STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075358	A. Building B. Wing	02/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bickford Health Care Center	14 Main Street Windsor Locks, CT 06096

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility documentation review, facility policy review, and interviews for one of four residents (Resident #1 and #5) reviewed for wandering behaviors, the facility failed to ensure the physician was notified timely following Resident #1's significant change in condition and failed to ensure the physician was notified timely when laboratory results were received (Resident #5). The findings include: Resident #1's diagnoses included dementia. Record review and facility documentation review identified MD #1 was the attending physician/Medical Director. Elopement risk evaluation dated 11-24-2025 identified Resident #1 ambulated independently, was cognitively impaired with poor decision-making skills, made statements that he/she was leaving and displayed behaviors that may indicate an attempt to leave. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) score of ten (10) indicating moderate cognitive impairment, had no pacing behaviors, wandering presence and frequency indicated the behavior occurred one (1) to three (3) days, transferred with moderate assistance, ambulated independently with supervision, and had no wander/elopement alarm. The Resident Care Plan dated 1-31-2026 identified Resident #1 had a wander guard on the right ankle. Interventions directed to redirect if near doors to outside. Check functioning per protocol. Physician order dated 1-15-2026 directed to ambulate with four (4) wheeled rolling walker with supervision. The facility submitted reportable event (RE) dated 2-8-2026 at 9:46 AM identified Resident #1 had a with diagnosis of dementia and history of wandering, was found outside of the building around 5:12 AM and was immediately brought back into the building. Nursing note written by the Director of Nursing (DNS) dated 2-8-2026 at 1:05 PM identified Resident #1 was observed by the overnight shift not to be in his/her room upon rounding. Per supervisor, a search was done, and Resident #1 was located on the grounds outside and was immediately brought inside the building. Assessment was done, warm clothes and blanket provided. 911 was called. Per Emergency Medical Technician (EMT) report, Resident #1 was pronounced deceased at around 6:46 AM. Family, physician and police were notified. A nursing note dated 2-10-2026 at 5:19 AM written by RN #1 identified on 2-8-2026 at approximately 5:00 AM, RN #1 was approached by a certified aid who reported a missing resident. A perimeter search of the building identified Resident #1 was found on the sidewalk, lying on his/her left side, and upper body on the snow. Resident #1 was blinking his/her eyes and responding to painful stimuli when applied and was not verbal. Resident #1 was brought back to the facility and placed in his/her room and into bed. RN #1 performed an assessment, including temperature, which indicated Low reading and had low pulses. Warm blankets and incontinent care was provided. Emergency services were called, with family and primary care physician were informed. All facility Administrators were contacted. EMS (emergency medical services) arrived, and Resident #1 was pronounced after evaluation. Addition review of the facility RE and investigation dated 2-8-2026 at 5:00 AM failed to identify that the physician was notified. Interview and (continued on next page)

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	record review with RN #1 on 2-8-2026 at 9:34 AM identified he was the Supervisor and Charge Nurse on 2-8-2026 when Resident #1 was identified missing and subsequently found outside the building at 5:12 AM. RN #1 stated he notified the Administrator and Director of Nursing (DON), and the Infection Control Nurse prior to calling 911. Interview failed to identify he called the physician. Interview with MD #1 on 2-10-2026 at 10:33 AM identified he was not notified of the incident that occurred on 2-8-2026. Interview with Technical Support (TS #1) with the facility physician on-call services on 2-11-2026 at 11:30 AM identified MD #1 was covering his own office during the hours of 11:00 PM (2-7-2026) through 7:00 AM (2-8-2026); there were no other providers on-call covering for MD #1. Although attempted, a subsequent interview with RN #1 regarding notification of the physician was unable to be obtained during the survey. Interview with the DON on 2-10-2026 at 3:30 PM identified that during the facility investigation of Resident #1's elopement that occurred on 2-8-2026, the investigative team was unable to determine whether RN #1 notified the physician at the time of the incident. The DON stated that RN #1 should have notified the on-call physician following initiation of emergency medical services. The DON stated the physician was on-call during that time and would have provided further medical direction, which likely would have included transfer to the hospital. Resident #5's diagnoses included influenza A, urinary tract infection, and hypothyroidism. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #5 had a Brief Interview for Mental Status (BIMS) score of thirteen out of fifteen (15/15), indicative of being cognitively intact and was partial to substantial assistance for ADL's (activities of daily living). Resident Care Plan dated 12-21-2025 identified Resident #5 was at risk for nutritional status related to vitamin deficiency and hypomagnesemia. Interventions directed to administer medications per physician orders, obtain lab work as ordered and report abnormal findings to the physician (routine thyroid lab work). laboratory results dated [DATE] identified Resident #5's TSH (Thyroid Stimulating Hormone) with free T4, reflex test result was 9.73 (normal range is 0.34 - 5.60 units/mL). The laboratory results did not have physician's signature of acknowledgement. Record review failed to identify the physician was notified of the laboratory results obtained on 12-30-2025. A physician progress note dated 1-14-2026 by APRN #1 identified Resident #5 had hypothyroidism and was seen for follow up related to a UTI (urinary tract infection. Resident #5 had complaints of dysuria in the past days, and urine was positive for E- coli, and was started on Ciprofloxacin (antibiotic). Recent labs reviewed TSH results of 9 on 12-20-2025, currently on Levothyroxine (treatment for hypothyroidism) 50 mcg (micrograms) daily, plan to increase to 75 mcg daily and recheck TSH in six (6) weeks. Interview and record review with the DON on 2-13-2026 at 1:45 PM identified the DON was unable to verify if the nursing had notified a physician/APRN regarding Resident #5's elevated TSH levels. Interview with MD #1 on 2-13-2026 at 2:30 PM identified the facility usual practice is for the facility to fax laboratory results to his office and MD #1 will review, sign, and send back the documents to the skilled nursing facility. MD #1 was unable to confirm if Resident #5's laboratory results from 12-30-2025 were reviewed by himself but indicated he was on-site at the facility on 1-1 and 1-8-2026 and was not notified of the lab results. Although attempted, an interview with APRN #1 was unable to be obtained during the survey. Review of the facility Change in Condition Policy dated 4/17 directed in part, the facility shall notify the resident, his or her attending physician, 911 as indicated, and representative (sponsor) of changes in the resident's medical/mental condition. The nurse will notify the residents' attending physician or on-call physician when there has been:An accident or incident involving the resident.A discovery of injuries of an unknown source.A reaction to medication.A significant change in the resident's physical/emotional/mental condition.A need to alter the resident's medical treatment (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	significantly.Refusal of treatment or medications.Abnormal laboratory reports.A need to transfer the resident to a hospital/treatment center.A discharge without proper medical authority; and/orInstructions to notify the physician of changes in the resident's condition.

