

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195423	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/28/2025
NAME OF PROVIDER OR SUPPLIER Carroll Health and Rehab LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 307 N Castleman St Oak Grove, LA 71263	

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 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights that includes measurable objectives and timeframes to meet a resident's medical, nursing, mental, and psychosocial needs that are identified in the comprehensive assessment for 1 (#40) of 1 resident reviewed for contractures and 2 (#72, #73) of 3 (#8, #72, #73) residents reviewed for elopement. Findings: Resident 73</p> <p>Review of the record for Resident #73 revealed an admission date of 07/15/2025 with diagnoses of vascular dementia, hemiplegia, cerebrovascular accident, heart failure, and mild cognitive impairment.</p> <p>Review of the Medicare 5 day Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #73 had a Brief Interview for Mental Status (BIMS) score of 6, which indicated severe cognitive impairment for daily decision making.</p> <p>Review of the Elopement Risk Evaluation dated 07/15/2025 revealed Resident #73 was at risk for elopement.</p> <p>Review of the record revealed no documented evidence of a care plan developed upon admission to address the elopement risk for Resident #73.</p> <p>On 07/28/2025 at 9:30 a.m. interview with S3Director of Nursing (DON) confirmed there was not an elopement care plan developed for Resident #73 upon admission.</p> <p>Resident 72</p> <p>Review of the medical record for resident #72 revealed an admission date of 07/02/2025. Resident #72 had diagnoses which included hyperlipidemia, rhabdomyolysis, hypertension, dementia and depression.</p> <p>Review of the admission MDS assessment dated [DATE] revealed Resident #72 had a BIMS score of 3, which indicated severe cognitive impairment for daily decision making.</p> <p>Review of the Elopement Risk Evaluation dated 07/02/2025 revealed Resident #72 was at risk for elopement.</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 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the record revealed no documented evidence of a care plan developed upon admission to address the elopement risk for Resident #72.</p> <p>On 07/28/2025 at 9:15 a.m. interview with S3DON confirmed there was not an elopement care plan developed for Resident #72 upon admission.</p> <p>Resident 40</p> <p>Record review revealed Resident #40 was admitted to the facility on [DATE] with diagnoses that included paraplegia incomplete, polyosteoarthritis and idiopathic neuropathy.</p> <p>Review of the quarterly MDS assessment dated [DATE] revealed a BIMS score of 15 which indicated no cognitive impairment.</p> <p>On 07/21/2025 at 10:24 a.m., observation revealed Resident #40 had bilateral contractures to both hands. Resident #40 reported she has requested splints and they put wash cloths in her hands a few times but not on a regular basis.</p> <p>On 07/23/2025 9:23 a.m., an interview with S7Therapy Director revealed Resident #40 had braces for both hands but she was noncompliant with wearing them, so she ordered new braces for both hands.</p> <p>Record review revealed there was no active care plan related to Resident #40's contracted hands.</p> <p>On 07/23/2025 10:18 a.m., an interview with S3DON confirmed there was not an active care plan related to Resident #40's bilateral hand contractures.</p>

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review the facility failed to ensure that residents received care consistent with professional standards of practice to prevent pressure ulcers for 1 (#11) of 3 (#11, #47, #50) residents reviewed for pressure ulcers. Findings: Review of the facility's policy (undated) related to Skin and Wound Management revealed the following in part: Pressure Ulcers/Skin Breakdown - Clinical Protocol Assessment and Recognition 1. The nursing staff and practitioner will assess and document an individual's significant risk factors for developing pressure ulcers; for example, immobility, recent weight loss, and a history of pressure ulcer(s). Record review revealed Resident #11 was admitted on [DATE] with diagnoses which included dementia, epilepsy, abnormal posture, melanoma of scalp, and age related disability. Record review of Resident #11's skin assessment using the Braden Score System dated 06/27/2025 revealed a score of 18 which indicated he was at risk for developing pressure ulcers. Review of the active care plan for July 2025 revealed Resident #11 used a wheelchair for ambulation. Further review of the care plan revealed he was at risk for skin impairment and had an intervention to place a cushion to the seat of his