reduce confusion and prevent wandering or elopement. ii. ED: The ED will oversee all corrective actions initiated on 11/6/2024 and continue monthly reviews during QAPI meetings. iii. CCO: Leading the Wandering and Elopement Team., the CCO will regularly review at-risk residents, assess intervention effectiveness, and adjust care plans as needed. This role also ensures that wandering management and elopement prevention practices are standardized, monitors staff compliance, coordinates equipment maintenance, educates staff, oversees data analysis, and conducts reviews to recommend preventive measures. iv. RCN: This role entails staying updated on regulatory changes, collaborating with the IDT to update policies, and ensuring staff adherence to these policies. It includes participating in quality improvement initiatives, analyzing compliance data, assisting with corrective actions, identifying risks, and investigating incidents to prevent recurrence. v. Director of Staff Education: This role involves educating staff on care planning, documentation, and protocols for elopement and wandering, covering incident reporting, preventive measures, and emergency responses. Responsibilities include training new hires on resident safety, conducting competency assessments, emphasizing risk assessment, and ensuring accurate documentation related to elopement and wandering prevention. 4. Identification of other residents who may need to be included (who may have been affected by the deficient practice: (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	d. Immediate Action: The elopement/wandering binder that already contained the list of all the residents with moderate/ serious significant risk for wandering and elopement was reviewed on 11/6/24. The elopement binder will be updated at least weekly by each Unit Director of Nursing (DON) and/or with new admissions that meet the significant/serious risk score. The wandering/elopement binder will be audited for completion and verification of list of patients every week by Medical Records Designee and any inconsistencies from the list will be provided to CCO to update and make corrections. e. System Change: Wandering and elopement risk assessment and missing resident policy has been updated on 11/6/24. f. System Change: Starting November 7, 2024, the Medical Records Department will use a monitoring tool to audit the documented frequency of routine checks/location for residents identified with a risk for wandering or elopement, based on their established care plans. Audits will be conducted daily for three days, then weekly for two weeks, and monthly thereafter. Immediately after completion of the audit, the Medical Records Designee will submit the findings of the audits to the CCO. Issues found by the CCO will be referred to the Wandering and Elopement IDT for further review and revision of the action plan and/or to determine any further training needed for staff involved. g. System Change: The Wandering/Elopement IDT will review post elopement events within 24-72 hours of incident for any revision of assessment need and/or plan of care interventions. 6. Training and Education Started on 11/6/24 by Director of Staff Education and/or Designee. a. Immediate action: Inservice training for staff license nurses was started on 11/6/24 on updating comprehensive care plans for residents that have been identified as wandering/elopement risk. A total of 11 nurses have been trained and will continue training until all staff nurses have attended and will continue training until all staff nurses have attended by 11/08/24. b. Immediate action: Inservice training for staff nurses was started on 11/6/24 on how to assess residents with elopement/wandering risk. A total of 11 nurses have been trained and will continue training until all staff nurses have attended and will continue training until all staff nurses have attended by 11/08/24. c. Immediate action: Inservice training for staff nurses was started on 11/6/24 on how to determine frequent monitoring needs based on elopement/wandering episodes and how to document the monitoring in the electronic medical records. A total of 27 clinical staff have been trained and will continue training until all staff nurses have attended and will continue training until all staff nurses have attended by 11/08/24. d. Immediate action: Inservice training on staff nurses was started on 11/6/24 on how to recognize behaviors that place residents at risk for elopement and who to report and how to follow up with residents. A total of 27 clinical staff have been trained and will continue training until all staff nurses have attended and will continue training until all staff nurses have attended by 11/08/24. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	e. Immediate action: Inservice training for staff nurses was started on 11/6/24 on how to identify residents that are at high risk for wandering using an orange band (a band placed on residents' wrist to indicate they are at risk for wandering). A total of 27 nurses have been trained and will continue training until all staff nurses have attended and will continue training until all staff nurses have attended by 11/08/24. f. Immediate action: Inservice training for staff nurses was started on 11/6/24 on elopement drill and what to do for missing residents. A total of 27 clinical staff have been trained and will continue training until all staff nurses have attended and will continue training until all staff nurses have attended by 11/08/24. g. Immediate action: The assigned door monitors were provided in-service training on how to monitor residents based on elopement binder list on 11/7/24. A total of 2 have already been training and will continue until all have attended by 11/8/24. Findings: During a review of Resident 1's Admission Record (Face Sheet), the Face Sheet indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including wedge compression fracture (a break or crack in the spine that usually occurs from too much pressure) of the thoracic vertebra (the 12 bones in the middle section of the spine between the neck and the bottom of the ribs), DM, and mild cognitive (ability to think and reason) impairment. The Face Sheet indicated Resident 1 prior to admission to the facility was unsheltered/homeless (when someone's primary night time residence is in a place that is not designed for sleeping such as a car). During a review of Resident 1's Minimum Data Set ([MDS] a federally mandated resident assessment tool) dated 9/16/2024, the MDS indicated Resident 1's cognition (ability to think and reason) was mildly impaired. The MDS indicated Resident 1 had no functional limitations in range of motion ([ROM] the direction a joint can move to its full potential) to his upper or lower extremities (arms/legs) and he required moderate assistance (helper does less than half the effort) for showering and dressing the lower body and he required supervision for toileting hygiene. During a review of Resident 1's Wandering Risk Scale assessment dated [DATE], the Wandering Risk Scale Assessment indicated Resident 1 was at risk for wandering due to his diagnosis of cognitive impairment. During a review of the Care Plan section of Resident 1's clinical records, the Care Plan section indicated there was no care plan developed for Resident 1's risk for wandering, based on his Wandering Risk Scale Assessment conducted 9/7/2024 . During a review of Resident 1's Physician's Order dated 9/7/2024, the Physician's Order indicated Resident 1 was to receive Regular Insulin (a short-acting injected medication, used to treat DM, that helps the body metabolize sugar) subcutaneously (administered under the skin) before meals and at bedtime per a sliding scale (pre-meal insulin dosage based on the b/s level before set intervals) as follows: For a b/s of 121 mg/dl -150 mg/dl give one unit of Regular Insulin (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	For a b/s of 151 mg/dl - 200 mg/dl give two units of Regular Insulin For a b/s of 201 mg/dl - 250 mg/dl give three units of Regular Insulin For a b/s of 301 mg/dl - 350 mg/dl give six units of Regular Insulin For a b/s of 351 mg/dl - 400 mg/dl give eight units of Regular Insulin For a b/s greater than 400 mg/dl give eight units of Regular Insulin and call the Medical Doctor (MD). During a review of Resident 1's Change in Condition (COC) Evaluation note dated 10/30/2024, the COC indicated on 10/30/2024 at 4:30 p.m., Resident 1 could not be located by facility staff and a Code Orange was called. During an interview on 11/1/2024 at 12:23 p.m., Certified Nursing Assistant (CNA 1) stated on 10/30/2024, she worked a double shift beginning 7 a.m. to 3 p.m., and continued 3 p.m. to 11 p.m., but was only assigned to Resident 1 from 3 p.m. to 11 p.m. CNA 1 stated the last time she saw Resident 1 was in his room, lying in bed awake after lunch around 1 p.m. CNA 1 stated she did not see Resident 1 on her next shift when she started at 3 p.m. CNA 1 stated at 3:40 p.m., she spoke to Resident 1's roommate (Resident 4), who told her Resident 1 informed him (Resident 4) that Resident 1 was upset because his room was being deep cleaned (a cleaning process where all furniture is removed from the residents room). CNA 1 stated she believed Resident 1 left through the front exit because he liked to sit on the couch and hang out in the front lobby. CNA 1 stated Resident 1 was able to walk holding onto a wheelchair and pushing the wheelchair in front of him. CNA 1 stated she reported to the Assistant Director of Nursing (ADON) at 4:15 p.m., that Resident 1 was missing, and the ADON called a Code Orange at 4:45 p.m., but they were unable to locate Resident 1 after searching the facility. During an interview on 11/1/2024 at 3:02 p.m., CNA 2 stated on 10/30/2024 she was assigned to Resident 1 for the first time from 7 a.m. to 3 p.m. and was not told when she was given report that Resident 1 was a wandering risk. CNA 2 stated the last time she saw Resident 1 on 10/30/2024 was before lunch, around 11 a.m., in the front lobby near the front door of the facility. CNA 2 stated she normally made rounds three times on her eight-hour shift, between 7:30 a.m. to 8 a.m., 12:30 p.m. to 1 p.m. and at 2:45 p.m., before her shift ended at 3 p.m. CNA 2 stated on 10/30/2024 it was busier than usual, residents' rooms were being deep cleaned, including Resident 1's room, and she had to take residents to the facility's Halloween event after lunch. CNA 2 stated she was unable to stick to her normal routine and forgot to check on Resident 1. During an interview on 11/1/2024 at 3:30 p.m., the MDS Nurse (MDSN) 1 stated, the admitting nurse was responsible for creating an initial care plan for residents at risk for wandering, based on the resident's Wandering Risk Scale assessment, which was completed on admission. MDSN 1 stated the Wandering Risk Scale assessment was completed for all newly admitted residents and if a resident was determined to be at risk for wandering, a care plan should be created. MDSN 1 stated the nursing staff and MDS department does not specify on the care plan how often a resident who was at risk for wandering should be monitored. MDSN 1 stated in her professional opinion a resident with mild cognitive impairment should be monitored every 1 to 2 hours, and more frequently for a more confused resident. MDSN 1 stated nurses should have communicated that Resident 1 was at risk for wandering during their huddle (a meeting discussing residents). (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 11/5/2024 at 9:40 a.m., Registered Nurse (RN 1) stated during admission, if a wandering risk assessment indicated a resident was at risk for wandering, a care plan should be created with interventions to monitor the resident at least once every 2 hours. RN 1 stated even if the resident does not exhibit wandering behaviors but was mildly confused, the resident could have impaired judgement and should be monitored. RN 1 stated during huddle, residents who need to be monitored closer due to wandering or confusion should be discussed