STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185165	A. Building B. Wing	12/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lyndon Crossing	1101 Lyndon Lane Louisville, KY 40222

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 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, review of the clinical record, and review of the facility policy, the facility failed to implement the resident(s) care plan interventions for 1 out of 9 resident(s) sampled for elopement risk, Resident (R)1.The facility admitted R1 on 07/08/2025 and was assessed to be a risk for elopement. The resident was required to reside on the secured memory care unit, which required supervision while on the unit. Per the policy and the resident's care plan, this was for the resident's safety. Additionally, the resident's care plan interventions included providing structured activities. On 09/15/2025, R1 left the facility unsupervised and without staff knowledge. Interviews with staff revealed the resident's care plan was not implemented due to staff providing care to other residents on the unit. Immediate Jeopardy (IJ) was identified on 10/24/2025 and was determined to exist on 09/15/2025 in 42 CFR 483.21 Develop/Implement Comprehensive Care Plan, F656 at a Scope and Severity (S/S) of a J. The facility was notified of the IJ on 10/24/2025 at 2:14 PM.On 10/24/2025 at 2:14 PM, the facility's Administrator, and Interim Director of Nursing (DON) were provided a copy of the IJ Template and notified of the facility's failure to implement interventions of a person-centered care plan to ensure resident safety was likely to cause serious injury, impairment, or death.The facility provided an acceptable IJ Removal Plan on 10/28/2025 at 12:46 PM, alleging removal of the IJ on 09/17/2025, prior to the State Survey Agency (SSA) entrance to the facility. On 10/28/2025, the SSA validated the facility implemented their removal plan on 09/17/2025 and was determined to be past IJ. Refer to F689 The findings include:Review of the facility's policy, Elopements and Wandering Residents, reviewed/revised 02/13/2024, revealed residents at risk for elopement received adequate supervision to prevent accidents, and received care in accordance with their person-centered plan of care addressing unique factors contributing to wandering or elopement risk. Review of the facility's policy, titled, Comprehensive Care Plan, reviewed/revised on 12/23/2023, revealed the facility was to develop and implement a comprehensive person-centered care plan for each resident. The care plan was to be consistent with resident rights, including measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the resident's comprehensive assessment.Review of the clinical record for R1 revealed the facility admitted the resident on 07/08/2025 with diagnoses of dementia with behavioral disturbance, cognitive communication deficit, anxiety, and major depressive disorder.Review of the facility's Elopement/Wandering Risk Evaluation, dated 07/08/2025 at 4:36 PM, revealed the facility assessed R1 for elopement/wandering and the resident received a score of three, which indicated moderate risk for elopement. Review of R1's admission Minimum Data Set (MDS) dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of five, which indicated severe cognitive impairment.Review of R1's Comprehensive Care Plan dated 07/09/2025 revealed the facility assessed the resident to reside on its secured unit, for her safety. Additionally, the Care Plan revealed the resident had impaired cognitive (continued on next page)

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185165	A. Building B. Wing	12/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lyndon Crossing	1101 Lyndon Lane Louisville, KY 40222

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 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	function/dementia or impaired thought processes. Continued review of the care plan revealed, under the focus of requiring the safety of the secured unit, the intervention was for the resident to be supervised while on the secured unit. Diversion interventions included to provide structured activities: toileting, walking inside and outside, reorientation strategies including signs, and pictures and memory boxes. Review of R1's Progress Notes, dated 09/12/2025, 09/14/2025, and 09/15/2025 revealed the resident expressed to staff her desire to go home. Review of the Progress Note dated, 09/15/2025, revealed the alarm went off on the female memory care unit and it was discovered that resident was not present. In an interview with the Sheriff Officer on 10/22/2025 at 12:05 PM, he stated he received a call from concerned citizens in the park around 8:33 PM and the call was dispatched around 8:35 PM. He stated the citizens reported they found a lady [R1] sitting on a park bench, stating she had been held captive for years and she ran way. Per the interview, the sheriff officer stated he did not know which facility the resident resided, so he started with the closest facility in proximity to the park. He stated he walked into the facility, told staff the resident's name, and asked if she was missing. He stated the staff reported, no, and informed him that the resident was in her room. The officer stated that when the staff went to R1's room, they noticed the resident was missing. He stated he communicated to the staff that the resident was found in the local park. He stated a nurse (LPN1) went with him to the park and convinced R1 to return to the facility with her. Further, he stated the resident did not want to return to the facility. The sheriff officer stated he was uncertain how long R1 was in the park before the 911 call came into dispatch. In continued interview, on 10/22/2025 at 12:05 PM, with the Sheriff Officer, he stated he believed R1 was able to exit the property by somehow figuring out how to unlock the gate connected to the privacy fencing. The officer stated that when he responded to the facility, no