STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215024	A. Building B. Wing	04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
White Oak Rehabilitation and Nursing Center	6500 Riggs Road Hyattsville, MD 20783

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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 0576 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents have reasonable access to and privacy in their use of communication methods. Based on staff interviews and review of facility records, it was determined that the facility failed to disseminate mail delivered to the facility for the residents. This was evident for 1 (Residents #167) out of 4 residents reviewed during the survey. The findings are: On 04/23/2025 at 10:58 AM, complaint MD00208416 was reviewed. Complaint MD00208416 indicated that Resident #167 mentioned that the facility's Business Office is holding resident mail longer than they should. On 04/23/2025 at 11:31 AM, the surveyor attempted to contact Resident #167 via telephone for an interview. Resident #167 did not answer the telephone call; therefore, the surveyor left a voicemail message on 4/23/2025 at 11:33 AM. As of 4/29/25, Resident #167 had not returned the surveyor's phone call. On 04/24/2025 at 9:25 AM, the Nursing Home Administrator staff #1 was interviewed. During the interview, the surveyor informed staff #1 of the complaint about the Business Office holding residents' mail. On 04/24/2025 at 9:32 AM, the Business Office Manager staff #17 was interviewed. During the interview, staff #17 mentioned that when he/she started working at the facility in September 2024, the residents' mail in the Business Office was backed up. Staff #17 also stated that residents' mail was backed up because the former Business Office Manager worked mostly remotely and was not in the office to distribute the residents' mail. Also, staff #17 stated that when he/she first started working at the facility in September 2024, he/she distributed the backed-up resident mail. On 04/29/2025 at 12:49 PM, review of facility records revealed that on page 18, in the Resident Handbook, under the Deliveries section, it states that mail, telegrams, gifts, and flowers will be promptly forwarded to the resident.

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. Based on resident interviews and staff interviews and review of facility documentation, it was determined that the facility failed to protect the resident's property from loss. This was evident for 2 (Resident #161 and #203) out of 6 residents reviewed during the survey. The findings include: A controlled drug log is delivered with the controlled medication. The log is completed as the medication is administered and once the medication is completed the form goes into the resident's medical record. Each form is designated to the packet of medications that it was delivered with. On a controlled drug log, the date the medication is delivered, the resident name, medication, amount that is delivered, dosage, and administration orders are all noted at the top of the form. As medication is administered, staff are to document date/time, dose, amount wasted if applicable, administered by, and amount remaining. Once a medication has been administered in its entirety, staff need to reorder the medication, and a new Controlled drug log will also be delivered with the corresponding medication. 1. Facility reported incident MD00207539 was reviewed on 4/25/27 at 7:30am. According to the facility's investigation, on 7/6/24 at 7:47am, Licensed Practical Nurse (LPN) staff #28 received and signed for a 30-tablet blister pack of PRN (when needed) Oxycodone IR 5mg for Resident #161. Staff #28 handed over the medication to LPN staff #29 who was assigned to the resident for 7am-3pm shift. Staff #29 handed over the medication to LPN staff #30 at 3:15pm during the change of shifts. On 7/6/24 at 6:11pm, staff #28 received and signed with the pharmacy delivery driver 2 blister packs of Oxycodone IR 5mg, one containing (30) tablets and the other containing (28) tablets for routine order. Staff #28 handed over the medications to staff #30. Staff #30 noticed while counting the medication that staff #30 documented 60 tablets on the narcotic sheet instead of the 58 that was received. Staff #28 and #30 recounted the medication and corrected the count sheet to read 58 tablets. On 7/6/24 at 10:58pm LPN staff #31 clocked in for night shift. Staff #30 gave staff #31 the keys to the medication cart in the hallway of the east Wing nurses station and left the facility at 11:03pm. Staff # 30 and Staff #31 did not count the controlled medications in the cart. A few minutes later staff # 31 handed the key to medication cart to the Supervisor RN (Registered Nurse) staff #32, after being assigned to another unit. Neither nurse counted the controlled medications in the