

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  175158	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/22/2024
NAME OF PROVIDER OR SUPPLIER  Garden Terrace at Overland Park		STREET ADDRESS, CITY, STATE, ZIP CODE  7541 Switzer Road Overland Park, KS 66214	

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)
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42966</b></p> <p>The facility identified a census of 156 residents. The sample included three residents. Based on observation, record review, and interviews, the facility failed to provide adequate supervision to prevent Resident (R) 1, a cognitively impaired resident who had a history of making comments about leaving and was at risk for falls, from eloping from the facility. On 07/15/24 at 01:20 PM, Housekeeping Staff U notified Licensed Nurse (LN) G that R1 made a statement to her that he wanted to go home. LN G retrieved a vital sign machine then went to R1's room to obtain his vital signs and noted he was not in his room. LN G asked other staff members if they had seen R1, but they had not. LN G informed Administrative Nurse D that R1 was missing at 01:21 PM. A Dr. [NAME] code was called to inform staff of a missing resident and a resident count began while the facility was searched. Administrative Nurse D and Social Services X exited the second-floor stairwell and exited the facility to the parking lot. R1 was found sitting on the grass, between two parked cars, holding a water glass at approximately 01:30 PM. The temperature outside at 01:00 PM was 92 degrees Fahrenheit (F) and at 02:00 PM was 93 degrees F. R1 wore a T-shirt and long shorts. The door alarm for the stairs where R1 exited did not alarm because the alarm had been turned off for unknown reasons. This placed R1 in immediate jeopardy.</p> <p>Findings included:</p> <ul style="list-style-type: none"> <li>- R1 admitted to the facility on [DATE].</li> </ul> <p>R1's Electronic Medical Record (EMR) documented diagnoses of an anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), chronic respiratory failure, chronic kidney disease (gradual loss of kidney function), and dependence on supplemental oxygen.</p> <p>The Admission Minimum Data Set (MDS), dated [DATE], documented R1 had a Brief Interview for Mental Status (BIMS) score of 11 which, indicated moderate cognitive impairment. R1 had no behaviors. R1 required supervision or touching assistance with transfers and walking.</p> <p>The Cognitive Loss/Dementia (progressive mental disorder characterized by failing memory, confusion) Care Area Assessment (CAA), dated 05/09/24, documented R1 had a BIMS score of 11, retained the ability to make his needs known, and ambulated with a walker.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>The Functional Abilities CAA, dated 05/16/24, documented R1 needed assistance with activities of daily living (ADLs).</p> <p>The Falls CAA, dated 05/16/24, documented R1 had a history of falls.</p> <p>R1's Care Plan, dated 05/03/24, documented R1 was at risk for falls and directed staff to assist R1 with ADLs as needed, place R1's call light within reach, complete fall risk assessment, and orient R1 to his room.</p> <p>R1's Care Plan, dated 05/23/24, documented R1 had a behavior problem with physical aggression and directed staff to administer medications as ordered, anticipate and meet R1's needs, explain all procedures to R1 before starting, allow him to adjust to changes, and intervene as necessary to protect the rights and safety of others.</p> <p>R1's EMR documented a Nursing (NRSG) Elopement Risk Evaluation, dated 05/03/24, that documented R1 as cognitively impaired with poor decision-making skills, which indicated a yes answer in the evaluation. The summary of findings asked if the resident was at risk for elopement at the time and any yes answer would indicate that the resident had a potential for elopement. The answer to the question was selected as no, R1 was not at risk for elopement at that time.</p> <p>R1's EMR revealed the following:</p> <p>A Behavior Note on 05/14/24 at 01:10 PM documented at around 12:50 PM, the housekeeper reported to the nurse that R1 threw an oxygen cylinder to the window. The nurse went to R1's room and found R1 getting to his couch. R1 stated to the nurse he would go through the window, that was what his intentions were, and all he wanted was to get out of the facility. R1 was agitated and wanted to fight. The Director of Nursing (DON) received an order from the Advanced Practice Registered Nurse (APRN) for Haldol (antipsychotic medication used to treat certain mental/mood disorders) five milligrams (mg) immediately. A quick assessment was done with no injuries noted to R1.