staff member reported to him that they were looking for or were missing a resident.During an interview with R1, on 10/21/2025 at 10:30 AM, she stated on the night she went to the park she prayed for an intervention from God and both exit doors opened. R1 stated the wood (fence slat) was faulty and she was able to get through it. She stated she was running as fast as she could. R1 stated that when she arrived at the park, she sat down on a bench. She stated she talked to a couple about her escape from the facility and they called the police. She stated she should not have told them because the police showed up and brought her back to this [facility] place. R1 continued to state that she was very unhappy in this place, adding, I don't belong here and if I am able to leave again, I will. In an interview with Certified Nursing Assistant (CNA)5 on 10/22/2025 at 1:57 PM, she stated she was assigned to work with the resident, on 09/15/2025, the night the resident went missing. She stated there were two CNAs and one nurse that worked the unit. Per the interview, CNA5 stated she was putting her residents to bed and had put R1 to bed twice. She stated that when she heard the alarm go off, she, along with CNA3 and Licensed Practical Nurse (LPN2) ran back to the exit door. CNA5 stated they looked for any other residents that may have gone outside and did not see anyone. She stated the nurse then turned the alarm off. Further, she stated she did not recall another alarm going off that evening. In continued interview with CNA5, she stated she did not implement the residents care plan, related to supervision of the resident while on the secure unit because she did not work the unit very often. Additionally, she stated that at the time the resident left the facility, she was giving a shower to two other residents and could not supervise the resident. In an interview with CNA3 on 10/21/2025 at 6:50 PM, she stated on the night of 09/15/2025 she was assigned the rooms on the women's memory care [secure] unit. However, CNA3 stated R1 was not assigned to her. Per the interview, she stated she was giving a shower to a resident when the alarm went off. The CNA stated she stopped what she was doing and went to the exit door. She (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185165	A. Building B. Wing	12/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lyndon Crossing	1101 Lyndon Lane Louisville, KY 40222

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 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	stated she saw R1 standing at the exit door and she moved R1 to the dining room. CNA3 stated she did not know the code to stop the alarm, so she went and got LPN2 to assist with turning the alarm off. The CNA stated that during that time, the door did not lock right away. CNA3 stated she went back to assisting her assigned residents with showers. She stated that after she had completed her task, she noticed the unit was quiet adding that R1 could be loud. She stated it was around 8:00 PM when the police showed up and the LPN2 was in the middle of administering the residents their medications. Further, CNA3 stated no one was actively looking for R1 that night. In an interview with LPN2 on 10/22/2025 at 2:17 PM, he stated he was working on the night of 09/15/2025 on the secure memory care unit. He stated he was in the middle of rounding, on the men's memory care unit, when he heard the alarm go off on the women's side. He stated he responded to the alarm and checked the courtyard. He stated the courtyard was empty. LPN2 stated he stepped outside and did not see anyone. He stated he started to check the resident's rooms, as per policy. Further, he stated that when the police arrived at the facility, he was doing the bed checks of residents. He stated the officer came and asked if he knew R1 and that was when he knew the resident was out of the facility. LPN2 stated the resident was not gone long, probably about five or ten minutes. LPN2 stated the alarm went off only one time that night. LPN2 stated he was working with two CNAs that night. Further, he stated the CNAs were in the middle of doing things with other residents when he responded to the sound of the alarm that came from the women's secured unit. In an interview with Licensed Practical Nurse (LPN)1 on 10/22/2025 at 9:37 AM, she stated on 09/15/2025 she worked late on day shift and was finishing charting when she observed an officer at the door. She stated he asked her if the facility knew R1. LPN1 stated she showed him a picture of R1 from her computer and the officer confirmed that it was R1. Further, she stated the officer told LPN1 that R1 was at the park. She stated she went with the officer in his car to the park. She said that when they arrived at the park, the resident stated she did not want to return to the facility. She stated R1 reported she wanted her freedom. Per the interview, LPN1 stated R1 told bystanders she was being held captive. In an in interview on 10/23/2025 at 12:22 PM with the Minimum Data Set (MDS) nurse, she stated when the facility admitted a resident, a baseline care plan was triggered for an admission evaluation. As things change or progress, MDS would update the resident's care plan as needed, or update in a morning meeting. Per the interview, she stated she would update the care plans as staff developed the interventions for the care plans. Regarding the elopement incident with R1, she stated the facility reviewed the factors that lead to the resident's elopement. She stated the resident had increased anxiety, as a new resident. She stated staff updated the resident's care plan the night of the incident and came up with several interventions. Per the interview, she stated the resident was placed on 15-minute checks for 72 hours to see if her anxiety would decrease following the incident. After 72 hours, the facility determined R1 was no longer a risk, and her anxiety had decreased. In an interview on 10/23/2025 at 3:54 PM with the