STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165478	A. Building B. Wing	07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbor Court	701 East Mapleleaf Drive Mount Pleasant, IA 52641

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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 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25855 Based on clinical record review, staff interview and facility policy the facility failed to provide the resident or the residents representative the facility bed-hold upon transfer to the hospital for 1 of 2 residents reviewed for bed holds (Resident #11). The facility reported a census of 55 residents. Findings include: The Minimum Data Set (MDS) dated [DATE] identified Resident #11 as cognitively intact with a BIMS (Brief Interview for Mental Status) score of 12 out of 15. The MDS included diagnoses: Coronary Artery Disease, Heart Failure and Renal Insufficiency (Kidney Failure). A review of a Progress Note dated 6/9/24 at 7:08 PM revealed Resident #11 transported to the hospital for evaluation, and admitted on [DATE] for intravenous antibiotic treatment for an urinary tract infection. Resident #11 transferred back to the facility on [DATE]. A review of the clinical record lacked documentation of a bed hold notice being given to the resident or residents representative upon transfer to the hospital. In an interview on 7/3/24 at 10:45 AM, Staff C, RN stated when a resident is sent to the hospital, the nurse sending the resident out is responsible for reviewing the Bed Hold Policy with the resident/family. The Bed Hold Policy should be reviewed with the resident/family within 24 hours of the transfer. Staff C stated there is a Bed Hold policy form but she has never filled it out and did not know if this should be documented in the electronic medical record. In an interview on 7/3/24 at 11:14 AM, the Administrator reported the Bed Hold Policy should be reviewed with resident/family by the nurse on duty within 24 hours. She could not recall where this should be documented. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 7/3/24 at 3:03 PM, the Director of Nursing (DON) stated when a resident is sent to the hospital, the nurse sending the resident out is responsible for reviewing the Bed Hold Policy with the resident/family. The Bed Hold Policy should be reviewed with the resident/family within 24 hours of the transfer. The DON stated there is a form that the resident/family signs or the nurse will get a verbal consent. This form gets scanned and entered into the electronic medical record. She could not explain why this had not been completed for Resident #11 as she was on medical leave at that time. A review of the facility policy, dated 11/15/22, titled Resident Bed Hold documented: The Facility will provide written information to the Resident and/or the Resident Representative regarding Bed Hold Policy prior to transferring a Resident to the hospital or Therapeutic Leave as required by State/Federal Guidelines.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25855 Based on observation, clinical record review and staff interviews the facility failed to properly code diuretic, hypnotic and anticoagulant medications on the Minimum Data Sets for 2 of 4 residents (Resident #33 and Resident #38) reviewed. The facility reported a census of 55 residents. Findings include: 1. The Minimum Data Set (MDS) dated [DATE] identified Resident #33 as cognitively intact with a BIMS (Brief Interview for Mental Status) score of 15 out of 15. The MDS included diagnoses: Atrial Fibrillation (an abnormal heart rhythm), Heart Failure and Diabetes Mellitus. The MDS failed to identify Resident #33 had taken a diuretic and had taken a hypnotic. A review of the Physician Orders revealed an order for toresemide (diuretic used to treat fluid retention) 40 mg (milligrams) 2 tablets twice daily on 1/11/24 related to ischemic cardiomyopathy (a condition that occurs when the heart's ability to pump blood is reduced due to damage to the heart muscle). And an order for temazepam (a hypnotic) 15 mg 1 tablet at bedtime for insomnia. An observation on 7/1/24 at 11:54 AM revealed Resident #33 lying in bed, properly positioned and appeared comfortable with his call light in reach and reported he had orders from hospice to receive a sleeping pill every night. In an interview on 7/3/24 at 10:45 AM, Staff C, RN reported Resident #33 had orders for torsemide, (a diuretic) and for temazepam (a hypnotic). In an interview on 7/3/24 at 12:30 PM, the Assistant Director of Nursing (ADON) stated she had been the MDS Coordinator from September 2023 to March 2024, prior to starting her current position. She stated if a resident has orders for a diuretic and hypnotic, they should be addressed on the MDS. The ADON stated she could not explain why the medications were not coded on Resident #33 MDS. In an interview on 7/3/24 at 3:03 PM, the Director of Nursing (DON) reported she would expect medications such as a diuretic and a hypnotic to be addressed on the MDS. 47336 2. The MDS assessment dated [DATE] revealed Resident #38 with scored a 15 out of 15 on the BIMS exam, which indicated cognition intact. The MDS lacked documentation regarding anticoagulant medications. The Care Plan revealed a focus area revised on 6/25/24 for anticoagulant therapy. The interventions dated 5/6/22 revealed administration of anticoagulant as currently prescribed by the physician. The EHR (Electronic Health Record) revealed the following Physician Orders: a. Xarelto tablet 10 mg (milligrams)- give 10 mg by mouth in the evening with a start date 3/27/24. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. Anticoagulant medication- monitor for bruising, bleeding, increased bloody drainage from wounds, discolored urine, black tarry stools, sudden severe headache, nausea/vomiting; diarrhea, muscle joint pain, lethargy, sudden changes in mental status and/or vital signs, shortness of breath, and nose bleeds- every shift for anticoagulant monitoring During an interview on 7/3/24 at 12:49 PM, the ADON (Assistant Director of Nursing) stated Resident #38 took Xarelto and yes, it should be coded on the MDS. During an interview on 7/3/24 at 1:50 PM, the DON confirmed Resident #38 took Xarelto and it was an anticoagulant, so it probably should be coded on the MDS. During an interview on 7/3/24 at 3:01 PM, the DON stated they didn't have a policy for MDS, the facility followed the guidelines of the RAI (Resident Assessment Instrument) Manual.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25855 Based on observation, clinical record review, resident and staff interview, the facility failed to update the care plan for 1 of 3 residents (Resident #48) to identify a focus area of smoking and needed interventions to ensure safety. The facility reported a census of 55 residents. Findings include: The Minimum Data Set (MDS) dated [DATE] identified Resident #48 as cognitively intact with a BIMS (Brief Interview for Mental Status) of 15 and had the following diagnoses: Seizure Disorder, Bipolar Disorder and Encephalopathy (a disease that affects the brain's function). The MDS identified Resident #48 as independent with most activities of daily living. The Admission assessment dated [DATE] Identified Resident #48 with a past history of smoking, however currently, not identified as a smoker. The Smoking Safety Evaluation Form dated 3/25/24 identified Resident#48 as a smoker with balance problems while sitting or standing. The Care Plan dated as last revised 6/27/24 did not identify Resident #48 as a smoker and include necessary interventions as per the facility policy. An observation on 7/2/24 at 3:10 PM Resident #48 sat in her wheelchair with both feet on foot pedals in the smoking area with Staff G, Certified Nursing Assistant (CNA) supervising her and the other residents. Staff G gave the resident one cigarette, and lit the cigarette. In an interview on 7/3/24 at 10:45 AM, Staff C, Registered Nurse (RN) stated the MDS Coordinator is responsible for updating Care Plans. She stated Resident #48 has been smoking for at least six months. Staff C stated if a resident smoked she would expect it to be included on the Care Plan, Smoking Assessments, evaluation for dexterity, smoking times, level of supervision needed, and the location of cigarettes and lighters at the nurses station. In an interview on 7/3/24 at 11:14 AM, the Administrator stated the MDS Coordinator, who started working a few weeks ago is responsible for updating the care plans. Resident #48 has been a smoker since March or April 2024 and a smoking assessment had been completed, and should have been added on the residents Care Plan. The Administrator stated common interventions would include: no cigarettes or lighters in the room, these are kept in a lock box, and smokers are to be supervised when out on 3 scheduled smoke breaks. In an interview on 7/3/24 at 12:30 PM, the ADON (Assistant Director of Nursing) stated she had been the MDS Coordinator from September 2023 to March 2024 then assumed the duties (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of the ADON. The MDS coordinator is responsible for updating the care plans, however, any nurse update the care plans. If a resident smoked, she would expect this to be addressed as a problem on the care plan. There should not be a reason for this not to be addressed on the care plan. Common interventions would include: supervised when out, cigarettes and lighter in lock box in nurse's station, and complete a Smoking Assessment A review of the undated Facility Policy titled: Smoking Policy/Safety had documentation of the following: a. Residents only may smoke in the designated smoking area in the front of the building. b. Residents may only smoke during scheduled smoke breaks at 10:00 AM, 2:00 PM and 7:00 PM. c. All smoking paraphernalia (cigarettes, lighters, e-cigarettes, etc) are to be locked up at the nurse's station in between smoke breaks. d. The smoking policy will be revisited at Care Plans for each smoking resident. e. All smoke breaks will be supervised.

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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** 45338 Based on observation, interview, facility investigation review, and facility policy review the facility failed to ensure a severely cognitively impaired resident identified at risk for elopement, with wandering behaviors free from elopement on 4/30/24. The resident went through a set of double doors into a common area by the beauty salon, went through a door into the unoccupied assisted living portion of the facility when the keypad was disengaged, and exited through a third door present on the unoccupied assisted living portion of the facility which lead directly to the outside of the facility. The third door the resident exited from, present on the unoccupied assisted living section of the facility, did not alarm to the nursing home section of the facility for 1 of 1 resident reviewed for elopement (Resident #25). This deficient practice resulted in an Immediate Jeopardy (IJ) to the health and safety of residents who resided at the facility. The facility also failed to adhere to the plan of care when a resident dependent on a mechanical lift was raised up off of a wheelchair via the assistance of a non-mechanical lift, resulting in skin tears and bruising to the left lower arm for 1 of 4 residents reviewed for accidents (Resident #53). The State Agency informed the facility of IJ that began as of April 30, 2024 on July 2,2024 at 