STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105995	A. Building B. Wing	04/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Adviniacare at Naples	7801 Airport Pulling Road N Naples, FL 34109

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	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** 37256 52390 Based on observation, record review, review of facility's policies and procedures and staff interviews, the facility failed to adequately supervise 3 (Residents #1, #2 and #3) of 3 cognitively impaired residents to prevent incidents of unsafe wandering and elopement. On 12/9/24 at 2:15 p.m., Resident #1, who had a diagnosis of Dementia, severe cognitive impairment and history of attempted elopement exited the facility through the front door and set off the alarm. Staff turned off the alarm without verifying the whereabouts of residents with wander alarm bracelets. On 12/9/24 at approximately 2:17 p.m., a staff member who was outside on break, saw the resident wandering unsupervised in the parking lot and returned him to the facility. On 2/24/25 at 4:30 p.m., Resident #2, who had severe cognitive impairment, was ambulatory and wore a wander alarm bracelet exited the facility without staff knowledge. A friend coming to visit the resident found him wandering unsupervised in the parking lot and notified the facility. On 3/29/25 (unknown time) Resident #3, who had a diagnosis of Traumatic Brain Injury, and severe cognitive impairment exited the facility without staff knowledge. On 3/29/25 at approximately 7:05 p.m., a staff member leaving work observed the resident unsupervised outside of the facility. She stayed with the resident until the nurse on duty took the resident back inside. 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 other cognitively impaired 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. The findings included: Cross Reference to F835 and F867. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the facility policy titled, Elopement Prevention with a last revised date of 10/2022 revealed, Elopement is the ability of a resident who is not capable of protecting himself or herself from harm to successfully leave the facility unsupervised and unnoticed and who may enter into harm's way . Wandering refers to a cognitively-impaired resident's ability to move about inside the facility aimlessly and without an appreciation of personal safety needs and who may enter into a dangerous situation . The physical plant is secured to minimize the risk of elopement such as: a. functional alarm systems for egresses and stairwells . Staff should be educated on the elopement policy on hire, annually and as needed per facility events. Facility should conduct and maintain tracking an elopement drill at least quarterly on each shift. Identifying staff knowledge of policy and need for further training/education . Review of the facility policy titled, Elopement-Missing Resident Plast revised 10/2022 revealed, A situation in which a resident leaves the premises or a safe area without the facility's knowledge and supervision, if necessary, would be considered an elopement. This situation represents a risk to the resident's health and safety and places the resident at risk of heat or cold exposure, dehydration and/or other medical complications, drowning or being struck by a motor vehicle . Facility administration should complete thorough investigation including assessing the [wander alert] system and evaluating any preventative measure that may have been in place . 1. Review of the clinical record for Resident #1 revealed an admitted [DATE]. Diagnoses included Dementia, Major Depressive Disorder (depression), Sepsis (serious condition where the body does not respond to an infection), and Atrial Fibrillation (irregular heartbeat). The Admission Minimum Data Set (MDS) assessment with a target date of 11/27/24 revealed Resident #1 scored 05 on the Brief Interview for Mental Status (BIMS), indicating severe cognitive impairment. The MDS noted Resident #1 used a wander/elopement alarm daily (alerts staff when a resident leaves a safe area). Review of the Elopement Evaluation dated 12/2/24 revealed the facility determined Resident #1 was at risk for elopement and a wander alarm bracelet was placed. Review of the social services progress note dated 12/2/24 at 2:31 p.m., revealed Resident #1 was making ongoing statements of leaving the facility. Review of the nursing progress note dated 12/2/24 at 7:54 p.m., revealed Resident #1 was exhibiting exit seeking behaviors. Review of the Care Plan initiated on12/3/24 revealed Resident #1 was at risk for elopement based on the elopement risk assessment, decrease safety awareness, history of wandering, new admission with poor adjustment. The Goal was for the resident to remain within the facility unless supervised and free from harm. The interventions included: Identification bracelet to be worn, photograph of resident in wander notebook, resident is 1:1 (one to one supervision) for safety, wander alert bracelet applied. