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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195594 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 08/01/2024 |
| NAME OF PROVIDER OR SUPPLIER Pilgrim Manor Skilled Nursing and Rehabilitation | | STREET ADDRESS, CITY, STATE, ZIP CODE 1524 Doctors Drive Bossier City, LA 71111 | |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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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 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</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** 44414</p> <p>Based on record review, video review, and interviews the facility failed to supervise a cognitively impaired resident from exiting the facility for 1 (Resident #1) of 9 (#1, #2, #3, #4, #5, #6, #7, #8 and #9) sampled residents reviewed for elopement.</p> <p>This deficient practice resulted in an Immediate Jeopardy on 07/23/2024 at 5:55 p.m. when Resident #1, a severely cognitively impaired resident who was ambulatory, was unsupervised and eloped from the facility. Resident #1 walked out of the front entrance of the facility after S5Evening Receptionist remotely released the front sliding doors to an open position for Resident #1 to exit. Staff had not realized Resident #1 eloped from the facility until 07/23/2024 at approximately 7:30 p.m., when the search began and local police and Resident #1's RP (Responsible Party) were notified. Resident #1 was found with no injuries on 07/23/2024 at approximately 8:25 p.m. by Resident #1's RP. Resident #1 was located at a local restaurant approximately one mile from the facility, in which Resident #1 had crossed two four-lane roads. Resident #1's RP returned Resident #1 to the facility on [DATE] at 8:34 p.m. Resident #1 had been inaccurately assessed upon admission to the facility on [DATE] as not at risk for elopement and protective measures had not been put into place related to Resident #1's history of elopement from home. Multiple observations throughout the survey revealed the front entrance door, which opened to a large sitting area accessible to the residents, was not locked during the day and allowed staff and visitors open access to enter the facility.</p> <p>S1Adminsitrator was notified of the Immediate Jeopardy on 07/30/2024 at 3:45 p.m.</p> <p>This deficient practice had the likelihood to cause more than minimal harm to any resident residing in the facility at risk for elopement.</p> <p>The Immediate Jeopardy was removed on 07/31/2024 at 4:05 p.m. when it was determined the facility had implemented an acceptable Plan of Removal as confirmed through onsite interviews, observations, and record reviews prior to exit.</p> <p>Findings:</p> <p>Review of the facility's Wandering and Elopements policy with a revision date of 11/15/2023 revealed in part:</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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p> | <p>Policy Statement: The facility will identify residents who are at risk of unsafe wandering and implement appropriate protective measure to help guard against a resident wandering from the facility. The facility strives to prevent harm while maintaining the least restrictive environment for residents.</p> <p>Identifying Residents at Risk</p> <p>1. On admission/readmission, quarterly during observation period of MDS (Minimum Data Set), annual, significant changes and PRN (as needed), the nursing staff will screen each resident for elopement risk using the Elopement risk Evaluation V (version) 2.0, or equivalent form. After reviewing this information, the nursing staff will determine if the resident is at risk for wandering/elopement.</p> <p>2. If identified as at risk for wandering, elopement, or other safety issues, the resident's care plan will include strategies and interventions to maintain the resident's safety.</p> <p>4. The following items will be used to increase staff awareness of residents at risk to wander/elope:</p> <p>A list of residents that are high risk for elopement or with security bracelets will be posted at the nurse's stations. Identification of each resident with a picture and face sheet will be with the resident list at the nurse's stations.</p> <p>Orientation of all staff to potential wanderers will be performed on an on-going basis.</p> <p>Review of the Resident #1's medical record revealed an admitted [DATE] at 12:58 p.m. with diagnoses including Dementia (unspecified severity) with Mood Disturbance, Chronic Obstructive Pulmonary Disease and Nicotine Dependence.</p> <p>Review of Resident #1's Elopement Risk Evaluation Audit Report revealed Resident #1, who had a history of elopement from home, was assessed as not at risk for elopement on 07/23/2024 at 3:59 p.m. by S4ADON (Assistant Director of Nursing).