12:25 PM. The Facility Staff removed the Immediate Jeopardy on July 2, 2024 through the following actions: a. 100% Headcount of all Residents on 4/30/24 b. 100% Elopement Risk assessment completed on all residents on 4/30/24 c. 100% Care plan audit for all residents determined to be at risk for elopement on 4/30/24 d. Facility conducted 100% audit of all external doors to ensure they are in proper working order on 4/30/24 e. Door lock changed on 4/30/24 to assisted living interior door f. Facility conducted elopement drills x 3 shifts 4/30-5/1/24 g. Facility conducted Ad Hoc QAPI to address this alleged deficient practice on 4/30/24 h. Elopement binder updated on 4/30/24 i. Staff in-service on Elopement Policy on 4/30/24 The scope lowered from a J to D at the time of the survey after ensuring the facility implemented education and their policy and procedures. The facility identified a census of 55 residents. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Findings include: 1. The Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #25 scored 3 out of 15 on a Brief Interview for Mental Status (BIMS) exam, which indicated severely impaired cognition. Per this assessment, the resident had inattention and disorganized thinking which fluctuated, had delusions, and wandered daily. Review of Medical Diagnoses for Resident #25 revealed, in part, paranoid personality disorder, schizophrenia, and vascular dementia without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. The Care Plan dated 1/30/24, revised and canceled on 5/3/24, revealed the following: History/potential for behavior problem. Resident is no longer allowed to smoke as he is at high risk for elopement. Interventions per the Care Plan included the following: a. (Initiated 1/30/24, revised/canceled 5/3/24): Administer medications as ordered. Monitor/document for side effects and effectiveness. b. (Initiated 1/30/24, revised/canceled 5/3/24): Anticipate and attempt to meet needs. c. (Initiated 1/30/24, revised/canceled 5/03/24): Explain all procedures before starting and allow time to adjust to d. (Initiated 1/30/24, revised/canceled 5/03/24): Intervene as necessary to protect the rights and safety of others. Approach/Speak in a calm manner. Divert attention. Remove from situation and take to alternate location as needed. e. (Initiated 1/30/24, revised/canceled 5/3/24):Observe behavior episodes and attempt to determine underlying cause. Consider location, time of day, persons involved, and situations. Document behavior and potential causes. f. (Initiated 2/2/24, revised/canceled 5/03/24): Wander Guard in Place The Care Plan dated 1/30/24 revealed, the resident has depression and insomnia with diagnosis of schizophrenia. The Elopement Risk Evaluation V 2.0 dated 1/29/24 and 4/2/24 revealed the resident at risk for elopement, and the resident scored 4 on both assessments. It was noted a score of greater than one indicated at risk for elopement. Review of Progress Notes prior to Resident #25's exit from the building on 4/30/24 revealed the following: (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Hospital Records from a visit dated 1/27/24 revealed, during time of his ED (emergency department) evaluation, patient had evaded our staff members when he was utilizing the bathroom, eloping from our facility as search was performed including contacting local law enforcement. Patient identified at gas station where [Hospital Name Redacted] EMS (Emergency Medical Services) identified him as well as patient voluntarily returned to our ED via EMS. Review of a Behavior Note dated 3/23/24 at 4:49 AM revealed, Resident has been pacing the halls constantly this shift, going in to other resident's rooms, and is short tempered with staff, especially when we attempt to redirect him from going into other resident's rooms. Message left with [Name Redacted, ARNP (Advanced Registered Nurse Practitioner)] awaiting response. The Risk Note dated 3/28/24 at 1:16 PM revealed, Risk IDT (interdisciplinary team) met to discuss residents more frequent wandering and agitation. Resident is not agitated with staff or residents almost seems as if he is agitated with himself or overwhelmed in this environment. Talked to SS (Social Services) about talking to [family member] to get him placed in a locked unit with less stimulus, will have her make prog [progress] note when she talks to [family member]. The Social Services Note dated 3/28/24 at 4:29 PM revealed, Contacted residents [family member, name Redacted] about potentially moving resident to a location that has less stimuli and calmer environment such as a locked dementia unit. The Behavior Note dated 3/31/24 at 3:46 AM revealed, Resident continues to have episodes of pacing, fidgeting with anything that is around him, and going in to other residents' rooms. Resident did settle down and has been sleeping in his bed since 9pm. The Nurses Note dated 4/1/24 at 11:26 AM revealed, Observed resident wandering up and down halls, noted to have layered clothing (a couple shirts) the top polo was on backwards. The Risk Note dated 4/5/24 at 1:52 PM revealed, Risk management held today to discuss residents behaviors. Resident continues to wander into other residents room and up and down hallways. Resident is easily redirected. Review of a Psychiatric Services Provider Clinical Note dated 4/9/24 revealed, Facilitator shared patient is wandering more and this is related to his dementia. She is working on a referral for him to move to a facility with a dementia unit that will be closer to family. The Nurses Note dated 4/12/24 at 3:46 PM revealed, Resident continues to wander throughout the facility on foot. No new behaviors observed or reported. The Behavior Note dated 4/14/24 at 12:49 AM revealed, Resident has been wandering all shift so far this shift. Going in to other resident's rooms, taking things off the med carts, trying to drink everyone's drink. Resident has yet to settle down and is still wandering and getting in to everything. The Behavior Note dated 4/15/24 at 2:49 AM revealed, Resident has been wandering all shift again this shift. Going into other resident's rooms, redirection has been mostly unsuccessful. At this time resident has finally went to his room and is laying in bed at this time. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Behavior Note dated 4/21/24 at 1:41 PM revealed, Resident continues to roam the halls. Called and spoke to [family member]. No other behaviors noted at this time. The Risk Note dated 4/25/24 at 1:39 PM revealed, Risk IDT met to discuss behaviors. Resident continues to wander daily. No new behaviors. The Nurses Note dated 4/25/24 at 6:46 PM revealed, Resident wondering facility. Not exit seeking. Redirected out of other residents room but resident continues to go into other residents rooms after aid redirected. Resident taken to his own room where he stood at door way opening and closing door. The Behavior Note dated 4/27/24 at 12:03 PM revealed, Resident continues to wander facility and into other residents rooms. Resident talked to [family member] this morning. He has been taking objects off of medication carts such as pens and markers. Very redirectable today. The Behavior Note dated 4/28/24 at 9:53 PM revealed, Resident noted to be sleeping in bed [Room number redacted, not resident's room]. Resident woke up and redirected back to his own bed where he laid down and has been asleep since. Review of a Psychiatric Subsequent assessment dated [DATE] revealed the resident was referred due to depression, anxiety, worrying, paranoia, hallucinations delusions, confusion, elopement, sleep disturbance, and paranoia. Review of Resident #25's clinical record and facility self report investigation regarding the resident's elopement on 4/30/24 revealed the following: The Facility Investigation for Resident #25 dated 4/30/24 revealed, On 4/30/24 at approximately 5:10am [Resident #25] was observed by staff standing on the east door sidewalk approximately 6-10 feet from the building, on facility property .Upon completion of the investigation, it was determined that [Resident #25] exited the facility through a door leading to the Assisted Living portion of the community which had a manual push button lock what was noted to disengage and exit through the door .[Resident #25] was last observed by CNA (Certified Nursing Assistant), during rounds at 4:40 am standing in his doorway to his room with no signs of distress noted and no signs or symptoms of exit seeking behavior demonstrated. Resident observed going back into room and shutting door at that time. Staff member [name redacted] reports that after seeing the resident at 4:40 am, she went to the area by the nursing station and returned to the hall to complete rounding at approximately 4:45 am in which she could not locate [Resident #25]. Nurse immediately notified and search initiated. During the resident interview, [Resident #25] reported he was sleepwalking and remembered last being in his room. Review of the Self Report for Resident #25 revealed approximate date/time event occurred as 4/30/24 at 5:05 AM. The Incident Summary per the Self Report documented, in part, Resident was standing in his doorway at approximately 4:45 AM, visually seen by CNA, as she exited room across hallway. CNA went towards nurses station to use restroom and after using restroom returned to hall. CNA went to [Resident #25's] room at approximately 5:05 as he was no longer in hall. [Resident #25] was not in his room, CNA made nurse aware and they began looking for him. No alarms were sounding. Nurse state she went outside and was hollering his name and seen him standing in grass approximately 15-20 feet from building. When he heard his name he turned around and when she got to him he willingly returned inside with her. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of staff statements included as part of the facility investigation revealed the following: a. Verbal statement from [Staff N, CNA] 04/30/24: I did rounds on resident throughout the night and resident was asleep in his bed until I saw resident standing in his doorway at 0430. Went into [another room number, redacted] to check and change resident. I needed supplies and came out of the room and saw resident at 0440 in his doorway again, when resident went back into room and shut his door. After rounding I used the rest room and went back down to check on resident when I noticed he was not in his room. Let [Staff K]RN (Registered Nurse) know that he was not in his room and staff started checking the building for resident as there had been no alarm sounding. At approximately 0510, resident was found outside at the east end of the building by [Staff K] RN. b. Verbal statement from [Staff M, CNA] 04/30/24: At approximately 0435 (4:35 AM), I witnessed resident in hallway, attempting to go into other residents rooms and get into the linen closet. I took resident back to his room and I did not see him after that time. After being told that resident was not in his room, I checked north hallway for resident and he was not in any room, bathroom, or closet. c. Verbal statement from [Staff J,CNA] 04/30/24: I went down east hall to help [Staff N] check and change [another room number, redacted] at approximately 0430 (4:30 AM). I saw resident standing in his doorway at that time. We finished checking resident and I went down west hall to do rounds when I was told that resident was no longer in his room. Checked the rooms, bathrooms, and closets down west and resident was not in any of the rooms. d. Verbal