wheelchair. On 07/21/2025 at 10:06 a.m., Resident #11 was observed sleeping in bed with his clothes on and his wheelchair was at his bedside in the locked position. Further observation revealed the wheelchair did not have a pressure reducing device in the seat. Velcro was observed in the wheelchair seat and appeared to be where a cushion should be applied. On 07/22/2025 at 9:05 a.m. and 07/23/2025 at 9:31a.m., observations revealed Resident #11 was observed sleeping in bed. Further observation revealed his wheelchair was observed at the bedside with no pressure relieving device in the seat of the chair. On 07/22/2025 10:19 a.m., an observation of Resident #11 was conducted in his room with S3Director of Nursing (DON). S3DON confirmed Resident #11 did not have a pressure relieving device in his chair. S3DON confirmed Resident #11 once had a cushion in his chair and needed one placed back in it.</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>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** I. Based on observation, record reviews and interviews the facility failed to have an adequate system in place to ensure residents at risk for elopement are supervised to prevent elopement from the facility for 1 (#73) of 3 (#8, #72, and #73) residents reviewed for elopement. The deficient practice resulted in an Immediate Jeopardy for Resident #73 on 07/21/2025. Resident #73 was last observed on 07/21/2025 at 9:51 p.m. Resident #73 was picked up by police on 07/22/2025 at 6:28 a.m. after being notified of Resident #73 pacing on the four-lane highway approximately 0.9 miles from the facility. The police returned Resident #73 to the facility on [DATE] at 6:52 a.m. without injury. Resident #73 exited the building through a window in his room. The deficient practice had the likelihood to cause more than minimal harm to any residents residing in the facility at risk for elopement. S1Manager and S3Director of Nursing (DON) were notified of the Immediate Jeopardy on 07/24/2025 at 7:54 p.m. The Immediate Jeopardy was removed on 07/25/2025 at 3:47 p.m. when it was determined the facility had implemented an acceptable Plan of Removal (POR) as confirmed through onsite interviews, record reviews and observations prior to the survey exit.</p> <p>Findings:</p> <p>Review of the facility's Elopement/Missing Resident Policy undated revealed in part:</p> <p>Purpose: Ensure a safe and secure environment for all residents.</p> <p>Procedure:</p> <p>1. All newly admitted residents will be screened for the potential of wandering and/or elopement, including past history and current cognitive status. Observation of the resident's behavior that may indicate the potential for wandering and/or elopement will continue for the initial 14 days in the facility. Such potential will be included in the baseline care plan for that resident within the initial 48 hours following admission. If identified after that 48-hour period, interventions to ensure the resident's safety will be added to the baseline care plan and included in the initial comprehensive plan of care.</p> <p>4. Appropriate facility staff will monitor resident whereabouts including the monitoring of responses/reactions to events/ activity in surroundings at the time wandering and report unusual behaviors to the supervisor immediately.</p> <p>Review of the medical record for Resident #73 revealed an admission date of 07/15/2025. Resident #73 had diagnoses including vascular dementia, hemiplegia, cerebrovascular accident, heart failure, and mild cognitive impairment.</p> <p>Review of the Elopement Risk Evaluation dated 07/15/2025 revealed Resident #73 was at risk for elopement with a score of 2.0 and had a BIMS score of 6 which indicated Resident #73 had severe cognitive impairment for daily decision making. Further review of the assessment revealed Resident #73 had a history of elopement or an attempted elopement while at home and a history of attempting to leave the facility without informing staff.</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>Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #73 had a Brief Interview for Mental Status (BIMS) score of 6 which indicated the resident had severe cognitive impairment for daily decision making.</p> <p>Review of the physician's orders revealed no documented evidence of any orders regarding elopement prior to the incident on 07/21/2025.</p> <p>Review of the interim care plan revealed no documented evidence of an elopement risk focused area noted in the care plan.</p> <p>Review of the Sheriff's Department Offense/Incident Report dated 07/22/2025 revealed the Sheriff's department received a call on 07/22/2025 at 6:22 a.m. regarding a male pacing on the highway carrying a book and almost got hit by two vehicles. The Sheriff's department arrived at the scene at 6:28 a.m. and Resident #73 was returned to the nursing facility on 07/22/2025 at 6:52 a.m.