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 12/9/24 at 2:58 p.m., a Social Service progress note documented Resident #1 continues to have confusion on placement and states that he is looking for his wife to go home. Resident will typically be found by the front door and stating he wants to go home. Resident remains on elopement program but is still at risk for leaving facility. The Social Worker documented calling the resident's spouse to go over sitter options due to the resident needing constant redirection. On 12/9/24 at 6:39 p.m., a late entry nursing progress note documented, This nurse was notified that resident was seen leaving the building with other people a few minutes later, and an employee went outside and resident was wheeling wheelchair towards cars stated was looking for his wife. She had left a few minutes earlier resident was brought back into facility . Resident continued to say he wanted to leave and was exit seeking was placed 1 to 1 (one to one supervision). Roam alert is in place and functioning . Review of the facility's investigation revealed: Resident #1 was admitted to the facility on [DATE]. On admission the resident was not considered an elopement risk. On 12/3/24 the resident was stating, I want to leave here and attempted to leave the front lobby area outside. Staff intervened. Resident #1 was reevaluated and determined he should be on the wander alert program. A new assessment was completed and a wander alert bracelet was placed. The investigation noted on 12/9/24 at around 2:15 p.m., alarms were ringing on the skilled side. The Maintenance Director went over to the skilled unit as he indicated he was wondering why the alarms were going off. He did see a bunch of people leaving the front door but did not think much about it. The licensed nurse (no name) was sitting at the nurse's station and heard the alarms but stated, I only saw visitors, so I thought it was a freak thing. On 12/9/24 at 2:17 p.m., the Admission Director was outside taking a break and noted Resident #1 in his wheelchair in the parking lot. Resident #1 said, I am going to see my wife. The Admission Director was able to bring Resident #1 back inside without incident. Resident #1 was placed on one on one supervision and was discharged from the facility on 12/16/24. The facility provided witness statements as part of the elopement investigation. The former Maintenance Director provided an undated statement that read, Walking towards the shop I hear the [NAME] [sic] alert alarm when I get there. There is several people walking out at the same time and some residents sitting in the sun. An undated statement with no name read, I was walking into parking lot and saw (Resident #1) out into the lot. I was aware that this pt. (patient) had a wonderguard [sic]. I brought the pt back in and settled him in and got him a sandwich. The Social Service Director wrote on a statement dated 12/10/24, Admission came to SS (Social Service) office at 2:19 p.m., + (and) stated she just brought (Resident #1) inside. He was in the parking lot. SS checked the [wander alert] that is working. Unsure how resident got out. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The previous Director of Nursing wrote in a witness statement dated 12/9/24, At the time of the incident when resident was outside of building I was in the conference room on skilled side with Dr. (name). The facility's analysis of the incident investigation conclusion noted the Maintenance Director did not realize it was the resident going out with the wander alert bracelet. Review of the facility's corrective actions revealed: Like Residents reviewed. The Like residents reviewed provided by the facility revealed the facility reviewed the individual service plan reports for three residents who had already been identified as an elopement risk. The facility was not able to provide documentation they reviewed any other residents. Elopement drill. The facility provided an In-Service Record Sign in sheet dated December 2024 with the subject matter, Elopement Drill. 10 of 37 staff members employed at the facility at the time signed the sign-in sheet. 2. Review of clinical record revealed Resident #2 was admitted to the facility on [DATE]. Diagnoses included sepsis (serious condition where the body does not respond to an infection), retroperitoneal abscess (infection in the abdomen) and atrial fibrillation (irregular heartbeat). The Admission Elopement Risk Review form dated 2/21/25 noted Resident #2 was at risk for elopement. Resident #2 was able to ambulate or maneuver his wheelchair independently. The resident had a diagnosis of dementia, verbalized desire to leave the facility, and had a history of wandering. The form noted Resident #2 was exhibiting exit-seeking behavior such as standing by the exit door, looking for someone, asking to go home etc. A wander alert bracelet was placed on the resident. The Admission note dated 2/21/25 at 4:33 p.m., documented Resident #2 was, somewhat confused, [wander alert] was placed to prevent elopement. The nursing progress note dated 2/21/25 at 8:10 p.m., noted Resident #2 was alert and oriented X1(person) and placed on elopement by attempted to leave the facility. The care plan initiated on 2/24/25 documented Resident #2 was an elopement risk/wanderer related to impaired safety awareness. The goal was to maintain the resident's safety and, The resident will not leave facility unattended. The interventions included to distract the resident by offering pleasant diversions and a wander alert to the right ankle. On 2/26/25 the care plan noted, Resident to have a sitter for safety. The Admission Minimum Data Set (MDS) with a target date of 2/28/25 revealed Resident #2 scored 07 on the Brief Interview for Mental Status, indicating severe cognitive impairment. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the social service progress note dated 2/24/25 at 3:46 p.m., revealed Resident #2 was ambulatory without an assistive device. The resident was placed on the roam alert program due to confusion and making statements that he would like to leave the hotel. Review of the late entry social service progress note dated 2/24/25 at 4:50 p.m., revealed Resident #2 was seen in the parking lot around 4:38 p.m., by a family member coming to visit. Resident had been in nursing station a few minutes prior. Resident #2 was brought back into the center by family and the Director of Nursing. Review of the facility's investigation dated 3/10/25 revealed the doors and wander alert bracelets were checked and functioning appropriately. Resident #2 was placed on one-on-one supervision. The facility's investigation did not determine how Resident #2 who had a wander alarm bracelet was able to exit the facility without staff knowledge. Review of facility's corrective actions revealed: Roam alert doors to be checked. Review of the roam alert door checks revealed the doors were checked on 2/24/25. No further door checks were documented. Post elopement drills. Record review revealed no post elopement drills were done. 3. Review of the clinical record revealed Resident #3 was admitted to the facility on [DATE]. Diagnoses included Traumatic Subdural Hemorrhage (bleeding in the brain), Chronic Obstructive Pulmonary Disease (lung disease) and Major Depressive Disorder (depression) Review of the Admission Elopement Risk Review dated 3/14/25 revealed Resident #3 was not at risk for elopement. The Admission Minimum Data Set (MDS) with a target date of 3/21/25 revealed Resident #3 had a Brief Interview for Mental Status (BIMS) score of 06 indicating severely impaired cognition. Review of progress note dated 3/29/25 at 7:34 p.m., revealed Resident #3 was noted to be out in front of the building just off the porch. She stated she was going to the drug store. She was brought back into the facility. The physician was notified with a new order to apply a wander alarm bracelet. Review of facility's elopement investigation revealed prior to the incident Resident #3 was sitting outside in the front of the facility's entrance with her brother. The brother brought the resident inside for dinner. After dinner Resident was found outside the front entrance of the facility. Resident #3 stated she was looking for her brother and didn't know she couldn't go outside. The facility Administrator documented, The root cause was resident looking for her brother who was just visiting with her prior to dinner and they were sitting outside. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the witness statements revealed on 3/29/25 Licensed Practical Nurse (LPN) Staff E documented on Saturday 3/29/25 at approximately 7:05 p.m., she was pulling out of the parking lot and observed Resident #3 in the rearview mirror. She was sitting in her wheelchair directly in front of the exit, approximately two to three feet out on the black top. She immediately stopped her vehicle, and called the Registered Nurse on duty to tell her the resident was outside. Resident #3 said she thought her brother was still here. She stayed with the resident until the nurses on duty made contact with the resident. The facility's corrective actions included: Elopement training. Review of the Elopement Training dated 3/31/25 revealed 23 of 43 staff employed at the facility at the time received training. Review of the sign-in sheet dated 4/3/25 revealed the Administrator provided training to 11 department managers on the facility's elopement policy. Ad Hoc (unplanned) QAPI (Quality Assurance and Performance Improvement Plan) was written on the sign-in sheet. Record review of the corrective actions implemented by the facility revealed no elopement drill, no audits, no Performance Improvement Plans, or Quality Assurance Performance Improvement. On 4/14/25 at 10:00 a.m., observation revealed the facility does not have a reception area. A nurse's station was located right across the entrance door. On 4/15/25 at 8:50 a.m., upon arrival at the facility, the entrance door opened automatically. No staff was observed at the nurse's station monitoring the entrance door. On 4/15/25 at 9:00 a.m., observation of the facility's surrounding area revealed the entrance/exit door of the skilled nursing facility is located approximately 300 feet from a four lane road with a busy strip mall across the street. Uneven terrain, overgrown area of mature trees, shrubs and overgrown bushes were observed behind the building. On 4/15/25 at 9:10 a.m., upon reentering the facility, the entrance door opened automatically. No staff member was at the nurse's station monitoring the entrance door. On 4/15/25 at 9:30 a.m., observation revealed the skilled nursing facility is connected to an adjoining Assisted Living Facility (ALF) through an unsecured hallway. Residents from the skilled nursing facility can walk freely to the ALF. The entrance/exit door of the ALF is approximately 150 feet from a busy six lanes highway. Cognitively impaired residents who exit the facility through the entrance/exit door of skilled nursing facility or the ALF without necessary supervision could cross the nearby busy streets, get hit by a car, or sustain a fall resulting in serious injury from walking the uneven ground behind the facility. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 4/14/25 at 2:10 p.m., in an interview Certified Nursing Assistant (CNA) Staff A said the ALF had a receptionist but the skilled nursing facility did not have a front desk or a receptionist. CNA Staff A said she could not remember the last elopement drill. She said she must have been off when they did the drill. On 4/14/25 at 2:38 p.m., in an interview the Maintenance Director said he did not remember when the last elopement drill was done. He said he was responsible to change the codes of the doors with keypads. He said the codes get changed as needed. On 4/15/25 at 9:43 a.m., the Maintenance Director used a wander alert bracelet to set off the wander alarm of the door at the end of the 150 hall. The audible alarm could not be heard at the nurse's station located approximately 125 feet away. No staff member responded to the wander alarm. The Maintenance Director then set off the wander alarm of the entrance door of the facility. The door locked but had no audible alarm to alert staff if a resident with a wander alarm bracelet approaches the exit door. On 4/15/25 at approximately 9:55 a.m., in an interview the Maintenance Director said when opened, the front door takes a long time to close and has no audible alarm. He said there was a potential for a resident to leave. The Maintenance Director said, Any time we have an elopement, it is through the front door. The ALF door also locks but does not alarm. The Maintenance Director said the problem with the doors has been going on for quite some time. On 4/15/25 at 10:05 a.m., in an interview with the Administrator and the Director of Nursing (DON), it was established that: There had been no elopement drills conducted since December 2024. All current residents had not been reevaluated for elopement risk since the last elopement on 3/29/25. There was no Performance Improvement Plan in place for elopement, and the Administrator or DON could not verify if 100% of staff had been re-educated in elopement policy and procedure, including adequate supervision of cognitively impaired residents to prevent unsafe wandering and elopement. The Administrator said she had only been at the facility since the second week of March and was figuring things out. The DON reiterated the doors would lock if a (wander alert) approached them. She said just because someone had a BIMS of 6 or 7, it wouldn't automatically make them an elopement risk. A BIMS score of 0 to 7 is indicative of severe cognitive impairment. Both the Administrator and DON said they did not know the entry doors of the skilled nursing facility and the ALF did not alarm. They both said they were not aware that a resident with a wander alarm bracelet could freely follow someone out already opened doors with no audible alert to staff. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 4/16/25 at 9:45 a.m., in an interview Licensed Practical Nurse (LPN) Staff B said she was aware residents could walk from the skilled nursing unit to the assisted living unit. She said she was also aware the front door had no audible alarm and there was no door with an alarm to let staff know if a resident was going to the assisting living area. She said if a resident goes over to the assisting living unit the ALF staff will let them know. On 4/16/25 at 9:49 a.m., in an interview Registered Nurse (RN) Staff C said she was aware residents could go freely from the skilled nursing facility to the ALF. She said the ALF staff will call them if a resident goes over there. She said she was also aware the entrance door to the facility would lock but not alarm if a resident with a wander alarm bracelet goes near the door. On 4/16/25 at 9:57 a.m., in an interview Certified Nursing Assistant (CNA) Staff D said she was aware residents from the skilled nursing facility could walk freely to the ALF. She said sometimes the front door of the skilled nursing does alarm when a resident with a wander alarm bracelet is near the door. She said she had a resident with a wander alarm sometime this year and the front door would alarm every time the resident was near the front door. She said she thought they might have had a different type of wander alert bracelet on. On 4/16/25 at 3:40 p.m., in an interview the Administrator said she was also the Risk Manager. She said the last Quality Assurance and Performance Improvement (QAPI) meeting was held on March 26th, 2025, to report on February data. She said they had discussed the scenario of alleged elopement of Resident #2 in February and the two current residents with wander alarm bracelets. She said they looked at the elopement books to make sure they were up to date, reviewed the wander alarm bracelets for expiration and proper functioning and ensured the care plans were updated. She said no official Performance Improvement Plan (PIP) had been put in place, but it was discussed in clinical meetings and maintenance checked the doors weekly. The Administrator said at her previous facility the doors were locked at all times, that was why she had a discussion with the Maintenance Director about calling a door company to see what could be done about the front door. She said other than that, nothing else was changed with the doors. She said the doors were locked down from 8:00 p.m., to 8:00 a.m., and she felt the residents were safe because the wander alarm bracelet would lock the door down if they approached it. When asked about a cognitively impaired person following someone out an already opened door, she said, You can't guarantee people wouldn't get out, they could open a window, anything to get out. You can't guarantee anything 100%. You are dealing with systems, you are dealing with people.