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and staff interviews, the facility failed to ensure the resident was free from neglect when the facility failed to notify the local police department within 15-minutes when a resident was identified missing from the facility in accordance with facility policy, and failed to notify emergency services timely when a resident was found unresponsive outside the building in below freezing temperatures. The failures resulted in a finding of Immediate Jeopardy. The findings include:Resident #1's diagnosis included dementia.The elopement evaluation dated 11-24-2025 identified Resident #1 was ambulatory or had independent wheelchair location, was cognitively impaired, made statements that he/she was leaving, and displayed behavior that he/she may attempt to leave. The evaluation identified Resident #1 was at risk for elopement and had a care plan for the risk.The quarterly Minimum Data Set assessment dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) score of ten (10) indicating moderate cognitive impairment, had no behaviors, transferred with moderate assistance, ambulated independently with supervision, and had no wander/elopement alarm.The Resident Care Plan (RCP) dated 12-2-2025 identified Resident #1 had a wander guard on the right ankle. Interventions directed staff to redirect Resident #1 if near the doors, check wander guard functioning per protocol. Physician order dated 12-7-2025 directed to ambulate with four (4) wheeled rolling walker with supervision. Physician order dated 1-15-2026 directed wander guard to right ankle, check placement every shift, and check function daily.Review of Nurse Aide (NA) documentation dated 2-8-2026 identified rounds were completed and Resident #1 was observed at 1 AM, and 3 AM sleeping in his/her bed.The Facility Reported incident form dated 2-8-2026 at 5:00 AM identified Resident #1 was found outside of the building around 5:12 AM and was immediately brought back into the building. NA #1 written statement dated 2-8-2026 identified about 1:30 AM she observed Resident #1 sleeping in bed and she placed the walker next to the bed so he/she could hold it if he/she got up. The statement indicated NA #1 saw Resident #1 again at 3:30-ish, sleeping in bed. Then about 4:30 AM, Resident #1 was not on his/her bed. NA #1 searched other rooms looking for Resident #1, then I went on the other wing to check and told my co-worker who also started searching with me while I went outside (to) look she went and told the nurse. The co-worker came outside the building to join me, while we both was looking around she stopped, Resident #1 (was) laying on the floor, by the walkway. I run quickly to get the nurse, also got some blankets. Registered Nurse (RN) #1 written statement dated 2-8-2026 identified a NA informed him at approximately 5 AM (30 minutes after NA #1 identified Resident #1 was missing) that Resident #1 was not in his/her room. He immediately instituted a room search again, with no success. He then instructed an outside search, then Resident #1 was found on the sidewalk outside of the facility. Resident #1 was only responding to painful stimuli and blinking his/her eyes. Resident #1 was brought back to the facility and applied warm blanket. 911 was called and upon arrival Resident #1 was still unresponsive.Nursing note written by the Director of Nursing (DNS) dated 2-8-2026 at 1:05 PM identified Resident #1 was observed by the overnight shift not to be in his/her room upon rounding. Per supervisor, a search was done, and Resident #1 was located on the grounds outside and was immediately brought inside the building. Assessment was done, warm clothes and blanket provided. 911 was called. Per Emergency Medical Technician (EMT) report, Resident #1 was pronounced deceased at around 6:46 AM. Family, physician and police were notified.Review of local weather on 2-8-2026 at 1:53 AM identified the temperature at 1:53 AM was 1 degree Fahrenheit with a wind of 14 mph, and at 5:53 AM the temperature was 0 degrees Fahrenheit with a wind of 12 mph. Observation on 2-8-2026 at 2:10 PM identified a local police car in front of the (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	building near the edge of the property with yellow tape around an area of the sidewalk and snow near the post office, and snow covered the ground. The sidewalk in front of the building along the street was shoveled to the approximate property line, the sidewalk along the driveway was shoveled, and snow on both sides of the sidewalk was approximately twenty (20) inches high. The pile of snow at the end of the shoveled sidewalk on the side closest to the building was taller than the approximate four (4) foot tall snow stake marking the edge of the sidewalk. The sidewalk beyond the property line was not shoveled.Interview and record review with the Administrator and DNS on 2-8-2026 at 2:22 PM identified Resident #1 had a history of dementia, ambulated independently with a walker, was a known wander risk, wore a wander guard bracelet, and had left the building without staff knowledge. Per staff, Resident #1 was last seen about 3:00 AM and was identified missing at about 4:45 AM. The NAs searched the two (2) nursing units before notifying the RN supervisor/RN #1. When NA #1 and NA #4 were unable to locate Resident #1 they notified RN #1 about 5 AM (Approximately 30 minutes after NA #1 identified Resident #1 was missing). RN #1 then initiated a search inside the building and then directed an outside search when Resident #1 was not located. Staff found Resident #1 about 5:12 AM, lying on the sidewalk at the front of the building. RN #1 directed a staff member to bring a wheelchair outside, and Resident #1 was lifted into a wheelchair and was returned inside the building. Resident #1 was unresponsive, and staff then removed Resident #1's wet clothing, applied dry clothing and blankets and then called 911. The Administrator and DNS stated the NAs should have notified the nurse immediately when Resident #1 was identified missing about 4:30 or 4:35 AM, and 911 should have been called immediately after Resident #1 was found outside. During an interview and record review with NA #1 on 2-9-2026 at 11:06 AM, NA #1 stated she observed Resident #1 in his/her bed at 1 AM and about 3:30 AM. NA #1 stated she identified Resident #1 missing about 4:35 or 4:45 AM and searched the unit with NA #3, and NA #3 notified RN #1. She then went to the back door near the kitchen with NA #4 and NA #4 searched the back parking lot. Then when she and NA #3 searched the front of the building, NA #3 located Resident #1 lying on his/her left side on the sidewalk in front of the building. Resident #1 was not moving, and his/her eyes were opening and closing. Resident #1 was wearing sneakers, socks, and pajamas, and his/her clothes were cold with ice on them. NA #1 stated she went into the building to get blankets, RN #1 brought a wheelchair and Resident #1 was returned inside the building and put into bed. The staff removed his/her clothes, dressed him/her in a johnny, and gave incontinent care, and tried to warm him/her up with warm blankets and towels with warm water, and RN #1 was running in and out of the room, and the only response was opening and closing his/her eyes. NA #1 stated when the ambulance came, they administered CPR. Interview and record review with RN #1 on 2-9-2026 at 9:34 AM identified he was notified about 5 AM (approximately 15 to 30 minutes after Resident #1 was identified missing) that Resident #1 was missing, and staff had already searched the facility without telling him that she was missing. He stated Resident #1 was known to exit seek and that was why he/she had a wander guard and he directed a second search inside and then to search outside. RN #1 stated he thought Resident #1 could have gone out the back door. NA #1 told him that Resident #1 was found outside in front of the building. Resident #1 was brought back inside in a wheelchair, had no response to painful stimuli, only blinked his/her eyes, and had a pulse. No blood pressure was heard (recorded) on the blood pressure machine, a temperature was attempted to be obtained, and the thermometer read LOW and his/her pulse was between 20's and 30's. He stated he wanted to make sure they get warm blankets for hypothermia and