cart. On 7/6/24 at 11:54 pm LPN staff #33 clocked in and received the medication cart keys at the reception desk from the Supervisor staff #32. Neither nurse counted the controlled medications in the cart. On 7/7/24 Staff #33 handed over the medication cart key in the morning to the oncoming nurse staff #29 after they counted the controlled medications together. On 7/7/24 at about 8:15am staff #29 attempted to medicate Resident #161 prior to his/her treatment and noticed that the routine Oxycodone IR 5mg (30) tablets blister pack was not among the medications that she counted with staff #33 and the signing sheet was also missing. She called and confirmed delivery with the pharmacy and notified the morning RN Supervisor staff # 34. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the medical record on 4/25/25 at 9am revealed a physician order dated 7/4/24 to administer Oxycodone 5 mg, one tablet by mouth two times a day and Oxycodone 5 mg, one tablet by mouth every 8 hours prn for pain. During an interview on 4/25/25 at 10:30am with the Assistant Director of Nursing (ADON) she stated, it was verified that the resident pain medication was missing from the medication cart and all nurses involved were reported to the Maryland Board of Nursing. 2. MD00201418 was reviewed on 4/28/25 at 9:00 AM for misappropriation of resident funds of $260.00. Review of the facility investigation revealed the following: Resident #203 reported to the nursing manager (staff # 36) on Med bridge Unit that s/he gave his/her personal bank cards to a Geriatric Nursing Assistant (GNA) #35 to get one thousand three hundred dollars ($1300) from ATM for him/her. The resident reported that this transaction took place on December 19th, 2023. The Resident reported that GNA #35 withdrew and returned the money and bank cards to him/her on 12/20/2023. According to the resident, The GNA proceeded to ask for a Two hundred and fifty dollars ($250) loan, and s/he loaned her Two hundred and Sixty dollars ($260) because the resident did not have change. The resident stated that s/he had a verbal agreement with the GNA #35 to return the money on 12/22/23. The resident stated that GNA #35 stopped taking his/her phone calls and refused to repay the money. During an interview on 4/28/25 at 11am with Resident #203 via phone, s/he stated, the GNA #35 told him/her that she didn't have any furniture for her new apartment and Christmas was coming soon. She made me feel sorry for her. During an interview with the ADON on 4/28/25 at 11:30 am she verified the incident took place. She stated the GNA #35 was terminated from the facility and the resident was repaid his/her money back by the facility.

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F 0603 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from separation (from other residents, his/her room, or confinement to his/her room). **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, and interview with residents and staff, and other pertinent documents it was determined that the facility subjected residents to involuntary seclusion by restricting their ability to move freely. This was evident for 4 (Resident #17, #30, #102, #108) out of 15 residents residing in the locked area of the Med Bridge unit. Additionally, due to the restriction, Resident #108 experienced distress resulting in self-inflicted physical harm in an attempt to exit the locked unit. As a result of the non-compliance an IJ (Immediate Jeopardy) was determined on 4/25/2025 at 3:30 PM. An IJ summary tool was provided to the facility on 4/25/25. The facility submitted a draft of their plan to remove the immediacy on 4/25/25 at 6:40pm, and it was not accepted. The facility submitted a second draft of their plan to remove the immediacy on 4/25/25 at 7:45pm and it was accepted by the State Agency on 4/25/2025 at 8:00pm. After removal of the immediacy, the deficient practice remained with a scope and severity of E. The Immediate Jeopardy was removed on 4/29/25 after on-site confirmation of the completion of the facility's plan of removal. The findings include: During an interview with the NHA (Nursing Home Administrator), the ADON (Assistant Director of Nursing) and Staff #2 on 4/16/25 at 1:11pm, Staff #2 stated that the locked unit was initiated on 10/31/24 following an elopement incident involving a resident. At the time of the interview, the door to the unit was unlocked and opened and remained that way during the rest of the survey. During record review on 4/25/25 at 11:40am, it was revealed that Resident #108 was observed by staff banging on the double doors of the locked portion of the Med Bridge unit on 11/6/24 at 7:00am. At 4:04pm, the resident had an X-ray performed which showed acute fractures of the distal radius and ulnar styloid. The resident was sent to the hospital on [DATE] for immobilization of the fractures. Prior