</p> <p>A Behavior Note on 05/24/24 at 02:55 PM documented R1 constantly removed his oxygen cannula. He got up multiple times, walked by himself, and stated he wanted to go home.</p> <p>An Orders- Administration Note on 06/19/24 at 01:27 PM, documented that staff administered lorazepam (antianxiety medication used to treat anxiety) 0.5 mg because R1 was anxious and trying to elope.</p> <p>An Orders- Administration Note on 06/21/24 at 01:16 PM, documented that staff administered lorazepam 0.5 mg because R1 kept trying to elope.</p> <p>A Physician/Physician Assistant (PA)/Nurse Practitioner (NP) note on 07/15/24 at 04:52 PM, documented the provider saw R1 after he had been outside for a short time. R1 was anxious and combative, and staff brought him back inside. The provider ordered a Haldol 1 mg injection one time to help calm R1 down. The provider ordered laboratory tests and Ativan (lorazepam) 0.5 mg three times a day scheduled to help with R1's agitation.</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>An Event Note on 07/15/24 at 05:06 PM, documented at approximately 01:20 PM, R1 told a housekeeper that he was going home, and she alerted the nurse. When the nurse checked on R1, he was missing from his room. The nurse asked staff members if they saw R1 enter other rooms and they stated no. Staff began looking for R1 and Administrative Nurse D was notified at 01:21 PM that staff could not locate R1. The facility called a Dr. [NAME] (code name used to indicate a missing resident) and staff searched for R1. Administrative Nurse D went to R1's unit and proceeded to the stairwell with Social Services X. Administrative Nurse D and Social Services X searched the stairwell, exited out of the stairwell door to the parking lot, and found R1 at 01:30 PM. R1 sat on the ground, on the grass, between two parked cars and another resident's family member was with him. R1 stated that he was going home and when he walked outside, he saw a lot of people, so he sat down between the cars to hide. Social Services X obtained a wheelchair from inside and staff assisted R1 back into the facility. R1 was agitated and tried to hit staff. Staff notified the provider at 01:33 PM and received an order for Haldol 1 mg injection. Staff notified R1's family at 01:36 PM and hospice at 01:38 PM.</p> <p>In a Witness Statement, dated 07/15/24, Housekeeping Staff U stated she went into R1's room to clean his room. R1 stated to her that he wanted to go home, and he was leaving. Housekeeping Staff U told Licensed Nurse (LN) G what R1 said, and LN G replied okay. Housekeeping Staff U stated she went into another resident's room and two to three minutes had passed when LN G went into R1's room, came out, and stated R1 was not in his room and asked Housekeeping Staff U if she saw R1 leave to which Housekeeping Staff U responded with no, she was in another resident's room.</p> <p>In a Witness Statement, dated 07/15/24, LN G stated while she was passing noon medications and was on hold for a nurse to give her report on a new admission, Housekeeping Staff U cleaned the floors. LN G stated Housekeeping Staff U told her R1 stated he wanted to go home. LN G stated R1 stated he wanted to go home on a regular basis. She stated she asked Housekeeping Staff U if R1 was agitated, and he was not according to Housekeeping Staff U. LN G stated she hung up the phone and walked down the other end of the hall to get the blood pressure machine for R1 but was interrupted by another resident about a wound on his arm. She stated she would be back to help him with a new bandage after getting vital signs on R1. LN G stated R1 was not in his room and no alarms went off to alert staff that a resident needed help. She stated she asked Housekeeping Staff U and Certified Medication Aide (CMA) R if they saw R1 enter another resident's room and they both said no. LN G stated she and CMA R searched the area and could not find R1. She stated she informed Administrative Nurse D that R1 was missing. LN G stated R1 was found and brought back to the unit after receiving Haldol injection for his combative behavior.