</p> <p>Review Resident #1's Nursing Admission assessment dated [DATE] revealed Resident #1 walked independently and needed no assistance from staff.</p> <p>Review of Resident #1's Brief Interview for Mental Status (BIMS) assessment dated [DATE] revealed Resident #1 had a BIMS score of 03, indicating severe cognitive impairment.</p> <p>Review Resident #1's Baseline Care Plan failed to reveal Resident #1 was at risk for elopement and had a history of elopement from home.</p> <p>Review of an internet mapping site revealed Resident #1 was located approximately 1 mile from the facility and had to cross two four-lane roads.</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 - Many</p> | <p>Review of Resident #1's Interdisciplinary Notes revealed a late entry by S7LPN (Licensed Practical Nurse) dated 07/24/2024 at 5:05 a.m. which read in part, (07/23/2024) 7:30 p.m., upon rounding, Resident #1 was not in room nor bathroom. S7LPN alerted staff. Search began. Notified S2DON (Director of Nursing). Notified RP. (07/23/2024) 8:45 p.m. Resident #1 returned to facility via private vehicle, accompanied by RP. Resident redirected to assigned room. Vital Signs: 133/70 (blood pressure), 68 (heart rate), 20 (respiratory rate), 97.7 (temperature) and 98% RA (oxygenation on room air). Body Audit performed. No bruising. No opened areas. Close monitoring in progress. Will continue to monitor.</p> <p>Observation on 07/29/2024 at 10:30 a.m. revealed Resident #1 smoking a cigarette on the designated smoking patio with an assigned CNA (Certified Nursing Assistant) present.</p> <p>During an interview on 07/29/2024 at 10:30 a.m., Resident #1 stated multiple times I want to go home; can you take me home? Resident #1 also asked do you have a car; can you take me home?</p> <p>During an interview on 07/29/2024 at 10:40 a.m., S10Agency LPN reported the off-going night nurse on 07/23/2024 informed her during shift change report, Resident #1 was to have 1 on 1 supervision at all times and could not go up front because the entrance doors do not lock.</p> <p>During an interview on 07/29/2024 at 11:00 a.m., S2DON confirmed Resident #1 told staff on admission day, he was ready to leave and go home. S2DON confirmed Resident #1 was seen on the facility video exiting through the front door on 07/23/2024 at 6:00 p.m. and S5Evening Receptionist opened the door remotely to let Resident #1 out. S2DON acknowledged staff did not realize Resident #1 was missing until around 8:00 p.m.</p> <p>During an interview on 07/29/2024 at 1:30 p.m., S2DON confirmed Resident #1 was not deemed at risk for elopement on the Admission Elopement Risk Evaluation dated 07/23/2024 at 15:59 p.m. by S4ADON and should have been.</p> <p>During an interview on 07/29/2024 at 1:40 p.m., S4ADON acknowledged she had interviewed Resident #1, who had a diagnosis of Dementia, upon admission and evaluated Resident #1 as not at risk for elopement. S4ADON acknowledged she performed an inaccurate assessment by not interviewing the family or RP who were present at the time. S4ADON acknowledged had she interviewed the family during the initial evaluation, Resident #1 may not have eloped from the facility.</p> <p>During an interview on 07/29/2024 at 2:40 p.m., S9Day Receptionist, reported she was not informed Resident #1 was a new admit or an elopement risk on 07/23/2024. S9Day Receptionist reported the front door was unlocked during the day for anyone to enter the facility and the sliding glass door automatically opens when a person approaches the front entrance.</p> <p>During an interview on 07/29/2024 at 4:15 p.m., Resident #1's RP reported he found Resident #1 at a local restaurant at approximately 8:25 p.m. Resident #1's RP further reported Resident #1 had eloped from home about 2 months ago and was found by a construction crew.</p> <p>During an interview on 07/29/2024 at 4:40 p.m., S5Evening Receptionist reported she was assigned to the front desk on the 07/23/2024 evening shift and acknowledged she had let Resident #1 out, not realizing he was a resident. S5Evening Receptionist further reported she was not notified on 07/23/2024 of any new admits who were at risk for elopement.</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 - Many</p> | <p>Review of the facility's surveillance video footage of the front entrance area on 07/30/2024 at 8:50 a.m. with S1Administrator and S3Corporate Nurse revealed in part, the following sequence of events on 07/23/2024:</p> <p>5:55:30 p.m. Resident #1 walked past the front desk with his personal coffee cup towards the front door and was seen by S5Evening Receptionist who was sitting at the front desk.</p> <p>5:55:41 p.m. S5Evening Receptionist unlocked and opened the front sliding doors with the remote control button for Resident #1 to exit.