Director of Nursing, she stated regarding the elopement, she got a call from the LPN2 that R1 had gotten out the door. She stated anyone in nursing can develop a care plan. Per the interview, she stated care plans were developed or revised when there was a change in resident status prompting a change to the care plan. The DON stated staff that provided oversight of the care plans were the nursing department, nurses' staff, CNAs, social workers, anyone that participates in any level of care for the resident. The DON stated she believed redirection by implementing directional activities according to the care plan were performed that night. However, interviews with CNA5 on10/22/2025 at 1:57 PM, CNA3 on 10/21/2025 at 6:50 PM, and LPN2 on 10/22/2025 at 2:17 PM, revealed they were with other residents during the time the resident exited the facility unsupervised, which was a failure to implement the (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185165	A. Building B. Wing	12/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lyndon Crossing	1101 Lyndon Lane Louisville, KY 40222

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 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	resident's care plan.In an interview on 10/23/2025 at 3:37 PM with the Administrator, he stated he got the call, regarding the elopement, in the evening 9:15 PM or 9:30 PM, on 09/15/2025. He stated R1 had interventions placed in her care plan. Per the interview, he stated R1 was pleasantly confused and have some sun downers. He stated the resident was placed on the secure unit for her safety. The Administrator stated R1 wanders. Further, he stated he did not recall a time the facility placed the resident on one-to-one supervision, but increase monitoring was provided on the first few days of the resident's admission. The Administrator stated staff were to provide diversional activities to the resident that were person centered adding the resident loved to dance, complete housework, and loved to preach. The Administrator stated he did not know if any of those interventions were offered to the resident the night of the elopement. Further, he stated the resident was care planned for diversional activities.The facility alleges removal of the Immediate Jeopardy as of 09/16/2025 and a copy of their removal plan is provided below verbatim:Date 10/24/25Regional Program ManagerCabinet for Health and Family Services 908 W. BroadwayLouisville, Kentucky 40203Re: [NAME] Crossing, LLCLetter of Notification of Removal of Immediate JeopardyAs required by state and federal law, please accept the following as [NAME] Crossing credible allegation of removal oflmmediate Jeopardy effective 9/17/2025. The facility submits this Allegation as it is required by Federal and State law. Submission of this Credible Allegation does not constitute an admission or agreement with the facts alleged or the conclusions set forth in the verbal and written notice of immediate jeopardy and/or any subsequent Statement of Deficiencies. The Facility reserves all rights to contest, appeal and dispute the IJ and the alleged facts and conclusions on which it is based. The following plan of action outlines immediate interventions employed by the Facility to abate immediate jeopardy.F656 Comprehensive Resident Centered Care Plan1. Actions Taken for Resident Affected/Immediate Intervention.Resident 1 's Care Plan was updated to include increased supervision by staff, q15 minute checks were immediately implemented, psychosocial visit/assessment 1 time per day for 3 days. Pain evaluation completed, no negative findings. Medication and Laboratory reviews conducted.Resident 1 was the only resident affected, at this time.Elopement drills conducted by Maintenance director on 9/16/2025 1 per shift (2 shifts) to ensure staff comprehension on elopement drill process. Staff acknowledged understanding via verbal validation.100% elopement evaluations on all facility residents by licensed nursing staff on 9/15/2025 completed on 9/16/2025.100% Elopement Care Plans by facility MOS Coordinator and Director of Nursing Services reviewed 9/15/2025 completed on 9/16/2025.100% staff education, including contract staff, on Elopement policy and procedure completed by Executive Director, Director of Nursing Services, and appropriate Department Heads on 9/15/2025 and 9/16/2025. Staff acknowledged understanding via verbal vaiidation.Staff education to Social Services staff and MDS Coordinator related to updating resident care plans and the implementation of interventions was completed by the Executive Director on 9/16/2025. Staff acknowledged understanding via verbal validation.2. Identification of Residents with Potential to be Affected/Immediate InterventionAll Residents' care plans were reviewed to ensure those at risk are reflected on the comprehensive care plan and Kardex by Executive Director/MOS/Regional [NAME] President of Clinical Services on 9/15/2025-9/16/2025. All care plans reviewed by Executive Director/MOS/Director of Nursing Services who trigger for 'at-risk' and 'high-risk' will have an elopement care plan.Revisions were made by MDS Coordinator to include residents at risk for elopement in residents' care plans. This task was completed by MDS Coordinator/Director of Nursing Services by 9/16/2025.Elopement Policy was reviewed by IDT to include individualized interventions for those residents at risk for elopement on 9/16/2025. IDT members include Executive Director, Director of Nursing Services, MDS Coordinator, Director of Rehab, Activity Director, Dietary Manager, and (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185165	A. Building B. Wing	12/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lyndon Crossing	1101 Lyndon Lane Louisville, KY 40222