</p> <p>In a Witness Statement, dated 07/15/24, CMA R stated he came out of his office and saw LN G in the hall. He stated LN G asked him if he had seen R1 and he stated no. CMA R stated he and LN G started looking down the hall and, in every room, bathroom, and closet. He stated when they did not find R1, LN G reported it to Administrative Nurse D.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>The facility's investigative report, dated 07/18/24, documented on 07/15/24 at approximately 01:20 PM, Housekeeping Staff U alerted LN G that R1 stated he was going to go home. LN G questioned Housekeeping Staff U if R1 seemed agitated or upset at that time and Housekeeping Staff U stated R1 did not appear upset. LN G waited on the phone to receive a report from another facility regarding a new admission. LN G hung up the phone and got the vital sign machine then headed for R1's room. She planned to assess R1 and gather his vital signs for his afternoon medications. By the time LN G got to R1's room, he was not in there. LN G asked two staff members if they observed R1 going into another resident's room, and they stated no. At that time, staff searched the unit for R1. LN G notified Administrative Nurse D at 01:21 PM that staff were unable to locate R1. At that time, Administrative Nurse D notified Administrative Staff A, and the facility called Dr. [NAME] code immediately. All staff searched for R1 while Administrative Nurse D and Social Services X exited the stairwell to the parking lot. Administrative Nurse D found R1 sitting on the grass in a seated position between two parked cars with a water glass in his hand. Another resident's family member was with R1 who had given her his phone and asked them to call 911. The family member gave the phone to Administrative Nurse D while Social Services X obtained a wheelchair from the facility. Staff brought R1 back into the facility. R1 was agitated and tried to hit staff. Staff notified the provider at 01:33 PM and obtained an order for Haldol 1 mg injection one time. Staff notified R1's family at 01:36 PM and hospice at 01:38 PM. Nursing staff completed a skin assessment with no injuries found along with a pain assessment without any complaints of pain. R1 wore a short-sleeve T-shirt and a long pair of shorts. The temperature outside at the time was approximately 97 degrees F.</p> <p>According to the Kansas State University Historical Weather website, the temperature on 07/15/24 at 01:00 PM was 92 degrees F and the temperature on 07/15/24 at 02:00 PM was 93 degrees F.</p> <p>On 07/22/24 at 12:12 PM, R1 sat in a recliner in the day area drinking water.</p> <p>On 07/22/24 at 12:12 PM, R1's room was the third room from the unit door to the stairwell at the end of the hall. Administrative Nurse D and Maintenance V accompanied the surveyor to the stairwell door. Administrative Nurse D pushed on the door which alarmed, and she continued pressing the door for 15 seconds until it opened. There was a keypad beside the top of the door to the left and a slider alarm located on the door in the top left corner. Observation of the area revealed the parking lot with uneven surfaces and the grassy hill sloped up towards another parking lot with uneven surfaces. There was a street that ran in front of the facility with a posted speed limit of 30 miles per hour (mph).</p> <p>On 07/22/24 at 02:02 PM, there was a box located over the keypad beside the unit stairwell door.</p> <p>On 07/22/24 at 02:17 PM, R1 stood up from the recliner and started walking while pushing a tray table. Nursing staff immediately went to him and asked if he needed the restroom, which he replied he did. The nursing staff took R1 to the bathroom down the hallway.</p> <p>On 07/22/24 at 12:12 PM, Administrative Nurse D stated the slider alarm was turned off on 07/15/24 when R1 eloped, and they did not know how or why it was turned off. She stated R1 went down the stairs and exited out the side door. R1 had a cup of water and his phone in his hand. Administrative Nurse D stated she found R1 sitting on a grassy hill directly in front of the door, between two parked cars.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 07/22/24 at 12:15 PM, Administrative Nurse D stated the road in front of the facility was open, not blocked off like it was today. She stated she asked R1 if he had fallen when she found him. Administrative Nurse D stated R1 told her he saw a lot of people, so he hid. She stated there was a band going into the facility, so she assumed that was what R1 saw. Administrative Nurse D stated a box was added over the keypad so the alarm could not be turned off unless they had the key and only limited staff had a key to the box.