</p> <p>5:55:46 p.m. Resident #1 walked out of the facility and remained on the front porch for a brief time.</p> <p>5:56:58 p.m. Resident #1 exited the facility's front porch and began walking away in a left direction.</p> <p>8:31:55 p.m. A white truck was observed to pull up to front entrance of facility.</p> <p>8:34:00 p.m. Resident #1 was observed getting out of the white truck and walked back into facility.</p> <p>Further review of facility's surveillance video footage of the front entrance area on 07/30/2024 at 8:50 a.m. with S1Administrator and S3Corporate Nurse revealed in part, the following sequence of events on 07/23/2024:</p> <p>6:59:40 p.m. S5Evening Receptionist left the front desk to assist a wheelchair bound resident towards the back of the facility.</p> <p>6:59:50 A visitor was observed entering the facility through the sliding doors, which opened upon approach to the entrance; front desk was observed to be unattended.</p> <p>7:03:15 p.m. S5Evening Receptionist, returned to front desk, having left the front desk unattended for approximately 3 to 4 minutes.</p> <p>During an interview on 07/30/2024 at 9:20 a.m., S11CNA reported she was working on 07/23/2024 and Resident #1 asked if she would open the front door because he wanted to go home.</p> <p>During a telephone interview on 07/30/2024 at 10:20 a.m., S7LPN reported she came to work on 07/23/2024 at 7:00 p.m. and did not see Resident #1 on initial rounds. S7LPN reported she began medication pass and by around 8:00 p.m. had still not located Resident #1 and that is when she and staff started searching and got S2DON involved. S7LPN acknowledged the day shift nurse reported to her on 07/23/2024 during change of shift report, Resident #1 was a wanderer.</p> <p>During an interview on 07/31/2024 at 1:05 p.m., S2DON reported once a resident has had an elopement assessment indicating at risk for elopement or a resident is known to wander, the resident's name will remain on the facility's Elopement List as an indicator of high risk for elopement, even if the resident has a follow-up assessment revealing no risk for elopement.</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 - Many</p> | <p>During an interview on 07/30/2024 at 9:00 a.m., S1Administrator, reported the S5Evening Receptionist not knowing Resident #1 was a resident and was at risk for elopement contributed to the safety process failure. S1Administrator acknowledged the front door was left unattended upon review of 07/23/2024's surveillance video and confirmed a resident could elope when someone enters the unlocked front door. S1Administrator acknowledged the front door entrance was not secure and there were times the desk may not be manned. S1Administrator further acknowledged the facility did not have a lock down unit or wander guard system in place to aide in measures to prevent elopement.</p> | | |

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| <p>F 0726</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> | <p>Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44414</p> <p>Based on record reviews, and interviews the facility failed to ensure the nursing staff possessed the competency to accurately assess a resident for elopement risk for 1 (Resident #1) of 9 (#1, #2, #3, #4, #5, #6, #7, #8 and #9) sampled residents reviewed for elopement.</p> <p>This deficient practice resulted in an Immediate Jeopardy on 07/23/2024 at 5:55 p.m. when Resident #1, a severely cognitively impaired resident who was ambulatory, was unsupervised and eloped from the facility. Resident #1 walked out of the front entrance of the facility after S5Evening Receptionist remotely released the front sliding doors to an open position for Resident #1 to exit. Staff had not realized Resident #1 eloped from the facility until 07/23/2024 at approximately 7:30 p.m. Resident #1 had been inaccurately assessed upon admission to the facility on [DATE] by S4ADON (Assistant Director of Nursing) as not at risk for elopement. S4ADON failed to interview Resident #1's family or RP (Responsible Party) at the time of the initial elopement risk assessment and did not capture Resident #1's history of elopement from home prior to admission to the facility, failed to capture Resident #1 told staff on the day of admission he was ready to leave and go home and family reported wandering behaviors. Therefore, protective measures had not been put into place related to Resident #1's elopement risk.</p> <p>S1Adminsitrator was notified of the Immediate Jeopardy on 07/30/2024 at 3:45 p.m.</p> <p>This deficient practice had the likelihood to cause more than minimal harm to any resident residing in the facility at risk for elopement.</p> <p>The Immediate Jeopardy was removed on 07/31/2024 at 4:05 p.m. when it was determined the facility had implemented an acceptable Plan of Removal as confirmed through onsite interviews, observations, and record reviews prior to exit.