STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105525	A. Building B. Wing	02/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Manatee Springs Rehabilitation and Nursing Center	5627 9th St E Bradenton, FL 34203

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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	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 observations, interviews, and record review, the facility failed to protect the resident's right to be free from neglect by failing to respond to an exit door alarm and provide supervision to prevent an elopement for one resident (#2) out of residents sampled. On 1/15/26 at approximately 2:30 a.m., Resident #2 exited the facility, unwitnessed by staff, through a second-floor stairwell door with an audible alarm sounding. The resident walked down two flights of stairs and exited to the back of the facility through a second alarmed door sounding. Resident #2 walked approximately 170 yards through a parking lot, across a four-lane road with a 40 mile per hour (mph) speed limit, and into a neighborhood where he was found by local police. Resident #2 sustained a left forehead laceration and left elbow skin tear as a result of a fall. The resident was taken to the local hospital for treatment by Emergency Medical Services (EMS). Resident #2 was missing from the facility for approximately two hours without staff knowledge. This failure created a situation that resulted in a worsened condition and the likelihood for serious injury and/or death to Resident #2 and resulted in the determination of Immediate Jeopardy on 1/15/26. The findings of Immediate Jeopardy were determined to be removed on 2/4/26 and the severity and scope was reduced to a D after verification of removal of immediacy of harm. Cross reference to F689 and F726. Findings included: A review of Resident #2's admission Record revealed an admission date of 12/18/25 with diagnoses to include dementia, falls, muscle weakness, lack of coordination, psychotic disorder with hallucinations, depression, and delusional disorder. A review of Resident #2's Minimum Data Set (MDS) assessment, dated 1/7/26, under section C - cognitive patterns, revealed a Brief Interview of Mental Status (BIMS) score of 6, indicating severe cognitive impairment. A review of Resident #2's Physician orders revealed the following:- Olanzapine oral tablet 7.5 MG [milligram] (Olanzapine) Give 1 tablet by mouth one time a day related to unspecified dementia, unspecified severity, with psychotic disturbance, with an order date of 1/14/26. A review of Resident #2's Care Plan revealed the following:- Resident is at risk for elopement related to Cognitive Impairment. see dxs. [diagnoses] Date Initiated: 12/19/2025., with interventions to include, Consult psychiatric and/ or psychology services as needed. Date Initiated: 12/19/2025, Maintain current phone and demographics information of the resident in the appropriate designated areas per protocol/ policy. Date Initiated: 12/19/2025, Notify other departments of resident's risk for elopement and wandering behavior. Date Initiated: 12/19/2025, Use verbal cues and distraction techniques to minimize exit seeking behavior. Date Initiated: 12/19/2025. - COGNITION: The resident has impaired cognitive function/dementia or impaired thought processes r/t [related to] Short term memory problem, Impaired decision making, see dxs. Date Initiated: 01/08/2026. A review of Resident #2's elopement risk assessments showed on 12/19/25 a score of 19 (a score of 12 or more means at risk for exit seeking, elopement, wandering), on 1/5/26 the assessment score was 10. A review of Resident #2's progress notes revealed the following:- 1/2/26, A BIMS assessment was completed for (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

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	asked why he did not respond to the alarm on 1/15/26, he said he thought it was another malfunctioning door. On 2/2/26 at 4:27 p.m., a telephone interview was conducted with Staff E, LPN. Staff E, LPN said on 1/15/26 at approximately 3:00 a.m. being in a resident's room. Staff E, said Staff D, CNA, Resident #2's assigned CNA, was taking a 30-minute break when the resident exited the facility. She stated, Nobody saw him [Resident #2] leave. She said she was not sure if another CNA was supposed to take over when the assigned CNA was on a break. Staff E, LPN stated, I did not check that and [Staff D, CNA] did let me know he was going on break. Staff E, LPN said she heard an alarm; it was a noise she did not recognize and did not know where it was coming from. She recalled the alarm sounding for a few minutes. She stated, I didn't know what was going on. She said she received a call from Staff A, LPN, who was on the first floor, that a resident exited through a door. Staff E, LPN said she thought the police were called by Staff A, LPN. Staff E, LPN thinks Resident #2 hurt his face or head but confirmed not observing him when he returned to the facility. Staff E, LPN said she last saw Resident #2 at 2:00 a.m. on 1/15/26. She said when she heard a resident was missing, she completed a count of the residents and called Staff A, LPN. Staff E, LPN stated she heard, He got out of a kitchen door that was not secure. She said Staff D, CNA went downstairs when Resident #2 returned. She said Staff A, LPN immediately sent Resident #2 to the hospital as he had an abrasion on his face. Staff E, LPN stated she was panicking and, Everything went really fast. She said she never completed elopement drills, was not aware of the sound of the alarmed door, and felt she was not provided the proper training. Staff E, LPN stated, He should have been on precautions,15-minute checks, and 1:1. Staff E, LPN said she had constant issues with him and was worried about keeping him safe. She stated, He was a major fall risk, he constantly tried to get up, was extremely confused and wandered. Staff E, LPN said Resident #2 could stand and walk around but was not steady on his feet. She said he did not express he wanted to leave. Staff E, LPN said she did not inform the DON of her concerns, but spoke to Staff A, LPN who was aware of his behaviors before the elopement. She said Staff D, CNA, was also aware of Resident #2's behaviors. On 2/3/26 at 10:59 a.m., a telephone interview was conducted with Staff F, CNA. She said on 1/15/26 at 4:30 a.m., she walked up to the nurse's station on the first floor and saw law enforcement knocking on the door. Staff F, CNA said they told her they found a man wandering across the street and asked if he was a resident at the facility. Staff F, CNA said she took the law enforcement officer to the supervisor who was Staff A, LPN. Staff F stated it was, Storming really bad that night. She said shortly after that, the paramedics arrived at the facility with Resident #2. She said she went outside with Staff A, LPN and another CNA to see if they could bring Resident #2 into the facility. Staff F, CNA observed a cut on the resident's eye and said Staff A, LPN thought it was best he went to the hospital to be evaluated. Staff F, CNA said she worked on the first floor and did not hear any door alarms that morning. She said she recalled maintenance staff was there at approximately 3:30 a.m., to turn off the door alarm. Staff F, CNA said she asked Staff A, LPN, if everything was okay after seeing the maintenance staff. Staff F, CNA said Staff A, LPN told her the door alarm had malfunctioned. She said where she was assigned, she did not hear the door alarm by the therapy hallway exit stairwell. She said she did not know Resident #2 eloped until law enforcement came to the facility. On 2/3/26 at 11:13 a.m., an interview was conducted with Staff G, Maintenance Assistant (MA). Staff G, MA said on 1/15/16 at approximately 2:30 a.m., he received a call from Staff A, LPN who told