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 37256 Based on observation, record review and staff interviews, the facility administration failed to utilize its resources effectively to ensure the safety of 3 (Residents #1, #2, and #3) of 3 cognitively impaired residents and prevent multiple incidents of unsafe wandering and elopement. Resident #1 had severe cognitive impairment, was at risk for elopement and used a wander alarm bracelet. On 12/9/24 at 2:15 p.m., staff did not appropriately respond to the door alarm when Resident #1 exited the facility. On 12/9/24 at approximately 2:17 p.m., a staff member who was outside on her break found the resident wandering in the parking lot unsupervised and returned him to the facility. Resident #2 had severe cognitive impairment, was at risk for elopement and used a wander alarm bracelet. On 2/24/25 at 4:30 p.m., staff did not adequately supervise the resident. Resident #2 exited the facility without staff knowledge. A friend coming to visit found Resident #2 wandering in the parking lot unsupervised. He notified the Director of Nursing (DON) who took the resident back inside. Resident #3 had severe cognitive impairment and was mobile. The facility determined the resident was not an elopement risk. On 3/29/25 at approximately 6:40 p.m., Resident #3 was not adequately supervised and exited the facility without staff knowledge. On 3/29/25 at approximately 7:05 p.m., a staff member leaving work found the resident outside, unsupervised. She notified the nurse on duty who came and took the resident back inside. The facility administration failure to use its resources effectively to maintain residents' safety created a likelihood of serious harm, serious injury or death of cognitively impaired residents who exit the facility without staff knowledge. The residents could cross the nearby busy four or six lane highway, get hit by a car, or sustain a fall resulting in serious injury from walking the uneven ground behind the facility. This failure resulted in the determination of Immediate Jeopardy. On 4/17/25 at 9:12 a.m., the Administrator was notified of the determination of Immediate Jeopardy. The findings included: Cross Reference to F689 and F867. Review of the Executive Director's job description signed on 3/3/25 revealed, The Executive Director is totally responsible for the management of the . Skilled Nursing Facility . Also, ensures high quality resident care services . Oversees and monitors nursing services . to ensure high quality nursing delivery systems . Implement quality assurance programs for all departments . Directs community safety . monitors adherence to safety rules and regulations and takes remedial action when necessary . The ability to take ownership for . the safety of the residents. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the Director of Nursing job description signed on 1/7/25 revealed, The Director of Nursing manages and directs the day-to-day functions of the Nursing Department in accordance with established policies, procedures, and practices that comply with federal, state, and local regulations . In addition, the Director of Nursing ensures adequate staffing patterns, and that staff are qualified and trained. Essential Functions . Provide basin nursing care to patients . that includes actions that meet psychosocial needs and physical needs. Oversees the management and daily operations of the nursing department . Ensures that each patient's needs are assessed and that a treatment plan is developed for nursing care . Review of the facility policy titled, Elopement Prevention with a last revised date of 10/2022 revealed, Elopement is the ability of a resident who is not capable of protecting himself or herself from harm to successfully leave the facility unsupervised and unnoticed and who may enter into harm's way . The physical plant is secured to minimize the risk of elopement such as: a. functional alarm systems for egresses and stairwells . Staff should be educated on the elopement policy on hire, annually and as needed per facility events. Facility should conduct and maintain tracking an elopement drill at least quarterly on each shift. Identifying staff knowledge of policy and need for further training/education . On 4/15/25, review of the facility's incident investigations for December 2024 through March 2025 revealed three incidents of elopement, which placed the affected residents with severe cognitive impairment at a likelihood of serious harm, serious injury or death. On 12/9/24 at 2:15 p.m., staff did not respond appropriately to the door alarm when Resident #1 who wore a wander alarm bracelet, exited the facility and set off the alarm. On 12/9/24 at approximately 2:17 p.m., a staff member who was outside on her break found the resident wandering in the parking lot unsupervised and returned him to the facility. As part of their investigations the facility provided a Four Step Plan of Correction to Prevent Recurrence. Under, What measures will be put into place or systemic changes made to ensure that the deficient practice will not occur? was the notation, Education sheet if you hear alarm, check everyone leaving, beware of tailgaters. The facility also provided an in-service dated 01/30/24 which included elopement and read, Elopement. When Code Orange is called all employees should assist with this code. A count will be made for all residents in facility . Front doors will lock when resident with wonder guard [sic] approaches door. The doors end of 170 hallway and 160 hallway will beep when a [wander alert] approaches door. These doors will also alarm when door opened, if alarm goes off must check outside to see if a resident has exited the facility. The door leading to the time clock is also alarmed and will beep and lock if a [wander alert] is close by . There was no sign-in sheet to determine how many staff members attended the in-service. On 2/24/25 at 4:30 p.m., staff did not adequately supervise Resident #2 who wore a wander alert bracelet. The facility staff was not aware of the resident's exit. A friend coming to visit found Resident #2 wandering in the parking lot unsupervised. He notified the DON who took the resident back inside. (continued on next page)