</p> <p>Review of the Incident/Accident report dated 07/22/2025 at 6:50 a.m. written by S17Licensed Practical Nurse (LPN) revealed a local emergency department called and asked if we had a resident named _____. S17LPN went and checked the room and the curtain was pulled and the window was opened. The Sheriff's department found Resident #73 at a store. A Certified Nursing Assistant (CNA) made rounds and he wasn't in his bed at 11:00 p.m. and the CNA thought he was in the hospital. The Sheriff's department brought him back at 7:15 a.m., Resident #73 did not have any injuries.</p> <p>On 07/24/2025 at 12:10 p.m. observation and interview of Resident #73 revealed he was sitting on the side of the bed and he had an orange band on his right wrist. Resident #73 was unable to verbalize where he currently was, but did state that he climbed out of the window the other night trying to get back home. Resident #73 denied injuring himself when he climbed out of the window.</p> <p>On 07/24/2025 at 12:30 p.m. review of the video surveillance dated 07/21/2025 at 9:51 p.m. revealed S19CNA went into Resident #73's room and came out of the room with a trash bag.</p> <p>On 07/24/2025 at 2:32 p.m. interview with S3DON confirmed she did not reinspect all staff after Resident #73 eloped from the facility on 07/21/2025.</p> <p>On 07/24/2025 at 2:45 p.m. a phone interview with S18Certified Nursing Assistant (CNA) revealed she was working 11:00 p.m. - 7:00 a.m. shift the night of 07/21/2025 when Resident #73 eloped from the facility. S18CNA revealed she went to check on Resident #73 at approximately 11:45 p.m., he wasn't in the room and she assumed he was in the bathroom. S18CNA further revealed at approximately 2:00 a.m. she went to check on Resident #73, he wasn't in the room and she assumed he was in the hospital. S18CNA confirmed she did not notify the nurse when she was unable to locate Resident #73. S18CNA revealed she was not aware that Resident #73 was at risk for elopement prior to the incident.</p> <p>On 07/24/2025 at 4:45 p.m. a phone interview with S19CNA revealed he worked on 07/21/2025 from 3:00 p.m. - 11:00 p.m. with Resident #73. Further interview with S19CNA revealed he provided incontinent care to Resident #73 on 07/21/2025 at approximately 9:30 p.m. S19CNA confirmed he was not aware that Resident #73 was at risk for elopement, and he was unsure if Resident #73 was wearing an orange wrist band to indicate at risk for elopement on 07/21/2025.</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 07/24/2025 at 5:45 p.m. interview with S3DON revealed she performed the elopement risk assessment on 07/15/2025 for Resident #73. S3DON confirmed she informed the day shift nurse on 07/15/2025 of Resident #73's risk for elopement but she did not inform any other staff members.</p> <p>On 07/25/2025 at 10:35 a.m. a phone interview with S17LPN revealed she worked the 11:00 p.m. to 7:00 a. m. shift on 07/21/2025. She revealed she gave his night time medications at approximately 9:00 p.m. S17LPN further revealed on 07/22/2025 at approximately 6:30 a.m. she received a call from the Sheriff's department and was informed they had Resident #73. Resident #73 was brought back to the nursing facility by the Sheriff's department, he was assessed and no injuries were noted.</p> <p>On 07/28/2025 at 9:30 a.m. interview with S3DON confirmed when Resident #73 was assessed to be at risk for elopement on 07/15/2025 and a care plan was not developed for Resident #73's at risk for elopement upon admission.</p> <p>On 07/28/2025 at 1:45 p.m. interview with S3DON revealed prior to the incident on 07/21/2025 with Resident #73, the facility did not have a plan in place to make sure the staff were informed of the residents that were at risk for wandering.</p> <p>The facility implemented an acceptable Plan of Removal as confirmed through onsite observations, interviews and record reviews prior to exit.</p> <p>The facility's POR submitted on 07/25/2025:</p> <p>Actions the facility will take-</p> <p>07/22/2025 DON or Designee will screen all new admits or readmits for potential wandering and/or elopement, including history and current cognitive status and continue with ongoing elopement risk assessments.</p> <p>07/22/2025 hourly observations for Resident #73 was initiated. 07/25/2025 hourly observations for all high risk for elopement residents were initiated.</p> <p>07/22/2025 ensured all high risk for elopement residents had on orange wristbands.</p> <p>07/22/2025 Maintenance Director secured all windows.