people were emotional with the situation. RN #1 stated he did paperwork, then called the Administrator who conferenced in the Director of Nursing (DNS) and he told them he was going to send him/her to the hospital and then he called 911. RN #1 stated he (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	was informed that he called 911 at 6:23 AM (1 hour and 11 minutes after he/she was found outside). RN #1 stated he looked at Resident #1's code status, it was just me, and he looked to get help he needed and to call facility people above him, and to do an assessment. He wanted the DNS and Administrator, to make sure he informed them that we had an emergency. He had to assess Resident #1 first before calling 911. Review of thermometer manufacturer manual identified the thermometer reads LO if the temperature is less than 89.6 Fahrenheit.Interview and record review with the DNS and Administrator on 2-9-2026 at 1:56 PM identified the DNS received a conference call from the administrator and RN #1 on 2-8-2026 at 6:08 AM (56 minutes after Resident #1 was found outside). The DNS stated that RN #1 indicated during the call that he had not called 911 because they were trying to get Resident #1 warm, and she directed RN #1 to call 911. Interview identified staff should have notified RN #1 immediately when Resident #1 was identified missing, when the resident was not found within 15 minutes the police should have been notified, and 911 should have been called immediately after Resident #1 was found. Review of EMS run sheet dated 2-8-2026 identified EMS was called at 6:23 AM and EMS initiated treament of the resident at 6:35 AM for a question of a cold exposure out of the facility. On arrival with police on scene, Resident #1 was found unresponsive, pulseless, apneic (not breathing). Staff reported the resident had wandered out of the facility possible 30 minutes prior and found laying on the ground outside, not responding to staff, placed in a wheelchair and returned into facility and bed when 911 was called. EMS noted severely cold temperatures. Once confirmed pulseless, Resident #1 was transferred to a stretcher and CPR was initiated due to no CPR bed board available and unknow DNR (Do Not Resuscitate), monitor placed with pads, asystole (no pulse) on monitor, no lung or heart sounds, extremely cold to touch with thermometer reading LO. Nurse provided paperwork for DNR. EMS also noted lividity (discoloration of the skin due to pooled blood after death) on the left flank (between ribs and hips), left hand and knee with possible blistering from outside temperature and positioning. Pupils were fixed and non-reactive. No other traumatic injuries noted. EMS noted resident was in a hospital gown with adult depends on. Patient was extremely cold to the touch and pale along with the lividity on the left side. Patient presumed (death) at 6:46 AM.Review of facility Elopement Management Policy dated 11-25 directed in part, if an employee discovers a resident is missing, to inform the supervisor or DNS while staff do a quick and thorough search of the unit and other departments. The supervisor or DNS will page overhead Calling Dr Hunt, and the Supervisor of DNS will instruct the NAs on the unit to repeat search of the unit as well as instruct to search outside the facility. Notify the police department within 15 minutes of not successfully locating the missing resident. When the missing resident is returned to the facility the nurse will immediately and thoroughly assess the resident for injuries.Review of facility Change in Condition Policy dated 6/23 directed in part 911 should be called immediately if a resident is unresponsive.

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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 clinical record reviews, facility documentation, facility policy review, and interviews for one of four residents (Resident #1 and #3) reviewed for wandering behaviors, the facility failed to ensure physician orders were obtained that directed to check the wander guards function, and failed to ensure an elopement risk assessment was completed timely. The findings include: Resident #1's diagnoses included dementia. Elopement risk evaluation dated 11-24-2025 identified Resident #1 ambulated independently, was cognitively impaired with poor decision-making skills, made statements that he/she was leaving and displayed behaviors that may indicate an attempt to leave. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) score of ten (10) indicating moderate cognitive impairment, had no behaviors, transferred with moderate assistance, ambulated independently with supervision, and had no wander/elopement alarm. Physician order dated 1-15-2026 directed to check wander guard bracelet placement every shift and check function daily. The Resident Care Plan dated 1-31-2026 identified Resident #1 had a wander guard on the right ankle. Interventions directed to redirect if near doors to outside. Check functioning per protocol. Physician order dated 1-31-2025 directed to check wander guard bracelet placement every shift and check function daily. Record review identified the physician order for wander guard use was reviewed with monthly physician order reviews, with the most recent dated of 1-15-2016. Review of Resident #1's Elopement Risk Evaluations identified the following:A quarterly elopement risk evaluation was completed on 1-30-2025.The next quarterly elopement risk evaluation was performed on 6-3-2025 (124 days later).The next quarterly elopement risk evaluation was performed on 11-24-2025 (174 days later). 2. Resident #3's diagnoses included dementia. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #3 had a Brief Interview for Mental Status (BIMS) score of six (6) of fifteen (15), indicating severe cognitive impairment, had no wandering behaviors, transferred with moderate assistance, ambulated independently with a wheelchair, and had wander/elopement alarm daily. Elopement risk evaluation dated 12-30-2025 identified Resident #3 ambulated independently, was cognitively impaired with poor decision-making skills and displayed behaviors that may indicate an attempt to leave.?? Resident Care Plan dated 1-22-2026 identified a risk for elopement. Interventions directed to check function and placement of wander guard every shift and daily. Review of Resident #3's Elopement Risk Evaluations identified the following:An admission elopement risk evaluation was completed on 7-4-2025.The next quarterly elopement risk evaluation was performed on 12-30-2025 (179 days later). Although additional record review identified a physician order that directed to check wander guard placement every shift, review failed to identify a physician order that directed nursing staff to perform function checks of Resident #3's wander guard. Interview and record review with the DON on 2-10-2026 at 3:30 PM identified Elopement risk evaluations are completed on admission, quarterly, and readmissions to the facility, and physician orders should be obtained that directed staff to check daily function of the wander guard bracelets. The DON stated the elopement risk evaluations for Resident #1 and Resident #3 were not completed quarterly (every 90 days) and they should have been completed. Interview failed to identify why they were not completed timely. DON was unable to identify why the assessments were not completed timely and why a physician order was not obtained that directed to check function of Resident #3's wander guard. Review of the Wandering Risk Assessment Policy dated 11/25 directed in part, a wandering risk assessment will be utilized and completed on all residents to determine their risk level. The assessment will be completed upon admission and quarterly. Review of the Wander-Guard Security System Policy dated 11/25 directed in part, the wander guard security device will be (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	placed on any resident that the resident care team decides is at risk for wandering away from the facility. The 11 PM to 7 AM supervisor shall check the door alarms and signaling devices on the resident. The night shift nurses are responsible for replacing any non-functional devices. Further, the policy directed that elopement risk assessments will be completed upon admission, quarterly, and annually.