him she could not get the door to reset, and it malfunctioned. Staff G, MA said Staff A, LPN had the code, tried the code, but the door was still alarming. He confirmed he could hear the alarm over the phone. He said at approximately 2:45 to 2:50 a.m. he arrived at the facility. He said he went directly to the alarming door which was by the therapy gym. Staff (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	to his left eyebrow. Staff A, LPN asked EMS to transport the resident to the hospital for treatment and evaluation. Staff A, LPN asked all staff 11 p.m. -7 a.m. to write witness statements. A review of the facility policy titled Abuse Policy - Prevention and Management, with a revised date of 9/8/22, revealed the following: POLICYThe Facility prohibits the mistreatment, neglect, and abuse of residents/patients and misappropriation/exploitation of resident/patient property by anyone including staff, family, friends, visitors, etc. The Facility has designed and implemented processes, which strive to ensure the prevention and reporting of suspected or alleged resident/patient abuse, neglect, mistreatment, and/or misappropriation/exploitation of property. The facility must provide a safe resident environment and protect residents from abuse., PROTOCOL . The Shift Supervisor is identified as responsible for immediate initiation of the reporting process . Neglect Failure of the Facility, its employees or service providers to provide goods and services necessary to avoid physical harm, pain, mental anguish, or emotional distress. Neglect occurs when the facility is aware of, or should have been aware of, goods or services that a resident(s) requires but the facility fails to provide them to the resident(s), that has resulted in or may result in physical harm, pain, mental anguish, or emotional distress. Neglect includes cases where the facility's indifference or disregard for resident care, comfort or safety, resulted in or could have resulted in physical harm, pain, mental anguish, or emotional distress. Neglect may be the result of a pattern of failures or may be the result of one or more failures involving one resident and one staff person. Training - Continued . Understanding behavioral symptoms of residents that may increase the risk of abuse and neglect and how to respond. These symptoms include, but are not limited to, the following:Aggressive and/or catastrophic reactions of residents;Wandering or elopement-type behaviors;Resistance to care;Outbursts or yelling out; andDifficulty in adjusting to new routines or staff. The facility's immediate actions to remove the Immediate Jeopardy included: A review of Resident #2's Physician orders revealed the following:- 1:1 [one to one] supervision with staff at all times due to elopement risk. every shift for safety, with an order date of 1/15/26.- May only go out on LOA [leave of absence] with responsible party, with an order date of 1/15/26.- Resident #2's care plan was updated: Family assisting with resident placement to secured unit. Date Initiated: 01/15/2026, Provide resident with 1:1 companion as needed to decrease risk of achieving exit. Date Initiated: 01/15/2026- On 1/15/26, assigned nursing supervisor and assigned nurse received immediate education, by ADON, related to responding to alarming doors and searching immediate surroundings, doing a head count with alarming doors, notifying the DON timely of elopement of residents. Same nurse supervisor and assigned CNA was suspended pending investigation.- Ad hoc quality assurance (QA) regarding elopement with Administrator, DON, ADON, [NAME] President (VP) of Clinical Operations, and Medical Director held via conference call on 1/15/26. Quality assurance performance improvement (QAPI) continued daily, on weekdays, through 1/30/26 discussing with the IDT-current audit tools and compliance, evaluation of performance indicators in care and service areas specifically related to response to alarming doors, elopement drills, performing a head count and prevention of neglect related to elopement.- On 1/15/26, the DON, ADON, and Administrator received education, via telephone, from the VP of Clinical Operations related to the elopement, policies affected, alarming doors, head count, assessments, care plans, head count, risk management reports, reporting to the agency for healthcare administration (AHCA), elopement drills, elopement audits, QAPI, hourly head count, investigation advisement, and ongoing education and monitoring required.- Department heads were in-serviced on responding to alarming doors and checking the surrounding areas to visually ensure area is secure by the Maintenance Director on 1/15/26. 100% completed.- Abuse and neglect policy education initiated with all current staff, especially pertaining to neglect (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	and the facility's responsibility to maintain a safe environment, prevention and specifically what action should be taken when a door alarm sounds, searching surrounding area and performing a head count. Initiated on 1/15/26 by the DON to department heads.- On 1/15/26, designated department heads in-serviced assigned staff on responding to alarming doors and checking the surrounding areas to visually ensure area is secure and performing a head count; neglect and elopement policy related to prevention and response: 100% all staff. 70% all roster received in-service and completed competency on 1/15/26 (education/competency daily and every shift education to all staff in facility, and those not scheduled, on 1/15-1/23/26 until 100% of all roster staff completed).- Elopement drills on every shift 1/16/26-1/18/26 and then random weekly drills performed by the DON/ADON/Designee.- Elopement education audits started 1/17/26, continued daily, then continue to be done on random shift, daily by DON/ADON/Designee.- Elopement risk reassessment completed for all residents on 1/15/26 by ADON, clinical unit managers and DON. No additional elopement risks were identified.- Care plans for residents at risk for elopement were reviewed on 1/15/26 by DON. No concerns were identified for current care plan focus or interventions for those identified to be at risk for elopement.- Elopement binder was reviewed for accuracy on 1/15/26 by DON. No concerns were identified with the elopement binder.- Audit of all current residents' leave of absence (LOA) orders in electronic health system performed on 1/15/26 by DON, ADON and unit managers. No concerns with LOA orders identified.- On 1/15/26 and daily through 1/22/26- routine operation of door monitors for alarming function check was performed for alarm functioning at all exit doors, by the Director of Maintenance.- On 1/27/26, exit alarms tested by third party independent contractor. No concerns identified.- On 2/3/26, CE-4 (policy number) Elopement Prevention Policy was updated by the Regional Clinical Consultant. Policy reviewed with IDT on 2/3/26 in ad hoc QAPI governed by Regional Clinical Consultant and re-issued to all departments, education provisions provided to all staff.- On 2/3/26, In-servicing related to the updated CE-4 Elopement Prevention Policy began with current staff in the facility. 100% in-house staff in-serviced.- Emergency in-servicing education related to responding to all alarming doors and treating as potential resident elopement and performing a head count. Only maintenance can identify a malfunctioning door alarm, and maintenance will

