STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185178	A. Building B. Wing	08/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Louisville East Post Acute	4200 Browns Lane Louisville, KY 40220

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 0655 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted (continued on next page)

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0655 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and facility policy review, the facility failed to ensure the residents' baseline care plan which provided instructions needed to provide effective and person-centered care for each resident was implemented for 1 of 5 (Resident (R) 9) sampled residents reviewed for elopement risk. Resident 9, who had major neurocognitive impairment, was care planned to be monitored frequently for his whereabouts, however, on 07/27/2025, the Resident left the facility by removing his bedroom window and climbing through it without staff knowledge/supervision. The Resident walked approximately 1.3 miles, in the dark. The failure to implement R9's baseline care plan to prevent R9's elopement during 81-degree heat with 90-degree heat index created Immediate Jeopardy with the likelihood for serious harm or death.Immediate Jeopardy (IJ) was identified on 08/13/2025 and was determined to exist on 07/27/2025 in the areas of 42 CFR S483.25, F689 Free of Accident/Hazards/Supervision/Devices and 42 CFR S 483.21, F656 Develop/Implement Comprehensive Care Plan. Substandard Quality of Care (SQC) was identified at 42 CFR S483.25, F689 Free of Accident/Hazards/Supervision/Devices. The facility was notified of the IJs on 08/13/2025.On 08/13/2025 at 4:00PM, the Director of Nursing, Administrator and the Regional Director of Clinical Services were notified of the Immediate Jeopardy (IJ) and provided a copy of the Center for Medicare & Medicaid Services (CMS) IJ Template and was notified that R9's elopement from the facility on 07/27/2025 constituted an IJ.The facility provided an acceptable plan for removal of the IJ on 08/15/2025, alleging removal on 08/04/2025. The State Survey Agency (SSA) survey team validated the IJ was removed on 08/04/2025, prior to the SSA entrance on 08/07/2025, according to the facility's implementation of the plan for removal of the immediate jeopardy. The deficient practice was determined to be past non-compliance. The findings include:Review of the facility's policy, Safety and Supervision of Residents ((C) 2001 MED-PASS, Inc.) revealed the facility used a facility and resident oriented approach to environmental safety. Per review, their systems approach considered hazard identified and individual resident risk factors and adjusted interventions accordingly. Per review, the facility mitigated safety and accident hazards with an individualized, resident-centered approach which included: identifying specific hazards by analyzing assessments and observations, provide targeted interventions, which may include adequate supervision. Review of the facility's policy Wandering and Elopements ((C) 2001 MED-PASS, Inc.) revealed the facility would identify residents at risk for unsafe wandering and elopement and strive to prevent harm while maintaining the lease restrictive environment. Per review, those identified at risk would have identified strategies and interventions included in their plan of care to maintain resident safety. Closed Record review of R9's Face Sheet, revealed the facility admitted R9 into its secure memory loss unit on 07/24/2025 with diagnoses including moderate dementia, cataracts and unilateral hearing loss.Review of R9's admission Minimum Data Set (MDS) Assessment, with an Assessment Reference Date (ARD) of 07/28/2025 revealed the resident had a Brief Interview for Mental Status (BIMS) score of 9/15, indicating moderate cognitive impairment. Per this MDS, R9 required supervision and/or touch prompts, throughout or intermittently, for indoor ambulation and he displayed wandering behaviors for 1-3 days during the assessment period. Review of R9's baseline care plan initiated on 07/24/2025 revealed the Resident was at risk for elopement. Multiple interventions were assigned; admission to secure memory loss unit, medications as ordered, document/notify physician if behavior interferes with daily function, monitor for environmental hazards - which may increase supervision requirements, check exit/stairwell/door alarms on a routine schedule for operability, monitor whereabouts frequently, redirect as needed, wander alarm (a device, usually placed on resident's ankle which triggers an alarm if exiting doors with companion equipment) checking placement and functionality every shift. Additionally, explain all care before providing to reduce resident tension and promote a comfortable experience, observe for behavior/cognitive status change and notify physician if they occur. Review of a Nursing note dated 07/24/2025 at 4:15 PM revealed R9 was pleasant but confused. Continued review revealed the resident started looking for his keys saying it was time to go. Per review of the note, the resident was placed on a wander alarm to his left ankle.Review of a Nursing note dated 07/24/2025 at 10:12 PM, revealed R9 stated he was ready to go home and wanted his keys. Review of a Nursing note dated 07/26/2025 at 5:00 AM described R9 as increasingly anxious the prior evening, 07/25/2025. R9 stated he was leaving the facility, packed up his personnel belongings in paper bags and approached the exit. Per review of the note, the Resident stayed near the exit door of the unit waiting to leave. However, there was no