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 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Clinical Managers.The DNS/ED will audit new admissions weekly X3/Months to ensure Elopement Risk and Interventions are in place and Care Plan and Kardex Updated accordingly. This was completed by DNS/ED on 9/16/2025.Education provided to nursing staff on updating Care Plans, Elopement Evaluation and Kardex as needed. This task was completed by DNS/ED by 9/16/2025. Nursing staff education to be continued by DNS/ED/Unit Manager/Staff Development Coordinator until complete with no new nursing staff working that is not educated after 9/16/2025. Nursing staff will not be able to work at the facility until educated, to include any new hires and contract staff. Staff acknowledged understanding via verbal validation.Elopement risk assessments completed by Director of Nursing Services/MOS Coordinator/Therapy Director on all residents. This task was completed by 9/16/2025.3. Systemic Measures/TrainingMOS/Social Services educated by 9/16/2025 regarding elopemei1t evaluation and implementing interventions based on evaluation findings; with individualized interventions related to supervision and observation, how to complete the elopement evaluations, importance of following care plan and Kardex and necessity of staff to be available and respond to aianns. Staff acknowledged and understanding via verbal validation.The DNS/StaffDevelopment Coordinator/Unit Managers educated 100% of staff by 9/16/2025 regarding the necessity to revise the care plan following the identification of at-risk residents per the elopement evaluation; with individualized interventions related to supervision and observation, how to complete the elopement evaluations, importance of following care plan and Kardex. Staff education to be continued by DNS/Staff Development Coordinator/Unit Managers until complete with no staff working that is not educated after 9/16/2025. Nursing staff will not be able to work at the facility until educated, to include any new hires and contract staff. Staff acknowledged understanding via verbal validation.The MOS Coordinator will review all baseline care plans and comprehensive care plans to ensure revision of the care plans following the identification of at-risk residents per the elopement evaluations; with individualized interventions related to supervision and observation. This task was completed by MOS by 9/16/2025.4. Quality Assurance Measures/MonitoringThe MOS Coordinator will review all Comprehensive Care Plans to ensure revision of the care plans following the identification of at-risk residents per the elopement evaluations; with individualized interventions related to supervision and observation. This task was completed by MOS on 9/16/2025.The DNS/ED will audit new admissions weekly X3/Months to ensure elopement risk and appropriate interventions are in place and care plan and Kardex updated accordingly. This was completed by Director of Nursing Services/ED by 9/16/2025.An Ad-Hoc QAPI meeting was held with the Executive Director, Medical Director, Director of Nursing Services, Social Services, MOS, Dietary Manager, HR Director, Maintenance Director Unit Managers to review the plan and findings. This action was completed by the Executive Director on 9/16/2025.Care Plan and Elopement Assessment audits will be forwarded to the Executive Director for review by the QAPI Committee (Executive Director, Medical Director, Director of Nursing Services, Maintenance Director, Food Service Director, and Business Office Manager). Monthly at a minimum of three months to ensure ongoing compliance.QAPI Meetings will be held Monthly. This will be completed by the Executive Director beginning on 9/16/2025.All monitoring will be audited and reviewed by the Executive Director and/or the Director of Nursing Services until ongoing compliance is achieved and maintained. Any deficient practices discovered during the monitoring process will be corrected immediately and referred to the QAPI Committee for further review and appropriate interventions.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185165	A. Building B. Wing	12/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lyndon Crossing	1101 Lyndon Lane Louisville, KY 40222

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 - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, record review, and review of the facility's policy, the facility failed to ensure each resident received adequate supervision for 1 out of 9 sampled residents. Resident (R)1.On 07/08/2025, the facility admitted R1 and assessed the resident to require the need to reside on its memory care [secure] unit with supervision provided while on the unit. According to the facility's policy and R1's care plan, this was for the safety of the resident. However, on 09/15/2025 the resident left the facility unsupervised. The resident was found at the park, approximately .4 miles away from the facility, by concerned citizens who called 911 to alert the police of the missing resident. When the [NAME] Officer questioned staff about the resident, staff stated they were unaware the resident had left the facility. Immediate Jeopardy (IJ) was identified on 10/24/2025 and was determined to exist on 09/15/2025, in 42 CFR 483.25 Quality of Care, F689 at a Scope and Severity (S/S) of a J. The facility was notified of the IJ on 10/24/2025 at 2:14 PM.On 10/24/2025 at 2:14 PM, the facility's Executive Director and interim Director of Nursing (DON) were provided a copy of the IJ Template and was notified that the facility's failure to ensure the resident's supervision and safety was likely to cause serious injury, impairment, or death.The facility provided an acceptable IJ Removal Plan, on 10/28/2025 at 12:46 PM, alleging the removal of the IJ on 09/17/2025, prior to the State Survey Agency (SSA) initial entrance to the facility on [DATE]. The SSA validated removal of the IJ and determined the IJ to be past. The findings include:Review of the facility's policy, Elopements and Wandering Residents, reviewed/revised on 02/13/2024, revealed residents who were at risk for elopement received adequate supervision to prevent accidents, and received care in accordance with