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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** Based on clinical record reviews, facility documentation, facility policies and interviews for one (1) of three (3) sampled residents (Resident #1), the facility failed to adequately supervise a resident with a diagnosis of dementia and was identified wander risk who ambulated independently. Resident #1 was able to exit the facility without staff knowledge in subfreezing temperatures. The failure resulted in a finding of Immediate Jeopardy. The findings include:Resident #1's diagnoses included dementia.Record review identified Resident #1's code status was Do Not Resuscitate (DNR).The quarterly Minimum Data Set assessment dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) score of ten (10) indicating moderate cognitive impairment, had no behaviors, transferred with moderate assistance, ambulated independently with supervision, and had no wander/elopement alarm.Elopement risk evaluation dated 11-24-2025 identified Resident #1 ambulated independently, was cognitively impaired with poor decision-making skills, made statements that he/she was leaving and displayed behaviors that may indicate an attempt to leave. Physician order dated 12-7-2025 directed to ambulate with four (4) wheeled rolling walker with supervision. Physician order dated 1-15-2026 directed to check wander guard bracelet placement every shift and check function daily.The Resident Care Plan dated 1-31-2026 identified Resident #1 had a wander guard on the right ankle. Interventions directed to redirect if near doors to outside. Check functioning per protocol. Review of Nurse Aide (NA) documentation dated 2-8-2026 identified rounds were completed and Resident #1 was observed at 1 AM, and 3 AM sleeping in his/her bed.The Facility Reported incident form dated 2-8-2026 at 5:00 AM identified Resident #1 was found outside of the building around 5:12 AM and was immediately brought back into the building. NA #1 written statement dated 2-8-2026 identified about 1:30 AM she observed Resident #1 sleeping in bed and she placed the walker next to the bed so he/she could hold it if he/she got up. The statement indicated NA #1 saw Resident #1 again at 3:30-ish, sleeping in bed. Then about 4:30 AM, Resident #1 was not on his/her bed. I went around again, I couldn't find Resident #1 on his/her bed. I first went to the bedroom to look for him/her, I went round the rooms looking for him/her, then I went on the other wing to check and told my co-worker who also started searching with me while I went outside (to) look she went and told the nurse. The co-worker came outside the building to join me, while we both was looking around she stopped, Resident #1 laying on the floor, by the walkway. I run quickly to get the nurse, also got some blankets. NA #3 written statement dated 2-8-2026 identified at about 4:45 AM she observed NA #1 looking for Resident #1 and asked NA #4 to assist in searching. Around 5 AM NA #3 informed the nurse that we were unable to locate Resident #1, and we search all areas inside the building. The nurse then suggested they put on jackets and check outside. The statement indicated as NA #3 walked down the sidewalk toward the post office (next door building), she observed Resident #1 on the ground. I immediately called out to my co-worker who then went to notify the nurse. Resident #1 was then brought back inside and they began attempting to warm him/her up while waiting for instructions.NA #4 written statement dated 2-9-2026 identified shortly after 4:30 AM, NA #1 asked for help that they could not find the patient. NA #4 told NA #1 to search her unit and he would search the other unit. After searching they met and he told NA #1 to go with him to search the back hallway area. They went to the back hallway to the back outside door. NA #4 asked NA #1 to prop open the door while he searched the back parking lot and between the cars. NA #4 then went to the nurse's station and RN #1 told them to get their coats to go outside to look. NA #4 got my phone and the time was 5:11 AM and after he went to search the back parking lot area, he returned to the nursing station and as he approached the front door he saw RN #1 pulling a wheelchair (continued on next page)

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	075358	A. Building B. Wing	02/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bickford Health Care Center	14 Main Street Windsor Locks, CT 06096

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	into the building with Resident #1 in wheelchair, NA #1 and NA #3 was with RN #1. The wander guard alarm triggered as Resident #1 was wheeled inside and I shut it off with the code. Resident #1 was transferred into bed. I checked for Resident #1's pulse on his/her right pulse and felt he/she was really cold and could not feel pulse. Resident #1 was unresponsive. RN #1 asked for a stethoscope and he said he thought he heard a heartbeat. NA #4 used the pulse ox (finger device to measure blood oxygen level) and had no reading. NA #4 helped get warm wet towel for the NAs and then left the room. Registered Nurse (RN) #1 written statement dated 2-8-2026 identified a NA informed him at approximately 5 AM that Resident #1 was not in his/her room. Immediately he instituted room checking to all the facility again, no success. He then instructed outside searching, then Resident #1 was found on the sidewalk outside of the facility. Resident #1 was only responding to pain stimuli and blinking his/her eyes. Resident #1 was brought back to the facility and applied warm blanket. 911 was called and upon arrival Resident #1 was still unresponsive.Nursing note written by the Director of Nursing (DNS) dated 2-8-2026 at 1:05 PM identified Resident #1 was observed by the overnight shift not to be in his/her room upon rounding. Per supervisor, a search was done, and Resident #1 was located on the grounds outside and was immediately brought inside the building. Assessment was done, warm clothes and blanket provided. 