to this incident, there had been no documentation to indicate Resident #108 had demonstrated similar behavior of banging on doors. During observation rounds on 4/16/25 at 7:56am, 15 residents were observed to be behind a locked door when the surveyor conducted an initial tour of the facility. The surveyor questioned the unit manager (Staff #18) regarding the lock unit. Staff #18 stated the locked door was not actually a locked unit and that it was part of a skilled unit. On 4/23/25 at 02:48pm, Staff #2 was interviewed for follow-up information regarding the decision to lock part of the Med Bridge unit. Staff #2 stated that the VPO (Vice President of Operations) initiated the locked portion of the unit as a temporary makeshift unit for the wandering residents. Brief Interview for Mental Status (BIMS) is an assessment tool used to screen and identify resident cognitive status. Scores of 8-12 indicate moderate cognitive impairment, scores of 13 or above indicate cognition is intact. (continued on next page)

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F 0603 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	BIMS scores were reviewed for all the residents residing in the locked area on 4/16/25. Three residents (#17, #30, #102) were identified to have BIMS scores above 11 indicating they would be interviewable. On 4/24/25 at 12:20 pm, interviews were conducted with the alert and oriented residents residing on the unit on 4/16/25 when the unit was found to be locked by the State Agency surveyors. Residents #17, #30, and #102 all stated they did not have the code to open the door and that when they needed to go off the unit that staff had to open the door for them. There was no evidence or documentation to indicate these residents needed to reside on a secure locked unit. The other 11 residents on the unit were determined to be not interviewable by review of their BIMS scores and had no documentation in their medical records indicating that they needed a locked unit for their safety. An immediate jeopardy was declared on 4/25/2025. The provision of the plan to remove the immediacy had a completion date of 4/25/25 and included the following: 1. The keypad on the doors was immediately disabled/deactivated and has remained open since 4/16/25 2. All residents in the facility, especially those who wander, have the potential to be affected. No doors in the facility except the door in question has a keypad. The keypad was deactivated on 4/16/25. 3. All double doors in resident care areas do not have keypad/unable to be locked except the doors referenced in this citation, which has been deactivated since 4/16/25. Residents who are noted to be wanderers are being monitored/redirected to their floors/units by the facility staff. All staff to be educated on resident's rights related to freedom from unnecessary restraint and seclusion. Training/in- service to be completed by 4/25/25 4. The facility administrator conducted an audit of all double doors in the resident care areas and no deficiency noted. This audit will continue daily x 4 weeks, weekly x 4 weeks and monthly x 3 months. Results of these audits will be submitted to the QA/QAPI committee for further recommendation(s)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 3. During an interview on 04/16/2025 at 12:00 PM Resident #50 stated that he/she reported to the facility that $20.00 was stolen from his/her room last year and no one had followed up with him/her as to what happened. During an interview on 04/16/2025 at 1:00 PM staff #1 was made aware, by surveyor, that Resident #50 reported that there was money stolen from his/her room. During an interview and review of facility documentation on 04/16/25 at 3:00 PM staff #1 submitted the Facility Reported Incident Initial Report Form (FRI) regarding Resident #50's missing money to surveyor. The (FRI) revealed that the facility documented having been aware of Resident #50 money missing on 10/03/24 but did not report it to the Office of Health Care Quality or other appropriate agencies within 24 hours of the time the money was reported missing. During an interview on 04/22/2025 at 9:14 AM staff #12 stated that Resident #50 reported money missing from his/her room on 10/03/2024 to him/her and it was not reported to the Office of Health Care Quality or any other agencies by the facility. Based on record review and interview with residents and facility staff, it was determined that the facility failed to timely report allegations of abuse within the required two-hour timeframe and failed to report an alleged violation of misappropriation of resident property/funds immediately or not later than 24 hours to the Survey Agency, the Office of Health Care Quality (OHCQ). This was evident for 3 resident's facility reported incidents (Resident #139, #353, and #50) out of 19 facility related incident