their person-centered plan of care addressing unique factors contributing to wandering or elopement risk. Additionally, the facility was equipped with door locks/alarms to help avoid elopements. Continued review of the policy revealed alarms were not a replacement for necessary supervision. Staff were to be vigilant in responding to alarms in a timely manner. Further policy review revealed, the facility was to establish and utilize a systematic approach for monitoring and managing residents at risk for elopement. The systematic approach was to include identification and assessment of risk.implementing interventions to reduce hazards and risks and monitoring the effectiveness and modifying interventions when necessary. The policy further revealed the interventions to increase staff awareness of the resident's risk would be added to the resident's care plan and communicated to the appropriate staff.Review of the clinical record for R1 revealed the facility admitted the resident on 07/08/2025 with diagnoses of dementia with behavioral disturbance, cognitive communication deficit, anxiety, and major depressive disorder. Further review of R1's discharge summary from the hospital revealed the resident required a secured unit, a locked unit, based on the resident's cognitive deficits, dementia, impaired safety decisions and poor safety awareness. Review of the facility's Elopement/Wandering Risk Evaluation, dated 07/08/2025 at 4:36 PM, revealed the facility assessed R1 to have a score of three, indicating R1 was a moderate risk for elopement. Review of the admission Minimum Data Set (MDS) revealed the facility assessed R1 to have a Brief Interview for Mental Status (BIMS) score of five, indicating R1 had severe cognitive impairment.Review of R1's Comprehensive Care Plan, dated initiated on 07/09/2025 and revised on 07/24/2025, revealed the goal of the resident's care plan was for the resident to maintain safety while residing on the secure unit. Further review revealed interventions included that Activities of interest would be provided to the resident and provide redirection as needed. Continued review revealed residents would be supervised while on the secured unit. Review of R1's Progress Notes, dated 09/12/2025, revealed the resident had behavioral issues .and (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185165	A. Building B. Wing	12/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lyndon Crossing	1101 Lyndon Lane Louisville, KY 40222

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 - Few	constantly stated she wanted to go home. Continued review of the Progress Note dated 09/14/2025, revealed the resident yelled out for God to get her out .and constantly expressed a desire to go home. Review of R1's progress note dated 09/15/2025 at 8:50 PM revealed staff responded immediately to [an] alarm sounding on the female memory care unit. Review of the website www.underground.com revealed on 09/15/2025 the temperature at 8:56 PM was 82 degrees Fahrenheit. In an interview with the Sheriff Officer on 10/22/2025 at 12:05 PM, he stated he received a call from concerned citizens in the park around 8:33 PM and the call was dispatched around 8:35 PM. He stated the citizens reported they found a lady [R1] sitting on a park bench, stating she had been held captive for years and she ran way. Per the interview, the sheriff officer stated he did not know which facility the resident resided, so he started with the closest facility in proximity to the park. He stated he walked into the facility, told staff the resident's name, and asked if she was missing. He stated the staff reported, no, and informed the sheriff officer that the resident was in her room. The sheriff officer stated that when the staff went to R1's room, they noticed the resident was missing. He stated he communicated to the staff that the resident was found in the local park. He stated a nurse [LPN2] went with him to the park and convinced R1 to return to the facility with her. Further, he stated the resident did not want to return to the facility. The officer stated he was uncertain how long R1 was in the park before the 911 call came into dispatch. In continued interview, on 10/22/2025 at 12:05 PM, the Sheriff Officer stated R1 was appropriately dressed. He stated he believed R1 was able to exit the property by somehow figuring out how to unlock the gate connected to the privacy fencing. The sheriff officer stated that when he responded to the facility, no staff member reported to him that they were looking for or missing a resident.Observation on 10/21/2025 at 10:30 am of the secured memory care unit revealed R1's room was directly kitty cornered to the facility's exit door. Continued observation revealed the exit door opened only when the code was entered into its keypad. Outside the exit door was a tall wooden fence that surrounded the courtyard. Further observations revealed the distance from the facility to the local park was approximately 0.4 miles. During an interview with R1, on 10/21/2025 at 10:30 AM, she stated on the night she went to the park she prayed for an intervention from God and both exit doors, located by her room, opened. R1 stated the wood (gate, connected to the fence surrounding the courtyard) was faulty and she was able to get through it. She stated she was running as fast as she could. R1 stated that when she arrived at the park, she sat down on a bench. She stated she told a couple who were at the park about her escape, and they called the police. She stated she should not have done that because the police showed up and brought her back to this [facility] place. R1 continued to state that she was very unhappy residing in the facility, adding, I don't belong here and if I am able to leave again, I will. In an interview with R1's State Guardian, on 10/22/2025 at 10:26 AM, she stated R1 was a new client to her and R1 wanted to return home to be near family. The State Guardian stated the resident was upset and did not like the