</p> <p>07/22/2025 DON or Designee will be responsible for updating the elopement binders for all high-risk new admissions and readmissions for elopement. To be placed at each nurses station with face sheets continuously.</p> <p>07/22/2025 elopement policy updated to include: any elopement risk resident will wear an orange wrist band as an identifier.</p> <p>07/25/2025 Charge nurses will meet with all staff (CNAs, nurses, any other direct/indirect care staff) at beginning of each shift to communicate high risk elopement residents.</p> <p>Education/Training Plan -</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>07/22/2025 DON and ADON inserviced nurses to complete hourly observations of high risk elopement residents and document on monitoring tool &ndash; completed inservice on 07/25/2025.</p> <p>07/22/2025 DON inserviced MDS nurse to update care plan to reflect elopement risk residents. Inservice was completed on 07/24/2025 by DON and ADON to all staff on elopement risk and orange wristbands. Education also added to the new hire orientation process.</p> <p>Monitoring of Implemented Actions -</p> <p>07/22/2025 DON or Designee will observe and document high risk elopement residents&rsquo; behaviors for initial 14 days in facility after new admission or readmission.</p> <p>07/22/2025 inserviced staff began using the hourly observations monitoring tool for Resident #73.</p> <p>07/24/2025 DON or Designee will monitor the completion of the hourly observations of high risk residents and the documentation on monitoring tool is complete 5 days a week times 2 weeks, then 3 days a week times 2 weeks, then randomly thereafter until compliance is met.</p> <p>07/24/2025 inserviced staff began using the hourly observations monitoring tool for all high risk elopement residents.</p> <p>07/25/2025 Maintenance Director will monitor windows to 3 random rooms a day times 5 days for 4 weeks, then randomly until compliance is met. All findings will be reported to Quality Assurance (QA) committee weekly.</p> <p>07/25/2025 hourly monitor tool binder on high risk elopement residents to be completed for the initial 14 days after new admission or readmission.</p> <p>07/25/2025 DON or Designee will monitor orange wristbands to ensure it is intact and to be changed as needed if soiled or dislodged on high risk residents 5 days a week times 2 weeks, then 3 days a week times 2 weeks, then randomly thereafter until compliance is met.</p> <p>07/25/2025 DON or Designee will complete elopement drills 3 times a week, 1 per shift times 2 weeks until compliance is met. All findings will be reported to the QA committee weekly.</p> <p>Date facility asserts the likelihood for serious harm to any recipient no longer exists: 07/25/2025.</p> <p>II. Based on observations, record reviews, and interviews, the facility failed to ensure the resident's environment remained as free of accident hazards as is possible by failing to ensure bedrails were properly secured for 3 (#2, #6, #50) of 4 (#2, #6, #50, #65) residents reviewed for bedrails.</p> <p>Findings:</p> <p>Review of the undated facility policy for Bedrails revealed the following, in part:</p> <p>Purpose: Ensure correct installation, use and maintenance of bedrails.</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>Procedure: This facility will attempt to use appropriate alternatives prior to installing a side or bedrail.</p> <p>If a bed or side rail is used, this facility must ensure correct installation, use and maintenance of bedrails, including but not limited to the following elements:</p> <p>1) Assess the resident for risk of entrapment from bedrails prior to installation and ensure that the bed's dimensions are appropriate for the resident's size and weight.</p> <p>4) Follow the manufacturers' recommendations and specifications for installing and maintaining bedrails.</p> <p>When installing and using bedrails, the facility should:</p> <ul style="list-style-type: none"> -Ensure that the bed's dimensions are appropriate for the resident. -Confirm that the bed rails to be installed are appropriate for the size and weight of the resident using the bed. -Install bedrails using the manufacturer's instructions to ensure a proper fit. -Inspect and regularly check the mattress and bed rails for areas of possible entrapment. <p>Resident #6</p> <p>Review of Resident #6's medical record revealed an admission date of 01/27/2024 with diagnoses of chronic obstructive pulmonary disease, major depressive disorder, and anxiety disorder.</p> <p>Review of Resident #6's Quarterly MDS assessment dated [DATE] revealed a BIMS of 14, which indicated no cognitive impairment. Further review of the MDS revealed Resident #6 had no impairment on both sides of upper and lower extremities.