STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075060	A. Building B. Wing	02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Salmon Brook Rehab and Nursing	72 Salmon Brook Drive Glastonbury, CT 06033

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50094 Based on record review, facility documentation, and staff interviews for one of three (Resident #1 and Resident #2) reviewed for accidents, the facility failed to ensure wander guard bracelet physician orders were obtained timely for residents identified as high wander risk and failed to ensure physician orders directed wander guard bracelet daily function checks. The findings include: 1. Record review identified Resident #1 had a diagnosis of Alzheimer's disease and delusional disorders, and Resident #1 had a Power of Attorney (POA) for care decisions and finances. Wander risk evaluation dated 1/10/2025 identified Resident #1 scored a 12 which indicated Resident #1 was a high wander risk. The Resident Care Plan (RCP) dated 1/14/2025 identified an elopement risk/wanderer related to disoriented to place. Interventions directed to distract from wandering by offering diversions, identify patterns of wandering, reorient, and use of a wander guard bracelet. Admission Minimum Data Set (MDS) dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) score of 13, indicating intact cognition, and ambulated independently. Physician order dated 1/22/2025 directed staff to check wander guard bracelet placement every shift and to check function every night during 11 PM to 7 AM. Record review failed to identify a physician order that directed wander guard use prior to 1/22/2025. Interview and record review with the DNS, Administrator, and Regional Nurse on 2/19/2025 at 12:50 PM identified staff assessment completed on 1/10/2025 indicated Resident #1 was a high wander risk. Physician orders were obtained to apply a wander guard bracelet on 1/22/2025 (12 days after the assessment was completed). Although the DNS stated he thought a wander guard bracelet was applied prior to 1/22/2025, he was unable to provide documentation prior to 1/22/2025. Review of the facility wander guard tracking book failed to identify a wander guard bracelet was signed out for use on Resident #1 prior to 1/22/2025. Interview identified a wander guard bracelet should have been applied on 1/10/2025 when Resident #1 was identified to be a high risk for wandering. 2. Resident #2 had diagnoses that included Parkinsonism, dementia, restlessness and agitation. (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Wander risk evaluation dated 1/13/2025 identified Resident #2 scored a 12 which indicated Resident #1 was a high wander risk. Admission MDS dated [DATE] identified Resident #2 had a BIMS of 13 (intact cognition), was independent with transfers and supervision for ambulation. The RCP dated 1/14/2025 identified Resident #2 was an elopement risk. Interventions directed to place a wander guard to the left ankle. Physician order dated 1/22/2025 directed staff to verify placement of wander guard bracelet every shift and to check the function of the wander guard bracelet every night during 11 PM to 7 AM. Physician order dated 2/7/2025 directed to discontinue to check the function of the wander guard bracelet every night. Record review failed to identify a current order directed staff to check the wander guard bracelet function every night. Interview and record review with the DNS on 2/19/2025 at 4:51 PM identified Resident #2 was a high wander risk. The DNS stated Resident #1 had a wander guard bracelet but did not have an order that directed staff to check the function of the wander guard bracelet. The DNS stated an order should be in place to check the wander guard function and he did not know why there was no order. Review of Wander Guard Security System Policy dated 7/2023 directed the 11 PM to 7 AM supervisor to test the wander guard device on each resident wearing one on the 11 PM to 7 AM shift.