</p> <p>On 07/22/24 at 12:20 PM, Administrative Nurse D stated on 07/15/24, she just finished a meeting around 01:20 PM and LN G went to her office to report they could not find R1. She stated Housekeeping Staff U reported to LN G that R1 stated he wanted to go home, and staff could not find R1 in his room. Administrative Nurse D stated the facility called a Dr. [NAME] which was a code for a missing resident and prompted all staff to look for the resident. She stated she went upstairs to search the unit with Social Services X. Administrative Nurse D and Social Services X proceeded down the stairwell and went outside. She stated they observed R1 sitting on the ground between the cars, on the grass with a cup of water. Administrative Nurse D stated another resident's family member had R1's phone because R1 asked her to call 911. The family member asked if they were looking for R1 and gave the phone to Administrative Nurse D. She stated Social Services X obtained a wheelchair from inside and they assisted R1 into the wheelchair and then into the facility. Administrative Nurse D stated R1 denied being hurt and staff completed skin and pain assessments. She stated R1 was agitated, stating he wanted to leave and find his girls. Administrative Nurse D stated R1 had two granddaughters that visit. She stated staff obtained an order for Haldol 1 mg injection on time and notified the family and hospice. Administrative Nurse D stated R1 was out of the staff's sight for about 10 minutes. She stated when R1 first admitted to the facility, he broke a window with his oxygen tank and nursing staff told her occasionally R1 stated he wanted to go home but never actually tried to exit. Administrative Nurse D stated she reviewed R1's nurse's notes but did not see any notes that he had exit-seeking behaviors in the past. She stated if a resident exhibited exit-seeking behaviors, she expected staff to provide redirection and if they were near doors then they notified the administration the resident was trying to elope. Administrative Nurse D stated on 07/15/24 when R1 went missing, there were no alarms going off because the slider alarm was turned off and the door opened after being pressed for 15 seconds.</p> <p>On 07/22/24 at 12:38 PM, Housekeeping staff U stated on 07/15/24, she entered R1's room to ask him if she could clean it and he said fine. She stated he said to her that he wanted to go home. Housekeeping Staff U stated she told LN G, and she replied okay. She stated LN G asked her if she saw R1 go into another room because he was not in his room, and she told LN G she had not. Housekeeping Staff U stated everybody started looking for R1 and the facility called a Dr. [NAME] code. She stated when she was in R1's room to clean it, he sat in his wheelchair. She stated the stairwell door at the end of the hallway did not alarm and no other alarms were on.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 07/22/24 at 12:44 PM, LN G stated on 07/15/24 around 01:20 PM, Housekeeping Staff U reported to her R1 said he wanted to go home. She stated R1 says he wants to go home a lot. LN G stated she was on the phone trying to verify orders for a new admission that day and immediately hung up the phone. She stated she went to the end of the other hall to get the vital sign machine and was on her way to R1's room when she was stopped by another resident for a bandage. She told him she would help him later after checking on R1. LN G stated she went down the hall as fast as she could with the vital sign machine to R1's room but he was not in his room. She stated she asked CMA R if he had seen R1, but he had not. She stated they checked every room and bathroom then she notified Administrative Nurse D when they were unable to locate R1. LN G stated she found out the door alarm to the stairwell door was off. She stated R1 took his oxygen off, left his wheelchair in his room, took his water with him, and went down the stairs. LN G stated R1 would say he wanted to go home, and she would talk to him about it but he had not had any exit-seeking behaviors on her shifts. She stated if a resident was actively exit-seeking, she redirected the resident with something they liked such as a snack, music, their family, or an activity. She stated she knew who an elopement risk was by the elopement risk assessments and by word of mouth. LN G stated the care plan addressed residents with elopement risks and the aides had access to the care plans.