STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215109	A. Building B. Wing	05/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rossville Rehabilitation and Healthcare Center	6600 Ridge Road Baltimore, MD 21237

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on medical record review, observation and interview, the facility staff failed to ensure residents had a curtain to maintain privacy during care. This was evident for 2 (Resident #10 and #13) of 25 residents observed during a complaint survey.The findings include:Observation of Resident #10 on 5/12/26 at 8:02 AM revealed no privacy curtain between the Resident and his/her roommate (Resident #13). At that time the Surveyor asked the Resident how long the curtain had been missing and the Resident stated, quite some time. The Resident was asked if he/she would like to have a privacy curtain and the Resident stated yes.Review of Resident #10's medical record on 5/12/26 revealed the Resident was assessed by facility staff to be dependent for care on the 3/19/26 MDS (Minimum Data Set) Assessment Section GG0130 Functional Abilities/Self Care.On 5/12/26 at 8:40 AM, the Surveyor brought Unit Manager (UM) #11 to Resident #10 and #13's room. At that time UM #11 confirmed there was no privacy curtain between Resident #10 and #13. UM #11 confirmed at that time Resident #10 is dependent for care by facility staff.On 5/12/26 at 9:00 AM the Administrator notified the Surveyor that a privacy curtain was just put in place for Resident #10 and #13.

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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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on medical record review, facility documentation review and interview, it was determined the facility failed to maintain an effective grievance system for residents. This was evident for 1 (Resident #10) of 4 residents reviewed for complaints during a complaint survey. The findings include:Review of Resident #10's medical record on 5/11/26 revealed the Resident was admitted to the facility in 2014.During interview with Resident #10's RP (Resident Representative) on 5/11/26 at 10:14 AM, the RP stated he/she came into visit the Resident on Christmas day in the afternoon. At that time the Resident was lying in a soiled diaper that was leaking on his/her resident gown. The RP stated he/she wrote up a grievance regarding the incident and personally handed it to the Administrator a few days later since the grievance contained names of staff working on Christmas day. The RP stated he/she has had no resolution to that grievance.Further review of Resident #10's medical record on 5/12/26 revealed the Resident was assessed by facility staff to be dependent for care on the 3/19/26 MDS (Minimum Data Set) Assessment Section GG0130 Functional Abilities/Self Care.The Surveyor requested the grievance logs from December 2025 through 5/12/26.On 5/12/26 the Surveyor reviewed the grievance logs provided by the Administrator. There were no grievances recorded for any residents in the month of December. There were no grievances on any of the logs from December 2025 through 5/12/26 for Resident #10.Interview with the Administrator on 5/12/26 at 9:12 AM, the Administrator stated that Social Work spear heads the grievance process and all grievances are reviewed by Social Work, the Administrator and the Department involved. The Administrator stated all grievances should be recorded on the log and they try to resolve them in 48-72 hours if possible. The Surveyor asked the Administrator if he remembered Resident #10's RP handing him a grievance related to Resident #10's care on Christmas Day 2025. The Administrator stated he did. The Administrator was asked why this grievance wasn't on the grievance log. The Administrator stated he was not sure why it was not on the log, but he may have a soft file on it.The Administrator followed up with the Surveyor on 5/12/26 at 10:59 AM. The Administrator stated he could not find any file on the grievance and even called the former Unit Manager #14. The Administrator confirmed at that time he was unable to provide any documentation that the grievance was investigated and resolved for Resident #10.