911 was called. Per Emergency Medical Technician (EMT) report, Resident #1 was pronounced deceased at around 6:46 AM. Family, physician and police were notified.Review of local weather on 2-8-2026 at 1:53 AM identified the temperature at 1:53 AM was 1 degree Fahrenheit with a wind of 14 mph, and at 5:53 AM the temperature was 0 degrees F with a wind of 12 mph. Observation on 2-8-2026 at 2:10 PM identified a local police car in front of the building near the edge of the property with yellow tape around an area of the sidewalk and snow near the post office, and snow covered the ground. The sidewalk in front of the building along the street was shoveled to the approximate property line, the sidewalk along the driveway was shoveled, and snow on both sides of the sidewalk was approximately twenty (20) inches high. The pile of snow at the end of the shoveled sidewalk on the side closest to the building was taller than the approximate four (4) foot tall snow stake marking the edge of the sidewalk. The sidewalk beyond the property line was not shoveled.Interview and record review with the Administrator and DNS on 2-8-2026 at 2:22 PM identified Resident #1 had a history of dementia, ambulated independently with a walker, was a known wander risk, wore a wander guard bracelet, and had left the building without staff knowledge. Per staff, Resident #1 was last seen about 3:00 AM and was identified missing at about 4:45 AM. The NAs searched the two (2) nursing units before notifying the RN supervisor/RN #1. When NA #1 and NA #4 were unable to locate Resident #1 they notified RN #1 about 5 AM (approximately 30 minutes after NA #1 identified Resident #1 was missing). RN #1 then initiated a search inside the building and then directed an outside search when Resident #1 was not located. Staff found Resident #1 about 5:12 AM, lying on the sidewalk at the front of the building. RN #1 directed a staff member to bring a wheelchair outside, and Resident #1 was lifted into a wheelchair and was returned inside the building. Resident #1 was unresponsive, and staff then removed Resident #1's wet clothing, applied dry clothing and blankets and then called 911. The Administrator and DNS stated Resident #1 should not have been able to exit the building without staff knowledge, the NAs should have notified the nurse immediately when Resident #1 was identified missing, and 911 should have been called immediately after Resident #1 was found outside. Further, the facility had no video of the doors, and they did not know how Resident #1 got out of the facility. The Administrator stated the wander guard alarm sounded when Resident #1 was returned into the building. Observation and interview with the Administrator on 2-8-2026 at 3 PM identified the only door in the facility with a wander guard alarm was the double fire doors near the nurse's station that led to (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	the lobby. Observation identified an exit door at the end of the hallway near Resident #1's room that led to the hairdresser and dietary area identified the door had no alarm system to alert staff if a resident went through the door. Next to dietary, there was a hallway that led to an exit door, also with no alarms. Going through that door was a door that led to the outside. The outside door had a keypad code for the door and the required code to unlock the door was posted on the wall above the keypad. The Administrator stated the code was posted above the keypad for staff use. Pressing on the door, the door opened and alarmed. Entering back into the hallway identified the door alarm was not audible inside the hallway. The Administrator stated the alarm did not alert at the nurse's station to notify staff that the door was opened. The Administrator stated they did not know how Resident #1 exited the building, and that it was a potential that a resident could exit through that door without staff knowledge, however she did not think Resident #1 could have walked that far to exit the back of the building and then be found in the front of the building. Interview with the DNS on 2-8-2026 at 3:41 PM identified Resident #1 was wearing sneakers and socks, pajama long sleeve top and pajama pants when he/she was found on the sidewalk.Interview with the Director of Maintenance on 2-8-2025 at 3:41 PM identified he was aware the exit door by dietary had the required keypad code posted and stated it should not be posted, that he should have taken it down before. He stated the doors leading to that exit were not alarmed and the facility never had a resident exit out that door. He believed Resident #1 exited out the lobby door but was unable to say how Resident #1 was able to exit through the doors with the wander guard alarm system. He stated the doors were tested and functioning correctly and the door alarmed when Resident #1 was returned into the building.During an interview and record review with NA #1 on 2-9-2026 at 11:06 AM, NA #1 stated she observed Resident #1 in his/her bed at 1 AM and about 3:30 AM. NA #1 stated she identified Resident #1 missing about 4:35 or 4:45 AM and searched the unit with NA #3, and NA #3 notified RN #1. She then went to the back door near the kitchen with NA #4 and NA #4 searched the back parking lot. Then when she and NA #3 searched the front of the building, NA #3 located Resident #1 lying on his/her left side on the sidewalk in front of the building. Resident #1 was not moving, and his/her eyes were opening and closing. Resident #1 was wearing sneakers, socks, and pajamas, and his/her clothes were cold with ice on them. NA #1 stated she went into the building to get blankets, RN #1 brought a wheelchair and Resident #1 was returned inside the building and put into bed. The staff removed his/her clothes, dressed him/her in a johnny, and gave incontinent care, and tried to warm him/her up with warm blankets and towels with warm water, and RN #1 was running in and out of the room, and the only response was opening and closing his/her eyes. NA #1 stated when the ambulance came, they administered CPR. Interview and record review with RN #1 on 2-9-2026 at 9:34 AM identified he was notified about 5 AM that Resident #1 was missing, and staff had already searched the facility without telling him that she was missing. He stated Resident #1 was known to exit seek and that was why he/she had a wander guard and he directed a second search inside and then to search outside. RN #1 stated he thought Resident #1 could have gone out the back door. NA #1 told him that Resident #1 was found outside in front of the building. Resident #1 was brought back inside in a wheelchair, had no response to painful stimuli, only blinked his/her eyes, and had a pulse. No blood pressure was heard (recorded) on the blood pressure machine, a temperature was attempted to be obtained, and the thermometer read LOW and his/her pulse was between 20's and 30's. He stated he wanted to make sure they get warm blankets for hypothermia and people were emotional with the situation. RN #1 stated he did paperwork, then called the Administrator who conferenced in the Director of Nursing (DNS) and he told them he was going to send him/her to the hospital and then he called 911. RN #1 stated he was informed that he called 911 at 6:23 AM (1 hour (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	and 11 minutes after he/she was found outside). RN #1 stated he looked at Resident #1's code status, it was just me, and he looked to get help he needed and to call facility people above him, and to do an assessment. He wanted the DNS and Administrator, to make sure he informed them that we had an emergency. He had to assess Resident #1 first before calling 911. Review of thermometer manufacturer manual identified the thermometer reads LO if the temperature is less than 89.6 degrees Fahrenheit.Interview and record review with the DNS and Administrator on 2-9-2026 at 1:56 PM identified the DNS received a conference call from the administrator and RN #1 on 2-8-2026 at 6:08 AM (56 minutes after Resident #1 was found outside). The DNS stated that RN #1 indicated during the call that he had