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	105995	A. Building B. Wing	04/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Adviniacare at Naples	7801 Airport Pulling Road N Naples, FL 34109

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 2/25/25 the former Executive Director documented in an email to 11 managers titled, AD HOC QAPI (Unplanned Quality Assurance and Performance Improvement), Team, we had an elopement with a skilled resident last night. Friend/Family driving to center and saw him in the parking lot. Resident on roam alert program, one to one placed, MD (physician) and Family Made Aware, Skin Check, Statements, Education, Post Elopement Drills, Like residents. All will be working on today to ensure we have a great credible evidence binder for the State. On 3/10/25 the current Executive Director documented an analysis of the incident and noted the wander alert bracelet the resident had on and the doors were checked and were working appropriately. The investigation did not include how Resident #2 was able to exit the facility without staff knowledge despite the wander alarm bracelet. The facility placed the resident on one to one supervision but did not include appropriate systemic measures to ensure residents' safety and prevent other cognitively impaired residents from exiting the facility without staff knowledge or supervision. On 3/29/25 at approximately 6:40 p.m., staff did not adequately supervise Resident #3 who was mobile and had severe cognitive impairment. Resident #3 exited the facility without staff knowledge. On 3/29/25 at approximately 7:05 p.m., a staff member leaving work observed the resident outside, unsupervised through her rearview mirror. She notified the nurse on duty who came and took the resident back inside. The facility's investigation included corrective actions which included an elopement evaluation for Resident #3. The resident was found at elopement risk and a wander alert bracelet was placed to the resident's right ankle. On 4/15/25 at 9:43 a.m., the Maintenance Director used a wander alert bracelet to set off the wander alarm of the door at the end of the 150 hall. The audible alarm could not be heard at the nurse's station located approximately 125 feet away. No staff responded to the wander alarm. The Maintenance Director then set off the wander alarm of the entrance door of the facility. The door locked but had no audible alarm to alert staff if a resident with a wander alarm bracelet approaches the exit door. On 4/15/25 at approximately 9:55 a.m., in an interview the Maintenance Director said when opened, the front door takes a long time to close and has no audible alarm. He said there was a potential for a resident to leave. The Maintenance Director said, Any time we have an elopement, it is through the front door. The ALF door also locks but does not alarm. The Maintenance Director said the problem with the doors has been going on for quite some time. The Maintenance Director said after the last elopement the Executive Director (Administrator) told him to get quotes for a lock on the doors that would require someone to physically push a button behind the nurse's station to open the door. The Maintenance Director said a company came out last week but had not sent a quote yet. On 4/15/25 at 10:05 a.m., an interview was conducted with the Administrator and the Director of Nursing (DON) to discuss residents' safety and elopement prevention. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Both the Administrator and DON said they did not know the entry doors of the skilled nursing facility and the ALF did not alarm. They both said they were not aware that a resident with a wander alarm bracelet could freely follow someone out already opened doors with no audible alert to staff. The Administrator said she had only been at the facility since the second week of March and was, figuring things out. On 4/16/25 at 3:40 p.m., in an interview the Administrator said at her previous facility the doors were locked at all times, that was why she had a discussion with the Maintenance Director about calling a door company to see what could be done about the front door. She said other than that, nothing else was changed with the doors. She said the doors were locked down from 8:00 p.m., to 8:00 a.m., and she felt the residents were safe because the wander alarm bracelet would lock the door down if they approached it. When asked about a cognitively impaired person following someone out an already opened door, she said, You can't guarantee people wouldn't get out, they could open a window, anything to get out. You can't guarantee anything 100%. You are dealing with systems, you are dealing with people. The Administrator verified two current residents were at risk for unsafe wandering and elopement at the facility and had a wander alarm bracelet.