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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 Note: The nursing home is disputing this citation.	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** 50094 Based on observations, record review, facility documentation, and staff interviews for one of three residents (Resident #1) reviewed for accidents, the facility failed to ensure a resident identified as high risk for wandering received adequate supervision to ensure the resident was not able to leave the facility without staff knowledge, which resulted in the facility unable to locate the resident for 4 hours and 40 minutes. The failures resulted in a finding of Immediate Jeopardy. The findings include: Record review identified Resident #1 had a diagnosis of Alzheimer's disease and delusional disorders, and Resident #1 had a Power of Attorney (POA) for care decisions and finances. Wander risk evaluation dated 1/10/2025 identified Resident #1 scored a 12 which indicated Resident #1 was a high wander risk. Admission Minimum Data Set (MDS) dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) score of 13, indicating intact cognition, and ambulated independently. The Resident Care Plan (RCP) dated 1/14/2025 identified an elopement risk/wanderer related to disoriented to place. Interventions directed to distract from wandering by offering diversions, identify patterns of wandering, reorient, and use wander guard bracelet. Nursing note dated 2/10/2025 at 3:52 PM identified Resident #1 was found wandering in the laundry room and was escorted back to his/her room. Social Worker (SW) note dated 2/12/2025 at 1:52 PM identified the Administrator, nursing supervisor and SW held a meeting with Resident #1's family to discuss potential discharge to a facility with a dementia locked unit. The family agreed that moving Resident #1 to another facility would be in his/her best interest. The family was provided with an application to one (1) facility. Nursing note dated 2/12/2025 at 5:43 PM identified Resident #1 was observed with wandering behavior. Nursing note dated 2/13/2025 at 2:21 PM identified the resident was wandering into other rooms. Facility reportable event dated 2/18/2025 at 5:00 AM identified Resident #1 was noted to be missing from his/her room at 4:00 AM. Staff were alerted and the building and grounds were searched. The local police, the Administrator, DNS, responsible party and physician were notified, the police responded, and the search continued. The report further indicated Resident #1 wandered and found him/herself in the dryer/laundry area and was located while police were searching for resident with dust and lint on person. Resident #1 was located at 8:30 AM. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Review of local police report dated 2/18/2025 identified the police were dispatched to the facility at 5:59 AM on a missing person complaint. The facility reported they had conducted numerous room checks prior to contacting the police. Staff reported all facility doors had alarms on them and Resident #1 was wearing an ankle bracelet that would alarm if the resident got too close to a secured door. Police and staff searched each unlocked room in the facility, and later an employee arrived with a master key to allow search of every locked door inside the facility. NA #1 reported Resident #1 was wearing a short sleeve red shirt with dark pants and black shoes. Staff informed the police that Resident #1 would walk into the kitchen frequently and ask for coffee. Police observed no access code was needed to get into the kitchen, and the rear entrance/exit to the kitchen was not alarmed and did not have an access code. Police determined there was a possibility that Resident #1 left the facility, and an exterior search was initiated, a Silver Alert was issued and area hospitals were contacted with negative results. At approximately 8:35 AM Resident #1 was observed walking outside near the rear kitchen entrance/exit and brought inside. Resident #1 was observed to have dryer lint on his/her clothes. The Report indicated the police believed Resident #1 walked outside the rear kitchen exit and entered an unlocked maintenance door to the industrial dryers around the corner. The Report indicated the door was checked by multiple officers and was always locked. Maintenance Worker #1 informed police that the door was normally left unlocked. Police observed that the door could be locked from the inside and Resident #1 most likely locked the door accidentally. The maintenance room was only accessible from the exterior of the facility. EMS arrived on scene and evaluated Resident #1, and the family did not want transport to the hospital. Emergency Medical Services (EMS) run sheet dated 2/18/2025 at 8:36 AM identified Resident #1 was missing for four (4) to five (5) hours and was found alert by staff in a dryer room. History of dementia and is confused at baseline, skin was pink, warm and dry, color and circulation were normal. No signs of trauma or injury. Spoke with the POA over the phone who indicated (hospital) transport was not necessary. Weather report review for 2/18/2025 identified the overnight weather was 17 degrees Fahrenheit (F) with wind up to 29 miles per hour, and dry. The temperature at 8:51 AM was 21 degrees F. Interview with Maintenance Worker (MW) #1 on 2/19/2025 at 9:53 AM identified after 8:00 AM he went outside and found Resident #1 outside the building. MW #1 stated he observed Resident #1 walking between the generator located on the other side of the parking lot and the back side of the building near the laundry service room where the laundry dryers vent outside. MW #1 stated it was cold outside, and Resident #1 was wearing pajama bottoms, socks, and a sweatshirt or sweater, was not sure if Resident #1 was wearing shoes or slippers, and indicated Resident #1 was not shivering. MW #1 held the resident's hand to bring him/her back into the building and the resident's hand was warm. MW #1 stated Resident #1 did not answer when he asked the resident what he/she was doing outside, and MW #1 brought Resident #1 inside the facility to the DON office. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Observations on 2/19/2025 identified directly across the hall from Resident #1's room was a door with a keypad lock that led directly into the laundry room. To the left of that door was a double swinging door that had no locks or alarms on the doors. The double swinging door led into a hallway, and there was a door on the left side of the hallway that led into the kitchen and a door on the right side that led into the laundry room. At the far end of the hall was a door that led to the back of the building exit. All three (3) doors were observed to have keypad locks on them. Inside both the kitchen and the laundry room were doors that exited directly to the outside with no locks or alarms on the doors; the doors opened freely when pushed outward. Observations when standing outside and facing the back of the building, there were dryer vents on the left side of the building. Located around the left side corner of the building was a separate access door that led into the dryer service room. Observation of the laundry service room on 2/19/2025 at 3:20 PM identified it was a long narrow room, approximately four (4) feet wide, with no light (unable to locate a light switch or light bulb), and had a metal wall behind the dryers with dryer vents and electrical wiring through the wall. The room was clean without any lint observed. Wiring was visible behind each dryer, and on the floor were four (4) silver-colored dryer vent tubing approximately 15- or 18-inches diameter behind each dryer, from left to right in front of the door. A written statement from NA #1 dated 2/18/2025 identified during her shift (11 PM to 7 AM), Resident #1 kept trying to come out of his/her room and she redirected him/her back into the room. NA #1 last observed Resident #1 at 3:15 AM when she went to check on other residents. About 3:50 AM, Resident #1's roommate rang the call bell and when NA #1 answered the call bell she noticed Resident #1 was missing. NA #1 then notified the supervisor and started searching for the resident. Interview with RN #1 on 2/19/2025 at 9:08 AM identified he was the supervisor on 2/18/2025 when Resident #1 was missing. RN #1 stated he had reported to the day shift supervisor and the DNS several times that Resident #1 had exit seeking behaviors, wandered into other resident rooms, had no orders for frequent checks or monitoring and during his shift staff keep an eye on his/her room. When RN #1 was notified Resident #1 was missing, he paged a missing resident announcement (Dr. Hunt). All staff responded and searched the facility and grounds. RN #1 stated when staff did not locate Resident #1, he notified the DNS about 4 AM, and the DNS arrived at the facility about 15-minutes later and took over the search. RN #1 stated after he was home, he was notified that Maintenance Worker #1 found Resident #1 by a door where the dryers get serviced, and Resident #1 could have been inside the (service) room. RN #1 stated the door to enter the dryer service area was outside the building, about 10 feet from the laundry room exit door, and Resident #1 exited the facility and then could have been inside the dryer service room when he/she was missing. Interview and observation with Director of Maintenance, Laundry Worker (LW) #1, LW #2 and LW #3 on 2/19/2025 at 10:44 AM identified MW #1 found Resident #1 outside the building, behind where the dryers vent to the exterior (behind the dryer service room). Interview identified Resident #1 had wandered into the laundry room multiple times and laundry staff would call the Administrator to come get Resident #1. The interview further identified the keypad locks observed on the laundry room and kitchen doors from the hallway were broken prior to when staff were unable to locate Resident #1, and laundry staff would place large buckets (approximate 5-gallon bucket size) of laundry soap against the inside of the door to prevent Resident #1 from accessing the laundry room. Interview identified the locks were replaced after Resident #1 was located and brought back into the building. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Interview and observation with [NAME] #1, [NAME] #2 and the Food Service Director (FSD) on 2/19/2025 at 11:15 AM identified the lock on the kitchen door from the hallway had been broken for a few weeks, and they had notified maintenance. The lock was replaced on 2/18/2025 after Resident #1 was returned to the facility. Further, the FSD stated the exit door from the kitchen to the back parking lot had no lock or alarm, and observation identified the door opened freely when pushed. Interview, observation, and record review with the DNS, Administrator, and Regional Nurse on 2/19/2025 at 12:50 PM identified Resident #1 ambulated independently, was identified a high wander risk on 1/10/2025, had been found in other resident rooms and the laundry room in the past, and Resident #1's room was directly across from the laundry and kitchen areas. When Resident #1 was observed in the laundry room on 2/10/2025 the facility capacity was 126 and the census was between 99 and 101. Although the facility had approximately 25 beds available, a room change to an area away from an unalarmed exit was not considered and staff did not have a discussion to move Resident #1. The DNS stated the laundry and kitchen locks were installed on 2/18/2025 after the incident because the locks were not working. Regional Nurse #1 stated the staff believe Resident #1 exited the facility and was in the dryer service room until MW #1 found Resident #1 outside the building, in the parking lot area. Interview identified that the dryer service room was unlocked, the room should have been locked, and the room was not searched when looking for the resident. Interview and record review with the DNS and Administrator on 2/19/2025 at 2:38 PM identified the DNS was notified Resident #1 was missing at 5:09 AM (1 hour and 19 minutes after staff identified Resident #1 was missing). The DNS stated he arrived at the facility about 5:15 AM, and the Administrator arrived about 5:30 or 5:40 AM. The DNS stated when he arrived, he drove to the back parking lot while looking for Resident #1. When behind the building, the DNS stated he brushed the handle of the doorknob to the dryer service room but he did not check to see if the door was locked, and he did not open the door to search for Resident #1 inside the room. The DNS stated the dryer service room should have been searched; the entire facility should have been searched. He then checked all the unit exit doors were locked and walked the perimeter to the front of the building searching for Resident #1. The DNS stated he called the police to notify them Resident #1 was missing about 5:20 AM or whatever (1 hour 30 minutes after Resident #1 was missing). Further, the DNS indicated he was aware the facility policy directed to notify the local police within five (5) to seven (7) minutes after not locating the resident, but stated that time was not feasible, and was unable to indicate a timeframe to notify the police that was feasible. Interview with Police Dispatch #1 on 2/19/2025 at 2:03 PM identified the police received a call at 6 AM (2 hours and 10 minutes after Resident #1 was identified missing) from the facility to notify them of a missing resident. Review of the facility undated Elopement Search Policy directed in part, the designated person in charge to coordinate the search after main business hours is the nursing supervisor. A facility and grounds search are initiated, and 5 to 7 minutes is required for the search. Step 4 directed staff that if the resident is not located during the initial search, to notify the police, Administrator, DNS, resident responsible party, and physician. The Policy further directed the person in charge will determine when to proceed to Step 4 (approximately 7 minutes).

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 50094 Based on observations, staff interviews, and review of facility policy, regarding medication administration, the facility failed to ensure the failed to ensure only authorized personnel had access to the keys, including keys to the medication rooms and medications, and failed to ensure separately locked, permanently affixed compartments for the storage of controlled drugs was maintained. The findings include: Interview and continuous observations with RN #2 on 2/19/2025 at 10:26 AM in a hallway located near the kitchen identified she does not keep the nursing supervisor keys on her person because they are too heavy and stated she keeps them in the nursing supervisor office. Observation of the supervisor office (located on a different wing) identified the supervisor door was open and APRN #1, ADNS and Resident #4 were in the office near a desk. Resident #4 was standing and ambulated independently. RN #2 opened an unlocked top drawer next to the door, and removed two (2) rings of keys. RN #2 demonstrated she had keys to all areas of the facility, including medication storage, medication rooms, medication carts, and oxygen storage. RN #2 demonstrated one (1) key opened a box on the wall behind the door, with keys to all the facility medication rooms. RN #2 stated emergency medications are on B-unit (different unit) along with narcotic emergency medications. Observation of the B-unit medication room identified no staff were in the room. A refrigerator approximately four (4) feet tall, was observed on a table, and had a clasp on the door for a keypad lock. The keypad lock was sitting on top of the refrigerator, leaving the refrigerator unlocked. Inside the refrigerator was a locked box, chained to the refrigerator that contained controlled emergency medications (including liquid Morphine and liquid Ativan). RN #2 stated the lock was supposed to be on the refrigerator, and was unable to explain why the refrigerator keypad lock was not on the refrigerator door. Interview with the DNS on 2/19/2025 at 11:52 AM identified the RN supervisor should carry the nursing supervisor keys and was unable to explain why RN #2 did not have possession/control of the keys. Further, the DNS stated he thought it was okay for the medication refrigerator lock to be sitting on top of the refrigerator. Review of Controlled Pharmaceuticals policy dated 4/2022 directed all keys to controlled substance containers shall be on a single key ring that is different from other keys. The nurse on duty will maintain the keys to controlled substance containers. Interview with the DNS identified the facility did not have a policy for narcotic/controlled medication storage.