STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105522	A. Building B. Wing	08/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lehigh Acres Healthcare & Rehab Center	1550 Lee Boulevard Lehigh Acres, FL 33936

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 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** 41905 Based on clinical record review, review of facility policies and procedures, resident representative and staff interviews, the facility failed to protect the residents' right to be free from neglect. The facility failed to re-evaluate the risk for elopement and implement adequate supervision to prevent unsafe wandering and elopement for 1 (Resident #1) of 3 sampled residents reviewed with severe cognitive impairment, confusion, and decreased safety awareness. Resident #1 was a vulnerable adult admitted to the facility on [DATE]. Diagnoses included Alzheimer's disease, cognitive communication deficit, and generalized muscle weakness. On 8/16/24, documentation in the nursing progress notes indicated Resident #1 was confused, wandering and said he wanted to go down the street to his house. The facility neglected to re-evaluate the risk for elopement and adequately supervise Resident #1. On 8/16/24 at approximately 7:30 p.m., Resident #1 was sitting in the front lobby with a bag of clothes on his shoulder. The receptionist neglected to verify the resident's identity. She unlocked the front door and allowed him to leave. The facility staff were not aware of the resident's exit until 8/16/24 at approximately 8:45 p.m. Resident #1 walked approximately 75 feet to a busy six lane road, got on a bus to Fort [NAME] located approximately 16 miles from the facility. Resident #1 could have been hit by a car while crossing the busy six lane road. He could have wandered into an unsafe area, get assaulted, causing serious injury or death. The facility's failure to provide the necessary care and services to prevent neglect created a likelihood of serious harm, serious injury, or death of Resident #1 and other cognitively impaired residents from unsafe wandering. This failure resulted in the determination of Immediate Jeopardy (IJ) at a scope and severity of Isolated (J) starting on 8/16/24. On 8/24/24, after verification of an acceptable Immediate Jeopardy removal plan, the Immediate Jeopardy was removed as of 8/24/24. The scope and severity were reduced to no actual harm with potential for more than minimal harm that is not Immediate Jeopardy. (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: 105522	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lehigh Acres Healthcare & Rehab Center	1550 Lee Boulevard Lehigh Acres, FL 33936

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The findings included: Cross reference F689. The facility's Standards and Guidelines for Abuse, Neglect and Exploitation revised on 11/1/2017 noted, It will be the standard of this facility [sic] honor residents' rights and to address with employees the seven (7) components regarding . neglect . Neglect is the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress . Training will focus on the following topics: Recognizing . neglect . The facility environment will be monitored to prevent any potential ANE [Abuse, Neglect, Exploitation] through: . Monitoring of residents with needs and behaviors that might lead to conflict . The facility's elopement policy revised August 2014 noted, The facility will strive to prevent unsafe wandering while maintaining the least restrictive environment for residents who are at risk for elopement . The staff will identify residents who are at risk for harm because of unsafe wandering or exit seeking (including elopement). Staff will utilize the Admission Nursing Comprehensive Evaluation to determine the residents risk for elopement . After the time of admission staff will utilize the Elopement evaluation as needed to determine the residents risk for elopement. The following are behaviors or changes in behavior that would require staff to re-evaluate a resident to determine their risk of Elopement. i. Resident expressing, he/she is looking to leave the facility . iii. Loitering around exit doors . The staff will assess at-risk individuals for potentially correctable risk factors related to unsafe wandering. The resident's care plan will indicate whether the resident is at risk for elopement or other safety issues. Interventions to try to maintain safety, such as a detailed monitoring plan will be included . Review of the clinical record revealed Resident #1 was admitted to the facility on [DATE] from an acute care hospital. Diagnoses included Alzheimer's disease and Dementia. The Admission Nursing Comprehensive evaluation dated 8/7/24 at 6:56 p.m., noted Resident #1 scored a 6 on the elopement risk evaluation indicating the resident was not at risk for elopement. The Licensed Nurse completing the assessment noted in History of elopement/wandering, Wanders, but has NEVER eloped. Resident #1 was totally or mostly dependent in locomotion, was discontent but agreeable to facility placement. The baseline care plan initiated on 8/8/24 documented Resident #1 had decreased cognitive skills related to cognitive/linguistic deficits and a potential for alteration in thought process related to diagnosis of dementia, Alzheimer's disease and altered mental status. The baseline care plan specified to observe Resident #1 for changes in cognitive function and notify the physician if noted. (continued on next page)