not called 911 because they were trying to get Resident #1 warm, and she directed RN #1 to call 911. Interview identified staff should have notified RN #1 immediately when Resident #1 was identified missing, and 911 should have been called immediately after Resident #1 was found. Review of EMS run sheet dated 2-8-2026 identified EMS was called at 6:23 AM and EMS initiated treatment of the resident at 6:35 AM for a question of a cold exposure out of the facility. On arrival with police on scene, Resident #1 was found unresponsive, pulseless, apneic (not breathing). Staff reported the resident had wandered out of the facility possible 30 minutes prior and found laying on the ground outside, not responding to staff, placed in a wheelchair and returned into facility and bed when 911 was called. EMS noted severely cold temperatures. Once confirmed pulseless, Resident #1 was transferred to a stretcher and CPR was initiated due to no CPR bed board available and unknow DNR (Do Not Resuscitate), monitor placed with pads, asystole (no pulse) on monitor, no lung or heart sounds, extremely cold to touch with thermometer reading LO. Nurse provided paperwork for DNR. EMS also noted lividity (discoloration of the skin due to pooled blood after death) on the left flank (between ribs and hips), left hand and knee with possible blistering from outside temperature and positioning. Pupils were fixed and non-reactive. No other traumatic injuries noted. EMS noted resident was in a hospital gown with adult depends on. Patient was extremely cold to the touch and pale along with the lividity on the left side. Patient presumed (death) at 6:46 AM.Observation of video obtained by local police identified a person (probable Resident #1) was observed at the back of the building near the rear parking lot at 1:50 AM (1 hour and 10 minutes before the NA documented that Resident #1 was alleged to be observed sleeping in his/her bed at 3 AM). The person came into view at the back corner of the building and walked along the side of the building past the main entrance toward the road. The person observed, appeared to be walking quickly, was upright (not stooped over), had no walker with them, and appeared to have no difficulty walking (no stumbling, weaving or unsteadiness). Continued observation identified when the person was nearing the front corner of the building (beyond the main facility entrance) near the road, his/her pace had slowed. Review of a second video obtained by local police identified the person appeared at the apron of the driveway at 1:55 AM (1 hour and 5 minutes before NA #1 documented Resident #1 was observed sleeping in his/her bed). The person was observed to hesitate near the road and then turned to his/her right and walked on the sidewalk in front of the building next to the road. The person's pace was slower, and there was snow along both sides of the sidewalk. As the person approached the property line, he/she stopped walking and at 1:57 AM, he/she bent down for a moment, then stood back upright and took a few steps forward. At 1:58 AM (1 hour and 2 minutes before NA #1 documented Resident #1 was sleeping in bed), the person was observed to fall face forward and extend both his/her hands out in front of him/her as he/she fell forward. There was no further movement observed on the video viewed. Continued review of video identified Resident #1 was still lying on the ground at the end of the sidewalk and two (2) people appeared at the apron of the driveway at 5:11 AM (3 hours and 21 minutes after Resident #1 was observed at the back of the (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	supervision assistance, ambulated independently with supervision, and had no wander/elopement alarm. Resident Care Plan dated 12-23-2025 identified Resident #2 wanders through out the hallway and into other rooms. Interventions directed to check wander guard every shift and as needed and to redirect into the hallway if found wandering in other resident's rooms. Elopement risk evaluation dated [DATE] identified Resident #2 ambulated independently, was cognitively impaired with poor decision-making skills and had a history of wandering into unsafe areas. Resident #3's diagnoses included dementia. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #3 had a Brief Interview for Mental Status (BIMS) score of six (6) of fifteen (15), indicating severe cognitive impairment, had no wandering behaviors, transferred with moderate assistance, ambulated independently with a wheelchair, and had wander/elopement alarm daily. Elopement risk evaluation dated 12-30-2025 identified Resident #3 ambulated independently, was cognitively impaired with poor decision-making skills and displayed behaviors that may indicate an attempt to leave.?? Resident Care Plan dated 1-22-2026 identified a risk for elopement. Interventions directed to check function and placement of wander guard every shift and daily. Resident #4 had diagnoses that included dementia. Significant change MDS dated [DATE] identified Resident #4 had a BIMS score of eight (8) indicating severe cognitive impairment and had no wandering behaviors in the prior seven (7) days, walked independently and used a wheelchair with independent mobility. Observation and interview with the Administrator on 2-8-2026 at 3:00 PM identified the only door in the facility with a wander guard alarm was the double fire doors near the nurse's station that led to the lobby. Observation identified an exit door at the end of the hallway near Resident #1's room that led to the hairdresser and dietary area identified the door had no alarm system to alert staff if a resident exited the unit and went through the door. Next to dietary, there was a hallway that led to an exit door, also with no alarms. Going through that door was a door that led to the outside. The outside door had a keypad code for the door and the required code to unlock the door, and the required code was posted on the wall above the keypad. The Administrator stated the code was posted above the keypad for staff use. Pressing on the door, the door opened and alarmed, and exited into the back parking lot. Entering back into the hallway (inside the inner door) identified the door alarm was not audible inside the hallway. The Administrator stated the alarm did not alert at the nurse's station to notify staff that the door had been opened. The Administrator stated they did not know how Resident #1 exited the building when he/she eloped on 2-8-2026. The Administrator stated it was a potential that a resident could exit through the exit door near dietary without staff knowledge, however she did not think Resident #1 could have walked that far to exit the back of the building and then be found in the front of the building. Continued observation identified the hallway near the front of the building identified an exit door that led to an enclosed courtyard. Observation of the door identified the door did not latch upon re-entry into the building and required several attempts to latch the door and then enter the code to reset the alarm. Observation of the dining room near the nurse's station identified a second door that led to the same courtyard. The door required a code to be entered to open the door. Observation of the door after it was opened identified the door did not lock when closed - it did not reactivate the lock. Interview with NA #5 and NA #6 who were present in the dining room at the time of the observation, identified the door had two (2) codes that could be entered. One (1) code would unlock the door and automatically relock it after the door was closed fully and relatched. The other code, which was the code the Administrator entered, unlocked the door and allowed for multiple entries/exits without relocking. Observation of the courtyard identified the courtyard was fenced in with two (2) gates in the fencing, both gates opened easily when a button was pushed and opened to the parking lot near the street. (continued on next page)