</p> <p>On 07/21/2025 at 9:20 a.m., 07/22/2025 at 9:25 a.m., and 07/23/2025 at 9:50 a.m., observations revealed Resident #6 was in bed and had quarter bedrails in place on both sides of her upper bed. The quarter bedrails were loose and were not secured properly to her bed.</p> <p>On 07/23/2025 at 1:10 p.m., S3DON and S4Director of Maintenance observed Resident #6's right bedrail and confirmed the bedrail was loose and needed to be repaired.</p> <p>Resident #50</p> <p>Review of Resident #50's medical record revealed an admission date of 04/22/2025 with diagnoses of acute kidney failure, adult failure to thrive, and cirrhosis of the liver.</p> <p>Review of Resident #50's MDS assessment dated [DATE] revealed a BIMS of 12 which indicated he was moderately cognitively impaired. Further review of the MDS revealed Resident #50 had no impairment on both sides of upper and lower extremities.</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews, and interviews, the facility failed to ensure that a resident received appropriate treatment and services to prevent urinary tract infections for 1 (#75) of 2 (#4 & #75) residents reviewed for urinary catheter. Findings:Review of the facility's Urinary Catheter Care Policy dated September 2014 revealed in part:Purpose: The purpose of this procedure is to prevent catheter-associated urinary tract infections.Infection Control2.b. Be sure the catheter tubing and drainage bag are kept off the floor. Review of the record for Resident #75 revealed an admission dated of 01/08/2019 with diagnoses that included diabetes mellitus, heart disease, urinary retention, and dementia.Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview of Mental Status (BIMS) score of 10 which indicated that Resident #75 had moderate cognitive impairment for daily decision making. On 07/21/2025 at 11:40 a.m. and 07/22/2025 at 9:05 a.m., observations of Resident #75 revealed the resident's catheter bag was observed lying on the floor in a plastic bag and the catheter tubing was lying directly on the floor. On 07/21/2025 at 11:45 a.m., interview with S20Licensed Practical Nurse (LPN) revealed the catheter bag and tubing should not have been on the floor and the catheter bag should not be stored in a trash bag. On 07/23/2025 at 9:20 a.m., an observation of Resident #75 with S3Director of Nursing (DON) revealed the indwelling catheter tubing was lying directly on the floor. S3DON confirmed that the tubing should not be on the floor.</p>

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NAME OF PROVIDER OR SUPPLIER Carroll Health and Rehab LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 307 N Castleman St Oak Grove, LA 71263	
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to 1) ensure a physician's order for bed rails was obtained for residents, 2) assess residents for risk of entrapment from bed rails prior to the installation of bed rails, and 3) ensure care plans reflected the use of bed rails for 4 (#2, #6, #50, #65) of 4 residents reviewed for bedrails. Findings:</p> <p>Review of the undated facility policy for Bedrails revealed the following, in part:</p> <p>1.) Assess the resident for risk of entrapment from bedrails prior to installation and ensure that the bed's dimensions are appropriate for the resident's size and weight.</p> <p>The facility will assess the resident's need for bedrails and all factors involved, including alternatives. Alternatives to bedrails will always be attempted before consideration of bedrail application. Documentation in the resident's record will reflect this assessment and related information, including how the alternatives failed to meet the resident's assessed needs.</p> <p>What assessed medical needs would be addressed by the use of bedrails; the resident's benefits from the use of bed rails and the likelihood of these benefits; the resident's risks from the use of bedrails and how these risks will be mitigated and alternatives attempted that failed to meet the resident's needs and alternatives considered but not attempted because they were considered to be inappropriate.</p> <p>Resident #6</p> <p>Review of Resident #6's medical record revealed an admission date of 01/27/2024 with diagnoses of chronic obstructive pulmonary disease, major depressive disorder, and anxiety disorder.</p> <p>Review of Resident #6's Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview Mental Status (BIMS) score of 14, which indicated no cognitive impairment. Further review of the MDS revealed Resident #6 had no impairment on both sides of upper and lower extremities.</p> <p>Further review of Resident #6's medical record revealed there was no documentation of the following regarding the use of bilateral quarter bedrails: physician's order, entrapment assessment prior to the installation of the bedrails, and care plan for the use of the quarter bedrails.