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 37256 Based on observation, record review and interview, the facility failed to thoroughly investigate elopement incidents for 3 (Residents #1, #2, and #3) of 3 cognitively impaired residents reviewed for elopement and failed to implement appropriate systemic corrective actions to prevent further incidents of unsafe wandering and elopement of mobile and confused residents. On 12/9/24 at 2:15 p.m., Resident #1 who had severe cognitive impairment and wore a wander alert bracelet exited the facility, setting off the door alarm. Staff did not appropriately respond to the alarm. A staff member who was outside on her break found the resident wandering unsupervised in the parking lot and brought him back. On 2/25/25 at 4:30 p.m., staff did not adequately supervise Resident #2 who had severe cognitive impairment and wore a wander alert bracelet. A friend coming to visit Resident #2 found him wandering unsupervised in the parking lot and notified the facility. The facility has not determined how Resident #2 was able to leave the facility despite the wander alert bracelet. On 3/29/25 at approximately 6:40 p.m., Resident #3, who had severe cognitive impairment and was mobile, was not adequately supervised and exited the facility without staff knowledge. A staff member leaving the facility saw the resident wandering unsupervised outside through her rearview mirror and called the nurse on duty to take the resident back inside. The facility failure to have an effective Quality Assurance and Performance Improvement program that identify quality deficiencies and implement appropriate systemic corrective actions created a likelihood of further unsafe wandering and elopement of cognitively impaired, confused residents which could result in serious harm, serious injuries or death of the residents. Cognitively impaired residents who exit the facility without staff knowledge and necessary supervision could cross the nearby busy four or six lane highway, get hit by a car, or sustain a fall resulting in serious injury from walking the uneven and overgrown grounds behind the facility. This failure resulted in the determination of pattern ongoing Immediate Jeopardy. On 4/17/25 at 9:12 a.m., the Administrator was informed of the determination of Immediate Jeopardy (IJ). The findings included: Cross reference to F689 and F835. (continued on next page)

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the facility's Quality Assurance and Performance Improvement (QAPI) Plan reviewed 2/7/21 revealed, (Company name) shall ensure that the Governing Body, Administration, Medical Director, Director of Nursing, clinical and non-clinical staff demonstrate a consistent endeavor to deliver safe, effective, optimal resident care and services in an environment of minimal risk . The organizational program, established by the Medical Director and Director of Nursing and Interdisciplinary Performance Improvement Committee . shall have the responsibility for monitoring every aspect of resident care and services (including contracted services), from the time the resident enters the facility through diagnosis, treatment, recovery and discharge in order to identify and resolve any breakdowns that may result in suboptimal resident care and safety, while striving to continuously improve and facilitate positive resident outcomes . The committee shall identify quality deficiencies and develop and implement plans of action to correct these quality deficiencies, including monitoring the effect of implemented changes and making needed revision to the action plan . Track the status of identified problems and action plans to assure improvement or problem resolution . On 4/14/25 at 9:24 a.m., in an interview the Director of Nursing (DON) said she was aware of the three resident elopements and the facility had not yet developed a Performance Improvement Plan (PIP) to address the elopements. They obtained orders and updated the care plans for the residents involved. On 4/15/25 at 10:05 a.m., an interview was conducted with the Administrator and the Director of Nursing (DON) to review the incident investigations related to Residents #1, #2, and #3's unsafe wandering and elopement, root cause analysis, and appropriate systemic actions to prevent recurrence. The Administrator said she started employment at the facility the second week of March and was trying to figure out what was going on here. She said she could not comment on Residents #1's elopement as she had not started employment at the facility. She verified she was aware of Resident #2's elopement and completed the investigation. The Administrator and DON verified Resident #3 eloped on 3/29/25 and was found unsupervised outside the facility. The Administrator said they did not conduct elopement drills after Resident #3's elopement but have been doing staff education. She said she's had only one QAPI meeting since she started employment at the facility the second week of March and she, was trying to figure out what is going on here. She said she had not developed a PIP as of yet to address the multiple incidents of residents' elopements. She said she thought the doors should be shutting if someone with a wander alert bracelet was there. She said she was not aware that someone with a wander alert bracelet could walk out with visitors. She verified the nurse's station was often empty and agreed cognitively impaired residents who require supervision could just get out. On 4/15/25 at 11:50 a.m., in an interview the DON said she was not present the day Resident #3 was found outside. Based on staff statements obtained the resident did not have a wander alert bracelet and was found sitting by the front door. She said she believed Resident #3 propelled herself out of the front door looking for her brother. The DON said she assumes no one was at the nurse's station at the time the resident eloped. (continued on next page)