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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. Based on complaint, record review, and staff interview, it was determined the facility failed to report an incident of elopement to the state survey agency, the Office of Health Care Quality. This was evident for 2 (Resident #6, #7) of 8 residents reviewed for elopement during the complaint survey.The findings include: On 5/11/26 at 8:30 AM a review of complaint 2988135 alleged on 4/16/26 at 5:51 PM a passerby stated that Resident #6 had a fall while pushing someone in a wheelchair (Resident #7). Resident #6 and Resident #7 were located on a sidewalk next to a closed restaurant on the corner of a heavily traveled road. This location was down the street from the facility. The complaint alleged Resident #7 was rambling incoherently and that Resident #6 had minor skin tears on the left leg. Resident #7 was observed standing behind the wheelchair, not wearing pants, and wearing only hospital-style grip socks. On 5/11/26 at 8:31 AM a review of Resident #6's medical record was conducted. Review of a 4/13/26 at 18:19 (6:19 PM) progress note for Resident #6 documented, wanderguard applied to the patient's left ankle due to identified risk of elopement. On 5/11/26 at 8:45 AM a review of Resident #7's medical record (Resident #6's spouse) was conducted. Review of a 4/13/26 at 18:20 (6:20 PM) progress note for Resident #7 documented, wanderguard applied to the patient's left ankle due to identified risk of elopement.On 5/11/26 at 12:37 PM an interview was conducted with Registered Nurse (RN) #17, the evening shift supervisor. RN #17 was asked if anyone had recently eloped from the facility. RN #17 stated that Resident #6 and Resident #7 eloped on 4/16/26 around 5:55 PM to 6:00 PM when she was alerted by the front desk that paramedics were in the lobby.On 5/11/26 at 1:07 PM the Nursing Home Administrator (NHA) and the current Director of Nursing (DON) were interviewed and confirmed that Resident #6 and Resident #7 left the building on 4/16/26. The NHA was asked if the elopement was reported to the state survey agency, the Office of Health Care Quality (OHCQ). The NHA stated the incident was not reported to OHCQ because it was not related to abuse. The NHA stated, there was no abuse, so it was not reported. If there was no abuse involved you don't report it. I asked my superiors and they told me just abuse is reported.The NHA and DON were informed that the incident should have been reported to OHCQ as the safety and welfare of Resident #6 and Resident #7 were jeopardized.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on medical record review and staff interview, it was determined the facility staff failed to ensure Minimum Data Set (MDS) assessments were accurately coded. This was evident for 3 (#6, #2, #17) of 24 residents reviewed during a complaint survey.The findings include: The MDS is part of the Resident Assessment Instrument that was Federally mandated in legislation passed in 1986. The MDS is a set of assessment screening items employed as part of a standardized, reproducible, and comprehensive assessment process that ensures each resident's individual needs are identified, that care is planned based on those individualized needs, and that the care is provided as planned to meet the needs of each resident.1)On 5/11/26 at 8:30 AM a review of Resident #6's medical record was conducted. A review of Resident #6's March 2026 Medication Administration Record (MAR) documented Resident #6 received Cyanocobalamin Solution 1000 mcg/ml injection on 3/28/26. The medication is a synthetic form of Vitamin B12 which is used to treat and prevent Vitamin B12 deficiency, which can cause severe anemia, stomach/bowel issues, and nerve damage. Review of Resident #6's admission MDS assessment with an Assessment Reference Date (ARD) of 3/30/26, Section N0300 Injections, was coded 0. The facility failed to capture the injection. On 5/14/26 at 11:56 AM MDS Coordinator #24 was interviewed and confirmed the injection was not captured.2)On 5/12/26 at 12:31 PM a review of Resident #2's medical record was conducted. Review of a 6/28/25 at 01:00 AM physician's history and physical note the chief complaint/nature of presenting problem was, admission to SNF (skilled nursing facility) for rehabilitation and continued medical management following fall with left lower extremity DVT (deep vein thrombosis), patellar fracture, and cognitive concerns. The note documented was admitted to the acute care facility on 