reports reviewed during the survey. The findings include: 1. On 4/21/25 at 12:43pm, the surveyor reviewed a facility reported incident which was related to possible abuse of Resident #139. According to the incident report filed with the State Agency, the Assistant Director of Nursing (ADON) was notified at 12:00am on 4/16/25, the NHA (Nursing Home Administrator) was made aware at 7am, and the initial report was submitted to the State Agency at 3:15pm. 2. On 4/22/25 at 8:11am, a record review of MD00212051 revealed that the DON (Director of Nursing) was made aware of the allegation of abuse involving Resident #353 on 11/21/24 at 11am, the administrator was notified at 11:30am, and the report was submitted to the State Agency on11/21/24 at 4pm. The reporting to the State Agency of both allegations of abuse was outside the two-hour window. On 4/22/25 at 12:54pm, during an interview with Staff #2 she reiterated that the expectation for abuse reporting is within 2 hours of being notified of the occurrence.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. Based on medical record review and staff interviews, it was determined the facility failed to ensure that resident or resident's representative received in writing the facility bed-hold policy before a resident was transferred to the hospital. This was evident for 1 resident (#156) out of 6 residents, reviewed during the survey. The findings include the following: Review of Resident #156's medical record on 04/21/25 at 10:51 AM revealed that resident was transferred to the hospital in August 2024 and before the transfer, there was no documentation found that resident or representative was notified of the facility bed-hold policy. During an interview on 04/22/25 at 8:34 AM with staff #1 stated there was no bed hold policy paperwork or documentation given to the resident or resident representative by the facility before the resident was transferred to the hospital.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 4a. Record review of Resident #23's medical record on 4/16/25 at 10:15 AM revealed a smoking care plan was initiated on 7/27/22 and revised on 2/5/25. It indicated the resident was a dependent smoker with the goal to monitor any issues or complications and assist the resident during smoking times. Additionally, on 5/22/23 a focus area was added to the care plan that the resident was non-compliant with wearing the recommended smoking vest and following the facility smoking policy; however, the goals and/or interventions did not address the resident's noncompliance. During observation rounds 4/16/25 at 9am resident #23 was observed reclining back in the wheelchair in the courtyard located on the first floor. The resident was observed with a lit cigarette hanging from his/her mouth and was unsupervised. On 4/17/25 at 8am Resident #23 was again observed by this surveyor in the upper level courtyard with his/her wheelchair reclined back. Resident #36 walked over to Resident #23 and put a lit cigarette in his/her mouth. At that time the Administrator was walking in the hall and verified the findings. The Administrator stated Resident #36 should not be giving Resident #23 or any other resident a cigarette. Review of Resident #36's record revealed s/he was assessed as being an independent smoker with a BIMs of 9 (moderately cognitive impaired). 4b. Review of Resident #125's medical record on 4/16/25 at 11am revealed the resident has a BIMs (brief interview of mental status) score of 7, (0-7 indicates severe cognitive impairment) as of 4/15/25. Continued review of the medical record revealed a Smoking-Safety Screen dated 2/4/25 assessing the resident as being an independent smoker. Resident #125 was observed ambulating back and forth in the upper level (1st floor) courtyard with a lit cigarette in his/her hand and was unsupervised. During an interview on 4/16/25 at 9:15am the Administrator and the Acting Director of Nursing were made aware of the observation. Both stated that dependent smoking residents should be monitored and should be going downstairs to the courtyard to smoke. It was verified by Both the Administrator and the ADON that resident #125 had been assessed as being a dependent smoker. During an interview with the Activities Director on 4/16/25 at 9:30am, she stated that she has spoken to residents on several occasions about lighting dependent resident cigarettes. She stated Resident #23 was non-compliant with the smoking policy and has been told several times that the dependent residents are to smoke in the downstairs courtyard where they can be supervised. Based on record reviews, observations, and interviews with staff and residents, it was determined that the facility failed to:1) ensure a system was in place to prevent exit seeking residents from leaving the facility unsupervised. This was evident for 2 (Resident #105 and Resident #154) out of 22 residents reviewed for exit seeking; 2) Assess, Supervise and monitor residents while smoking. This was evident for 4 (Resident #106, #23, #125, and #51) out of 22 residents reviewed for smoking; 3) Assess and monitor residents with known wandering behaviors. This was evident for 1 (Resident # 108) out of 25 residents reviewed for wandering. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	As a result of this deficient practice, an Immediate Jeopardy was identified on 4/25/2025 at 9:10 PM. An IJ summary tool was provided to the facility on 4/25/2025. The facility submitted the first plan to remove the Immediacy on 4/25/2025 at 11:18PM. The first plan was not accepted. The facility submitted a 2nd plan to remove the Immediacy on 4/26/2025 at 2:01AM. The 2nd plan was not accepted. The facility submitted a 3rd plan to remove the Immediacy on 4/26/2025 at 3:21AM. The 3rd plan was not accepted. The facility submitted a 4th plan to remove the immediacy on 4/26/2025 at 3:55AM which was accepted at 4:22AM. After removal of the immediacy, the deficient practice remained with a scope and severity of E. The Immediate Jeopardy was removed on 4/29/25 at 3:15 PM after on-site confirmation of the completion of the facility's plan of removal. The Findings Include: Wandering is a pattern of aimless and often repetitive walking that significantly increases the risk of injury to the individual. Elopement or exit seeking risk are those who are at risk for leaving a place unnoticed and unsupervised. 1. On 04/18/25 at 9:20 AM, a review of resident #154's medical record and facility investigation revealed a care plan focus area, created on 07/29/2022, stated that resident #154 has a risk for elopement and patient wanders related to Impaired Safety Awareness. The resident had a Brief Interview for Mental Status (BIMS) score of 02/15 on 10/21/2024, which indicated the resident was severely cognitively impaired. Further review of an Elopement Risk Tool assessment dated [DATE] revealed resident #154 was a high risk for elopement and exit seeking. A care plan focus area, created on 10/22/2024, stated the resident was at risk for elopement related to dementia and the patient wears a wander guard. On 04/18/2025 at 10:00 AM a review of the facility investigation revealed that on 10/30/2024 approximately. 4:34 PM the facility was first made aware when a phone call from hospital alerting them that resident #154 was found and brought to the emergency room by Emergency Medical Services (EMS). EMS received a call from someone in the community that resident #154 was on their property, EMS responded and took the resident to the Emergency Room. Per facility investigation on 10/30/2024 the resident was last seen by Nurse staff #20 at 2:00 PM standing in the hallway of the unit. Staff #20 said he heard the back door alarm go off and responded immediately with other staff members and they went outside the door but did not see anyone, the alarm was deactivated and staff returned to the unit. The investigation revealed that the staff did not take any additional steps to validate that Resident #154 was still on the unit and in the facility. Further review of resident #154's medical record and facility investigation revealed that on 10/30/2024 at 7:30 PM Resident #154 returned to the facility from the emergency room and the Nurse Supervisor verified that the resident was wearing a wander guard, staff completed an assessment on resident and determined that resident had no injuries, facility placed a one on one caregiver with resident upon return to the facility. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 04/22/2025 at 12:09 PM during an interview - Regional Consult for Clinical staff #2 stated on 10/30/2024, day of the elopement, it was on the downstairs unit, 2-3 staff members went through the first door on the unit leading to the stairwell to go to a training on another unit upstairs. The door closed and shortly after Resident # 154 went through the first door entering the stairwell, then Resident #154 went to the left and went through the second door that leads to the outside and staff responded to the alarm, they looked around outside and did not see anyone and came back into the center. On 04/22/2025 at 1:45 PM during observation rounds of facility and interview with Maintenance Director staff #13, Assistant Director of Nursing staff #11 and Regional Consult for Clinical staff #2, the Maintenance Director stated the doors that Resident #154 eloped from were located on the lower level of the facility near room [ROOM NUMBER]. After the elopement of Resident #154 the keypad, release button on the inside of stairwell door and wander guard system leading out the first door into the stairwell was noted to be broken. The wander guard system only works if the resident is wearing a wander guard and presses the door