statement from [Staff K, RN] 4/30/24: I was alerted at approximately 0445 (4:45 AM) that resident was not in his room. Did a search of the building, in all rooms, bathrooms, and closets and resident could not be located. Called DON (Director of Nursing), [name redacted] and let her know that resident could not be located. No alarms were sounding. Could not locate resident in the building. At approximately 0510 (5:10 AM), I went outside and saw resident at the east side of the building in the grass, with no shoes on. Resident came back into facility with no incidents. Skin and pain assessment completed. No signs or symptoms of trauma noted. VSS (vital signs stable). Review of the Nurses Note dated 4/30/24 at 5:15 AM revealed, Resident was last seen inside his doorway at approx 440 am when the CNAs (Certified Nursing Assistants) had come out of a room across the hallway. Resident was then seen outside on east side of building in the grass. Resident came back inside facility without incident and one on one care was <sic> initiated. The Social Services Note dated 4/30/24 at 11:39 AM revealed, I met with resident concerning this morning behavior. I asked resident if he was looking for something or wanting/needing something. Resident stated, I don't know what I was doing. My memory is bad. Maybe I was looking for some money I dropped (resident began to laugh). No, I am just joking. I don't know what I was doing. Observations and interviews conducted onsite during the time of the survey revealed the following: (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 7/2/24 at 9:35 AM, a voicemail message was left for the State Climatologist. Information as to the weather in [Location where facility located redacted] requested for 4:40 AM to 5:10 AM. On 7/2/24 at 11:05 AM, the State Climatologist provided the following observations: Temperature: 46 degrees F (Fahrenheit), relative humidity: 93%, winds calm to [NAME] at 3 mph (miles per hour), wind chill: 45 degrees F, and fair conditions with no precipitation detected. On 7/1/24 at approximately 11:00 AM, the Administrator queried about camera locations at the facility, explained which areas had cameras, and the response provided did not include the area of the facility where the resident had exited the facility. A walk through was conducted of the doors the resident would have traveled through with the facility's Administrator. Observation revealed first was a set of double doors which went into a common area where the beauty salon was located, referred to by staff as the East day area. It was explained if the door was cracked [ajar], the door would not alarm. The second door was a door from the East day room into the unoccupied assisted living (AL) portion of the facility, and it was explained the lock on the door to the AL had not reengaged. Upon entry to the hallway of the unoccupied AL portion of the facility, a door (exterior door) observed to the right. It was explained the alarm to the door, noted to be third door in travel path, was not hooked to the main section of the facility. Observations of the double doors which lead from the end of 300 hallway into the East day area revealed no alarm sounded at the following times the door was opened by staff and/or surveyor: a.7/2/24 at 9:56 AM b. 7/2/24 at 9:59 AM c. 7/2/24 at 10:12 AM d. 7/2/24 at 2:56 PM. Observation revealed although the right side of the door had an alarm that sounded, the left side of the set of double doors could be opened without an alarm sounding. On 7/2/24 at 3:06 PM, observation conducted of the surrounding area of the facility revealed the facility was located on a two lane road with speed limit of 25 miles per hour. Observation of the area outside of the door where the resident exited the facility (from the assisted living section) revealed a concrete pad, then sidewalk which extended right towards the parking lot in front of the facility. The sidewalk did not have handrails present, and a gap of approximately three inches existed in places between the edge of the sidewalk and the grass. Outside of the door where Resident #25 exited the facility, there was a grass strip of approximately 10 to 15 feet wide between the facility and the parking lot of the neighboring business. On 7/2/24 at 5:56 PM, Resident #25 observed walking down the hall. The resident held a staff member's hand, and observed with tennis shoes to his feet. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Observation on 7/2/24 at 6:25 PM revealed Resident #25 walked independently with tennis shoes to his feet. The resident stood upright and walked near a chair to the front common area/television area at the front of the facility. The resident held onto another chair while he attempted to sit in a stationary chair, and then sat down. On 7/3/24, observation of Resident #25 revealed the resident in his room with the wrong tennis shoe (left shoe) on his right foot, and wanderguard present to the resident's left ankle. Staff assisted the resident with his shoes. When queried if he (Resident #25) ever went out of the facility real early in the morning, the resident responded no. Observation revealed the resident again put the wrong shoe on his right foot. On 7/2/24 at 9:13 AM, Staff M, CNA, who worked the night the resident got out of the facility, explained the following about Resident #25: The previous night the resident was up and down, tried to feed him and he would eat a little bit and get back up. The resident said he wanted to go to bed, and a few minutes later was back up. Per Staff M, some nights the resident slept all night. When queried if she worked the night the resident got out, Staff M responded she was. Per Staff M, she was down North hall, and usually had an aide each hall. Per Staff M, the other