</p> <p>Findings:</p> <p>Review of the facility's Admission Assessment and Follow Up: Role of the Nurse with a revision date of September 2012 revealed in part:</p> <p>Purpose: the purpose of this procedure is to gather information about the resident's physical, emotional, cognitive, and psychosocial condition upon admission for the purposes of managing the resident, initiating the care plan, and completing required assessment instruments, including the MDS (Minimum Data Set).</p> <p>Steps in the Procedure:</p> <p>5. Conduct an admission assessment (history and physical), including:</p> <p>a. A summary of the individual's recent medical history, including hospitalization s, acute illnesses, and overall status prior to admission .</p> <p>(continued on next page)</p> | | |

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| <p>F 0726</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> | <p>b. Relevant medical, social and family history if available.</p> <p>Review of the facility's Wandering and Elopements policy with a revision date of 11/15/2023 revealed in part:</p> <p>Policy Statement: The facility will identify residents who are at risk of unsafe wandering and implement appropriate protective measure to help guard against a resident wandering from the facility. The facility strives to prevent harm while maintaining the least restrictive environment for residents.</p> <p>Identifying Residents at Risk</p> <p>1. On admission/readmission, quarterly during observation period of MDS, annual, significant changes and PRN (as needed), the nursing staff will screen each resident for elopement risk using the Elopement risk Evaluation V (version) 2.0, or equivalent form. After reviewing this information, the nursing staff will determine if the resident is at risk for wandering/elopement.</p> <p>2. If identified as at risk for wandering, elopement, or other safety issues, the resident's care plan will include strategies and interventions to maintain the resident's safety.</p> <p>4. The following items will be used to increase staff awareness of residents at risk to wander/elope:</p> <p>A list of residents that are high risk for elopement or with security bracelets will be posted at the nurse's stations. Identification of each resident with a picture and face sheet will be with the resident list at the nurse's stations.</p> <p>Orientation of all staff to potential wanderers will be performed on an on-going basis.</p> <p>Review of the Resident #1's medical record revealed an admitted [DATE] at 12:58 p.m. with diagnoses including Dementia (unspecified severity) with Mood Disturbance, Chronic Obstructive Pulmonary Disease and Nicotine Dependence.</p> <p>Review of Resident #1's Elopement Risk Evaluation Audit Report revealed Resident #1, who had a history of elopement from home, was assessed as not at risk for elopement on 07/23/2024 at 3:59 p.m. by S4ADON (Assistant Director of Nursing).</p> <p>Review Resident #1's Nursing Admission assessment dated [DATE] revealed Resident #1 walked independently and needed no assistance from staff.</p> <p>Review of Resident #1's Brief Interview for Mental Status (BIMS) assessment dated [DATE] revealed Resident #1 had a BIMS score of 03, indicating severe cognitive impairment.</p> <p>Review Resident #1's Baseline Care Plan failed to reveal Resident #1 was at risk for elopement and had a history of elopement from home.</p> <p>During an interview on 07/29/2024 at 10:30 a.m., Resident #1 stated multiple times I want to go home; can you take me home? Resident #1 also asked do you have a car; can you take me home?</p> <p>(continued on next page)</p> | | |

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| <p>F 0726</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> | <p>During an interview on 07/29/2024 at 11:00 a.m., S2DON (Director of Nursing) confirmed Resident #1 told staff on admission day, he was ready to leave and go home and Resident #1's family reported he had wandering behaviors. S2DON reported Resident #1 should have been placed on the list of Residents at risk for elopement.