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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 observations, interviews, and record review, the facility failed to respond to two exit door alarms and provide adequate supervision to prevent one resident (#2), who was severely cognitively impaired and identified as a fall and elopement risk, from exiting the facility out of four residents sampled for risk of elopement. On 1/15/26 at approximately 2:30 a.m., Resident #2 exited the facility, unwitnessed by staff, through a second-floor stairwell door with an audible alarm sounding. The resident walked down two flights of stairs and exited to the back of the facility through a second alarmed door sounding. Resident #2 walked approximately 170 yards through a parking lot, across a four-lane road with a 40 mile per hour (mph) speed limit, and into a neighborhood where he was found by local police. Resident #2 sustained a left forehead laceration and left elbow skin tear as a result of a fall. The resident was taken to the local hospital for treatment by Emergency Medical Services (EMS). Resident #2 was missing from the facility for approximately two hours without staff knowledge. This failure created a situation that resulted in a worsened condition and the likelihood for serious injury and/or death to Resident #2 and resulted in the determination of Immediate Jeopardy on 1/15/26. The findings of Immediate Jeopardy were determined to be removed on 2/4/26 and the severity and scope was reduced to a D after verification of removal of immediacy of harm. Cross reference to F600 and F726.Findings included: Findings included: A review of Resident #2's admission Record revealed an admission date of 12/18/25 with diagnoses to include dementia, falls, muscle weakness, lack of coordination, psychotic disorder with hallucinations, depression, and delusional disorder. A review of Resident #2's Minimum Data Set (MDS) assessment, dated 1/7/26, under section C - cognitive patterns, revealed a Brief Interview of Mental Status (BIMS) score of 6, indicating severe cognitive impairment. A review of Resident #2's Physician orders revealed the following:- Duloxetine HCl [hydrochloric acid] Oral Capsule Delayed Release Particles 20 MG (Duloxetine HCl) Give 1 capsule by mouth one time a day related to depression, unspecified, with an order date of 1/1/26.- Meclizine HCl Oral Tablet 25 MG (Meclizine HCl) Give 1 tablet by mouth every 12 hours as needed for dizziness, with an order date of 12/31/25.- Olanzapine oral tablet 2.5 MG (Olanzapine) Give 1 tablet by mouth in the morning related to unspecified dementia, unspecified severity, with other behavioral disturbance, with an order date of 1/8/26. - Olanzapine oral tablet 7.5 MG (Olanzapine) Give 1 tablet by mouth one time a day related to unspecified dementia, unspecified severity, with psychotic disturbance, with an order date of 1/14/26. A review of Resident #2's Care Plan revealed the following:- MY FALLS: I am at risk for falls related to impaired cognition/ poor safety awareness, Afib [atrial fibrillation]/pacemaker, myasthenia gravis, h/o [history of] fall, use of psychotropic meds [medications], hydrocephalus. Date Initiated: 12/18/2025.- Resident is at risk for elopement related to Cognitive Impairment. see dxs. [diagnoses] Date Initiated: 12/19/2025., with interventions to include, Consult psychiatric and/ or psychology services as needed.Date Initiated: 12/19/2025, Maintain current phone and demographics information of the resident in the appropriate designated areas per protocol/ policy. Date Initiated: 12/19/2025, Notify other departments of resident's risk for elopement and wandering behavior. Date Initiated: 12/19/2025, Use verbal cues and distraction techniques to minimize exit seeking behavior. Date Initiated: 12/19/2025.- MY MOOD DISORDER: I have a diagnosis of depression, dementia with psychotic features/delusions. I take daily medications to help me feel better and stabilize my mood. Date Initiated: 01/01/2026.- Resident takes an anticoagulant medication secondary to Atrial Fibrillation Date Initiated: 01/01/2026.- COGNITION: The resident has impaired cognitive function/dementia or impaired thought processes r/t [related to] Short term memory problem, Impaired decision (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	making, see dxs. Date Initiated: 01/08/2026. A review of Resident #2's Fall Risk Assessments, dated 12/19/25, 12/31/25, and 1/13/26, showed six or more questions were answered, Yes, which indicated Resident #2 was at high risk for falls based on the scoring criteria. A review of Resident #2's Elopement Risk Assessments showed on 12/19/25 a score of 19 (a score of 12 or more means at risk for exit seeking, elopement, wandering), on 1/5/26 the assessment score was 10. A review of Resident #2's Progress Notes revealed the following:- 1/2/26, A BIMS assessment was completed for [Resident #2] with a score of 6.0 indicating resident is Severe Impairment. Refer to assessment for more information.- 1/6/26 . [Resident #2] is an [personal health information (PHI)] who was admitted to [hospital name] from 12/19/2025 through 12/30/2025 following a witnessed mechanical fall at [facility name]. The patient reportedly fell while attempting to sit in a chair, which moved, resulting in a fall with impact to the left elbow and head, without loss of consciousness. He sustained a small skin tear to the left elbow. He was recently discharged on December 18 after hospitalization for self-harm concerns, during which he was treated with Olanzapine 5 mg nightly and Duloxetine, and subsequently discharged to skilled nursing care. On evaluation, he remained confused and disoriented x3, consistent with baseline dementia, and unable to provide a reliable history . He was independent with functional mobility and gait using a single-point cane (SPC) and managed indoor mobility without difficulty. Prior to his hospital re-admission, the patient was on the physical therapy caseload at this facility on 12/19/25,during which he required contact guard assistance for bed mobility, transfers, and gait using a rolling walker. His friend reported that his [family member] plans to transition him to an assisted living facility with memory care . History of: Dementia with Paranoid Delusions-Behavioral medications, redirection,rehabilitation nursing. Acute Interventions as warranted. Monitor closely for medication side effects and safety. 8. Precautions/Barriers: Confusion, fall risk, and elopement risk.- 1/8/26, Staff reports resident continues to wander, impulsive and agitated, concern for safety. Currently taking Olanzapine 5mg at bedtime, start Olanzapine 2.5mg in AM [morning] and monitor for effectiveness.- 1/8/26 . Readmission, sent to ER [emergency room] after fall and hitting head History of Present Illness: [PHI] seen for readmission to the facility after being sent to the hospital for a falling and hitting head while on blood thinners. Per hospital records CT [computed tomography] of brain normal but WBC [white blood cells] were elevated and treated for a UTI [urinary tract infection]. Resident has dementia and unable to provide any information but denies pain, headache or dizziness. unspecified dementia, unspecified severity, with psychotic disturbance Continue olanzapine 5mg h.s [every night at bedtime] Staff will continue to redirect resident and re-orient as needed . unspecified fall, subsequent encounter Staff will perform frequent checks for safety, resident unable to remember to call for help due to dementia.- 1/13/26, Resident alert with confusion, but able to make needs known. Vital signs WNL [within normal limits]. The resident has tried to get up multiple times but is very unstable, resident redirected multiple times to sit down and not get up by himself.- 1/13/26, .Resident continues to wander and become agitated, difficult to redirect . [PHI] seen today for staff reports that since return from the hospital he continues to be impulsive in his actions, becomes agitated and wanders aimlessly in the halls even with his Olanzapine. Staff states he is difficult to redirect and concerned about his safety. Resident unable to provide information due to cognition. unspecified dementia, unspecified severity, with psychotic disturbance Start Olanzapine 2.5mg in the morning and monitor for effectiveness Continue Olanzapine 5mg h.s . unsteadiness on feet will continue with therapy as ordered and staff will assist resident with transfers and mobility .- 1/14/26, Resident alert with confusion, but able to make needs known. The resident has tried to get up multiple times but is very unstable, resident redirected multiple times to sit down and not get (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Manatee Springs Rehabilitation and Nursing Center	5627 9th St E Bradenton, FL 34203