handle. The second door that the resident went through leading to the outside of the building had not been connected to the fire alarm system but will now open and alarm only when the fire alarm is alarming. At the time of rounds the first door leading to the stairwell did alarm when the door was pressed while holding a wander guard device near the door and the second door was noted to be locked and able to be opened only by using the keypad with a code. On 04/23/2025 at 9:48 AM during observation rounds with Maintenance Director staff #13 and Nursing Home Administrator staff # 1 revealed the wander guard systems did not alarm when a wander guard device was placed next to the doors which demonstrated that the wander guard system was not working for the following doors: a. the upper East Wing door, b. the lower level East Terrace door next to the physical therapy room, c. the lower level East Terrace door between physical therapy room and DON office, d. the upper level Main Dining Room door and the upper level door next to the Dietician office 2. On 4/22/2025 at 11:00AM, a review of Resident #105's electronic medical record revealed that the resident was admitted to the facility on [DATE] with a diagnosis of but not limited to dementia and anxiety. The resident had a Brief Interview for Mental Status (BIMS) score was 13/15, which indicated the resident was cognitively intact. There was a care plan focus created on 4/25/2023, which stated that the resident wanders related to impaired safety awareness secondary to Dementia. Further review revealed an admission Elopement Risk Assessment on 4/24/2023 which indicated the resident was at a high risk for elopement/exit seeking. The resident had physician orders dated 10/5/2023 for a wander guard on the right wrist, to check function weekly every day shift on Wednesdays, and to check placement every day, every shift and a quarterly Elopement Risk Assessment on 10/27/2023 which indicated the resident was at risk for elopement/exit seeking. (continued on next page)

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	215024	A. Building B. Wing	04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
White Oak Rehabilitation and Nursing Center	6500 Riggs Road Hyattsville, MD 20783

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 4/22/2025 at 10:45AM, a review of a facility reported incident (FRI) investigative file revealed that on 1/10/2024 at approximately 9PM, Resident #105 and a visitor were allowed out of the building by a Geriatric Nursing Assistant (GNA) staff member. The GNA staff member assumed the resident was going on a leave of absence with a family member. The GNA turned off the wander guard alarm at the main entrance door after the resident's wander guard triggered the alarm. Further review of the FRI revealed that on 1/10/2024 at approximately 9:24PM, Resident #105 was returned to the facility accompanied by two police officers who saw the resident walking along the sidewalk down the street from the facility. The resident informed the officers that he/she resided at the facility and did not go out and wanted to take a walk. The resident sustained no injuries. 3. On 4/18/2025 at 7:37AM a review of the facility's current smokers list as of 4/7/2025, revealed Resident #106 was an independent smoker, indicating the resident did not need to be supervised while smoking. During review of Resident #106's electronic medical record, the Surveyor discovered a quarterly smoking safety screen assessments with scores. Scores of 0-4 mean the resident may smoke unsupervised and scores 5 or greater means the resident requires supervision with smoking. Resident #106 was assessed as a smoker and had a smoking safety screen score of 0 on 4/17/2024, score of 7 on 7/17/2024, and a score of 2 on 10/18/2024. On a 1/20/2025 smoking safety screen assessment it documented the resident did not smoke and had a score of zero. Further review of the electronic medical record revealed a care plan created on 4/14/2023 and updated on 3/26/2025 with a focus which stated the resident prefers to smoke with interventions for nursing staff to complete a smoking assessment as needed and all staff to supervise with smoking. On 4/18/2025 at 7:00AM, the Surveyor observed Resident #23 and Resident #125 in the upper-level courtyard smoking unsupervised. On 4/18/2025 at 7:50AM during an interview with Activity Director #12, the Surveyors were informed that she does the smoking assessments and that the nursing staff should follow up with them. 6. On 4/22/25 at 11:11 AM, during review of the medical record for Resident #108, the resident's care plan from 5/4/24 read as follows [Resident 108] is an elopement risk/wanderer related to impaired safety awareness. The following interventions were in place Monitor the resident while on the unit as indicated, Redirect the resident as needed. These