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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. (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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and facility policy review, the facility failed to ensure the residents' environment remained free of accident hazards and provide adequate supervision for one (Resident (R) 9) of five sampled residents reviewed for elopement risk. Resident 9, who had major neurocognitive impairment, eloped from the facility on 07/27/2025. Facility safety processes and systems used for supervision failed when the resident left the facility by removing the bedroom window and climbing through it without staff knowledge/supervision. The resident walked approximately 1.3 miles, in the dark. The failure to prevent R9's elopement during 81-degree heat with 90-degree heat index created Immediate Jeopardy with the likelihood for serious harm or death.Immediate Jeopardy (IJ) was identified on 08/13/2025 and was determined to exist on 07/27/2025 in the areas of 42 CFR S483.25, F689 Free of Accident/Hazards/Supervision/Devices and 42 CFR S 483.21, F656 Develop/Implement Comprehensive Care Plan. Substandard Quality of Care (SQC) was identified at 42 CFR S483.25, F689 Free of Accident/Hazards/Supervision/Devices. The facility was notified of the IJs on 08/13/2025.On 08/13/2025 at 4:00PM, the Director of Nursing, Administrator and the Regional Director of Clinical Services were notified of the Immediate Jeopardy (IJ) and provided a copy of the Center for Medicare & Medicaid Services (CMS) IJ Template and was notified that R9's elopement from the facility on 07/27/2025 constituted an IJ.The facility provided an acceptable plan for removal of the IJ on 08/15/2025, alleging removal on 08/04/2025.The State Survey Agency (SSA) survey team validated the IJ was removed on 08/04/2025, prior to the SSA entrance on 08/07/2025, according to the facility's implementation of the plan for removal of the immediate jeopardy. The deficient practice was determined to be past non-compliance. The findings include:Review of facility policy titled, Emergency Response (Emergency Preparedness Planning and Resource Manual, pages 18-21, undated), revealed the facility defined elopement as, a situation where a resident with impaired decision making ability who was oblivious to his/her own safety needs and therefore at risk for injury outside the confines of the facility had left the facility without the knowledge of staff. Further review revealed the Resident plan of care would identify interventions to reduce the risk of elopement through use of alarms, exit avoidance, visual cues, engagement, distraction, and increased supervision. Closed Record review of R9's Face Sheet, revealed the facility admitted R9 to the secure memory loss unit on 07/24/2025 with diagnoses including moderate dementia, cataracts and unilateral hearing loss. Review of R9's admission Minimum Data Set (MDS) Assessment, with an Assessment Reference Date (ARD) of 07/28/2025, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 9/15, indicating moderate cognitive impairment. Per this MDS, R9 required supervision and/or touch prompts, throughout or intermittently, for indoor ambulation and he displayed wandering behaviors for 1-3 days during the assessment period. These factors indicated R9 was at a significant risk of potential danger, if outside the facility unsupervised. Review of R9's admission summary, dated [DATE] revealed R9 was a falls risk and would be evaluated by therapy. Additionally, an admission elopement and wandering risk observation/assessment completed the same day, triggered a risk score of 10, moderate risk of elopement., based on R9's risk factors, as follows; independent ambulation, disorientation/confusion, both his hearing and his vision were impaired, psychotropic medication which may cause irritability and/or restlessness.Review of R9's baseline care plan initiated on 07/24/2025 revealed the Resident was at risk for elopement. Multiple interventions were assigned; admission to secure memory loss unit, medications as ordered, document/notify physician if behavior interferes with daily function, monitor for environmental hazards - which may increase supervision requirements, check exit/stairwell/door alarms on a routine schedule for operability, monitor whereabouts frequently, redirect as needed, wander alarm (a device, usually placed on resident's ankle which triggers an alarm if exiting doors with companion equipment) checking placement and functionality every shift. Additionally, explain all care before providing to reduce resident tension and promote a comfortable experience, observe for behavior/cognitive status change and notify physician if they occur.Review of R9's initial skilled nursing assessment dated [DATE] entered by Advanced Practice Nurse Practitioner (APRN) revealed R9 was found wandering the streets, unable to identify where he lived on 07/14/2025. He was hospitalized on a Geriatric Psychiatric unit, where he was treated for aggression, depression and dementia. Resident 9 was admitted to the facility on [DATE] directly from the Geriatric Psychiatric unit. Review of R9's progress notes in the Electronic Medical Record (EMR) revealed a steady increase in exit seeking behavior and irritability, following his admission up to his