girl said Resident #25 was missing. Staff M explained room to room checks and closet check done, Staff M said she could not find the resident. Per Staff M, the alarm must have been going off. When queried if alarms had been going off, Staff M responded she didn't hear any. Per Staff M, she thought the resident needed to be in a locked unit where he could roam free, explained sometimes at night may be in with a resident in another hall and may not see Resident #25 or notice him being gone. Staff M explained for the resident's safety, would be best if he could be in a locked unit. On 7/2/24 at 9:37 AM, interview conducted with Staff J, CNA, who worked when Resident #25 exited the building. Per Staff J, herself and another CNA went down East hall, and went down to answer a call light. Staff J explained the first time, she saw Resident #25 out of his room standing in his doorway. The second time, the door was cracked and she could tell Resident #25 wasn't in there, and Staff J had a feeling the resident was not in there. Staff J explained she went fully in the room and looked and the resident was not in there. Staff J further explained she and the CNA started looking all around all the hallways, looked everywhere, looked in the day area where the double doors were, and never thought to look at [AL name] as it was supposed to be locked. Per Staff J, she and the CNA told the nurse the resident was not in his room, and the resident was in there 20 minutes ago. Staff J explained they looked and looked and looked, and finally had to stop because pharmacy came. Per Staff J, the resident was outside the church's parking lot. Staff J further explained there had been three CNAs and one nurse, and all started looking, looked outside the back and the resident wasn't out there, pharmacy came, the nurse went out, and the resident was in the church parking lot. When queried if pharmacy found the resident, Staff J responded no, and said after pharmacy came looked again, and the resident was in the church parking lot in between the grass and the church. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Staff J explained they did not hear alarms, the resident did not have a wanderguard on, and was supposed to as at risk for wandering. Per Staff J, the alarm to the double door was on , but they did not hear that go off at all, and thought it malfunctioned. Staff J further explained she found out later the resident went out that way to the [AL name redacted], call lights in the [AL] were going off, that is how figured out he was out there (figured out next day). Resident #25 went into the double door to the [AL], was messing with call lights and stuff, went out the side door, and was found in the church/facility grass area. When queried who first saw him outside, Staff J identified Staff K, Registered Nurse (RN), the nurse. Per Staff J, she knew trying to move the resident to a locked facility because the resident wandered too much and because of the incident in April. When queried about the resident's behaviors prior to April, Staff J responded the resident wandered a lot, still did, was very confused, and did not like to listen when told where his room was. Per Staff J, the resident's room had been moved so many times she did not think he (Resident #25) knew where room was at. Staff J further explained the resident got very agitated when told to do stuff, and Staff J explained did not have the staff or the right things to keep the resident in one spot. Per Staff J, the resident had previously escaped from the hospital, and one of the facility employees went on break to the gas station and Resident #25 was standing there. Staff J expressed they felt the resident needed to be moved to an actual locked facility as the resident wandered so much as to no one could keep an eye on him. Staff J also explained the resident was very fast, and the previous night they had to shut the double doors to each hallway, resident kept by the nursing station,and explained being so busy they could not keep eyes on Resident #25 24/7. Per Staff J, Resident #25 went into other peoples' rooms, and there were those that did not like that. On 7/02/24 at 10:32 AM during an interview with Staff L, Certified Medication Aide (CMA), Staff L explained Resident #25 was very restless and she felt like he was confused. Staff L explained the day before she had to sit with Resident #25 for lunch, and the resident wasn't understanding he could take a bite of bread. Per Staff L, the resident tried to take a fork and stab the bread. Staff L further explained the resident had certain areas that were familiar to him, where used to have his room, and the resident would stick by the nurses station. When queried if Staff L ever worked when the resident got out of the building, Staff L responded not when he got out, and one time out smoking and the resident kept going. Staff L explained need to have another face go hey, come back this way. Staff L explained the purpose of the alarm between the 300 hall and East day area was for Resident #25. The resident's previous room noted to have been in right next to the double doors to the East day area. Staff L explained the resident's room had been switched closer to the nurses station. Staff L explained a lot of times the resident would come back to the East day area and would need to be told to come to the front as it was vacant [in East day area]. On 7/2/24 at 10:51 AM during an interview with the Maintenance/Housekeeping Supervisor, the following was explained: The door to the AL had a manual code lock, and if someone put in the code it stayed until opened the door. Per the Maintenance/Housekeeping Supervisor, they though that it what happened, the resident found the door open, and went around the corner. The Maintenance/Housekeeping Supervisor also explained the following for the third door (door to exterior): the alarm was localized, and would not get an alarm at the nurses station. The old pad (to the AL) would only reset when the handle was turned and if put in the code and did not turn the handle, it stayed unlocked. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 7/02/24 at 2:40 PM, Staff A, CNA who worked nights, explained the following about Resident #25: When queried if the resident wandered, Resident #25 said yes. When queried how the facility instructed to address this, Staff A explained she would ask the resident if they wanted to go to the dining room, get something to eat, or watch television in the day area. When queried if it was successful, Staff A responded sometimes, and recently, if told the resident to do something, he forgot right away and started doing his own thing. When queried how long this had occurred, Staff A responded a few weeks ago. When queried if she worked when the resident got our of the facility in April, Staff A responded no. When queried how the resident presented prior, Staff A responded since he went down hill started wandering and went to the East day area (where beauty shop is). Per Staff A, they would catch the resident. Staff A explained there was always an alarm unless someone forgot to turn it back on. Per Staff A, everyone had a different opinion of what the resident was trying to do, and when Staff A looked at the resident, looked like the resident was trying to get us, he would watch, and knew what was going on. Staff A explained it seemed like the resident knew a way to get out back there. On 7/02/24 at 4:44 PM during an interview with the Social Services Director (SSD), the SSD queried about Resident #25's behaviors. Per the SSD, the resident's behaviors as of right now were very mild compared to what he was before when the resident first came. Per the SSD, the resident was doing much better, and what she meant by that of course was not trying to run off. The SSD further explained the reason the resident was running was the voices were telling him. Per the SSD, at that point the resident wasn't on psychotropic medications for schizophrenia, and the resident now saw [psychiatric services provider] for counseling and the psychiatric ARNP (Advanced Registered Nurse Practitioner). Per the SSD, the resident had a lot of wandering tendencies at times, and the resident was able to be redirected. The SSD explained that sometimes the resident would state someone was after him to kill him, and further explained that was the voices, and Resident #25 would be asked if the voices were being bad today. The SSD Director further explained they had been really trying to get the resident to another location closer to [family member], and had one place that was able to get a memory unit/locked unit so that the resident could get in a dementia unit to be more closely monitored so he wouldn't wander out. Per the SSD, the resident could be redirected easily, and was stubborn. When queried how long trying to seek out a locked unit for the resident, the SSD said she was not sure, and she knew it had been over a month. The SSD further explained the resident would be better in a setting that was quieter with more routine and structure. Per the SSD, the resident went from being able to dress himself to now, disorganized, and she thought there was an increase in vascular dementia quite a bit with trying to stabilize symptomatic concern with schizophrenia. The SSD explained the resident had even eloped from the hospital, the resident ended up at a gas station, and a facility staff member was off work getting gas. Per the SSD, that was prior when he resident did not have medications for schizophrenia. The SSD explained the resident did have a POA (Power of Attorney), and further explained the resident had previously tried to take off when in the smoking area because of the voices, and staff went after the resident. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 7/2/24 at 5:14 PM, Staff B, CNA, explained the resident was very distracted very easily. Staff B explained a lot of time spent redirecting the resident because he liked to go into other people's rooms, was very confused, and did not know where his room was because he was moved so much. Per Staff B, the resident tried to go into offices and down corridors. Staff B explained the door alarm (double doors between 300 hall and East day area) was supposed to be on 24/7 and there were numerous times where herself and numerous CNAs would go down the hall and make sure the alarm on, if busy doing something in other people's rooms want to hear alarms, and numerous times staff went out the door and did not turn the alarm on. Per Staff B, people would go back there and not turn on the alarm when came out. During an interview conducted 7/2/24 at 6:32 PM, Staff N, CNA explained the following about the incident: Resident #25 kept peeking his head out all night long. When Staff N attended to duties, and when we came back 5 to 10 minutes later, walked back down to make sure the resident went to bed, and the resident was not in his room. Staff N explained they started checking doors, checking every resident room, bathroom, and closet trying to find Resident #25. Staff N explained couldn't find the resident. Staff N explained she did not know who long it was from the time started looking and someone came back with Resident #25. When queried who came back with Resident #25, Staff N responded she did not know, and said she was outside a lot of the time running around. When queried how the resident did at night, Staff N explained sometimes the resident slept all night and other nights the resident would come hang out all night long, and in and