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 8/8/24 the Speech Language Pathologist checked the boxes in a therapy screen form indicating Resident #1 had a change in cognitive function, and a change in safety awareness/judgement in the section for The following changes in condition have been observed/reported. The Speech Language Pathologist documented Resident #1 scored a 03 on the Brief Interview for Mental Status assessment (used to evaluate a resident's cognition, behavior and mood), indicative of severe cognitive impairment. On 8/8/24 the Physical Therapist documented in an evaluation Resident #1 was able to ambulate 150 feet with minimal assistance. Resident #1's goal was, I want to go home. The Therapist documented the potential for achieving the goal was fair, limited by the resident's impaired cognition and safety awareness. Review of the progress notes revealed the Attending Physician assessed Resident #1 on 8/8/24, 8/9/24, 8/15/24, and 8/16/24. The physician documented during each visit, Cognitive impairment. Monitor for worsening symptoms or changes in mental status. On 8/15/24 the Psychiatrist documented Resident #1 had impaired cognition, confusion, restlessness, excessive worry, oriented to person only, poor insight, poor judgment, poor short term and long term memory. The Psychiatrist documented to monitor for mood and behavior. On 8/16/24 at 3:50 a.m., Licensed Practical Nurse (LPN) Staff A documented in a progress note, Pt [Patient] is alert with confusion. Pt wanders and doesn't know where he is, stated I am going down the street to my house. The clinical record lacked documentation the facility reevaluated the resident's risk for elopement and initiated adequate supervision to ensure the safety of the resident. On 8/16/24 at 10:00 p.m., LPN Staff B documented in a progress note Resident #1, was last seen sitting in the lobby at approximately 7:25 p.m. We [sic] was asked to go back to his room but he declined stating that he was fine where he was. Resident was calm and not agitated so he was left to lounge in the lobby. Elopement protocol followed; room search, 911 called, family notified, hospitals called to search for resident, facility searched. Review of the facility's investigation report dated 8/17/24 showed documentation Resident #1 was, his own person with no advance directives and no incapacity. On 8/16/24 at around 7:15 [p.m.] he was at the front lobby fully dressed and with a bag of clothes around his shoulder and then proceeded to walk out the front door when it opened and when asked by the receptionist if he was a visitor or resident/patient he stated he was a visitor and kept on going. Review of staff statements obtained as part of the investigation revealed: (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 8/16/24 LPN Staff B said at approximately 7:20 p.m., she observed Resident #1 walking toward the lobby. She was receiving report from the morning nurse. She told Certified Nursing Assistant (CNA) Staff C to ask Resident #1 to return to his room and continued to get report. On 8/16/24 at 7:30 p.m., CNA Staff D asked her in reference to resident. She advised the CNA that Resident #1 was walking in the hallway near his room. On 8/16/24 at 8:45 p.m., CNA Staff D informed her that Resident #1 was not in his room. They started to search for the resident and he, wasn't easily found. They notified the Nurse Manager. On 8/16/24 CNA Staff D wrote she was doing her rounds at 7:30 p.m. and notified the nurse that Resident #1 was not in his room. The nurse said, He is walking around. She continued to do her work. On 8/16/24 at 8:45 p.m., she went back to see if Resident #1 was in his room. She told the nurse the resident was not in his room, or in any room she was assigned to. She went outside the facility to look for the resident near a discount department store by the hospital. The receptionist wrote in an undated statement that on 8/16/24 at around 7:10 p.m., she noticed a gentleman taking a seat in the lobby. He was neatly dressed and had a bag over his shoulder that appeared to have clothes in it. She was tending to another gentleman who was signing out from visiting his mother. After about five minutes the gentleman (Resident #1) that was sitting in the chair casually got up and walked to the exit door with his bag over his shoulder. She had not seen this individual before. The way he was dressed, he looked like a visitor. As Resident #1 approached the door, she asked him if he was a resident or a visitor. He was not wearing any name band. He said he was a visitor and proceeded to walk out the door. She tried to get his attention to sign out. He kept walking and she did not call him to come back and sign out. She locked the door at 7:30 p.m. at the end of her shift. She received a call at approximately 9:00 p.m., to 9:30 p.m. asking about Resident #1. She told the facility she saw him go out and he stated he was a visitor. On 8/22/24 at 3:02 p.m., in a telephone interview the receptionist said she was working on the day Resident #1 eloped. She said around 7:20 p.m., she made the announcement for visitors to come to the front lobby since visiting hours were over at 7:30 p.m. She said at approximately 7:10 p.m., Resident #1 came and sat on a chair in the lobby. He looked like a visitor and had a large bag, the kind you would put clothes in. He looked like he was watching people leaving. She thought he was waiting for a ride. Resident #1 told her he was a visitor which she thought was kind of strange. He did not have a wrist band on. He got up slowly and walked toward the door. He exited the facility when she let another visitor out. The receptionist