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 50094 Based on clinical record review, facility documentation review, facility policy review, and interviews for facility Administration review, the facility failed to ensure the facility administered its resources effectively and to ensure effective administrative oversight of staff and resident care timely to maintain the highest practicable physical, mental and psychosocial well-being of residents. The findings include: The facility administration failed to: Ensure a Governing Body was in place. Ensure the Medical Director was appointed by a Governing Body. Ensure the State Agency was notified timely of a reportable event. Ensure the clinical record was complete and accurate to include documentation or an RN assessment. Ensure prevent a resident with a known wander risk had access to unlocked egress from the facility. Ensure wander guard bracelet orders were accurate and timely. Ensure medications were secured and only authorized staff had access to keys. Ensure annual in-service training was completed timely. Ensure facility policies were reviewed and approved annually. Ensure there were not differing, duplicate facility policies. a. Review of facility undated Elopement Policy (provided on 2/19/2025), and review of facility Elopement Policy dated 6/2023 (provided on 2/28/2025) identified the policies did not match. Interview with the DNS, Administrator, and Regional Nurse on 2/25/2025 at 11:36 AM identified the facility had three (3) Elopement Policies currently in effect, and each policy was different. One (1) policy was from the emergency preparedness book, one (1) was from the nursing policy book, and the third policy had an unidentified source. Interview failed to identify which policy the staff had been educated on prior to the elopement on 2/18/2025. Although the Administrator worked at the facility since May 2024, and the DNS since October 2024, interview identified the facility policies the Administrator and DNS had not reviewed the policies. Further, although the policies should be reviewed annually, the policies had not been reviewed annually by Medical Staff. Please cross reference F684, F689, F761, F837, F842 and F947. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on the deficiencies during the survey, immediate jeopardy and substandard care was identified in the area of Accidents. Interview with the DNS, Administrator and Regional Nurse on 2/27/2025 at 11:11 AM failed to identify a process for administrative oversight of the facility processes for a Governing Body, appointment of the Medical Director, medication storage, notification to the State Agency of reportable events, annual in-service training, annual policy review, physician orders, resident access to unlocked egress from the facilty, and elopement policy/procedure. The facility failed to utilize resources effectively to attain/maintain the resident's well-being. No facility policy was provided for review.

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F 0837 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Establish a governing body that is legally responsible for establishing and implementing policies for managing and operating the facility and appoints a properly licensed administrator responsible for managing the facility. 50094 Based on facility documentation, facility record review, and interviews for governing body review, the facility failed to ensure that they had a governing body, or designated persons functioning as a governing body that is legally responsible for establishing and implementing policies regarding the management and operation of the facility, and failed to ensure the Administrator was appointed by a governing body. The findings include: Review of facility documentation failed to identify a facility governing body. Review of the Administrator's employee file failed to identify the Administrator was appointed by the facility governing body. The review of facility policy and procedure master manual failed to identify an annual review of the facility policies was conducted. Review of facility Elopement Policy with no date provided on 2/19/2025, and review of facility Elopement Policy dated 6/2023 provided on 2/28/2025 identified the policies did not match. Interview with the DNS, Administrator, and Regional Nurse on 2/25/2025 at 11:36 AM identified the facility had three (3) Elopement Policies currently in effect, and each policy was different. One (1) policy was from the emergency preparedness book, one (1) was from the nursing policy book, and the third policy had an unidentified source. Interview failed to identify which policy the staff had been educated on prior to the elopement on 2/18/2025. Although the Administrator worked at the facility since May 2024, and the DNS since October 2024, interview identified the facility policies the Administrator and DNS had not reviewed the policies. Further, although the policies should be reviewed annually, the policies had not been reviewed annually by Medical Staff. Interview with the DNS, Administrator, and Regional Nurse on 2/27/2025 at 11:11 AM identified the facility did not have a governing body. Review of facility Governing Body By-Laws (undated) directed the Governing Board is charged with the responsibility to exercise due care and diligence in the overall supervision and management of the organization with the primary focus on the provision for the well-being of the residents entrusted to the facilities care. The Governing Body will meet quarterly.