circumstances that lead to her becoming a resident within the facility. In an interview with Certified Nurse Assistant (CNA)5 on 10/22/2025 at 1:57 PM, she stated she was assigned to work with the resident, on 09/15/2025, the night the resident went missing. She stated there were two CNAs, which included herself, and one nurse who worked the unit with a total of 16 residents. Per the interview, CNA5 stated she was putting her residents to bed and had put R1 to bed twice. She stated that when she heard the alarm go off, she, along with CNA5, and LPN2 ran back to the exit door leading to the courtyard. She stated she saw a lady [a resident] in her wheelchair. She stated the resident in the wheelchair was moved out of the way. CNA5 stated they looked for any other residents that may have gone outside and did not see anyone. She stated LPN2 then turned the alarm off. Further, she stated she did not recall (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185165	A. Building B. Wing	12/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lyndon Crossing	1101 Lyndon Lane Louisville, KY 40222

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 - Few	another alarm going off that evening. CNA5 stated the police came to the facility and asked if the resident had left the facility. Per the interview, CNA5 stated they were unaware the resident had left her room. CNA5 stated she had no idea how R1 was able to leave. She stated R1 must have gone through the exit door when the alarm went off.In a subsequent interview on 10/23/2025 at 3:06 PM with CNA5, she stated R1's behaviors included packing a suitcase and making statements of wanting to leave the facility. Per the interview, she stated that earlier that week, there was an issue with R1 pushing on the exit doors. She stated staff kept R1 up front to keep R1 from pushing on the doors. CNA5 stated that earlier that day, on 09/15/2025, the resident was antsy and wanted to get out. She stated the resident stated, I want to get out. Further, she stated she could not recall what R1 was wearing when she eloped. She stated R1 typically wore her clothes to bed, as this was her preference. CNA5 stated she had given R1 a shower at around 8:30 PM and placed a robe on her and assisted the resident to bed. She stated that after she placed the resident in her bed, the resident got up and went to the dining room and laid on the floor. CNA5 stated she got the resident up off the floor and escorted R1 back to her room. She stated that was the last time she saw the resident as she had to give showers to two other residents.In an interview with CNA3 on 10/21/2025 at 6:50 PM, she stated on the night of 09/15/2025 she was assigned the rooms of the women's memory care [secure] unit. However, CNA3 stated R1 was not assigned to her. Per the interview, she stated she was giving a shower to a resident when the alarm went off. The CNA stated she stopped what she was doing and went to the exit door. She stated she saw R1 standing at the exit door and she moved R1 to the dining room. CNA3 stated she did not know the code to stop the alarm, so she went and got LPN2 to assist with turning the alarm off. The CNA stated that during that time, the door did not lock right away. CNA3 stated she went back to providing a shower to a resident. She stated that after she had completed her task, she noticed the unit was quiet adding that R1 could be loud. She stated it was around 8:00 PM when the police showed up and the nurse (LPN2) was in the middle of administering the residents their medications. Further, CNA3 stated no one was actively looking for R1 that night.In an interview with Certified Nursing Assistant (CNA)1 on 10/21/2025 at 1:26 PM, she revealed she had not worked the night of the incident but was familiar with R1 as she had worked with her on the memory care unit. According to CNA1, R1 could read, and the door had a sign that stated to push [the door had a push bar] until the alarm sounded and the door would be opened in 15 seconds. Per the interview, CNA1 stated that was how the resident got out. CNA1 revealed the resident used to push on the door all the time and always looked at the door to see if someone would go out of it. Further, the CNA stated the resident continued to make statements of wanting to go home.In an interview with Licensed Practical Nurse (LPN)1 on 10/22/2025 at 9:37 AM, she stated on 09/15/2025 she worked late on day shift and was finishing charting when she observed an officer at the door. She stated he asked her if the facility knew R1. LPN1 stated she showed him a picture of R1 from her computer and the officer confirmed that it was R1. Further, she stated the officer told LPN1 that R1 was at the park. She stated she went with the officer in his car to the park. She said that when they arrived at the park, the resident stated she did not want to return to the facility. She stated R1 replied, she wanted her freedom. Per the interview, LPN1 stated R1 told bystanders she was being held captive. In an interview with LPN2 on 10/22/2025 at 2:17 PM, he stated he was working on the night of 09/15/2025 on the secure memory care unit. He stated he was in the middle of rounding, on the men's memory care unit, when he heard the alarm go off on the women's side. He stated he responded to the alarm and checked the courtyard. He stated the courtyard was empty. LPN2 stated he stepped outside and did not see anyone. He stated he started to check the resident's rooms, as per policy. Further, he stated that when the police arrived at (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185165	A. Building B. Wing	12/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lyndon Crossing	1101 Lyndon Lane Louisville, KY 40222