6/19/25 after being found down on the floor of his/her home. The resident had apparently fallen and was unable to get up.Review of Resident #2's admission MDS with an ARD of 7/3/25, Section J1700, fall history on admission/entry or reentry; A: did the resident have a fall any time in the last month prior to admission/entry or reentry? documented, no. This was an error as the resident fell on 6/19/25 at home. The facility failed to capture the fall.Continued review of Resident #2's medical record revealed documentation that Resident #2 had a fall on 8/17/25, 8/18/25, and 8/21/25.Review of Resident #2's Discharge MDS with an ARD of 9/23/25: Section J1800, any falls since admission/entry or reentry or Prior Assessment, documented, no. This was incorrect as the resident had 3 falls since the 7/3/25 admission MDS assessment.On 5/14/26 at 11:49 AM an interview was conducted with MDS Coordinator #24. He reviewed the hospital discharge summary and the change in condition forms and confirmed the errors. He said he didn't know how he missed them.3)On 5/14/26 at 10:30 AM a review of the elopement binder at the front desk revealed 8 names of residents that were an elopement risk. The binder included Resident #17. On 5/14/26 at 10:40 AM a review of Resident #17's medical record revealed an April 2026 Treatment Administration Record (TAR) and a January 2026 TAR that documented Resident #17 wore a wanderguard bracelet every shift.Review of Resident #17's significant change MDS Assessment with an ARD of 1/17/26 and a quarterly MDS assessment with an ARD of 4/19/26, Section P0200 E, wander/elope alarm, was coded no. This was an error as the nurses checked off each shift that the resident was wearing a wanderguard bracelet.On 5/14/26 at 1:44 PM MDS Coordinator #24 reviewed the MDS with the surveyor and confirmed the errors.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on medical record review and interview, the facility staff failed to 1) assess a resident's wounds weekly to include measurements and 2) failed to follow wound care provider's orders for a resident. This was evident for 1 (Resident #8) of 3 residents reviewed for wound care during a complaint survey.The findings include:Review of Resident #8's medical record on 5/11/26 revealed the Resident was admitted to the facility in January 2026 from the hospital with a diagnosis to include peripheral vascular disease (PVD). PVD is a slow and progressive circulation disorder characterized by narrowing, blockage or spasms in blood vessels, commonly affecting the legs. Review of the Resident's hospital discharge summary revealed the Resident had a wound from a right 4th toe amputation. Further review of Resident #8's medical record revealed on admission the facility staff assessed the Resident to also have a right heel wound.1)The facility staff failed to do a weekly assessment with measurements of Resident #8's wounds.Further review of Resident #8's medical record revealed the Resident was assessed by the Wound NP on 1/27/26. Review of the Wound NP notes revealed the Wound NP included assessment, measurements and treatment orders for the Resident's right 4th toe amputation and right heel wounds.Further review of Resident #8's medical record revealed on 2/2/26 the Wound NP documented: Patient was unable to be evaluated by the skin and wound team today; patient out of bed times 3 at time of visit. On 2/4/26 the Wound NP documented: Patient was unable to be evaluated by the skin and wound team today; patient at dialysis during time of visit. On 2/9/26 the Wound NP documented: Patient was unable to be evaluated by the skin and wound team today; patient at dialysis during time of visit.Further review of Resident #8's medical record revealed the next wound assessment with measurements was completed by the Wound NP on 2/11/26, 15 days later.During interview with the Director of Nursing (DON) on 5/12/26 at 12:00 PM, the DON confirmed the facility staff failed to assess Resident #8's wounds weekly with measurements from 1/27/26 until 2/11/26. 2)The facility staff failed to administer all wound treatments as ordered for Resident #8.Review of Resident #8's January, February and March 2026 Treatment Administration Records on 5/12/26 revealed the facility staff failed to administer right heel and 4th right toe wound treatments on 1/28, 2/4, 2/7 and 3/15/26.Interview with the Director of Nursing on 5/12/26 at 12:00 PM confirmed the facility staff failed to administer right heel and 4th right toe wound treatments on 1/28, 2/4, 2/7 and 3/15/26 for Resident #8.