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 4/16/25 at 3:25 p.m., in an interview the Administrator said she was the Risk Manager for the facility. The last Quality Assurance Meeting was held on 3/26/25 to present the February 2025 data. They discussed Resident #2's elopement and talked a little about the scenario and the two residents with wander alert bracelets. The Administrator said she believes Resident #2 was trailing behind people that were leaving. She immediately placed the resident on one to one supervision. The wander alert books were reviewed, the bracelets checked and the care plans were updated. She held a town hall meeting with staff around the time of the elopement and discussed the elopement. She said they did not do any elopement drills. She usually starts with education but scheduled an elopement drill for this week on Thursday. She said Resident #3 was not an elopement risk and did not have a wander alert bracelet. They applied one after she eloped. She said after the third elopement, the Maintenance Director and her started talking about what could be done about the door and started calling door companies. The Medical Director was aware of the elopements. He attended the last QAPI meeting and had no comments. She said securing the hallway connecting the skilled nursing facility to the Assisted Living Facility was not considered since she's been here. She verified the front door of the facility open automatically and is not supervised. The Administrator said nothing was 100% full proof that someone can't get out, crazy things happen. She said she felt the residents were safe because the wander alert bracelets would lock the door down. She said again, Nothing is 100% full proof. You are dealing with systems and people. The Administrator verified the elopement investigations failed to identify the lack of audible alarm of the wander alert system on the exit doors to notify staff if a confused resident with a wander alert bracelet followed visitors through the opened doors. The investigations did not identify the lack of monitoring of exit doors to prevent cognitively impaired residents from exiting the facility unsupervised. Review of the facility's approved Immediate Jeopardy removal plan revealed as part of their immediate corrective actions, the facility educated 35 of 42 staff on residents at risk for elopement and elopement interventions. Staff was educated on new process for doors to be locked and someone will have to allow entrance and exit of residents, families and guests. The staff member must observe doors until they are fully closed. Staff educated on elopement procedures including verifying all residents are accounted for prior to shutting alarm off. Staff was educated on all residents who are at risk for elopement along with elopement interventions, behavioral sign and symptoms of elopement and elopement interventions. Review of the education program agenda dated 4/17/25 revealed the content of the education was, Know the process of elopement. If you have a resident who voiced they want to leave the facility, please notify a supervisor. If you hear an alarm, make sure there is nobody outside and make sure you notify your nurse or your supervisor. Know elopement behavioral sign and symptoms of elopement and interventions to take when that is occurring. When you have someone actively experienced [sic] exit seeking behavior. As the nurse, contact your physician right away and your DON and administrator to make sure the resident is safe at all cost by etc. [sic] . placing the resident on 1:1 or [wander alert bracelet] per physician orders. Make sure to verify all residents are accounted prior to shutting alarm off. The sign-in sheet noted 30 staff members attended the in-service, including dietary, housekeeping, medical records and laundry staff. (continued on next page)

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 4/18/25 at 12:02 p.m., in an interview Licensed Practical Nurse Staff G said she started employment at the facility a week ago. She came in to be educated on the elopement process. She said the DON told her if she saw a resident outside, secure the resident and do an assessment. The DON did not talk to her about elopement prevention but she overheard the DON speaking to someone else about elopement prevention. The immediate actions in the facility's approved removal plan also included, Elopement drills will be done on all shifts. Elopement drills were conducted on 4/15/25, 4/16/25, 4/17/25 and 4/18/25. Review of the Elopement. Post-Elopement Drill Checklist dated 4/18/25 revealed the Maintenance Director completed the form. He documented the resident missing time was 8:45 a.m., and the resident found time was 8:55 a.m. The form noted staff verified the resident was not signed out, checked the unit, a full search of the facility and grounds was implemented. The search was called off when the resident was found. The staff performance result was good and staff did respond in accordance with established procedures. Review of the sign-in sheet for the elopement drill of 4/18/25 revealed 17 staff members responded to the drill, including the DON and Minimum Data Set (MDS) Coordinator Staff H. On 4/18/25 at 12:45 p.m., in an interview MDS Coordinator Staff H said she came to work at 6:00 a.m. She did not hear an announcement for an elopement drill and did not participate in an elopement drill. Staff H said the Maintenance Director came to her office and asked her questions. He asked, If this happens (elopement), what would you do basically. On 4/18/25 at 1:05 p.m., in an interview the Maintenance Director verified he completed the elopement drill of 4/18/25. The Maintenance Director said normally he would gather staff but this time he went person to person and asked each staff member individually what they would do in case of an elopement, and what they would look for. He announced an elopement drill but not in a group setting. He said he even educated the laundry girls and considered the education an elopement drill. On 4/18/25 at 1:45 p.m., an interview was held with the DON and the Administrator to discuss implementation of the facility's Immediate Jeopardy removal plan. The Administrator said she did not know the Maintenance Director did not conduct the elopement drill and would reeducate him. The Administrator verified the staff education provided was generalized and not specific to each department.