interventions were in place to prevent Resident #108 from wandering into areas that could lead to an unsafe situation. Review of the previous care plans for Resident #108 showed that he/she was identified as a wanderer since being admitted in April 2023. The prior care plans were dated 5/9/23, 8/8/23 and 11/6/23 and all identified Resident #108 as a wanderer. On 4/24/25 at 2:19pm, review of the progress notes for Resident #108 revealed that on 5/21/24 the resident had wandered into Resident #154's room and when asked to leave, Resident #108 took his/her shoe and threatened to hit Resident #154. Staff separated the residents and took Resident #108 back to his/her room. The resident care plan was not updated with any additional interventions after this incident. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility's investigation related to facility-reported incident MD00206662 was reviewed on 4/22/25 at 10:17 AM. In the investigation, the facility substantiated there was an altercation on 6/13/24 between Resident #108 and Resident #19. The investigation revealed that Resident #108 wandered into Resident #19's room. Resident #19, unable to call for help due to their medical condition, attempted to go into the hall for assistance and used an emergency whistle to get attention from staff. When no one came to assist, Resident #19 felt he/she was in danger and pepper sprayed Resident #108. Resident #108 had a BIMS (Brief Interview for Mental Status) score of 0 on the most recent assessment dated [DATE] prior to this incident. BIMS scores of 0-7 indicate severe cognitive impairment. Resident #108 was found by staff screaming and holding his/her hands over his/her eyes. The resident was evaluated by the physician at the facility and was ordered to be sent for further evaluation at the hospital. The resident was diagnosed with chemical burns of the eyes at the hospital and was prescribed eye drops for 5 days. On 4/23/25 at 01:40pm, an interview with Resident #19 was conducted. He/she stated that the incident with Resident #108 was not the first time that a wandering resident had entered his/her room and that he/she had alerted administration and staff that it was a recurrent problem. He/She also said that he/she was pushed to the floor in the past by another resident who wandered into his/her room. On 4/23/25 at 8:46am, the facility provided 2 more incident reports which involved Resident #108 wandering into other resident rooms. On 10/27/24 Resident #108 wandered into a resident's room and hit the resident with a plastic hanger, which was substantiated by a witness. The corrective actions related to this incident were to conduct staff in-service on close monitoring and redirection of wandering residents. On 12/2/24, Resident #108 was involved in another incident where Resident #108 wandered into a different resident's room and allegedly kicked his/her leg but there were no other witnesses, and the altercation could not be substantiated. The facility's investigation found that staff did not see Resident #108 enter the other resident's room that night and no witnesses could confirm the event occurred. The corrective action for this incident was as follows, [Resident #108] is being monitored by staff. There were no modifications to the interventions in Resident #108's care plan following the incident on 6/13/24. Further review of the progress notes showed that Resident #108 continued to wander into other residents' rooms with documented examples from the dates 11/21/24, 11/27/24, 12/5/24, 12/12/24, 1/2/25, 2/3/25, 2/20/25, 2/23/25, 3/23/25, and 4/19/25. On 4/24/25 at 09:35am, an interview was conducted with the NHA (Nursing Home Administrator) who stated that the expectations for standard practice at this facility were to monitor the wandering residents anytime they are in the hallways. An Immediate Jeopardy was identified on 4/25/2025. The provision of the plan to remove the Immediate Jeopardy immediacy had a completion date of 4/29/2025 and included the following: 1. Resident #154 no longer resides in the facility; Resident #105 still resides in the facility with a wander guard in place, functioning checked and the wander guard functioning properly. 2. Resident #23, #36, #125, and #51 still reside in the facility and will be supervised during smoking activity. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	a. Resident # 23 will be provided reeducation on the designated smoke areas and times and was provided with the smoking acknowledgment form for compliance. b. Resident #125 will be provided supervision during smoking activity. A designated staff member will be stationed at the upper-level courtyard door. 3. Wander guards are in place and working properly for Resident #141, 121, and #108. Facility staff will supervise both smoking areas located in the upper and lower level of the facility throughout all scheduled smoke times whether dependent or independent. 