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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. Based on a review of a complaint, medical records, interviews, and facility investigative documents, it was determined that the facility failed to have an effective system to prevent 2 residents with cognitive impairment, exit-seeking behavior, and an assessed risk for elopement from leaving the facility without appropriate supervision. This failure placed both residents at risk for harm due to hazards, including no sidewalk, which forced them into a road, which led them to a heavily traveled road and one resident not being properly dressed. These actions resulted in an Immediate Jeopardy (cited as past non-compliance). This was evident for 2 (Resident #6, #7) out of 8 residents reviewed for elopement/wandering risk during a complaint survey.The facility implemented effective and thorough corrective measures following this incident prior to the start of this survey. The facility's plan and action were verified during this survey; therefore, this deficiency was found to be past noncompliance with a compliance date of 4/23/26.The findings include:On 5/11/26 at 8:30 AM a review of complaint 2988135 stated on 4/16/26 at 5:51 PM a passerby stated that Resident #6 had a fall while pushing someone in a wheelchair (Resident #7). Resident #6 and Resident #7 were located on a sidewalk next to a closed restaurant on the corner of a heavily traveled road. This location was down the street from the facility. The complaint alleged Resident #7 was rambling incoherently and that Resident #6 had minor skin tears on the left leg. Resident #7 was observed standing behind the wheelchair, not wearing pants, and wearing only hospital-style grip socks. On 5/11/26 at 8:31 AM a review of Resident #6's medical record was conducted. A review of a 3/24/26 at 22:52 (10:52 PM) admission note documented that Resident #6 had short-term memory loss and a BIMS (brief interview of mental status) score of 7.0, indicating severe impairment.A review of a 3/27/26 at 12:48 PM practitioner's note documented that Resident #6 was admitted from an acute care facility following Adult Protective Services concerns regarding the resident's inability to care for self and spouse in an unsafe home environment. It was determined that Resident #6 lacked capacity due to multiple prior chronic lacunar infarcts and a Vitamin B12 deficiency. Chronic lacunar infarcts are small, healed areas of dead tissue deep within the brain caused by the blockage of tiny penetrating blood vessels. Resident #6 was assessed for elopement and had an elopement score of 8.0 which indicated low risk.On 5/11/26 at 8:45 AM a review of Resident #7's medical record (Resident #6's spouse) documented a 3/24/26 nursing admission assessment showing an elopement risk score of 10.0, high risk for elopement.Review of a 3/27/26 at 12:49 PM practitioner note for Resident #7 documented a history of severe baseline dementia. It was documented that Resident #7 could not care for him/herself, experienced poor hygiene, was malnourished, and had an incapacitated status.Review of a 3/31/26 at 1:29 AM practitioner note for Resident #7 documented, severe dementia with behavioral symptoms (wandering) and safety risk. Baseline severe cognitive impairment with wandering behavior and supervision provided in hallway. Continue staff supervision.Continued review of Resident #6's medical record revealed a second elopement risk assessment done on 4/13/26 documented a score of 14, indicating a high elopement risk.Review of Resident #6 and Resident #7's care plans revealed an elopement care plan initiated for each resident on 4/13/26 with interventions including, placed wanderguard on, picture of ID to front desk.A 4/13/26 at 18:19 (6:19 PM) progress note for Resident #6 documented, wanderguard applied to the patient's left ankle due to identified risk of elopement. A 4/13/26 at 18:20 (6:20 PM) progress note for Resident #7 documented, wanderguard applied to the patient's left ankle due to identified risk of elopement.Review of Resident #6's April 2026 Treatment Administration Record (TAR) documented the physician's order written on 4/13/26 at 23:00 (11:00 PM), wanderguard: check placement to left ankle every shift for safety. The wanderguard was checked off as on during the 4/13/26 night shift and 4/14/26 day shift. The 4/14/26 evening shift denoted a 9 which indicated the wanderguard bracelet was not on. A corresponding eMAR (electronic medication administration record) note documented, pt. removed. The note did not say how the (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	wanderguard bracelet was removed.Continued review of Resident #6's April 2026 TAR revealed 4/14/26 night shift documented the bracelet was on and on 4/15/26 