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	called code purple to notify the staff to initiate a head account. The DON said on 1/15/26 the Director of Plant Operations checked every exit door for malfunction and did not find any concerns. The NHA said before Resident #2 eloped, the doors were checked weekly and documentation supported the door had not malfunctioned in the weeks prior to the elopement. On 2/2/26 from 1:02 p.m. to 1:17 p.m., a re-enactment of Resident #2 exiting the facility was conducted with the DON, RNC, and the Director of Plant Operations. The RNC was observed at Resident #2's room on the second floor. She said his room is five doors away from the nurse's station. The Director of Plant Operations showed a camera pointed at the exit door by the nurse's station. He confirmed the camera did not point towards the resident hallways. The RNC and DON said Resident #2 did not exit the door next to the wound care nurse's office, which was closest to the resident's room. The Director of Plant Operations pointed out a speaker on the ceiling in front of the wound care nurse's office and facing the elevator towards the therapy gym. He said it was installed prior to Resident #2's elopement and it was loud. The RNC said Resident #2 walked past the elevator in front of the therapy gym to the exit door in Zone 6 by the therapy hall. A, Do not enter, sign was observed hanging to the right side of the exit door. The Director of Plant Operations said the sign is typically across the door. He confirmed there are flashing lights on the exit doors, which indicated what door was alarming. The RNC and Director of Plant Operations said the resident walked down two flights of stairs to the first floor exit door towards the back of the facility. The Director of Plant Operations said there was a red screamer on the first floor exit door when Resident #2 eloped. He said the red screamer was louder, but after approximately 10 to 15 minutes it self-terminated. He said the first-floor staff would have heard the alarm on 1/15/26 if they were by that door. The RNC said Resident #1 exited towards the back of the facility that faced the back parking lot. A paved path was observed from the back to the front of the building. The DON and RNC said Resident #2 crossed a four-lane street and walked to one of the homes where he knocked on the window. An observation of the four-lane street revealed a sign showing a speed limit of 40 mph. The DON stated Resident #2 told her he, Went through a jungle, and thought it was one of the houses with many trees. The house observed had multiple overgrown trees with debris and furniture items on the ground. Photographic evidence obtained during the tour. On 2/2/26 at 1:24 p.m., an interview was conducted with the Director of Plant Operations. He said the video footage cannot be rolled back, and it cleared after 24 hours. He said he viewed the video footage as soon as he was made aware of the event. The Director of Plant Operations said he arrived at the facility on 1/15/26 at 4:00 a.m., which was his typical schedule. He stated that morning, Nobody said a word to me, including Staff A, LPN who he saw when he arrived. He said Staff G, Maintenance Assistant was called to the facility because of the alarm that was activated by the therapy hall exit door. He said Staff G, Maintenance Assistant told him Staff A, LPN did not know how to reset the alarm, and she thought it was another door alarming. He stated he spoke to Staff A, LPN on Monday, 1/12/26 about the code for the doors. The Director of Plant Operations said he showed her on Monday the door flashes when opened, as well as the speaker he installed which faced the therapy hall. He stated, Staff A, LPN knew how to reset the doors. He said when he heard a resident eloped, after he completed his rounds that morning, he reviewed the video footage. He stated he observed an older gentleman walking down the therapy hallway, Wearing parachute pants and he had a limp. He stated the resident did not have a walker or wheelchair. He said Resident #2 was holding on to the railing as he walked down the hall. The Director of Plant Operations observed Resident #2 lean on the door and the alarm went off at approximately 2:32 a.m. according to the tape time. He stated he heard, Exit now exit now, then the door opened and closed. He stated, Anything can happen at that stairwell. The Director of Plant (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Operations stated he could hear staff talking and a resident was heard saying, Shut that off, and a door slammed. He said he heard both the first and second floor alarms. The Director of Plant Operations said he observed Staff A, LPN go to the elevator, push the button, and go inside the elevator. He stated there were no cameras outside or in the stairwell. He said as he watched the footage, he hoped staff would go to door, but he did not see any staff respond. The Director of Operations said he stopped watching the footage about 20 minutes after the alarm sounded. A review of the facility's Logbook documentation with task name check operation of door monitors and patient wandering system, showed for the week of 1/11/26 to 1/15/26 all the doors on the second floor passed. On 2/3/26 at 9:24 a.m., a phone interview was conducted with Staff D, CNA. He said on 1/15/26 he informed Staff E, LPN, he was going on break. He confirmed Resident #2 was assigned to him that night. Staff D, CNA checked on Resident #2 before going on break and said he was asleep in bed. He said about 10 to 15 minutes into his break, he received a call from Staff A, LPN, who asked him if he knew how to turn off the alarm. Staff D, CNA said Staff A, LPN assumed it was a malfunctioning alarm. He stated he felt like she was calling in a Nonchalant way. He said he did not recall the approximate time he received a call from Staff A, LPN or when he returned, but he was on break for about 30 to 35 minutes. He said he returned from his break, answered multiple call lights, and recalled the alarm was still sounding. Staff D, CNA stated, I don't remember checking [Resident #2's] room when he returned from his break. He said later on in his shift he sat at the nurse's station and watched the hallway. Staff A, LPN called again and told him Resident #2 was found by the police. He said he told Staff E, LPN and went downstairs. Staff D, CNA said he observed the resident who had bruises around his eye and was cold and wet. He stated, It was raining that night. Staff D, CNA said he recalled the alarm door malfunctioning a week prior to Resident #2's elopement. He said the supervisor did not initiate the elopement protocol at that time and Staff D, CNA did not check on his residents. Staff D, CNA said he recalled the DON and the Maintenance staff being called when the alarm malfunctioned a week before. He said Staff A, LPN did not know the code at that time. He stated, Everyone was like, how do you turn it off? He said Resident #2 was able to get in his wheelchair and walk a little. Staff D, CNA stated, He should have been 1:1, as he would get out of the bed and his wheelchair. He said he would have to re-direct him to the chair or the bed. He said when they had a resident like that, the person was typically 1:1. He stated, Administration