out wanting snack/drink. Staff N explained hit or miss in terms of communication, explained the resident was very confused, and talked about how this (facility) was his house and everything. Interview conducted on 7/2/24 at 6:44 PM with Staff K, RN, revealed the following: Per Staff K, they were back in the back getting supplies when Staff K was called on the walkie [talkie] and told couldn't find Resident #25. Staff K explained she was told staff taking care of resident across the hall, Resident #25 peeked his head out, and had been in the room most of shift and was awake. Staff K explained Resident #25 stuck his head out standing in the doorway, staff took care of another resident, and when came back out, went to take care of someone else, went to Resident #25 and he was not in his room. Per Staff K, they went through a roster and checked resident in each room and kept looking for the resident. Staff K explained looking room to room, and explained all did so. Staff K explained they notified the Administrator and then called the police. Staff K explained looking outside in the parking lots once determined not in the building, and acknowledged looked for quite a while. Staff K further explained she remembered being out in the back walking around, came back in, still searching, explained she walked out the front, and Resident #25 was coming this way. It was explained the resident was right out in the grass by the front parking area, Staff K said the resident's name, and the resident came walking and said he was hungry. When queried what the resident was wearing, Staff K responded regular clothes she was sure because the resident never changed, and was fully dressed. When queried about footwear, Staff K responded she could not remember, and then said socks, and explained she assessed his feet and the resident didn't have shoes on. Per Staff K, she thought the resident had socks on, and explained the resident had no clue he did anything or went anywhere he was not supposed to go. Staff K explained the following about the incident: Before the incident, it went back and forth, and depended on whether the resident [TRUNCATED]

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 48374 Based on observation, interviews and facility policy review the facility failed to utilize standard hand hygiene precautions for infection control when handling soiled laundry. The facility reported a census of 55 residents. Findings include: During an observation on 07/02/24 at 03:20 PM Staff O, Housekeeping, brought a clear garbage bag of soiled laundry into the laundry room. Staff O attempted to use the bag as a barrier but ended up using her bare hand to get soiled laundry out of the bag and into the wash machine. Staff O stated the load of laundry was dirty clothing protectors from the residents. Staff O did not wash her hands after handling the soiled laundry. During an interview on 07/02/24 at 3:40 PM, the Administrator was queried about the process of handling dirty laundry. The Administer stated staff would be expected to use appropriate PPE when handling any soiled laundry including gloves. The Administrator stated she is comfortable knowing facility staff have good hygiene. When clarified the Administrator stated she would expect staff to wash their hands before or immediately after exiting the laundry room and many staff members carry small containers of hand sanitizer in their pockets. During an interview on 07/03/24 at 10:56 AM Staff F, Infection Control and Preventionist was queried regarding appropriate hand hygiene. Staff F stated all staff are trained for appropriate hand hygiene. Staff are required to go through both online and in person refreshers. The facility also does random audits where staff are required to perform hand hygiene to demonstrate competency. When handling soiled laundry all staff are required to wear gloves. When done handling dirty laundry should take off gloves and do appropriate hand hygiene before leaving laundry or touching anything else. Appropriate hand hygiene should be used every single time they take off gloves and definitely before leaving the laundry room. Staff F stated before handling any dirty laundry staff should put gloves on, open the bag, use their hand to put laundry in the wash machine and then throw away the dirty trash bag, take off gloves and perform hand hygiene. We have been doing continuous education with staff and making sure staff new and seasoned staff are aware of when they need to use PPE. On 07/03/24 at 02:49 PM Staff O was queried regarding hand hygiene. Staff O stated she is aware she did not utilize or practice appropriate hand hygiene in the laundry room the previous day. She stated she should have been wearing gloves and she should have stopped and washed her hands before leaving the laundry room. I forgot to put my gloves on and I should have washed my hands in the laundry room before leaving the area. A review of the policy policy, dated 4/28/22, titled Hand Hygiene documented the following: The facility will provide guidelines to employees on proper hand washing and hand hygiene techniques that will aid in the prevention of the transmission of Infections. Employees will be trained and receive ongoing education on the importance of Hand Hygiene in preventing the transmission of Health Care Associated Infections. Hand Hygiene should be performed following the Clinical Indications: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. Before/after providing care. 2. Before/after performing aseptic task (e.g., placing an indwelling device). 3. Contact with blood, body fluids, or contaminated surfaces. 4. Before/after applying/removing gloves/PPE. 5. After handling soiled linens/items potentially contaminated with blood, body fluids, or secretions.