</p> <p>On 07/21/2025 at 9:20 a.m., 07/22/2025 at 9:25 a.m., and 07/23/2025 at 9:50 a.m., observations revealed resident #6 was in bed and had bilateral quarter bedrails in place on both sides of her upper bed.</p> <p>On 07/23/2025 at 9:30 a.m., an interview with S3Director of Nursing (DON) confirmed the facility failed to have the following documentation regarding Resident #6's quarter bedrail: physician order, risk for entrapment, and the care plan was not developed.</p> <p>Resident #50</p> <p>(continued on next page)</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident #50's medical record revealed an admission date of 04/22/2025 with diagnoses of acute kidney failure, adult failure to thrive, and cirrhosis of the liver.</p> <p>Review of Resident #50's MDS assessment dated [DATE] revealed a BIMS score of 12 which indicated he was moderately cognitively impaired. Further review of the MDS revealed Resident #50 had no impairment on both sides of upper and lower extremities.</p> <p>Further review of Resident #50's medical record revealed there was no documentation of the following regarding the use of a bilateral quarter bedrail: physician's order, entrapment assessment prior to the installation of the bedrails, and care plan for the use of the quarter bedrail.</p> <p>On 07/21/2025 at 1:04 p.m., 07/22/2025 at 2:28 p.m., and 07/23/2025 at 9:45 a.m., observations revealed resident #50 was in bed and had a raised quarter rail in place on the right side of his upper bed.</p> <p>On 07/23/2025 at 9:30 a.m., an interview with S3DON confirmed the facility failed to have the following documentation regarding Resident #50's quarter bedrail: physician order, risk for entrapment, and a care plan was not developed.</p> <p>Resident #2</p> <p>Review of the record revealed Resident #2 was admitted to the facility on [DATE] with diagnoses including unspecified open wound of lower back and pelvis without penetration into retroperitoneum; paraplegia, bipolar disorder, anxiety disorder and acquired absence of left leg below knee.</p> <p>Review of Resident #2's quarterly MDS assessment dated [DATE] revealed a BIMS score of 15, which indicated no cognitive impairment.</p> <p>On 07/21/2025 at 9:18 a.m., 07/22/2025 at 9:32 a.m., and 07/23/2025 at 8:45 a.m., observations of Resident #2's bed revealed a metal 1/2 bedrail attached to upper left side of resident's bed.</p> <p>On 07/22/2025 at 11:00 a.m., record review revealed the following: no order for bedrail use, no care plan for bedrail, and no bedrail entrapment assessment.</p> <p>On 07/23/2025 9:30 a.m., an interview with S3DON confirmed the facility did not have the following: a physician's order for side rail use, an entrapment risk assessment completed, or a care plan for side rail usage.</p> <p>Resident #65</p> <p>Review of Resident #65's medical record revealed an admission date 07/16/2024. Resident #65 had diagnoses including diabetes mellitus, morbid obesity, heart disease, osteoarthritis, and muscle weakness.</p> <p>Review of Resident #65's Annual Minimum Data Set (MDS) assessment dated [DATE] revealed a BIMS of 13, which indicated intact cognition for daily decision making.</p> <p>(continued on next page)</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident #65's medical record revealed there was no documentation of the following regarding the use of bilateral quarter bed rails: physician's order, entrapment assessment prior to the installation of the bedrails, and a care plan for the use of the quarter bed rails.</p> <p>On 07/21/2025 at 1:12 p.m. and 07/23/2025 at 9:00 a.m., observations revealed Resident #65 was in bed and had quarter bedrails in place on both sides of her upper bed.</p> <p>On 07/23/2025 at 9:30 a.m., an interview with S3DON confirmed the facility failed to have the following documentation regarding Resident # 65's quarter bedrails: physician order, risk for entrapment, and a care plan was not developed for the use of bed rails.</p>		

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<p>F 0835</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Administer the facility in a manner that enables it to use its resources effectively and efficiently.</p> <p>(continued on next page)</p>