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F 0772 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have an agreement with an approved laboratory to obtain services, if on-site laboratory services aren't provided. Based on facility document review, policy review, and staff interview, the facility failed to maintain and provide a written agreement for laboratory services to ensure required laboratory services are available timely to meet resident needs. The findings include: Review of facility documentation failed to identify a written agreement or contract verifying arrangements with a Clinical Laboratory Improvement Amendments (CLIA)-certified laboratory for the provision of laboratory services when such services are not provided directly by the facility. Interview with the Administrator on 2-13-2026 at 5:00 PM identified she was unable to locate the requested laboratory services contract at the time of survey. The Administrator stated that due to a recent facility-wide evacuation, binders containing important documents were relocated; however, the requested agreement could not be produced. The facility was unable to provide documentation verifying how laboratory services are formally arranged and maintained in compliance with regulatory requirements.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075358	A. Building B. Wing	02/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bickford Health Care Center	14 Main Street Windsor Locks, CT 06096

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F 0776 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, approved x-ray services, or have an agreement with an approved provider to obtain them. Based on facility document review, policy review, and staff interview, the facility failed to maintain and provide a written agreement for radiology and other diagnostic services to ensure required diagnostic services were available timely to meet resident needs. The findings include: Review of facility documentation failed to produce a written agreement or contract verifying arrangements for radiology and other diagnostic services when such services are not provided directly by the facility. Interview with the Administrator on 2-13-2026 at 5:00 PM identified she was unable to locate the requested radiology services contract at the time of survey. The Administrator reported that due to a recent facility-wide evacuation, binders containing important documents were relocated; however, the requested agreement could not be produced. The facility was unable to provide documentation verifying how radiology and other diagnostic services are formally arranged and maintained in compliance with regulatory requirements.

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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. Based on facility document review, policy review, and staff interview, the facility failed to maintain and provide evidence of physician coverage available 24-hours per day for emergency care. The findings include: Review of facility documentation failed to produce a written agreement, contract, or other documentation verifying physician services are available 24-hours a day to respond to resident medical emergencies Interview with the Administrator on 2-13-2026 at 5:00 PM identified she was unable to provide documentation demonstrating how physician services are ensured on a 24-hour basis. The Administrator reported that due to a recent facility-wide evacuation, important binders were relocated; however, the requested documentation could not be produced at the time of survey. Additionally, the facility was unable to provide a policy or procedure outlining how 24-hour physician availability is arranged, maintained, and verified to ensure timely medical oversight during emergencies.

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F 0837 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. Based on facility document review, policy review, and staff interview, the facility failed to maintain and provide a written transfer agreement policy to ensure appropriate transfer arrangements with a hospital. The findings include: Review of facility documentation failed to produce a written transfer agreement policy outlining the facility's process for transferring residents to a hospital when medically necessary.Interview with the Administrator on 2-13-2026 at 5:00 PM identified she was unable to provide the requested transfer agreement policy at the time of survey. The Administrator reported that due to a recent facility-wide evacuation, binders containing important documents were relocated; however, the requested documentation could not be produced.Additionally, the facility was unable to provide evidence of a current written transfer agreement or documentation verifying formalized arrangements with a hospital to ensure timely transfer of residents requiring acute care services.

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F 0841 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Designate a physician to serve as medical director responsible for implementation of resident care policies and coordination of medical care in the facility. Based on facility document review, policy review, and staff interview, the facility failed to maintain and provide evidence of a written agreement designating a Medical Director responsible for implementation of resident care policies and coordination of medical care in the facility. The findings include:Review of facility records failed to produce a written contract or agreement verifying the appointment and ongoing contractual relationship between the facility and the Medical Director. Interview with the Administrator on 2-13-2026 at 5:00 PM identified she was unable to locate the Medical Director contract at the time of the survey. The Administrator reported the facility recently experienced a facility-wide evacuation during which important binders were relocated; however, the requested contract could not be produced. Additionally, the facility was unable to provide a policy or procedure outlining the process for maintaining, retaining, or ensuring accessibility of the Medical Director contract.