knew this, workers knew this, we all kept an eye on him as best as we could. When asked why he did not respond to the alarm on 1/15/26, he said he thought it was another malfunctioning door. On 2/2/26 at 4:27 p.m., a telephone interview was conducted with Staff E, LPN. She said on 1/15/26 at approximately 3:00 a.m. she was in a resident's room. She said Staff D, CNA, Resident #2's assigned CNA, was taking a 30-minute break when the resident exited the facility. She stated, Nobody saw him [Resident #2] leave. She said she was not sure if another CNA was supposed to take over when the assigned CNA was on a break. Staff E, LPN stated, I did not check that and [Staff D, CNA] did let me know he was going on break. She said she heard an alarm; it was a noise she did not recognize and did not know where it was coming from. She recalled the alarm sounding for a few minutes. She stated, I didn't know what was going on. She said she received a call from Staff A, LPN, who was on the first floor, that a resident exited through a door. Staff E, LPN said she thought the police were called by Staff A, LPN. She thinks Resident #2 hurt his face or head but confirmed she did not observe him when he returned to the facility. Staff E, LPN said she last saw Resident #2 at 2:00 a.m. on 1/15/26. She said when she heard a resident was missing, she completed a count of the residents and called Staff A, LPN. Staff E, LPN stated she heard, He got out of a kitchen door that was not secure. She said Staff D, CNA went downstairs when Resident #2 returned. She (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	said Staff A, LPN immediately sent Resident #2 to the hospital as he had an abrasion on his face. Staff E, LPN stated she was panicking and, Everything went really fast. She said she never completed elopement drills, was not aware of the sound of the alarmed door, and felt she was not provided the proper training. She stated, He should have been on precautions,15-minute checks, and 1:1. Staff E, LPN said she had constant issues with him and was worried about keeping him safe. She stated, He was a major fall risk, he constantly tried to get up, was extremely confused and wandered. Staff E, LPN said Resident #2 could stand and walk around but was not steady on his feet. Staff E, LPN said she did not inform the DON of her concerns, but spoke to Staff A, LPN who was aware of his behaviors before the elopement. She said Staff D, CNA, was also aware of Resident #2's behaviors. On 2/3/26 at 10:55 a.m., a follow-up interview was conducted with the Director of Plant Operations. He said the door that goes out to the smoking patio and a door, used only by staff, have had some issues. The Director of Plant Operations confirmed he came to the facility on Monday, 1/12/26, before Resident #2 eloped to assist/re-educate Staff A, LPN on how to turn the door alarm off. He said he did not document when he gets called to the facility. He said he documented in the electronic system that showed tasks where maintenance is needed/completed. He said there have been no recent door malfunctions documented in the electronic system. On 2/3/2

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure nursing staff were knowledgeable and competent to provide care and services to prevent an elopement for one resident (#2) out of four sampled residents when they failed to respond to exit door alarms. On 1/15/26 at approximately 2:30 a.m., Resident #2 exited the facility, unwitnessed by staff, through a second-floor stairwell door with an audible alarm sounding. The resident walked down two flights of stairs and exited to the back of the facility through a second alarmed door sounding. Resident #2 walked approximately 170 yards through a parking lot, across a four-lane road with a 40 mile per hour (mph) speed limit, and into a neighborhood where he was found by local police. Resident #2 sustained a left forehead laceration and left elbow skin tear as a result of a fall. The resident was taken to the local hospital for treatment by Emergency Medical Services (EMS). Resident #2 was missing from the facility for approximately two hours without staff knowledge. This failure created a situation that resulted in a worsened condition and the likelihood for serious injury and/or death to Resident #2 and resulted in the determination of Immediate Jeopardy on 1/15/26. The findings of Immediate Jeopardy were determined to be removed on 2/4/26 and the severity and scope was reduced to a D after verification of removal of immediacy of harm. Cross reference to F600 and F689.Findings included: A review of Resident #2's admission Record revealed an admission date of 12/18/25 with diagnoses to include dementia, falls, muscle weakness, lack of coordination, psychotic disorder with hallucinations, depression, and delusional disorder. A review of Resident #2's Minimum Data Set (MDS) assessment, dated 1/7/26, under section C - cognitive patterns, revealed a Brief Interview of Mental Status (BIMS) score of 6, indicating severe cognitive impairment. A review of Resident #2's Physician orders revealed the following:- 1:1 [one to one] supervision with staff at all times due to elopement risk. every shift for safety, with an order date of 1/15/26.- May only go out on LOA [leave of absence] with responsible party, with an order date of 1/15/26. A review of Resident #2's Care Plan revealed the following:- Resident is at risk for elopement related to Cognitive Impairment. see dxs. [diagnoses] Date Initiated: 12/19/2025., with interventions to include, Consult psychiatric and/ or psychology services as needed.Date Initiated: 12/19/2025 Family assisting with resident placement to secured unit. Date Initiated: 01/15/2026 Maintain current phone and demographics information of the resident in the appropriate designated areas per protocol/ policy. Date Initiated: 12/19/2025 Notify other departments of resident's risk for elopement and wandering behavior. Date Initiated: 12/19/2025 Provide resident with 1:1 companion as needed to decrease risk of achieving exit. Date Initiated: 01/15/2026 Use verbal cues and distraction techniques to minimize exit seeking behavior. Date Initiated: 12/19/2025.- COGNITION: The resident has impaired cognitive function/dementia or impaired thought processes r/t [related to] Short term memory problem, Impaired decision making, see dxs. Date Initiated: 01/08/2026. A review of Resident #2's elopement risk assessments showed on 12/19/25 a score of 19 (a score of 12 or more means at risk for exit seeking, elopement, wandering), on 1/5/26 the assessment score was 10, and on 1/15/26 the assessment score was 26. A review of Resident #2's progress notes revealed the following:- 1/2/26, A BIMS assessment was completed for [Resident #2] with a score of 6.0 indicating resident is Severe Impairment . Refer to assessment for more information.- 1/6/26 . [Resident #2] is an [personal health information (PHI)] who was admitted to [hospital name] from 12/19/2025 through 12/30/2025 following a witnessed mechanical fall at [facility name]. The patient reportedly fell while attempting to sit in a chair, which moved, resulting in a fall with impact to the left elbow and head, without loss of consciousness. He sustained a small skin tear to (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	the left elbow. He was recently discharged on December 18 after hospitalization for self-harm concerns, during which he was treated with olanzapine 5 mg nightly and duloxetine, and subsequently discharged to skilled nursing care. On evaluation, he remained confused and disoriented 3, consistent with baseline dementia, and unable to provide a reliable history . He was independent with functional mobility and gait using a single-point cane (SPC) and managed indoor mobility without difficulty. Prior to his hospital readmission, the patient was on the physical therapy caseload at this facility on 12/19/25,during which he required contact guard assistance for bed mobility, transfers, and gait using a rolling walker. His friend reported that his [family member] plans to transition him to an assisted living facility with memory care . History of: Dementia with Paranoid Delusions- Behavioral medications, redirection,rehabilitation nursing. Acute Interventions as warranted. Monitor closely for medication side effects and safety. 