</p> <p>On 07/22/24 at 01:09 PM, Certified Nurse Aide (CNA) M stated she knew what residents were at risk for elopement by the elopement book at reception and the Kardex (a nursing tool that gives a brief overview of the care needs of each resident). She stated if a resident was exit seeking, she told the nurse and redirected the resident with something they were interested in to shift their mind off of the behavior.</p> <p>On 07/22/24 at 02:10 PM, Maintenance V stated when the unit door was pushed, the magnetic lock alarmed and the slider alarm went off. He stated the slider alarm went off regardless of if the code was put into the keypad or not and the slider alarm was supposed to stay turned on.</p> <p>On 07/22/24 at 02:16 PM, CMA R stated on 07/15/24 when R1 eloped, he did not hear any alarms going off.</p> <p>On 07/22/24 at 02:18 PM, Social Services X stated on 07/15/24, she heard a Dr. [NAME] code called and went upstairs to look for R1. She stated she and Administrative Nurse D went to the end of R1's hall. Social Services X stated there were no alarms going off.</p> <p>On 07/22/24 at 02:31 PM, Administrative Staff A stated on 07/15/24, she was in her office on a call when Administrative Nurse D came in and reported they could not find R1. She stated Social Services X came in for a wheelchair for R1 and staff assisted him into the wheelchair and then brought him inside. She stated R1 was very agitated and said he was hiding from the facility. Administrative Staff A stated the slider alarm was turned off on the unit's stairwell door. She stated her expectations if a resident had exit-seeking behaviors or made a comment about going home the CNA would tell the nurse or if a housekeeper heard it, they were to stay with the resident and use the call light for assistance.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>The facility's Elopement Policy revised 07/09/14, directs each resident will have an individualized care plan identifying the risk of elopement and appropriate interventions for their safety. Residents who are identified as High Risk for elopement will be determined by a yes to any of the following questions: history of elopement from home prior to admission; history of leaving the unit or facility without staff knowledge; expressing a desire to go home, packing belongings, or staying near or attempting to exit door; new admission; family or responsible party voiced concerns that the resident may try to leave.</p> <p>The facility failed to provide adequate supervision for R1 who eloped from the facility on 07/15/24 at approximately 01:20 PM. R1 was found outside in the parking lot and the temperature outside was 92 to 93 degrees F. The door alarm to the second-floor stairwell door was not turned on and did not alarm to alert staff the resident exited the building. This deficient practice placed R1 in immediate jeopardy.</p> <p>The facility completed the following corrective actions, which were verified by the onsite surveyor::</p> <ol style="list-style-type: none"> <li>1. The facility placed R1 on one-on-one supervision immediately on 07/15/24.</li> <li>2. The facility updated R1's Care Plan to include the resident's risk for elopement on 07/15/24.</li> <li>3. An Ad-Hoc Quality Assurance and Performance Improvement (QAPI) meeting was held on 07/15/24.</li> <li>4. Maintenance audited exit doors and alarms on 07/15/24 with continued audits planned.</li> <li>5. A key-access-only box was placed over the keypad for the second-floor stairwell door on 07/15/24.</li> <li>6. Staff education on elopement was completed from 07/15/24 to 07/16/24.</li> <li>7. An elopement drill was completed on 07/16/24.</li> <li>8. Residents with a BIMS of 12 or below were audited from 7/15/24 to 7/16/24.</li> <li>9. Residents at risk for elopement were audited with their care plans updated accordingly from 7/15/24 to 7/16/24.</li> </ol> <p>Because all corrective measures were implemented and completed prior to the onsite survey, this deficient practice was cited as past noncompliance. The scope and severity remain a J.</p>		