all 3 shifts documented the bracelet was on. On 4/16/26 all 3 shifts documented a 9, indicating the bracelet was not on. A corresponding eMAR note dated 4/16/26 at 11:22 AM documented, not on.Review of Resident #7's April 2026 TAR documented the physician's order written on 4/13/26 at 23:00 (11:00 PM), wanderguard: check placement to left ankle every shift for safety. The wanderguard was checked off as on during the 4/13/26 night shift and 4/14/26 day shift. The 4/14/26 evening shift documented a 9. There was a corresponding eMAR note dated 4/14/26 at 20:26 (8:26 PM) that stated, rt removed. Continued review of Resident #7's April 2026 TAR for 4/15/26 day shift denoted a 9, indicating the bracelet was not on, however the evening and night shifts documented the bracelet was on. A corresponding eMAR note dated 4/15/26 at 12:13 PM documented, none. On 4/15/26 night shift the bracelet was documented as on, however on 4/16/26 day shift it was documented as 9 and on 4/16/26 the evening shift was blank. A corresponding eMAR note dated 4/16/26 at 11:22 AM documented, not on. There was no documentation in either medical record as to why the bracelet was not on and how the bracelets were removed.Further review of the medical record failed to produce documentation of the elopement of Resident #6 and Resident #7 on 4/16/26. There was no documentation on 4/16/26 until a 10:14 PM nursing note that documented a wanderguard was applied to Resident #6 and a 10:26 PM note that the wanderguard was applied to Resident #7.On 5/11/26 at 12:37 PM an interview was conducted with Registered Nurse (RN) #17, the evening shift supervisor. RN #17 was asked if anyone had recently eloped from the facility. RN #17 stated that Resident #6 and Resident #7 eloped on 4/16/26 around 5:55 PM to 6:00 PM when she was alerted by the front desk that paramedics were in the lobby. They said they saw 2 residents down by the corner of Ridge Road and Philadelphia Road, were alerted by someone calling 911, and brought them back to the building. RN #17 stated that Resident #6 had scrapes on the knees. RN #17 was asked if she documented the assessment of the residents in the medical record or wrote a note about the elopement. RN #17 stated that she did not document the incident and that the nurse working that evening would document the findings.During the continued interview, RN #17 was asked how the residents got out of the building. RN #17 stated that the front door was locked so someone buzzed them out. RN #17 stated there was a book at the front desk with pictures of residents' faces to identify those at elopement risk. The person at the front desk should have contacted the nurse to verify if they could go out, checking if they were with a family member or had a doctor's order allowing them to leave. The nurse should have been notified, or the supervisor should have been called. On 5/11/26 at 12:51 PM an interview was conducted with Licensed Practical Nurse (LPN) #8, who worked the evening shift on 4/16/26. LPN #8 stated both residents previously had wanderguard bracelets, but when she came on duty at 3:00 PM she noticed they did not have them on. Management told her they were getting the bracelets and would bring them to her. LPN #8 stated, we were trying to watch them while taking care of other residents.During the continued interview, LPN #8 stated, that week Resident #6 kept cutting the wanderguard off and I made management aware. We searched the resident's room the first time the wanderguard was cut off and found scissors. The second time the wanderguard was found cut off we found nail clippers. We realized the wanderguard bracelets were too small, therefore an order was placed for larger bracelets, and they had not been placed on the residents the day they eloped.LPN #8 stated, I feel like they were strategically waiting for us to be busy to make their exit. It was quick. I gave them their medication, and I was in another patient's room and then I was made aware that the fire department was here letting us know that they had them both.LPN #8 was asked if she documented the incident and the assessment of Resident #6 and Resident #7 in their medical records. LPN #8 stated that she documented it in risk. She didn't know she was supposed to document in the medical record also. The risk file is part of the electronic medical record system. The electronic medical record system also contains reports and administrative files and is not considered part of the resident's electronic medical record.On 5/11/26 at 1:07 PM the Nursing Home Administrator (NHA) (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	and the current Director of Nursing (DON) were interviewed and confirmed that Resident #6 and Resident #7 left the building on 4/16/26. The NHA was asked if the elopement was