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075060	A. Building B. Wing	02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Salmon Brook Rehab and Nursing	72 Salmon Brook Drive Glastonbury, CT 06033

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50094 Based on record review, facility documentation, and staff interviews for one of three residents (Resident #1) reviewed for quality of care, the facility failed to ensure the record was complete and accurate to include an RN assessment following an elopement. The findings include: Record review identified Resident #1 had a diagnosis of Alzheimer's disease and delusional disorders. Admission Minimum Data Set (MDS) dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) score of 13, indicating intact cognition, and ambulated independently. The Resident Care Plan (RCP) dated 1/14/2025 identified an elopement risk/wanderer related to disoriented to place. Interventions directed to distract from wandering by offering diversions, identify patterns of wandering, reorient, and use wander guard bracelet. Facility reportable event dated 2/18/2025 at 5:00 AM identified Resident #1 was noted to be missing from his/her room at 4:00 AM. Staff were alerted and the building and grounds were searched. The local police, the Administrator, DNS, responsible party and physician were notified, the police responded, and the search continued. The report further indicated Resident #1 wandered and found him/herself in the dryer/laundry area and was located while police were searching for resident with dust and lint on person. Resident #1 was located at 8:30 AM. Review of local police report dated 2/18/2025 identified the police were dispatched to the facility at 5:59 AM on a missing person complaint. At approximately 8:35 AM Resident #1 was observed walking outside near the rear kitchen entrance/exit and brought inside. Resident #1 was observed to have dryer lint on his/her clothes. The Report indicated the police believed Resident #1 walked outside the rear kitchen exit and entered an unlocked maintenance door to the industrial dryers around the corner. EMS arrived on scene and evaluated Resident #1. Please cross reference F689. Record review failed to identify an RN assessment was conducted following the elopement. Interview and record review with the DNS, Administrator, and Regional Nurse on 2/19/2025 at 12:50 PM identified staff located Resident #1 outside and was brought to the DNS office. The DNS stated RN #2 completed an RN assessment, however the DNS was unable to provide documentation of the assessment. The DNS stated RN #2 should have documented the assessment in the clinical record and he did not know why it was not documented. Interview with RN #2 was not obtained during survey. Review of the Charting and Documentation policy dated 6/2023 directed the following information was to be documented in the resident medical record: events, incidents or accidents involving the resident and documentation in the medical record will be objective complete, and accurate.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 50094 Based on facility documentation review and interviews for two of five employee files (NA #2 and NA #3) reviewed for in-service training, the facility failed to ensure the Nurse Aides had 12 hours of annual training. The findings include: Review of NA #2 employee file identified NA #2 was hired on 8/10/2023. Additional review identified the only education provided during 2023, 2024 and through 2/27/2025 included Intravenous (IV) therapy education. No additional education, including general orientation education was provided. Review of NA #3 employee file identified NA #3 was hired on 7/20/2023. Additional review identified NA #3's annual education included education on resident rights, abuse/retaliation, and dementia. Review of facility employee files for NA #2 and NA #3 failed to identify 12 hours of annual in-service training was provided. Interview with the DNS on 2/27/2025 at 10:52 AM identified all NAs should have a minimum of 12 hours annual in-service training. The DNS was unable to explain why NA #2 and NA #3 did not have the required 12 hours of annual in-service education training completed since NA #2 and #3 were hired during 2023. Review of Facility Assessment Tool dated 8/2024 directed annual education was to be completed on the following topics: Abuse Resident rights Confidentiality Hazard and safety Blood borne pathogens Handwashing Infection control prevention Disaster and emergency plan Fire and safety Resident handling safety Sexual harassment (continued on next page)

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Falls and elopement COVID-19 Proper protective equipment donning and doffing Ongoing education and noted issues with the facility