amongst staff. During an interview on 11/5/2024 at 10:14 a.m., the Director of Staff Development (DSD) stated residents should be visually checked at a minimum of once every two hours and more as needed, which is determined by any licensed nurse. The DSD stated monitoring frequency for residents at risk for wandering was at the discretion of the licensed nurse who should communicate the frequency needed to monitor the resident to the CNAs during their huddle, then the licensed nurse should oversee the CNA to make sure the residents were being monitored. During an interview on 11/5/2024 at 10:59 a.m., Licensed Vocational Nurse (LVN 1) stated Resident 1 was ambulatory (able to walk) and would often walk through the facility pushing his wheelchair daily. LVN 1 stated Resident 1 was not in his room most of the day on the day he eloped from the facility (10/30/2024) because his room was being deep cleaned from 10:15 a.m. to 3 p.m. LVN 1 stated she last saw Resident 1 before lunch when she attempted to take Resident 1's b/s, and she assumed he was at the facility's Halloween event. LVN 1 stated Resident 1 was not discussed in their huddle at the beginning of the shift on 10/30/2024, she was not aware Resident 1 was at risk for wandering, and she was not sure if Resident 1 had a care plan related to his at risk for wandering. LVN 1 stated, normally CNAs make rounds to monitor residents three times on an eight-hour shift but for residents at risk for wandering she instructed the CNAs to do rounds every 1 to 2 hours. During an interview on 11/5/2024 at 11:59 a.m., the ADON stated the purpose of completing a wandering risk assessment was to identify residents who were at risk for elopement, and the purpose of creating a care plan, based on the wandering risk assessment, was to ensure all staff were aware to monitor the resident. The ADON stated charge nurses were responsible to familiarize themselves with a resident's care plan and communicate those needs to the CNAs. The ADON stated residents who were at risk for wandering should be monitored once an hour or more. The ADON stated care plans should be clear and not left open for interpretation so goals could be measured to know if the goals were being met or not. During an interview on 11/6/2024 at 12:38 p.m., the Director of Quality Assurance (DOA) stated the last time she saw Resident 1 was in the facility's front lobby near the front door at 2 p.m., on 10/30/2024. The DOA stated a wandering risk assessment should be completed for all residents, and a care plan should be created if a resident was at risk for wandering, in order to document the care needed for a resident and implement it. The DOA stated a care plan should have been created for Resident 1's risk of wandering by the admitting nurse. The DOA stated Resident 1 should have been monitored at least four times during an eight-hour shift based on his mild cognitive impairment and ability to walk. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056488	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunnyside Nursing Center	22617 So. Vermont Ave Torrance, CA 90502

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	During an interview on 11/6/2024 at 10:36 a.m., the DON stated per their policy when a resident was assessed as a wandering risk, a care plan should be created to make everyone aware of the resident's specific care needs. The DON stated for residents at risk for wandering, monitoring should be done at least six times during an eight-hour shift. The DON stated the reason why a wandering/elopement care plan was not created for Resident 1 was because he did not exhibit any actual wandering behaviors. The DON stated different frequencies of monitoring were dependent on the resident. During an interview on 11/6/2024 at 1:22 p.m., the DON stated the purpose of a care plan was to identify appropriate care for residents based on their needs and preferences. The DON stated a care plan should have been developed to address Resident 1's risk for wandering and documentation should have been completed to monitor Resident 1's location to prevent him from eloping from the facility and potentially getting hurt. The DON stated Resident 1 was diabetic and required insulin depending on his b/s levels and could suffer a medical emergency if he did not get his medication as prescribed. The DON stated Resident 1 was living in his van prior to admission to the facility and he voiced wanting to be discharged from the facility to go back to his van, but the physician stated it was unsafe for him to leave at that time. During an interview on 11/12/2024 at 1:14 p.m., Admission Nurse Assistant (ANA 1) stated she had been an ANA at the facility for six months and part of her duties included completing the wandering risk assessment for newly admitted residents. ANA1 stated she was not instructed to complete a care plan for residents who were assessed at risk for wandering. ANA 1 stated her understanding was that wandering care plans were to be completed by the MDS department. During a review of facility's P&P titled Wandering Residents - No Facility Wide Wandering Notification System dated 11/2016, the P&P indicated residents at risk for wandering shall have a care plan implemented with interventions appropriate to the resident to help prevent wandering out of the facility during the day. During a review of facility P&P titled Care Plans - Baseline and Summary dated 10/2024, the P&P indicated a baseline care plan should be developed for each resident within 48 hours of admission to provide instructions for the provision of effective and person-centered care to each resident, striking a balance between conditions and risks affecting the residents' health and safety. During a review of facility's P&P titled Routine Resident Checks dated 10/2024, the P&P indicated to ensure the safety and well-being of residents nursing staff shall make a routine resident check on each unit at least once per 8-hour shift, but frequency adjustments will be made according to individual needs.