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<p>F 0835</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews, the facility failed to be administered in a manner that enabled its resources to be used effectively and efficiently to attain or maintain the highest practicable physical, mental and psychosocial well-being for 1 (Resident #73) of 3 (#8, #72 and #73) sampled residents reviewed for elopement. S3Director of Nursing (DON) failed to 1) notify staff that Resident #73 was assessed to be at risk for elopement and 2) initiate the interim care plan with appropriate interventions to prevent elopement after S3DON assessed Resident #73 to be at risk for elopement. The deficient practice resulted in an Immediate Jeopardy for Resident #73 on 07/21/2025. Resident #73 was last observed on 07/21/2025 at 9:51 p.m. Resident #73 was picked up by police on 07/22/2025 at 6:28 a.m. after being notified of Resident #73 pacing on the four lane highway approximately 0.9 miles from the facility. The police returned Resident #73 to the facility on [DATE] at 6:52 a.m. without injury. Resident #73 exited the building through a window in his room. The deficient practice had the likelihood to cause more than minimal harm to any residents residing in the facility at risk for elopement. S1Manager and S3Director of Nursing (DON) were notified of the Immediate Jeopardy on 07/24/2025 at 7:54 p.m. The Immediate Jeopardy was removed on 07/25/2025 at 3:47 p.m. when it was determined the facility had implemented an acceptable Plan of Removal (POR) as confirmed through onsite interviews and observations prior to the survey exit. Findings, Cross Reference F689: On 07/24/2025 at 5:45 p.m. interview with S3DON revealed she completed the Elopement Risk Evaluation on 07/15/2025 for Resident #73. S3DON confirmed she informed the day shift nurse on 07/15/2025 that Resident #73 was at risk for elopement but did not inform any other staff members. On 07/25/2025 at 1:10 p.m. a phone interview with S2Corporate Registered Nurse (RN) revealed when S3DON assessed Resident #73 to be at risk for elopement she should have placed the resident closer to the nurses' station, communicated with the staff to inform them that Resident #73 was at risk for elopement. Further interview with S2Corporate RN revealed S3DON should have updated the elopement binder and should have made sure the care plan included Resident #73's elopement risk assessment. On 07/28/2025 at 2:15 p.m. a phone interview with S2Corporate RN revealed S3DON was responsible for staff training regarding elopement. The facility implemented an acceptable Plan of Removal as confirmed through onsite observations, interviews and record reviews prior to exit. The facility's POR submitted on 07/25/2025: Action the facility will take- 07/22/2025 Maintenance Director secured all windows. 07/22/2025 DON or Designee updated elopement risk binders and placed at each nurse station. 07/22/2025 Minimum Data Set (MDS) nurse updated Resident #73 care plan to reflect high risk for elopement and completed 100% audit of residents' elopement care plan to ensure compliance. 07/22/2025 Body assessment conducted immediately on Resident #73 upon arrival to facility by DON and Social Worker. 07/22/2025 elopement policy updated to include: any elopement risk resident will wear an orange wrist band as an identifier. Education/Training Plan-07/24/2025 Inservices were initiated and completed by DON or Designee to all staff on elopement risk and orange wristbands. Education also added to new hire orientation process. DON and Administrator inserviced by corporate compliance consultant on elopement assessment, safety, and how to train staff completed on 07/24/2025. Educational Review from Corporate Compliance: DON or designee will verify on admission or readmissions if a resident is at high risk for elopement. DON or designee will communicate to MDS nurse high risk residents and care plan will be updated. DON or designee will communicate with the Nurse Manager for the residents with high risk of elopement. Nurse Manager or designee will place orange wrist band on resident. Nurse Manager will communicate with Certified Nursing Assistant (CNAs) of high risk elopement residents. Assistant Director of Nursing (ADON) or designee will update elopement binder at each nurses station as needed. Nurse Manager or designee will observe resident behaviors for 14 days after readmission/new admission. The facility must have written policies and procedures that include training new and existing nursing home staff and in-service training on wandering or elopement type behaviors. The facility's policies should clearly define the mechanisms and procedures for assessing or identifying, monitoring, and managing residents at risk for elopement that can help to minimize the risk of a resident leaving a safe area without the facility's awareness and or supervision. All new admissions, readmissions, and those residents with changes in condition that can present as wandering, exit seeking behavior or statements, improved mobility, mental status changes and other changes should be assessed/re-assessed for elopement risk. Residents identified to be an elopement risk should have interventions in their comprehensive plan of care to address the potential for elopement</p>		