8. Precautions/Barriers: Confusion, fall risk, and elopement risk.- 1/8/26, Staff reports resident continues to wander, impulsive and agitated, concern for safety. Currently taking olanzapine 5mg at bedtime, start Olanzapine 2.5mg in AM [morning] and monitor for effectiveness.- 1/13/26, .Resident continues to wander and become agitated, difficult to redirect . [PHI] seen today for staff reports that since return from the hospital he continues to be impulsive in his actions, becomes agitated and wanders aimlessly in the halls even with his Olanzapine. Staff states he is difficult to redirect and concerned about his safety. Resident unable to provide information due to cognition. unspecified dementia, unspecified severity, with psychotic disturbance Start Olanzapine 2.5mg in the morning and monitor for effectiveness Continue Olanzapine 5mg qhs . unsteadiness on feet will continue with therapy as ordered and staff will assist resident with transfers and mobility . A review of Resident #2's emergency room records from 1/15/26 revealed the following:- .Reg Dt/Tm [registration date/time] 01/15/2026 05:29 . Disch [discharge] Dt/Tm: 01/15/2026 11:39 . Admit Reason: fall . History source: Patient, EMS [emergency medical services]. Arrival mode: Ambulance. Chief Complaint from Nursing Triage Note: 1/15/2026 5:46 EST [eastern standard time] Chief Complaint EMS from outside of [facility name] due to a ground level fall with head injury. Patient missing from facility approx. [approximately] 2hours before being found. [Local law enforcement] has been called and is investigating. The patient presents following fall. The onset was unknown. The occurrence was unknown. Location: Left head. Associated symptoms: none. Patient brought in after a fall. Unknown details but reportedly fall within past two hours. Patient was from memory care unit andapparently was missing for period of time and had a fall. EMS brought him in with injury to left forehead/eyebrow. Patient unable to give any additional history. No known vomiting. No other complaints . Head: Normocephalic, Left eyebrow contusion superficial abrasion;. Neurological: No focal neurological deficit observed, normal motor observed, normal speech observed, Aware he is in [county name] and alert, but otherwise confused - knows this is January, but thought 1966. Further review of the emergency room records showed an EMS run report with the following: .Clinical Impression . Onset Time 03:00:00 01/15/2026 . Chief Complaint Laceration to Left Eyebrow Duration 2 Hours . Injury Falls . Assessment Time: 01/15/2026 04:57:44 Narrative [NAME] [moderate priority, non-life-threatening, but serious illness or injury] [medic unit] dispatched emergency response to private residence via 911 system for a fall . Crew was rerouted to [facility name] . upon arrival on scene EMS crew found a [PHI] sitting upright in the back of a [local law enforcement] cruisier. Per [local law enforcement] patient is a resident of [facility name], the patient was found walking outside and called in by a nearby resident, it is unknown how long patient has been eloped from facility. Nursing staff present, history was provided by nursing staff. Per nursing staff this is patients baseline secondary to a history of dementia, patient states he tripped and fell hitting his head on the sidewalk. Patient denies (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	LOC [loss of consciousness]. Patient has a laceration, approximately 1 inch, to left eyebrow, bleeding controlled without intervention. Patient was transferred from cruisier to stretcher via [by] stand and pivot with assistance of x2 [two individuals] EMS crew. Patient was transported to ambulance and loaded without incident. Patient was transported to [hospital name]. Incident times . Call Received 01/15/2026 04:34:51 . En Route 01/15/2026 04:51:13 . On Scene 01/15/2026 04:52:56 . Depart Scene 01/15/2026 05:16:01 At Destination 01/15/2026 05:26:58 Pt. [patient] transferred 01/15/2026 05:42:29. A review of the local law enforcement incident sheet revealed the following: Incident Information . Reported Date: 01/15/2026 05:16 . Narrative: At 01/15/2026 at approximately 0448hrs [hours] I was dispatched to the [neighborhood address] reference an elderly male with an injury to his head knocking on doors asking for help. Upon arrival and through investigation gathering personal details it was established that [Resident #2] was a patient of the memory care unit at [facility name] . while talking with the supervisor at [facility name] [Staff A, Licensed Practical Nurse] stated that they received an open door alarm at approximately 0300hrs telling them that one of their doors had been opened but thought nothing of it, almost ignoring it. [Resident #2] when he was found had been outside for over an hour, was soaking wet as it had been raining and shivering cold because of the rapidly dropping temperatures outside and also had a gash on his left eyebrow which he was transported to [hospital name] for reference because it possibly needs stitches. Staff A, LPN informed when I asked if there was anyone supposed to be on watch she stated yes but that person was on break and he was not replaced with anybody during that time. It should be noted that the memory care unit at [facility name] is on the second floor of the building and [Resident #2] would have to walk past several nurses stations to exit the building. On 2/2/26 at 9:32 a.m., an interview was conducted with Staff B, Registered Nurse (RN). She confirmed she was Resident #2's assigned nurse, but he was currently hospitalized for pneumonia. She said the exit door alarms are very loud and are heard throughout the second floor. She said when the exit door was pushed, after 15 seconds it would unlock. Staff B, RN said some doors needed a key and others needed a code to turn the alarm off. She said she was not working when Resident #2 eloped. Staff B, RN said she worked on 1/15/26, the morning he returned from the hospital. She stated she was told, He went to the hospital, he tried to escape, and the police were called to find him. She said Resident #2 was able to walk with assistance and he used a wheelchair. She stated, His major concern was falls. She said when he first came to the facility, he was weak and falling all the time. On 2/2/26 at 9:53 a.m., an interview was conducted with Staff C, RN. He said the protocol was always to call a code purple (resident suspected missing) when the exit alarm sounded. Staff C, RN said he heard a resident exited a few weeks ago but did not know who the resident was. He said he would not be able to hear the therapy hall door alarm from where he is assigned to the back hall. Staff C, RN said there was a specific, high-pitched sound on the exit doors and confirmed they are loud. He said the first-floor staff could hear the second-floor alarm if they were by that area. On 2/2/26 at 12:06 p.m., an interview was conducted with the Director of Nursing (DON), Regional Nurse Consultant (RNC), and the Nursing Home Administrator (NHA). The DON said she was notified by phone on 1/15/26 at 7:45 a.m., by Staff A, LPN, that Resident #2 eloped, was found outside in front of the facility, and taken to the hospital. She said she had one missed call at approximately 5:00 a.m., from Staff A, LPN. The DON said Resident #2 was last seen on 1/15/26 at 2:30 a.m. in his room, in bed sleeping, by Staff D, CNA. She said shortly after 2:30 a.m., an emergency stairwell exit door by the therapy department had alarmed. She said Staff A, LPN initially went to the wrong exit door, by the wound care nurse's office, because she thought it was that door alarming. The DON said Staff A, LPN attempted to silence the alarm, but she could not recall the code. The DON confirmed (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Manatee Springs Rehabilitation and Nursing Center	5627 9th St E Bradenton, FL 34203