</p> <p>During an interview on 07/29/2024 at 1:30 p.m., S2DON reported she reviewed Resident #1's initial Admission Elopement Evaluation on the night Resident #1 eloped and Resident #1 had been evaluated as not at risk for elopement by S4ADON (Assistant Director of Nursing) on 07/23/2024 at 3:59 p.m. S2DON confirmed S4ADON did not complete an accurate Admission Elopement Risk Evaluation for Resident #1 and should have. S2DON reported she had not looked at Resident #1's initial evaluation again until 07/29/2024, when she realized some of the answers had been changed. Review of Resident #1's Elopement Risk Evaluation Audit Report dated 07/29/2024 with S2DON revealed questions #3 and 5 had been changed from no as entered on 07/23/2024 at 3:59 p.m. to yes on 07/24/2024 at 7:55 a.m. by S4ADON. Further review of Resident #1's Admission Elopement Risk Evaluation dated 07/23/2024 revealed in part, a 'yes' answer to any question identified with an asterisk (*) identifies a risk for elopement: Question #3. *Does the resident have a history of elopement or an attempted elopement while at home and Question #5. *Has the resident verbally expressed the desire to go home, packed belongings to go home or stayed near an exit door? S2DON confirmed these answer changes made Resident #1 at a high risk for elopement. S2DON reported S4ADON should not have changed answers on the initial elopement risk evaluation and a new elopement evaluation should have been completed after Resident #1 eloped.</p> <p>During an interview on 07/29/2024 at 1:40 p.m., S4ADON acknowledged she had interviewed Resident #1, who had a diagnosis of Dementia, upon admission and evaluated Resident #1 as not at risk for elopement. S4ADON acknowledged she performed an inaccurate assessment by not interviewing the family or RP who were present at the time. S4ADON further acknowledged she changed some of the answers on Resident #1's initial elopement risk evaluation on the morning of 07/24/2024 to reflect Resident #1 was at risk for elopement, after she learned Resident #1 had eloped on 07/23/2024. S4ADON acknowledged she should not have changed the answers and instead should have opened a new elopement assessment. S4ADON reported risk assessments were a new task and was not sure if she was doing it right because she was not accustomed to performing assessments. S4ADON acknowledged she did not alert staff or put elopement interventions into place for Resident #1 until after he had eloped on 07/24/2024. S4ADON acknowledged had she interviewed the family during the initial evaluation and put protective measures into place, Resident #1 may not have eloped from the facility.</p> <p>During an interview on 07/29/2024 at 4:15 p.m., Resident #1's RP reported Resident #1 had eloped from home about 2 months ago and was found by a construction crew.</p> <p>During an interview on 07/29/2024 at 4:40 p.m., S5Evening Receptionist reported she was assigned to the front desk on the 07/23/2024 evening shift and acknowledged she had let Resident #1 out, not realizing he was a resident. S5Evening Receptionist further reported she was not notified on 07/23/2024 of any new admits who were at risk for elopement.</p> <p>During an interview on 07/30/2024 at 9:00 a.m., S1Administrator, reported the S5Evening Receptionist not knowing Resident #1 was a resident and was at risk for elopement contributed to the safety process failure.</p> <p>(continued on next page)</p> | | |

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| <p>F 0726</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> | <p>During an interview on 07/30/2024 at 9:10 a.m., S3Corporate Nurse, reported she reviewed Resident #1's initial elopement assessment the night Resident #1 eloped and confirmed Resident #1 had been evaluated as not at risk for elopement by S4ADON. S3Corporate Nurse further acknowledged the 07/23/2024 elopement evaluation was inaccurate and S4ADON should have interviewed the family during the initial elopement assessment. S3Corporate Nurse acknowledged the initial assessment was changed the following day 07/24/2024 by S4ADON and should not have been.</p> <p>Review of S4ADON's personnel record failed to reveal nursing assessment competencies were completed.</p> | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195594 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 08/01/2024 |
| NAME OF PROVIDER OR SUPPLIER Pilgrim Manor Skilled Nursing and Rehabilitation | | STREET ADDRESS, CITY, STATE, ZIP CODE 1524 Doctors Drive Bossier City, LA 71111 | |
| 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 0835</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p> | <p>Administer the facility in a manner that enables it to use its resources effectively and efficiently.