said they used to give visitors an orange sticker but it stopped during COVID. They started it again after Resident #1 eloped. On 8/22/24 at 3:33 p.m., in a telephone interview Resident #1's daughter said the case manager at the hospital told her the facility had a memory care unit. She found out when her father got to the facility that they did not. She wanted him safe in a memory unit. She voiced her concern to the nurse who told her they monitor their residents all the time. She said her father took a bus and got dropped off in a downtown area (approximately 16 miles from the facility) and was found sitting outside of a bar. He had no identification on and would not know his address. She said Resident #1 was currently at a different skilled nursing facility in a secured memory unit. On 8/22/24 at 5:30 p.m., in an interview the Administrator said on 8/16/24 Resident #1's family was with him the whole day on 8/16/24 and he did not display unsafe wandering or exit seeking behaviors. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 8/23/24 at 10:22 a.m., in a telephone interview LPN Staff A said on 8/15/24 she worked from 7:00 p.m., to 7:00 a.m., on 8/16/24. She said that night Resident #1 was very confused. She documented in a progress note that he was wandering and he walked pretty well. When he got into bed, he did not remove his shoes. She told the oncoming nurse about the resident's wandering and expressing desire to leave the facility to go down the street to his house. He did not know where he was so she didn't think he really knew if he lived down the street. LPN Staff A said Resident #1 was not safe to leave the facility unsupervised. She said she should have placed a wander alarm band (alerts staff when a resident leaves a safe area) on him. She said if she had done that, the alarm would have gone off and Resident #1 would not have left. She said on 8/16/24 at 7:00 a.m., when she gave report to the oncoming nurse, Resident #1 was again sitting in the front lobby. On 8/23/24 at 11:05 a.m., in an interview the Speech Language Pathologist (SLP) said he evaluated Resident #1 on 8/8/24 and saw him three times during his stay. He clearly was cognitively impaired. His orientation was pretty bad, His BIMS was 03. He was not safe to leave the facility unsupervised. He was a lot better physically than cognitively. His orientation, decision making, and short term memory were severely impaired. He would not trust him to go to the convenience store nearby by himself because he would not come back. The SLP said Resident #1 kept saying he wanted to go home. He said, What made this resident's situation unsafe is the fact that he was very confused but very mobile. On 8/23/24 at 11:07 a.m., in a telephone interview the Psychiatrist said on 8/15/24 when she assessed Resident #1, he was very depressed, crying and confused. He could not give much information. The information was obtained from the daughter and hospital notes. He did not know where he was and was very confused. He was cognitively impaired. He was not safe to walk out, he was not safe to catch the bus and was not able to make his own decisions. She saw the consent for treatment form that was signed by the wife and thought Resident #1 had an existing incapacity. She thought the wife was the power of attorney. The facility did not ask her to write an incapacity statement. The psychiatrist repeated Resident #1 could not be out on his own. On 8/23/24 at 11:49 a.m., in an interview the Physical Therapy Assistant said Resident #1 was confused but hid it well. He said he was almost afraid to make the resident better physically due to his severe cognitive impairment. That would predispose Resident #1 to get into dangerous situations. He could leave the facility, go into the wrong building, and get into dangerous situations. He would not be able to make the right decision for anything such as walking in the middle of the street, going into the wrong building. Resident #1 kept saying he wanted to go home. He was not safe to leave the facility unsupervised. On 8/23/24 at 2:00 p.m., in an interview the Attending Physician said anything bad could have happened to the resident. He was not safe the leave the facility unsupervised and could have been seriously harmed. She said it was a blessing that his defibrillator (implanted device that sends electric shock to the heart to restore normal rhythm) went off and he went to the hospital. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the emergency room (ER) Physician's progress note dated 8/17/24 showed documentation Resident #1 was at the nursing facility in [NAME] when he eloped from the nursing facility, got on a bus and went to a bar. He was a silver alert (Public notification system to help locate missing people 60 or older). They were in the process of trying to find him with helicopters, police dogs, personnel search when his defibrillator fired. EMS was called for his chest pain which is when they located him. The physician wrote, On bedside physical exam he is awake he follows commands he is confused he knows the year not the month or time of year. He believes he is in Maine. He cannot remember what state he currently lives in. In the medical decision making of the progress note the ER Physician documented, Medical hold was placed on his chart as he is a flight risk and he did try to elope from the emergency department. After verification of implementation of an acceptable Immediate Jeopardy removal plan, the Immediate Jeopardy was removed as of 8/24/24. The Immediate actions implemented by the facility