reported to the state survey agency, the Office of Health Care Quality (OHCQ). The NHA stated the incident was not reported to OHCQ because it was not related to abuse. The NHA stated, there was no abuse, so it was not reported. If there was no abuse involved you don't report it. I asked my superiors and they told me just abuse is reported.During the continued interview, the DON confirmed there was no documentation of the elopement in the medical record, but it was documented in risk. The DON was asked if risk was part of the medical record and the answer was, no.On 5/11/26 at 1:15 PM the NHA provided the surveyor with a copy of the facility's investigation regarding the elopement which included a copy of the abatement plan for IJ (immediate jeopardy) - patients took a walk without notifying staff. Review of the investigation with the NHA and the DON revealed a written statement from Receptionist #9 documenting that on 4/16/26 at approximately 5:30 PM, while entering a new admission into the computer at the front desk, 2 individuals exited the building. They were dressed in regular clothing, and based on that, I believed they were visitors, as we frequently have elderly couples entering and exiting the building. I understand that the residents were listed in the wanderguard/elopement book at the front desk. Receptionist #9 documented that he was not specifically instructed or trained that he was required to review and memorize the contents of the book at the start of each shift or use it as a primary method of identifying elopement risk residents in real time and that he was not informed that these residents were elopement risks. The NHA stated during the 5/11/26 interview at 1:15pm that Receptionist #9 was suspended and then resigned from the facility.On 5/11/26 at 1:28 PM the DON, who was the Assistant Director of Nursing (ADON) at the time of the incident, stated that prior to the elopement, wanderguard bracelets were placed on both residents on 4/13/26, but Resident #6 cut them both off. The DON stated the nurses put new wanderguard bracelets on and they were cut off again. The DON stated she told the previous DON that they needed larger strapped wanderguard bracelets, which the facility was ordering, and in the meantime, she felt both residents needed one-to-one supervision. The DON stated the previous DON informed her they did not have enough staff for one-to-one supervision, so nothing further was done.The DON stated that after the 4/16/26 elopement, wanderguard bracelets were placed on Resident #6 and Resident #7. The DON stated the residents were monitored every 15 minutes until they were moved upstairs to the locked dementia unit the next day.On 5/13/26 at 2:36 PM Physician #13 was asked if he was aware of the elopement. Physician #13 stated, yes, and how? I raised a stink about it. If anyone is at risk for wandering and has enough dexterity to manipulate a door and frequently come out of the room you have to let me know so I can intervene. We have to figure out why they are wandering. I can't believe it happened.On 5/14/26 at 10:01 AM Geriatric Nursing Assistant (GNA) #21 was interviewed and stated, they were exit seeking. Usually, Resident #6 was exit seeking. Resident #6 would put Resident #7 in a wheelchair and start to walk down the hall, and they would say that they were leaving.Review of the abatement plan provided to the surveyors included staff education, audits, elopement assessments on all residents, and QAPI (Quality Assurance and Performance Improvement) ad hoc sign-in sheets. Immediate interventions included:Resident #6 and Resident #7 were both assessed and placed on one-to-one supervision after the elopement on 4/16/26 until midnight, then placed on every 15-minute checks until they were relocated to the second-floor locked dementia unit on 4/17/26.Wanderguard bracelets were placed on their wheelchairs and left ankles.The care plan for Resident #6 was updated to include the behavior of clipping off the wanderguard bracelets.The physician, Medical Director, and family were notified.The QAPI Ad hoc meeting was conducted.On Friday, 4/17/26 both residents were moved to the second floor locked dementia unit.The exits and stairwell door alarms were checked for functionality by the maintenance assistant.The ADON coordinated and initiated education on the Elopement and Wandering Policy for current staff. Staff not educated on the policy will not work until the Elopement Prevention and Wandering Inservice is completed.A facility-wide elopement assessment audit was coordinated by the ADON on Friday, 4/17/26, on current residents to determine (continued on next page)

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	215109	A. Building B. Wing	05/15/2026