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 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Resident #2 crossed a four-lane street and walked to one of the homes where he knocked on the window. An observation of the four-lane street revealed a sign showing a speed limit of 40 mph. The DON stated Resident #2 told her he, Went through a jungle, and thought it was one of the houses with many trees. Photographic evidence obtained. On 2/2/26 at 1:24 p.m., an interview was conducted with the Director of Plant Operations. He said the video footage cannot be rolled back, and it cleared after 24 hours. The Director of Plant Operations said he arrived at the facility on 1/15/26 at 4:00 a.m., which was his typical schedule. He stated that morning, Nobody said a word to me, including Staff A, LPN who he saw when he arrived that morning. He said Staff G, Maintenance Assistant was called to the facility because of the alarm that was activated by the therapy hall exit door. He said Staff G, Maintenance Assistant told him Staff A, LPN did not know how to reset the alarm, and she thought it was another door alarming. He confirmed he spoke to Staff A, LPN on Monday, 1/12/26 about the code for the doors. The Director of Plant Operations said he showed her that Monday the door flashes when opened, as well as the speaker he installed which faced the therapy hall. He stated, Staff A, LPN knew how to reset the doors. He said when he heard a resident eloped, he reviewed the video footage. He stated he observed an older gentleman walking down the therapy hallway, Wearing parachute pants and he had a limp. He confirmed the resident did not have a walker or wheelchair. He said Resident #2 was holding on to the railing as he walked down the hall. The Director of Plant Operations observed Resident #2 lean on the door and the alarm went off at approximately 2:32 a.m. He stated he heard, Exit now exit now, then the door opened and closed. The Director of Plant Operations stated he could hear staff talking and a resident was heard saying, Shut that off, and a door slammed. He said he heard both the first and second floor alarms. The Director of Plant Operations said he observed Staff A, LPN go to the elevator, pushed the button, and go inside the elevator. He confirmed there are no cameras outside or in the stairwell. He said as he watched the footage, he hoped staff would go to door, but he did not see any staff respond. The Director of Operations said he stopped watching the footage about 20 minutes after the alarm sounded. A review of the facility's logbook documentation with task name check operation of door monitors and patient wandering system, showed for the week of 1/11/26 to 1/15/26 all the doors on the second floor passed. On 2/3/26 at 9:24 a.m., a telephone interview was conducted with Staff D, CNA. He said on 1/15/26 he informed Staff E, LPN, he was going on break. He confirmed Resident #2 was assigned to him that night. Staff D, CNA checked on Resident #2 before going on break and said he was asleep in bed. He said about 10 to 15 minutes into his break, he received a call from Staff A, LPN, who asked him if he knew how to turn off the alarm. Staff D, CNA said Staff A, LPN assumed it was a malfunctioning alarm. He stated he felt like she was calling in a Nonchalant way. He said he did not recall the approximate time he received a call from Staff A, LPN or when he returned, but he was on break for about 30 to 35 minutes. He said he returned from his break, answered multiple call lights, and recalled the alarm was still sounding. Staff D, CNA stated, I don't remember checking [Resident #2's] room, when he returned from his break. He said later on in his shift he sat at the nurse's station and watched the hallway. Staff A, LPN called again and told him Resident #2 was found by the police. He said he told Staff E, LPN and went downstairs. Staff D, CNA said he observed the resident who had bruises around his eye and was cold and wet. He stated, It was raining that night. Staff D, CNA said he recalled the alarm door malfunctioning a week prior to Resident #2's elopement. He said the supervisor did not initiate the elopement protocol at that time and Staff D, CNA did not check on his residents. Staff D, CNA said he recalled the DON and the maintenance staff being called when the alarm malfunctioned a week before. He said Staff A, LPN did not know the code at that time. He stated, Everyone was like, how do you turn it off? He said (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Resident #2 was able to get in his wheelchair and walk a little. Staff D, CNA stated, He should have been 1:1, as he would get out of the bed and his wheelchair. He said he would have to re-direct him to the chair or the bed. He said when they had a resident like that, the person was typically 1:1. He stated, Administration knew this, workers knew this, we all kept an eye on him as best as we could. When asked why he did not respond to the alarm on 1/15/26, he said he thought it was another malfunctioning door. On 2/2/26 at 4:27 p.m., a telephone interview was conducted with Staff E, LPN. She said on 1/15/26 at approximately 3:00 a.m. she was in a resident's room. She said Staff D, CNA, Resident #2's assigned CNA, was taking a 30-minute break when the resident exited the facility. She stated, Nobody saw him [Resident #2] leave. She said she was not sure if another CNA was supposed to take over when the assigned CNA was on a break. Staff E, LPN stated, I did not check that and [Staff D, CNA] did let me know he was going on break. She said she heard an alarm; it was a noise she did not recognize and did not know where it was coming from. She recalled the alarm sounding for a few minutes. She stated, I didn't know what was going on. She said she received a call from Staff A, LPN, who was on the first floor, that a resident exited through a door. Staff E, LPN said she thought the police was called by Staff A, LPN. She thinks Resident #2 hurt his face or head but confirmed she did not observe him when he returned to the facility. Staff E, LPN said she last saw Resident #2 at 2:00 a.m. on 1/15/26. She said when she heard a resident was missing, she completed a count of the residents and called Staff A, LPN. Staff E, LPN stated she heard, He got out of a kitchen door that was not secure. She said Staff D, CNA went downstairs when Resident #2 returned. She said Staff A, LPN immediately sent Resident #2 to the hospital as he had an abrasion on his face. Staff E, LPN stated she was panicking and, Everything went really fast. She said she never completed elopement drills, was not aware of the sound of the alarmed door, and felt she was not provided the proper training. She stated, He should have been on precautions,15-minute checks, and 1:1. Staff E, LPN said she had constant issues with him and was worried about keeping him safe. She stated, He was a major fall risk, he constantly tried to get up, was extremely confused and wandered. Staff E, LPN said Resident #2 could stand and walk around but was not steady on his feet. She said he did not express he wanted to leave. Staff E, LPN said she did not inform the DON of her concerns, but spoke to Staff A, LPN who was aware of his behaviors before the elopement. She said Staff D, CNA, was also aware of Resident #2's behaviors. On 