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 - Few	the facility, he was doing the bed checks of residents. He stated the [NAME] officer came and asked if he knew R1 and that was when he knew the resident was out of the facility. LPN2 stated the resident was not gone long, probably about five or ten minutes. LPN2 stated the alarm went off only one time that night. LPN2 stated he did not report a missing resident to the sheriff officer. He stated that when the alarm went off, he had to leave the men's secure unit to report to the women's secure unit, which was one unit over, separated by a door with a keypad entrance. LPN2 stated he was working with two CNAs that night. The CNAs were in the middle of doing things with other residents when I was coming over from the men's side. LPN2 stated R1 was able to leave the facility by pushing open the gate from the courtyard.In interview on 10/21/2025 at 10:25 AM with the Maintenance Director, he stated the courtyard gate through which R1 used to exit the courtyard, after exiting the facility was decrepit. He stated R1 was able to push through the gate's wood boards and then place the boards back on the gate. Further, the Maintenance Director stated R1 placed empty plant pots against the gate on the opposite side to secure the gate, which was why the nurse [LPN2] thought it was secured when checked. He stated the gate was replaced the next morning by in-house staff using materials purchased locally. Further, he stated a magnetic lock with a keypad was also installed by a Contractor.In a follow-up interview with the Maintenance Director, on 10/23/2025 at 9:09 AM, he stated he did not fix or replace the gate prior to R1's elopement because it was still securing the lock, however, admitted ly he stated the actual wood boards to the gate were beginning to deteriorate. Per the interview with the Maintenance Director, he stated he did not realize this was a concern until the resident eloped from the facility. He stated that when R1 pushed through the gate, he knew it was time to fix it. In an interview with Social Services on 10/21/2025 at 11:46 AM, he stated when R1 initially arrived [to the facility] the resident was disoriented from the long ride to the facility in the ambulance and it took three weeks to develop a routine. Since then, Social Services stated R1 has improved with participation in activities. He stated the resident becomes agitated at times due to not being able to see her parents, who have passed away. Social Services stated that on the day of the resident's elopement, R1 stated to staff that she needed to get to her mother because she was dying. Social Services stated that on this day, R1 was not redirectable. Per the interview, Social Services stated a referral was made to the Nurse Practitioner (NP) related to the resident's increased agitation.In an interview with the Nurse Practitioner (NP) on 10/22/2025 at 12:28 PM, she stated that since the resident's arrival to the facility, she has made comments of not wanting to reside at the facility. She stated R1 often packs her suitcase frequently. She stated that if given the opportunity, R1 would try to leave again. The NP stated the resident would always be someone who would exit seek.In an interview on 10/23/2025 at 3:54 PM with the Director of Nursing (DON), she stated she received a call from LPN2, on 0915/2025 around 9:15 PM to 9:30 PM, to alert her of R1's elopement. She stated LPN2 started a head count of all the residents at that time and she came to the facility to assess the resident to ensure the resident was safe and not harmed from being away from the facility. In an interview on 10/23/2025 at 10:35 AM with the Administrator, he stated on R1's admission hospital records, it indicated she was an elopement risk. Per the interview, he stated the only room available on the unit was the one catty-cornered to the exit door. Per the interview, the Administrator stated that there was a sense of urgency to admit R1, based upon her family history, adding, it was not safe for her to return home. He stated the resident was placed on a secure unit, and it should not have mattered where the resident was placed. Further, he stated the resident was placed on the secure unit for her safety. In further interview, with the Administrator, on10/23/2025 at 10:35 AM, he stated he did not recall a time the facility placed the resident on one-to-one [1:1] supervision, but (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185165	A. Building B. Wing	12/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lyndon Crossing	1101 Lyndon Lane Louisville, KY 40222

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 - Few	increase monitoring was provided on the first few days of the resident's admission. In continued interview with the Administrator, he stated staff were to provide diversional activities to the resident that were person centered adding, the resident loved to dance, complete housework, and loved to preach. The Administrator stated he did not know if any of those interventions were offered to the resident the night of the elopement, but staff should have implemented those interventions. Interviews, however, with CNA3 on 10/21/2025 at 6:50 PM; CNA5 on 10/22/2025 at 1:57 PM; and LPN2 on 10/22/2025 at 2:17 PM, revealed they were all with other residents providing care at the time of R1's elopement and thus could not provide supervision while on the secure unit nor diversional activity, as per the facility's policy and R1's plan of care. The facility's removal plan, alleging jeopardy removal on 09/16/2025 is copied below verbatim:Date 10/24/2025Regional Program Manager 908 [NAME] Broadway116 Commerce AvenueLouisville, Kentucky 40203Re: [NAME] Crossing, LLCLetter of Notification of Removal of Immediate JeopardyAs required by state and federal law, please accept the following as [NAME] Crossing credible allegation of removal oflmmediate Jeopardy effective 10/24/2025. The facility submits this Allegation as it is required by Federal and State law. Submission of this Credible Allegation does not constitute an admission or agreement with the facts alleged or the conclusions set forth in the verbal and written noticeof immediate jeopardy and/or any subsequent Statement of Deficiencies. The