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	like residents and was completed on 4/23/26.Residents with wanderguards were inspected by the unit manager on Thursday, 4/16/26, to assure the devices were present and functioning.No additional residents were determined to require wanderguards.Daily audits began and then weekly audits were conducted.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on complaint, medical record review and interview, it was determined the facility failed to maintain complete and accurate medical records in accordance with accepted professional standards. This was evident for 3 (#6, #7, #10) of 10 residents reviewed for complaints during a complaint survey. The findings include: A medical record is the official documentation of a healthcare organization. As such, it must be maintained in a manner that follows applicable regulations, accreditation standards, professional practice standards, and legal standards. All entries to the record should be legible and accurate. 1) On 5/11/26 at 8:30 AM a review of complaint 2988135 stated on 4/16/26 at 5:51 PM a passerby stated that Resident #6 had a fall while pushing someone in a wheelchair (Resident #7). Resident #6 and Resident #7 were located on a sidewalk next to a closed restaurant on the corner of a heavily traveled road. This location was down the street from the facility. The complaint alleged Resident #7 was rambling incoherently and that Resident #6 had minor skin tears on the left leg. Resident #7 was observed standing behind the wheelchair, not wearing pants, and wearing only hospital-style grip socks. On 5/11/26 at 8:31 AM a review of Resident #6's medical record was conducted. Review of a 4/13/26 at 18:19 (6:19 PM) progress note for Resident #6 documented, wanderguard applied to the patient's left ankle due to identified risk of elopement. On 5/11/26 at 8:45 AM a review of Resident #7's medical record (Resident #6's spouse) was conducted. Review of a 4/13/26 at 18:20 (6:20 PM) progress note for Resident #7 documented, wanderguard applied to the patient's left ankle due to identified risk of elopement. Review of Resident #6 and Resident #7's April 2026 Treatment Administration Records documented several shifts where the wanderguard was not applied to Resident #6 and Resident #7. There was no documentation in either medical record as to why the bracelet was not on and how the bracelets were removed. Further review of the medical record failed to produce documentation of the elopement of Resident #6 and Resident #7 on 4/16/26. On 5/11/26 at 12:37 PM an interview was conducted with Registered Nurse (RN) #17, the evening shift supervisor. RN #17 was asked if anyone had recently eloped from the facility. RN #17 stated that Resident #6 and Resident #7 eloped on 4/16/26 around 5:55 PM to 6:00 PM when she was alerted by the front desk that paramedics were in the lobby. RN #17 stated that Resident #6 had scrapes on the knees. RN #17 was asked if she documented the assessment of the residents in the medical record or wrote a note about the elopement. RN #17 stated that she did not document the incident and that the nurse working that evening would document the findings. There was no documentation found in the medical record about Resident #6's scrapes on the knees. On 5/11/26 at 12:51 PM an interview was conducted with Licensed Practical Nurse (LPN) #8, who worked the evening shift on 4/16/26. LPN #8 was asked if she documented the incident and the assessment of Resident #6 and Resident #7 in their respective medical records. LPN #8 stated that (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	she documented in risk. She didn't know she was supposed to document in the medical record also. On 5/11/26 at 1:07 PM the Nursing Home Administrator (NHA) and Director of Nursing (DON) were interviewed. The DON confirmed there was no documentation of the elopement in the medical record, but it was documented in risk. The DON was asked if risk was part of the medical record and the answer was, no. Risk is a part of the electronic medical record system. The electronic medical record system also contains reports and administrative files and is not considered part of the resident's electronic medical record. On 5/11/26 at 1:28 PM the DON stated that prior to the elopement Resident #6 had cut off the bracelets a couple of times, however there was no documentation that Resident #6 had cut the bracelets off and what the resident used to cut them off. Continued review of the medical record failed to produce documentation that the family was notified of the elopement. On 5/11/26 at 1:51 PM the NHA and the Regional Director of Clinical Operations (RDCO) #7 gave the surveyor a copy of the incident where it was documented that the family was notified. They were asked where the family notification was located in the resident's