2/3/26 at 10:55 a.m., a follow-up interview was conducted with the Director of Plant Operations. The Director of Plant Operations confirmed he came to the facility on Monday, 1/12/26, to assist/re-educate Staff A, LPN on how to turn the door alarm off. He said the door was not malfunctioning at that time. The Director of Plant Operations said he did not document when he gets called to the facility. He said he documented in the electronic system that showed tasks where maintenance is needed/completed. He said there have been no recent door malfunctions documented in the electronic system. On 2/3/26 at 10:59 a.m., a telephone interview was conducted with Staff F, CNA. She said on 1/15/26 at 4:30 a.m., she walked up to the nurse's station on the first floor and saw law enforcement knocking on the door. She said they told her they found a man wandering across the street and asked if he was a resident at the facility. Staff F, CNA said she took the law enforcement officer to the supervisor who was Staff A, LPN. She stated it was, Storming really bad that night. She said shortly after, the paramedics arrived at the facility with Resident #2. She said she went outside with Staff A, LPN and another CNA to see if they could bring Resident #2 into the facility. Staff F, CNA observed a cut on the resident's eye and said Staff A, LPN thought it was best he went to the hospital to be evaluated. She said she worked on the first floor and did not hear any door alarms that morning. She said she recalled maintenance staff was there at approximately 3:30 a.m., to turn (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	off the door alarm. She said she asked Staff A, LPN, if everything was okay after seeing the maintenance staff. Staff F, CNA said Staff A, LPN told her the door alarm had malfunctioned. She said where she was assigned, she did not hear the door alarm by the therapy hallway exit stairwell. She said she did not know Resident #2 eloped until law enforcement came to the facility. She said she was not aware of any door that had malfunctioned or false alarms in the last few weeks. On 2/3/26 at 11:13 a.m., an interview was conducted with Staff G, Maintenance Assistant. He said on 1/15/16 at approximately 2:30 a.m., he received a call from Staff A, LPN who told him she could not get the door to reset, and it malfunctioned. Staff G, Maintenance Assistant said Staff A, LPN had the code, tried the code, but the door was still alarming. He confirmed he could hear the alarm over the phone. He said at approximately 2:45 to 2:50 a.m. he arrived at the facility. He said he went directly to the alarming door which was by the therapy gym. Staff G, Maintenance Assistant confirmed that was the only door alarming when he arrived. He said he reset the alarm, the door shut and the magnet locked like it was supposed to. Staff G, Maintenance Assistant confirmed there were no issues with the door, and it was not malfunctioning. He stated the alarm was, Pretty loud, and could be heard by the nurse's station on the second floor. He stated, If you were standing there on the first floor by that door [by the therapy hall stairwell], you could hear that alarm. On 2/3/26 at 2:12 p.m., a telephone interview was conducted with Staff H, RN. She said she worked on the first floor on 1/15/26. She said she went on a break around 3:00 a.m. Staff H, RN said while on her break, a CNA came in and appeared frantic. Staff H, RN asked the CNA what was going on; the CNA told her an alarm was going off and thought a resident had exited the facility. Staff H, RN said they both checked outside, did not see anyone, then went back inside. She said she completed a head count of her residents. She said she recalled a CNA told her a maintenance staff was there to turn an alarm off. Staff H, RN said Staff A, LPN told her there was an alarm going off as a resident pushed against the door and exited the facility. Staff H, RN said the police and EMS were involved. She said she initiated assisting with finding the resident but first communicated with the resident's assigned nurse. Staff H, RN said she called Staff E, LPN and told her the person missing might be her resident. Staff H, RN said she never heard the door alarm at any point. She was familiar with Resident #2 as she worked on the second floor sometimes. She said Resident #2 was confused, he would walk out of his room without assistance, and at times remove his clothes. Staff H, RN said there were many times that staff needed to escort and re-direct him. She thinks Resident #2 possibly had an infection. She confirmed she had received elopement training/in-services. Staff H, RN said they were instructed to complete a head count, make sure all residents are there, and make an announcement overhead. She stated, I think I overlooked that part of the process. I ended up calling the nurse directly. She said no one told her there was a malfunctioning alarm that morning and while she had been working at the facility all the door alarms functioned. On 2/3/26 at 4:27 p.m., a telephone interview was conducted with Staff J, Medical Doctor (MD). He said he had not met Resident #2 in-person until after the elopement. He said Staff I, Nurse Practitioner (NP) was the resident's main medical provider. He said Resident #2 had advanced dementia. Staff J, MD said Resident #2 was ambulatory but his awareness around him, ability to communicate, and insight into situations was compromised. He said the resident's baseline cognition made him a high risk for elopement and falls. Staff J, MD stated Resident #2 was, Probably appropriate for a memory care center. He said 1:1 supervision prior to the incident would have been appropriate based on what he knows about Resident #2. On 2/3/26 at 4:36 p.m., a telephone interview was conducted with Staff I, NP. She said Resident #2 had advanced dementia, confusion, and cognition dysfunction. She said he expressed he wanted to go home, was very impulsive, restless, and difficult to re-direct in (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	certain areas. Staff I, NP said Resident #2's family was trying to place him in a facility with memory care. She confirmed he was at risk of falls because of his cognition and muscle weakness. Staff I, NP said she reviewed in previous records/history that Resident #2 developed a shuffling gait and muscle weakness. She stated, He is an elopement risk because of cognition. A memory type unit is the safest environment for people with his level of dementia. Staff I, NP said she was told Resident #2 pushed through an alarmed door, staff heard the alarm but thought the alarm stopped, and there was not a response because staff assumed someone checked. On 2/3/26 at 2:37 p.m., an interview was conducted with Staff K, Physical Therapist (PT). She confirmed therapy services were provided to Resident #2 from 1/1/26 to 1/26/26. She said the resident would go up and down mobility wise because of his cognition; at times he could be more alert and sometimes he was semi-lethargic. Staff K, PT said Resident #2 required one to two step commands and typically followed directions. She stated, I would take him in a wheelchair to the gym and use a walker to with him. She said she would support him with a gait belt when they would walk. Staff K, PT said Resident #2 could walk about 150 feet but needed a walker because he would shuffle and did not have a wide base of support. She stated, I do not think it would have been safe for him to walk just holding a handrail. She was surprised about the distance he walked, as well as going downstairs when he eloped. She said he could have fallen walking alone without a walker. She said she never tried stairs with the resident during therapy. On 2/4/26 at 10:49 a.m., an interview and review of the facility's investigation was conducted with the Assistant Director of Nursing (ADON). Sh