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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** Based on clinical record reviews, facility documentation, facility policy review and interviews for three of four residents (Resident #1, #2, and #3) reviewed for wandering behaviors, the facility failed to ensure the clinical record was complete and accurate to include rounds performed for resident location (Resident #1's care checks) and to accurately document the resident's (#1, #2, and #3) wander guard devices. The findings include: Resident #1's diagnoses included dementia. Elopement risk evaluation dated 11-24-2025 identified Resident #1 ambulated independently, was cognitively impaired with poor decision-making skills, made statements that he/she was leaving and displayed behaviors that may indicate an attempt to leave. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) score of ten (10) indicating moderate cognitive impairment, had no behaviors, transferred with moderate assistance, ambulated independently with supervision, and had no wander/elopement alarm. Physician order dated 1-15-2026 directed to check wander guard bracelet placement every shift and check function daily. The Resident Care Plan dated 1-31-2026 identified Resident #1 had a wander guard on the right ankle. Interventions directed to redirect if near doors to outside. Check functioning per protocol. ?? Physician order dated 1-31-2025 directed to check wander guard bracelet placement every shift and check function daily. Record review identified the physician order for wander guard use was reviewed with monthly physician order reviews, with the most recent dated of 1-15-2016. Review of the MAR/TAR (Medication and Treatment Administration Record) for the month of February 2026 identified the following:An order to check function of wander guard to left ankle once daily, RN #2 failed to document that this was performed on 2-2 and 2-4-2026.An order to check the placement of the wander guard to left ankle every shift, RN #2 failed to document that this was performed on 2-2 and 2-4-2026. Facility reportable event (RE) dated 2-8-2026 at 9:46 AM identified Resident #1 had a with diagnosis of dementia and history of wandering, was found outside of the building around 5:12 AM and was immediately brought back into the building. Nursing note written by the Director of Nursing (DNS) dated 2-8-2026 at 1:05 PM identified Resident #1 was observed by the overnight shift not to be in his/her room upon rounding. Per supervisor, a search was done, and Resident #1 was located on the grounds outside and was immediately brought inside the building. Assessment was done, warm clothes and blanket provided. 911 was called. Per Emergency Medical Technician (EMT) report, Resident #1 was pronounced deceased at around 6:46 AM. Family, physician and police were notified. Review of Nurse Aide (NA #1) Care Check Rounds Documentation (shift rounds) identified NA #1 indicated she observed Resident #1 asleep in his/her bed at 1:00 AM and again at 3:00 AM. Additional review of the rounds documentation identified NA #1 provided care, including turning and repositioining, for Resident #1's roommate (Resident #5) at 3:30 AM. NA #1 written statement dated 2-8-2026 identified about 1:30 AM she observed Resident #1 sleeping in bed and she placed the walker next to the bed so he/she could hold it if he/she got up. The statement indicated NA #1 saw Resident #1 again at 3:30-ish, sleeping in bed. Then about 4:30 AM, Resident #1 was not on his/her bed. The statement identified after searching the facility, Resident #1 was found outside laying on the sidewalk in front of the facility. During an interview and record review with NA #1 on 2-9-2026 at 11:06 AM, NA #1 stated she observed Resident #1 in his/her bed at 1 AM and again about 3:30 AM. Observation of video obtained by local police identified a person (probable Resident #1) was observed at the back of the building near the rear parking lot at 1:50 AM (1 hour and 10 minutes before the NA documented that Resident #1 was alleged to be observed sleeping in his/her bed at 3 AM). The person came into view at the back corner of the building (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and walked along the side of the building past the main entrance toward the road and then appeared at the apron of the driveway at 1:55 AM (1 hour and 5 minutes before NA #1 documented Resident #1 was observed sleeping in his/her bed). Additional video review identified staff located Resident #1 on the sidewalk in front of the building at 5:11 AM. Resident #2's diagnoses included Alzheimer's disease, dementia, and depression. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #2 had a Brief Interview for Mental Status (BIMS) score of ninety-nine (99) indicating Resident #2 was unable to complete the interview, and had severe cognitive impairment for daily decision making, had wandering behaviors daily, transferred with supervision assistance, ambulated independently with supervision, and had no wander/elopement alarm. Resident Care Plan dated 12-23-2025 identified Resident #2 wanders through out the hallway and into other rooms. Interventions directed to check wander guard every shift and as needed and to redirect into the hallway if found wandering in other resident's rooms. Elopement risk evaluation dated [DATE] identified Resident #2 ambulated independently, was cognitively impaired with poor decision-making skills and had a history of wandering into unsafe areas. Review of the MAR/TAR for the month of February 2026 identified the following:An order to check functioning of wander guard to left ankle once daily, RN #2 failed to document that this was performed on 2-2, 2-3, and 2-4-2026.An order to check placement of wander guard to left ankle every shift, RN #2 failed to document that this was performed on 2-2, and 2-4-2026. Resident #3's diagnoses included dementia. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #3 had a Brief Interview for Mental Status (BIMS) score of six (6) of fifteen (15), indicating severe cognitive impairment, had no wandering behaviors, transferred with moderate assistance, ambulated independently with a wheelchair, and had wander/elopement alarm daily. Elopement risk evaluation dated 12-30-2025 identified Resident #3 ambulated independently, was cognitively impaired with poor decision-making skills and displayed behaviors that may indicate an attempt to leave.?? Resident Care Plan dated 1-22-2026 identified a risk for elopement. Interventions directed to check function and placement of wander guard every shift and daily. Review of the MAR/TAR for the month of February 2026 identified the following:An order to check placement of wander guard to left ankle every shift, LPN #2 failed to document that this was performed on 2-3-2026, and LPN #3 failed to document the placement was checked on 2-5-2026.Additional review failed to identify a physician order was obtained to monitor the wander guard for placement every shift and to check the function daily. Interview and record review with the DON on 2-10-2026 at 3:30 PM identified it was her expectation that nursing staff document all areas of provided care that was performed. The DON stated that Resident #1, #2, and #3's documentation was incomplete/missing, and that the nursing staff should have ensured all areas were documented if performed. The DON stated orders should be obtained for all residents to check wander guard placement every shift and function daily, and the nurse should document when it is done. Interview failed to identify why they were not done. Interview failed to identify why NA #1 documented on 2-8-2026 that she observed Resident #1 asleep in his/her bed at 3 PM, when the video showed Resident #1 exited the facility at 1:50 AM. Review of a Documentation Policy dated 11/25 identified the facility will ensure nursing documentation is accurate, timely, complete, and reflective of the care provided.

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F 0843 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have an agreement with at least one or more hospitals certified by Medicare or Medicaid to make sure residents can be moved quickly to the hospital when they need medical care. Based on facility document review, policy review, and staff interview, the facility failed to maintain and provide a written transfer agreement policy to ensure appropriate transfer arrangements with a hospital. The findings include: Review of facility documentation failed to produce a written transfer agreement policy outlining the facility's process for transferring residents to a hospital when medically necessary.Interview with the Administrator on 2-13-2026 at 5:00 PM identified she was unable to provide the requested transfer agreement policy at the time of survey. The Administrator reported that due to a recent facility-wide evacuation, binders containing important documents were relocated; however, the requested documentation could not be produced.Additionally, the facility was unable to provide evidence of a current written transfer agreement or documentation verifying formalized arrangements with a hospital to ensure timely transfer of residents requiring acute care services.