medical record and they stated, it is in risk, to which the surveyor stated, which is not part of the medical record. RDCO #7 confirmed that it was not in the resident's medical record. Review of the incident report that RDCO #7 showed the surveyor had documented on the bottom of the form, privileged and confidential – not part of the medical record – do not copy test. On 5/13/26 at 2:15 PM an interview was conducted with the Owner of the Facility #16. The elopement was discussed and the failure to have documentation about the elopement in the medical record that anything happened. Facility Owner #16 stated that he agreed that there should have been documentation and he would have to make a change to make sure when the staff are documenting, it should go into risk and the medical record. 2) The facility staff failed to document in Resident #10's medical record notification to the RP (responsible party) for a change of condition. Review of Resident #10's medical record on 5/11/26 revealed the Resident was admitted to the facility in 2014. The Resident's medical diagnosis includes Dementia. Dementia is a general term for loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life. Further review of Resident #10's medical record revealed the facility staff assessed the Resident on 3/19/26 to have a BIMS (Brief Interview for Mental Status) of 10 of 15, indicating moderate cognitive impairment. In an interview with Resident #10 on 5/11/26 at 9:50 AM, Resident #10 was asked if she wanted her RP to have updates on his/her changes in condition. Resident #10 stated yes. During interview with the Resident's RP on 5/11/26 at 10:14 am, the RP stated the facility staff don't keep him/her updated on all the Resident's changes in condition. The RP gave an example of recently the Resident had a skin tear and the facility staff didn't notify him/her. The RP stated he/she didn't find out until a few days later when he/she came to visit the Resident and a staff member was providing wound care. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of Resident #10's medical record on 5/12/26 revealed a change of condition on 2/4/26. Registered Nurse #15 documented the Resident had a skin tear measuring 2 cm by 3 cm. Registered Nurse #15 documented on 2/4/26 the physician was notified, the physician ordered treatment and the Resident was notified. Further review of the Resident's medical record revealed no documented notification of Resident #10's 2/4/26 skin tear to the RP until 2/9/26, 5 days later. Interview with the Director of Nursing on 5/13/26 at 9:30 AM confirmed the facility staff failed to document notification to the RP of Resident #10's skin tear on 2/4/26 in the medical record.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Based on documentation review and interview, it was determined the facility failed to ensure nurse aide competency training occurred no less than 12 hours per year as determined in nurse aides' performance reviews. This was evident for 5 of 5 personnel files reviewed during the complaint survey.The findings include: On 5/15/26 at 10:30 AM a review was conducted of Geriatric Nursing Assistant (GNA) personnel files. A review of GNA #25's personnel file revealed GNA #25 was hired on 9/29/21. There was no evidence found that the required 12-hour yearly training was done within the past 12 months. A review of GNA #26's personnel file revealed GNA #26 was hired on 2/3/22. There was no evidence found that the required 12-hour yearly training was done within the past 12 months. A review of GNA #27's personnel file revealed GNA #27 was hired on 4/13/22. There was no evidence found that the required 12-hour yearly training was done within the past 12 months. A review of GNA #28's personnel file revealed GNA #28 was hired on 5/20/24. There was documentation that on 5/20/24 the 12-hour yearly training was completed. There was no documentation that the 12-hour yearly training has been done since 2024. A review of GNA #29's personnel file revealed GNA #29 was hired on 9/5/17. There was no evidence found that the required 12-hour yearly training was done within the past 12 months. On 5/15/26 at 11:00 AM an interview was conducted with the Human Resources Manager (HR #30). HR #30 stated there was no documentation in personnel files or in the computer when the last 12-hour training occurred. HR #30 stated that there could be documentation in the previous Director of Nursing (DON)'s office but was not sure. HR #30 stated that they were switching to a new system in order to track the education and other personnel documentation.On 5/15/26 at 12:00 PM an interview was conducted with the Nursing Home Administrator (NHA) who stated that he could not find documentation in the previous DON's office related to any 12-hour training for the GNAs.