and verified by the survey team included: On 8/17/2024 an ad hoc (unplanned) QAPI (Quality Assurance and Performance Improvement) meeting was held, and a root cause analysis of the incident was done. Attendees of the QAPI included the Medical Director, Director of Nursing, Administrator, Human Resources, Social Service, Activities, Therapy Director, Minimum Data Set nurse, Nurse, CNA. The Licensed Nurses neglected to assess Resident #1 with severe cognitive impairment, confusion and decreased safety awareness to prevent unsafe wandering and elopement. The receptionist neglected to verify the identity of Resident #1 before allowing him to leave the facility. On 8/24/24 the surveyor verified through review of the QAPI meeting. On 8/17/2024 the DON completed an audit of all 119 current residents to ensure each resident is receiving the appropriate care and services to prevent neglect focusing on adequate assessment and supervision of residents with severe cognitive impairments, confusion and decrease safety awareness to prevent unsafe wandering and elopement. 43 residents were identified with a BIMs score below 13. All 43 residents were reviewed to ensure each resident is receiving appropriate care and services to prevent neglect. On 8/24/24 the surveyor verified through review of the audits completed and review of two randomly selected residents with impaired cognition for evidence of adequate assessment and supervision. One resident was identified to be at risk of unsafe wandering and elopement. The care plan was updated to ensure the safety of the residents. Resident was placed in the elopement binder and elopement binder was updated to reflect current elopement risk residents. There are 4 binders in the facility. One is at the receptionist desk and one on each of the three nursing stations in the facility. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 8/24/24 the surveyor verified through observation and content of the four binders with one resident identified at risk for unsafe wandering and elopement. On 8/17/2024 the DON initiated education of all staff on abuse, neglect and exploitation, focusing on adequate supervision to ensure the safety of cognitively impaired residents to prevent unsafe wandering and elopement. As of 8/24/2024, 45 of 53 Licensed nurses, 49 of 54 Certified Nursing Assistants, 17 of 17 Therapists, 3 of 3 receptionists and 42 of 47 staff from other departments completed their education. Knowledge verification was done through a posttest. Any staff who has not completed the education will be required to complete the required training prior to the start of their next shift. On 8/24/24 the surveyor verified through review of the training provided. On 8/24/24, one receptionist, six licensed nurses and three CNAs were interviewed. They were able to verbalize content of training and process to identify and ensure adequate supervision of cognitively impaired residents to prevent unsafe wandering and elopement. On 8/23/24 the DON initiated the education with the Licensed Nurses on prevention of neglect of cognitively impaired residents by ensuring accurate assessment and adequate supervision to prevent unsafe wandering and elopement. As of 8/24/24, 28 of the 53 Licensed Nurses received education. The remaining 25 Licensed Nurses will be educated before their next shift begins. On 8/24/24 the surveyor verified through review of the content of education provided and interview with six licensed nurses. Each nurse was able to verbalize the content of the education on neglect prevention by ensuring accurate assessment and adequate supervision to prevent unsafe wandering and elopement. The DON/Designee will audit the clinical record of new admissions and random residents to ensure appropriate care and services are provided to prevent neglect. On 8/24/24 the surveyor verified through interview with the DON and review of audits completed, and review of two random residents records to ensure accurate assessment and interventions to prevent neglect related to unsafe wandering and elopement.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 21322 Based on record review, review of facility's policies and procedures, and staff interviews, the facility failed to ensure an allegation of neglect was reported to the State Survey Agency within the prescribed timeframe for 1 (Resident #1) of 3 residents reviewed. The findings included: Review of the facility's Standards and Guidelines for Abuse, Neglect and Exploitation investigations with a revised date of 11/1/2017 noted, All allegations of . neglect . are to be reported immediately to the Administrator and according to Federal and State Regulations . The facility will . file the Federal Immediate Report to the State Agency (if applicable). A 5 Day Follow-up Federal Report must be submitted within 5 days of the event occurring or when the Facility was made aware of the allegation . Review of the facility's incident investigations showed on 8/16/24 at around 7:30 p.m., Resident #1 with a diagnosis of Alzheimer's disease and mild cognitive impairment eloped from the facility. The preliminary report was submitted to the State Survey Agency on 8/20/24, four days after the facility became aware of the allegation of neglect related to the resident's elopement. The 5 Day follow up report was submitted to the State Survey Agency on 8/23/24, seven days after the facility became aware of the allegation of neglect. On 8/23/24 at approximately 1:30 p.m., in an interview the Administrator verified the report was not submitted within the required time frame.