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44414</p> <p>Based on record review, video review, an interviews, the facility failed to be administered in a manner that enabled its resources to be used effectively and efficiently by failing to implement a system to provide quality care to meet the needs of each resident by failing to:</p> <ol style="list-style-type: none"> 1. Ensure a process was in place to prevent a cognitively impaired resident from exiting the facility for 1 (Resident #1) of 9 (#1, #2, #3, #4, #5, #6, #7, #8 and #9) sampled residents reviewed for elopement. and 2. Ensure the nursing staff possessed the competency to accurately assess a resident for an elopement risk. <p>The lack of administrative oversight resulted in an Immediate Jeopardy on 07/23/2024 at 5:55 p.m. when Resident #1, a severely cognitively impaired resident who was ambulatory, was unsupervised and eloped from the facility. Resident #1 walked out of the front entrance of the facility after S5Evening Receptionist remotely released the front sliding doors to an open position for Resident #1 to exit. Staff had not realized Resident #1 eloped from the facility until 07/23/2024 at approximately 7:30 p.m., when the search began and local police and Resident #1's RP (Responsible Party) were notified. Resident #1 was found with no injuries on 07/23/2024 at approximately 8:25 p.m. by Resident #1's RP. Resident #1 was located at a local restaurant approximately one mile from the facility, in which Resident #1 had crossed two four-lane roads. Resident #1's RP returned Resident #1 to the facility on [DATE] at 8:34 p.m. Resident #1 had been inaccurately assessed upon admission to the facility on [DATE] by S4ADON (Assistant Director of Nursing) as not at risk for elopement. S4ADON failed to interview Resident #1's family or RP (Responsible Party) at the time of the initial elopement risk assessment and did not capture Resident #1's history of elopement from home prior to admission to the facility, failed to capture Resident #1 told staff on the day of admission he was ready to leave and go home and family reported wandering behaviors. Therefore, protective measures had not been put into place related to Resident #1's elopement risk. Multiple observations throughout the survey revealed the front entrance door, which opened to a large sitting area accessible to the residents, was not locked during the day and allowed staff and visitors open access to enter the facility.</p> <p>S1Administrator was notified of the Immediate Jeopardy on 07/30/2024 at 3:45 p.m.</p> <p>This deficient practice had the likelihood to cause more than minimal harm to any resident residing in the facility at risk for elopement.</p> <p>The Immediate Jeopardy was removed on 07/31/2024 at 4:05 p.m. when it was determined the facility had implemented an acceptable Plan of Removal as confirmed through onsite interviews, observations, and record reviews prior to exit.</p> <p>Findings:</p> <p>Cross Reference F689 and F726</p> <p>(continued on next page)</p> | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195594 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 08/01/2024 |
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| <p>F 0835</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p> | <p>Review of facility's surveillance video footage of the front entrance area on 07/30/2024 at 8:50 a.m. with S1Administrator and S3Corporate Nurse revealed in part, the following sequence of events on 07/23/2024:</p> <p>6:59:40 p.m. S5Evening Receptionist left the front desk to assist a wheelchair bound resident towards the back of the facility.</p> <p>6:59:50 A visitor was observed entering the facility through the sliding doors, which opened upon approach to the entrance; front desk was observed to be unattended.</p> <p>7:03:15 p.m. S5Evening Receptionist, returned to front desk, having left the front desk unattended for approximately 3 to 4 minutes.</p> <p>During an interview on 07/29/2024 at 2:40 p.m., S9Day Receptionist reported the front door was unlocked during the day for anyone to enter the facility and the sliding glass door automatically opened when a person approaches the front entrance.</p> <p>During an interview on 07/30/2024 at 9:00 a.m., S1Administrator, reported the S5Evening Receptionist not knowing Resident #1 was a resident and was at risk for elopement contributed to the safety process failure. S1Administrator acknowledged the front door was left unattended upon review of 07/23/2024's surveillance video and confirmed a resident could elope when someone enters the unlocked front door. S1Administrator acknowledged the front door entrance was not secure and there were times the desk may not be manned. S1Administrator further acknowledged the facility did not have a lock down unit or wander guard system in place to aide in measures to prevent elopement.</p> <p>During an interview on 07/30/2024 at 9:10 a.m., S3Corporate Nurse, reported she reviewed Resident #1's initial elopement assessment the night Resident #1 eloped and confirmed Resident #1 had been evaluated as not at risk for elopement by S4ADON. S3Corporate Nurse further acknowledged the 07/23/2024 elopement evaluation failed to include the family in the elopement assessment process, and S4ADON should have, to capture a history of elopement from the home.</p> <p>Review of S4ADON's personnel record failed to reveal nursing assessment competencies were completed.</p> | | |