Facility reserves all rights to contest, appeal and dispute the IJ and the alleged facts and conclusions on which it is based. The following plan of action outlines immediate interventions employed by the Facility to abate immediate jeopardy.F689 Quality of Care: Accident & Incidents1. Actions Taken for Resident Affected/Immediate Intervention.Resident 1 was the only resident affected, at this time.Elopement drill conducted by Maintenance director on 9/16/2025 l per shift (3 shifts) to ensure staff comprehension on elopement drill process.100% audit of door and lock evaluations conducted, no negative findings conducted on 9/15/2025 100% elopement evaluations 9/15/2025 completed on 9/16/2025100% staff education, including contract staff, on Elopement policy and procedure and appropriate Resident supervision completed by Executive Director, Director of Nursing Services, and appropriate Department Heads on 9/15/2025 and 9/16/2025.The Executive Director and Director of Nursing Services initiated an investigation of the incident on 9/15/2025. The investigation included interviews with the following staff: [NAME] White, LPB, [NAME], LPN, CNAs [NAME], [NAME] Daguindeau, and Audrie [NAME]. All of whom were on-shift at the time of the incident. Further, the investigation included a root cause analysis which detennined that the Resident admitted to the facility in an emergency situation due to APS initiating an investigation into the Resident's son related to abuse and neglect. A review of the Resident's admission revealed a likelihood of wandering or exit seeking. The Resident was admitted with noted cognitive impainnent and a BIMS of 8. Interventions were implemented at the time of admission, i.e., increased supervision, diversional activities, etal. During the course of the investigation, it was detennined that the Resident exited the facility through an alanned door leading to a gad courtyard. Facility staff responded to the alarm and initiated the facility's Elopement Policy. The investigation also revealed that the gate in the courtyard was defective. Facility staff and a licensed contractor repaired the gate on 9/16/2025. All doors, locks, and gates throughout the facility were inspected to ensure proper functioning.At the time of the incident on 9/15/2025, additional interventions were added to the Resident's care plan: increased supervision, q15 minute checks x 72 hours, and a review of medication and labs. Increased supervision includes adjusting the exit door on the Memory Care Unit to prevent delayed egress.It is also noted that a review of the Resident's activity log for the day of the incident and the two days prior reveal that the Resident participated in daily activities 15 times. The Resident participated in organized activities on (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185165	A. Building B. Wing	12/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lyndon Crossing	1101 Lyndon Lane Louisville, KY 40222

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 - Few	the day of the incident 5 times, including Coffee Hour, Entertainment/Movie, Personal Care, Exercise Hour, Glam Nails, Bingo, and Social Hour Additional interventions in place during the time prior to the incident, included toileting, ambulation, water pass, meals, showers, and HS snacks, among others.Also part of the investigation included a review of staffing at the time of the incident. Staffing on the Women's Memory Care Unit included one LPN and two CNAs for a resident census of 16. The facility's scheduler, Director of Nursing, and the Executive Director review daily staffing to ensure sufficient staff is in place to ensure necessary supervision of Residents.2. Identification of Residents with Potential to be Affected/Immediate InterventionElopement Policy was reviewed by IDT to include individualized interventions for those residents at risk for elopement on 9/16/2025. IDT members include Executive Director, Director of Nursing Services, MDS Coordinator, Director of Rehab, Activity Director, Dietary Manager, and Clinical Managers.The DNS/ED will audit new admissions weekly X3/Months to ensure Elopement Risk and Interventions are in place accordingly. This was completed by DNS/ED on 9/16/2025.Elopement risk assessments completed by Director of Nursing Services/MDS Coordinator/Therapy Director on all residents. This task was completed by 9/16/2025.3. Systemic Measures/TrainingMDS/Social Services educated by 9/16/2025 regarding elopement evaluation and implementing interventions based on evaluation findings; with individualized interventions related to supervision and observation, how to complete the elopement evaluations, and necessity of staff to be available and respond to alanns.4. Quality Assurance Measures/MonitoringThe DNS/ED will audit new admissions weekly X3/Months to ensure elopement risk and appropriate interventions are in place. This was completed by Director of Nursing Services/ED by 9/16/2025.An Ad-Hoc QAPI meeting was held with the Executive Director, Medical Director, Director of Nursing Services, Social Services, MDS, Dietary Manager, HR Director, Maintenance Director Unit Managers to review the plan and findings. This action was completed by the Executive Director on 9/16/2025.Elopement Assessment audits will be forwarded to the Executive Director for review by the QAPI Committee (Executive Director, Medical Director, Director of Nursing Services, Maintenance Director, Food Service Director, and Business Office Manager). Monthly at a minimum of three months to ensure ongoing compliance.QAPI Meetings will be held Monthly. This will be completed by the Executive Director beginning on 9/16/2025. Any deficient practices identified by monitoring will be corrected immediately and reported to and reviewed by the QAPI Committee for fmiher action until ongoing compliance is achieved.Elopement drills completed by facility maintenance director/maintenance assistant each shift xl day and monthly ongoing, completed by 9/16/2025.