4. All individuals identified as a smoker, wanderer, or at risk for elopement have the potential to be affected. A facility wide audit was conducted to verify accuracy of assessments for all residents completed by 4/29/2025. 5. All doors with the wander guard system were checked for proper functioning by the vendor on 4/24/2025 and the following was corrected: a. Checked all secure units, lobby, east wing, exit to kitchen, stairwell by lounge, west by central supply, east terrace by smoking area, east terrace by rehab, main dining room, and exit by maintenance shop. Replaced strobe alarm at terrace smoking door. Disconnect door switch to allow alarm to activate. Verify alarms at all remaining doors while approaching the door. 6. All doors with a wander guard system were checked for proper functioning by the Maintenance Director on 4/26/2025 at 12:45AM and confirmed to be functioning properly. 7. All residents with the wander guard bracelets were checked for placement and function on 4/26/25 at 12:45AM. 8. All residents with wandering behavior will be provided monitoring to ensure safety and wellbeing with the use of an individual hourly monitoring log daily to be completed by nursing and care plan reviewed and revised accordingly. 9. To ensure the accuracy and use of appropriate safety devices, the facility will conduct a new assessment on all current wandering and elopement risk residents by 4/29/2025. 10. To accurately determine the level of assistance needed, all smoking residents will receive a new assessment for 4/29/2025. 11. To safeguard residents, staff will be trained on alarm response and thorough search procedures, followed by a headcount to ensure all are present and accounted for by 4/29/2025. 12. For resident safety, a designated staff member will always provide supervision for all residents during scheduled smoking times. Training will be provided to all staff on facility smoke policy by 4/29/2025. 13. All residents identified for wandering, elopement risk, and smoking will have behavior monitoring implemented as needed by 4/29/2025 (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	a. Wander guard device functioning will be checked weekly by central supply b. Wander guard device placement will be checked every shift by the charge nurse and/or the supervisor. 14. 100% audit was conducted of the wander guard door a;arm system and bracelets completed. The Maintenance Director will complete a daily audit on exit doors x4 weeks, weekly audits x4, and monthly audits x3; daily monitoring of the smokers supported with an audit tool will be completed daily by the nursing staff daily x4 weeks, weekly x4 weeks, and monthly x3; Nursing will monitor all wandering residents Q hourly utilizing a monitoring log to ensure safety daily x4 weeks, weekly x4 weeks, and monthly x3; wander guard device placement audit will be conducted daily x4, weekly x4 and monthly x3 by central supply. 15. All results of the audits will be submitted to the QA/QAPI committee for further recommendation (s) monthly and as needed. 5. On 04/25/25 at 01:41 PM, review of resident records revealed that Resident #51's Smoking Safety Screen, dated 4/18/25, indicated that Resident #51 was a smoker, has dexterity problems, cannot use a lighter independently, requires a smoking apron/blanket while smoking, and must be supervised while smoking. On 04/25/2025 at 1:43 PM, review of resident records revealed that Resident #51 has a medical diagnosis of ataxia and muscle weakness. On 04/25/25 at 01:47 PM, review of resident records revealed that Resident #51's care plan indicated that Resident #51 must be supervised while smoking. Resident #51's care plan did not indicate that Resident #51 must use a smoking apron/blanket while smoking. On 04/25/25 at 01:12 PM, during observation rounds on 4/16/25 and 4/17/25, Resident #51 was noted smoking unsupervised. On 04/25/25 at 01:12 PM, during observation rounds on 4/18/25, 4/21/25, 4/22/25, 4/23/25 and 4/24/25 Resident #51 was observed smoking unsupervised without wearing a smoking apron/blanket. On 04/25/25 at 2:18 PM, Activity Director staff #12 was interviewed. During the interview, staff #12 stated that many dependent smoking residents and independent smoking residents are non-compliant with following the smoking policy. Dependent smoking residents have been told several times that they must smoke in the downstairs courtyard where they can be supervised by staff as well as wear a smoking apron/blanket. Staff #12 also stated that they have told independent smokers not to light cigarettes for dependent smokers. On 04/25/25 at 2:49 PM, Resident #51 was interviewed. During the interview, Resident #51 indicated that he/she was aware that they must be supervised by staff and must wear a smoking apron/blanket while smoking.