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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** 41905 Based on clinical record review, review of facility's policies and procedures, resident representative and staff interviews the facility failed to recognize risk factors for elopement and adequately supervise 1 (Resident #1) of 3 sampled residents with severe cognitive impairment, confusion, wandering behavior and poor safety awareness who expressed desire to leave the facility. On 8/16/24 at approximately 7:30 p.m., Resident #1 who was confused, wandered, and voiced desire to leave the facility sat in the front lobby with a bag of clothes. The receptionist unlocked the door to the front lobby and allowed the resident to leave the facility without verifying his identity. The facility staff were not aware of the resident's exit until 8/16/24 at approximately 8:45 p.m. Resident #1 walked approximately 75 feet to a busy six lane road, got on a bus to Fort [NAME] located approximately 16 miles from the facility. Resident #1 was at a bar, complained of chest pain and was transported to a local emergency room via Emergency Medical Services and admitted to the hospital. The facility failure to implement adequate supervision to prevent unsafe wandering and elopement of cognitively impaired, and confused residents created a likelihood of avoidable accidents for Resident #1 and other cognitively impaired and confused residents at risk for elopement which could result in serious harm, serious injury, serious impairment or death of the residents. This failure resulted in the determination of Immediate Jeopardy. On 8/24/24 after verification of an acceptable removal plan, the immediate Jeopardy was removed as of 8/24/24. The scope and severity were reduced to no actual harm with potential for more than minimal harm (D) that is not Immediate Jeopardy. The findings included: Cross reference to F600. The facility's elopement policy revised August 2014 noted, The facility will strive to prevent unsafe wandering while maintaining the least restrictive environment for residents who are at risk for elopement . The staff will identify residents who are at risk for harm because of unsafe wandering or exit seeking (including elopement). Staff will utilize the Admission Nursing Comprehensive Evaluation to determine the residents risk for elopement . After the time of admission staff will utilize the Elopement evaluation as needed to determine the residents risk for elopement. The following are behaviors or changes in behavior that would require staff to re-evaluate a resident to determine their risk of Elopement. i. Resident expressing, he/she is looking to leave the facility . (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	iii. Loitering around exit doors . The staff will assess at-risk individuals for potentially correctable risk factors related to unsafe wandering. The resident's care plan will indicate whether the resident is at risk for elopement or other safety issues. Interventions to try to maintain safety, such as a detailed monitoring plan will be included . Review of the clinical record revealed Resident #1 was a vulnerable [AGE] year-old male admitted to the facility from an acute care hospital on 8/7/24. Diagnoses included Dementia and Alzheimer's disease. On 8/7/24 the Licensed Practical Nurse documented in an elopement risk evaluation Resident #1 scored a 6 on the elopement risk evaluation indicating he was not at risk for elopement. The resident was alert and oriented X 1 (Oriented to person) or had periodic confusion. Resident #1 wandered but has never eloped. Resident #1 was discontent but agreeable to facility placement. The Admission Comprehensive Nursing Evaluation with an effective date of 8/7/24 noted Resident #1 was alert with some confusion. The resident's balance while standing, sitting and during transitions was not steady but Resident #1 was able to stabilize self without assistance. The baseline care plan initiated on 8/8/24 documented Resident #1 had decreased cognitive skills related to cognitive/linguistic deficits and a potential for alteration in thought process related to diagnosis of dementia, Alzheimer's disease and altered mental status. The baseline care plan specified to observe Resident #1 for changes in cognitive function and notify the physician if noted. On 8/8/24 the Speech Language Pathologist (SLP) checked the boxes in a therapy screen form indicating Resident #1 had a change in cognitive function, and safety awareness/judgment. The SLP noted the resident's cognition was severely impaired with a score of 03 on the Brief Interview for Mental Status assessment (used to evaluate a resident's cognition, behavior and mood). On 8/8/24 the Physical Therapist (PT) documented in an evaluation Resident #1 was able to ambulate 150 feet with minimal assistance. Resident #1's goal was, I want to go home. The PT documented the potential for achieving the goal was fair, limited by the resident's impaired cognition and safety awareness. Review of the progress notes revealed the Attending Physician assessed Resident #1 on 8/8/24, 8/9/24, 8/15/24, and 8/16/24. The physician documented during each visit the resident's cognition was impaired and, Monitor for worsening symptoms or changes in mental status. On 8/15/24 the Psychiatrist documented Resident #1 was referred for an evaluation for Depression and anxiety. The resident's daughter reported he has been showing sundowning behavior (confusion that occurs in the late afternoon and lasts into the night) with more anxiety specially at nighttime. The psychiatrist documented, Cognitive impairment, Confusion. Resident #1's insight, judgment, short-term, and long-term memory were poor. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The treatment plan noted to monitor for changes in mood or behaviors. On 8/16/24 at 3:50 a.m., Licensed Practical Nurse (LPN) Staff A documented in a progress note, Pt [Patient] is alert with confusion. Pt wanders and doesn't know where he is, stated, I am going down the street to my house. Patient in bed with call light within reach and bed in lowest position. Care ongoing. The clinical record lacked documentation LPN Staff A communicated the change in behavior to the interdisciplinary team, reevaluated the resident's risk for elopement and initiated adequate supervision to ensure the safety of the resident. Review of the Medication Administration Record for August 2024 showed documentation on 8/16/24 Resident #1 received his scheduled 5:00 p.m. medications. Review of the Certified Nursing Assistant (CNA) documentation for 8/16/24 showed the last entry was at 5:22 p.m., for eating. No other progress note was found in the clinical record for 8/16/24 addressing the resident's confusion with wandering behavior and voiced desire to leave the facility. On 8/16/24 at 10:00 p.m., LPN Staff B documented in a progress note Resident #1, was last seen sitting in the lobby at approximately 7:25 p.m. We [sic] was asked to go back to his room but he declined stating that he was fine where he was. Resident was calm and not agitated so he was left to lounge in the lobby. Elopement protocol followed; room search, 911 called, family notified, hospitals called to search for resident, facility searched. The clinical record lacked documentation Resident #1 was adequately supervised to prevent unsafe wandering and elopement while sitting in the lobby. Review of the facility's investigation report dated 8/17/24 showed documentation Resident #1 was, his own person with no advance directives and no incapacity. On 8/16/24 at around 7:15 [p.m.] he was at the front lobby fully dressed and with a bag of clothes around his shoulder and then proceeded to walk out the front door when it opened and when asked by the receptionist if he was a visitor or resident/patient he stated he was a visitor and kept on going. On 8/16/24 LPN Staff B documented in a statement at approximately 7:20 p.m., she observed Resident #1 walking toward the lobby. She was receiving report from the morning nurse. She told Certified Nursing Assistant (CNA) Staff C to ask Resident #1 to return to his room and continued to get report. On 8/16/24 at 7:30 p.m., CNA Staff D asked her in reference to resident. She advised the CNA that Resident #1 was walking in the hallway near his room. On 8/16/24 at 8:45 p.m., CNA Staff D informed her that Resident #1 was not in his room. They started to search for the resident and he, wasn't easily found. They notified the Nurse Manager. The clinical record lacked documentation staff coordinated with the receptionist and adequately supervised Resident #1while he was sitting in the front lobby. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of the undated statement by the receptionist documented that on 8/16/24 at around 7:10 p.m., she noticed a gentleman taking a seat in the lobby. He was neatly dressed and had a bag over his shoulder that appeared to have clothes in it. She was tending to another gentleman who was signing out from visiting his mother. After about five minutes the gentleman (Resident #1) that was sitting in the chair casually got up and walked to the exit door with his bag over his shoulder. She had not seen this individual before. The way he was dressed, he looked like a visitor. As Resident #1 approached the door, she asked him if he was a resident or a visitor. He was not wearing any name band. He said he was a visitor and proceeded to walk out the door. She tried to get his attention to sign out. He kept walking and she did not call him to come back and sign out. She locked the door at 7:30 p.m. at the end of her shift. She received a call at approximately 9:00 p. m., to 9:30 p.m. asking about Resident #1. She told the facility she saw him go out and he stated he was a visitor. On 8/22/24 at 3:02 p.m., in a telephone interview the receptionist said she was working on the day Resident #1 eloped. She said around 7:20 p.m., she made the announcement for visitors to come to the front lobby since visiting hours were over at 7:30 p.m. She said at approximately 7:10 p.m., Resident #1 came and sat on a chair in the lobby. He looked like a visitor and had a large bag, the kind you would put clothes in. He looked like he was watching people leaving. She thought he was waiting for a ride. Resident #1 told her he was a visitor which she thought was kind of strange. He did not have a wrist band on. He got up slowly and walked toward the door. He exited the facility when she let another visitor out. On 8/22/24 at 3:33 p.m., in a telephone interview Resident #1's daughter said the case manager at the hospital told her the facility had a memory care unit. She found out when her father got to the facility that they did not. She wanted him safe in a memory unit. She voiced her concern to the nurse who told her they monitor their residents all the time. She said her father took a bus and got dropped off in a downtown area (approximately 16 miles from the facility) and was found sitting outside of a bar. He had no identification on and would not know his address. She said Resident #1 was currently at a different skilled nursing facility in a secured memory unit. On 8/23/24 at 10:22 a.m., in a telephone interview LPN Staff A said on 8/15/24 she worked from 7:00 p.m., to 7:00 a.m. She said that night Resident #1 was very confused. She documented in a progress note that he was wandering and he walked pretty well. When he got into bed, he did not remove his shoes. He did not know where he was so she didn't think he really knew if he lived down the street. LPN Staff A said Resident #1 was not safe to leave the facility unsupervised. She said she should have placed a wander alarm band (alerts staff when a resident leaves a safe area) on him. She said if she had done that, the alarm would have gone off and Resident #1 would not have left. She said on 8/16/24 at 7:00 a.m., she gave report to the oncoming nurse and told her about the resident's exit seeking behavior during the night. She said Resident #1 was already sitting in the front lobby while she gave report to the oncoming nurse. On 8/23/24 at 11:05 a.m., in an interview the SLP said he evaluated Resident #1 on 8/8/24 and saw him three times during his stay. He clearly was cognitively impaired. His orientation was pretty bad. He was not safe to leave the facility unsupervised. He was a lot better physically than cognitively. His orientation, decision making, and short term memory were severely impaired. He would not trust him to go to the convenience store nearby by himself because he would not come back. The SLP said Resident #1 kept saying he wanted to go home. He said, What made this resident's situation unsafe is the fact that he was very confused but very mobile. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 8/23/24 at 11:07 a.m., in a telephone interview the Psychiatrist said on 8/15/24 when she assessed Resident #1, he was very depressed, crying and confused. He could not give much information. The information was obtained from the daughter and hospital notes. He did not know where he was and was very confused. He was cognitively impaired. He was not safe to walk out, he was not safe to catch the bus and was not able to make his own decisions. She saw the consent for treatment form that was signed by the wife and thought Resident #1 had an existing incapacity. She thought the wife was the power of attorney. The facility did not ask her to write an incapacity statement. The psychiatrist repeated Resident #1 could not be out on his own. On 8/23/24 at 11:49 a.m., in an interview the Physical Therapy Assistant said Resident #1 was confused but hid it well, he was in his own world. He said he was almost afraid to make the resident better physically due to his severe cognitive impairment. That would predispose Resident #1 to get into dangerous situations. He could leave the facility, go into the wrong building, and get into dangerous situations. He would not be able to make the right decision for anything such as walking in the middle of the street, going into the wrong building. Resident #1 kept saying he wanted to go home. He was not safe to leave the facility unsupervised. The therapist said Resident #1 was definitely able to walk about 300 feet. He said when he got tired, he would start staggering and go back onto his heels and that would put him at risk for falls. On 8/23/24 at 1:15 p.m., in an interview the Administrator said the SLP and the PTA did not report their concerns to him. He said he was not aware the PTA was almost afraid to make him physically better due to his severe cognitive impairment. On 8/23/24 at 2:00 p.m., in an interview the Attending Physician said anything bad could have happened to the resident. He was not safe the leave the facility unsupervised and could have been seriously harmed. She said it was a blessing that his defibrillator (implanted device that sends electric shock to the heart to restore normal rhythm) went off and he went to the hospital. After verification of implementation of an acceptable Immediate Jeopardy removal plan, the Immediate Jeopardy was removed as of 8/24/24. The Immediate actions implemented by the facility and verified by the survey team included: On 8/16/2024 Resident #1 was admitted to the hospital and has not returned to the facility. On 8/24/24 the surveyor verified through review of the facility census, and review of Resident #1's clinical record On 8/17/2024 an ad hoc (unplanned) QAPI (Quality Assurance and Performance Improvement) meeting was done, and a root cause analysis of the incident was conducted. Attendees of the QAPI meeting included the medical director, Director of Nursing, Administrator, Human Resources, Social Service, Activities, Therapy director, MDS (Minimum Data Set) coordinator, Nurse, and CNA. The receptionist did not follow facility protocol and failed to verify the identity of Resident #1, opened the door and allowed the resident to leave On 8/16/2024 Resident #1 was confused, wandering and voiced desire to leave the facility. The Licensed Nurse failed to implement adequate supervision to ensure the safety of the resident. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 8/24/24 the surveyor verified through review of the Ad Hoc QAPI meeting and root cause analysis. On 8/17/2024 the DON (Director of Nursing) completed an audit with 119 current residents, focusing on accuracy of elopement risk. One resident was identified as at risk of elopement and the care plan was updated to ensure their safety. Resident was placed in the elopement binder and elopement binder was updated to reflect current elopement risk residents. There are 4 binders in the facility. One is at the receptionist desk and one on each of the three nursing stations in the facility. On 8/24/24 the surveyor verified through review of the audit and review of the audit completed, and review of two randomly selected residents with impaired cognition for evidence of accurate elopement risk assessment, care plan and adequate supervision. The surveyor verified the location and information in the four elopement binders. On 8/17/2024 the facility initiated a new process for visitors: The front lobby door of the facility will remain locked. On 8/23/24 and 8/24/24 random observations showed the front lobby door of the facility remained locked. Visitors must press the doorbell and receptionist unlocks the door. All visitors will sign the visitor log and will be provided with a visitor badge. On 8/23/24 and 8/24/24 random observation of visitors entering the facility showed the receptionist provided each visitor with a visitor's badge and made sure each visitor signed the visitor's log. All visitors will be required to sign out and turn in visitors' identification before exiting. On 8/23/24 and 8/24/24 random observation of visitors leaving the facility showed the receptionist made sure each visitor signed out and returned the visitor's badge before unlocking the door. The identity of any person without a visitors' badge will be verified prior to leaving the facility. On 8/24/24 at 6:15 p.m., in an interview the receptionist on duty was able to verbalize the process to verify the identity of anyone leaving the facility who did not have a visitor's badge. The receptionist had a resident's list which is updated with new admissions daily. She would ask for an identification and compare with the resident's list. She also said she would call the nurse in charge before allowing anyone without a badge to leave. On 8/24/24 at approximately 6:18 p.m., LPN Staff C and Unit Manager, Registered Nurse (RN) Staff D were able to describe the new visitation process. RN Staff D said one of the attending physicians also requires staff to call him before any of his residents leave the facility. On 8/24/24 five additional licensed nurses and three CNAs were interviewed and able to describe the process for visitors. All CNAs said they do not open the door for anyone who wishes to leave the facility after 7:30 p.m. when the receptionist leaves. They would call the nurse. The nurse would make sure the visitor signs out and returns the badge. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 8/17/2024 the Administrator started education with the three receptionists on the new process for visitors. As of 8/19/2024, all three receptionists were educated before their shifts began. Competency was verified through observation of the three receptionists implementing the new procedures for signing visitors in and out of the facility. On 8/24/24 the surveyor verified through review of the education provided by the Administrator. On 8/24/24 at 6:15 p.m., the receptionist on duty confirmed she received education related to the updated visitation policy and was able to describe the process. The receptionist was observed following the process to let visitors in and out of the facility. The receptionists leave at 7:30 p.m After 7:30 p.m., the licensed nurses are responsible for letting visitors in and out of the facility. Starting on 8/17/2024 the DON/Designee educated the licensed nurses on the new process for visitors. As of 8/23/2024 45 of the 53 licensed nurses received education on the new process, including all 14 licensed nurses who work the night shift (7:00 pm to 7:00 am). Competency was verified through verbalization of the process and written post education questionnaire. On 8/24/24 the surveyor verified through review of the education provided. On 8/24/24 six licensed nurses were interviewed. All six nurses verified they received training on the updated visitation policy and were able to describe the process. The DON/Designee will educate the remaining 8 nurses on the new visitors' process prior to the start of their shift. On 8/24/24 the surveyor verified through interview with the Director of Nursing. As of 8/17/2024, the Administrator or designee will conduct an audit of the visitors log to ensure staff (Receptionist and Licensed nurses) are following the processes. On 8/24/24 the surveyor verified through review of the audit completed and observation of the visitor's log. As of 8/17/2024 each visitor received a copy of the new process for visitor badge and signing in and out of the facility. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 8/24/24 at 6:15 p.m., the surveyor verified through interview of the receptionist on duty. The receptionist was observed providing visitors a memo signed by the Administrator describing the name badge process. The instructions included, You must turn in your Visitor Badge when you sign out prior to exiting the facility. If you do not have a Visitor Badge when you are exiting the facility staff will not be allowed to open the exit door until they have verified that you are a Visitor and not a resident of the facility. As of 8/17/2024 the Licensed Nurses, Certified Nursing Assistants, and Therapists were assigned a comprehensive online training module that covered elopement prevention, elopement evaluation, identifying change in behavior, including wandering, verbalization of wanting to leave the facility and immediate interventions to ensure the safety of the residents. The understanding of the training was verified through a posttest evaluation. Upon completion of the training and passing the posttest a certificate was issued. As of 8/23/2024 45 of the 53 Licensed nurses, 49 of the 54 Certified Nursing Assistants and 17 of the 17 Therapists completed the training and received the certificate. The remaining licensed personnel will receive the training and complete the posttest before their next shift begins. On 8/24/24 the surveyor verified through review of the training provided. On 8/24/24 six licensed nurses and three CNAs were interviewed and were able to describe the content of the training. On 8/23/2024, the DON initiated additional training for the licensed nurse on identifying changes in cognition, recognizing behaviors that may lead to elopement, unsafe wandering, and need to complete an elopement evaluation, and update the care plan in the electronic health record to ensure the safety of the resident. As of 8/24/2024, 28 of 53 Licensed Nurses were educated. The remaining Licensed nurses will be educated before their next shift starts. On 8/24/24 six licensed nurses were interviewed and were able to verbalize content of the training and immediate actions to ensure the safety of cognitively impaired residents with behaviors that may lead to elopement. Elopement Drills are conducted at least once per shift every month. Post incident Elopement drill was conducted on 8/24/2024 to ensure process is followed and will continue until all staff have participated. On 8/24/24 the surveyor verified through review of the elopement drill completed on 8/24/24.

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F 0843 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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. 41905 Based on record review and staff interview, the facility failed to have a written transfer agreement in effect with one or more hospitals approved for participation under the Medicaid and Medicare programs. The findings included: Review of the facility's assessment tool showed the facility had an agreement with multiple entities to allow for a smooth operation. The agreements did not include a transfer agreement with one or more hospitals approved for participation under the Medicare and Medicaid programs. On 8/24/24 at 3:47 p.m., in an interview the Assistant Director of Nursing said the facility did not have an existing transfer agreement with a hospital. On 8/24/24 at 4:49 p.m., in an interview the administrator verified the facility did not have an existing transfer agreement with one or more hospitals approved for participation under the Medicare and Medicaid programs.