STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265534	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/14/2024
NAME OF PROVIDER OR SUPPLIER: Heritage Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 4401 North Hanley Road Saint Louis, MO 63134	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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** 40291 Based on observation, interview, and record review, the facility failed to provide adequate supervision to one of five sampled residents with a history of elopement, hallucinations/delusions, behavioral difficulties and/or mental illness symptoms requiring 24 hour monitoring/management, and limited insight and judgement. Facility staff failed to make visual observations of the resident hourly, staff failed to follow up after not seeing the resident to administer ordered medications, and failed to ensure exit doors were working properly. Resident #1 left the building without staff's knowledge on [DATE] at 6:37 AM. Facility staff responsible for conducting visual checks- failed to do so, although they were documented as completed. The resident remained gone from the facility for over 24 hours before staff realized the resident was missing on [DATE] at 8:00 AM. The resident was not located until [DATE] at approximately 2:00 P.M. by another area police department at a gas station. The census was 107. The Administrator was notified on [DATE] at 5:36 P.M. of an Immediate Jeopardy (IJ) past-noncompliance which began on [DATE]. The facility conducted an investigation and immediately in-serviced staff prior to the start of their shift regarding the following: Code white (facility's elopement code), secured doors, shift reports and rounds, falsifying documentation; completed elopement assessments on all residents to make sure appropriate placement, monitored exit doors one on one until they verified all working properly, charge nurses do two hour checks and document, management audits face check documentation, and the Administrator created a department head rotation schedule for completing random rounds in the facility at various times, other than regular daily rounds, to include evening and night shift. The IJ was corrected on [DATE]. Review of the facility's Elopement and Wandering Residents policy, updated [DATE], showed: -Purpose: This facility ensures that residents who exhibit behavior and/or at risk for elopement receive adequate supervision to prevent accidents, and receive care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering or eloping risk; -Definitions: - Elopement occurs when a resident leaves the premises or a safe area without authorization (i.e, an order for discharge or leave of absence) and/or any necessary supervision to do so; -Policy: (continued on next page)

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

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

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Preventing Elopements: -The facility is equipped with door locks/alarms to help avoid elopements; -Alarms are not a replacement for necessary supervision. Staff are to be vigilant in responding to alarms in a timely manner; -The facility shall establish and utilize a systematic approach to monitoring and managing residents at risk for elopement or unsafe wandering, including identification and assessment of risks, evaluation and analysis of hazards and risks, implementing interventions to reduce hazards and risks, and monitoring for effectiveness and modifying interventions when necessary. -Monitoring and managing residents at risk for elopement or unsafe wandering; -Residents will be assessed for risk of elopement and unsafe wandering upon admission and throughout their stay by the interdisciplinary care plan team; -The interdisciplinary team will evaluate the unique factors contributing to risk in order to develop a person-centered care plan; -Interventions to increase staff awareness of the resident's risk, modify the resident's behavior, or to minimize risks associated with hazards will be added to the resident's care plan and communicated to appropriate staff; -Adequate supervision will be provided to help prevent accidents or elopements; -Charge nurses and unit managers will monitor the implementation of interventions, responses to interventions, and document accordingly. Review of the facility's Intensive Monitoring Policy, revised on [DATE], showed: -Procedure: -Residents who require more intensive monitoring due to crisis, behavior/psychiatric symptoms will be monitored by the facility staff. -Intensive monitoring: -Intensive monitoring is provided as periodic (e.g. hourly, every two hours, or every shift) check by a facility staff member; -Residents may require more intensive monitoring based on their crisis, behavior, psychiatric issues. The level of intensive monitoring shall be identified by the specific situation or resident assessment; (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Residents who are showing poor impulse control including crisis, behavior, psychiatric issues, such as, verbal/ physical aggression/elopement ideations, suicidal/homicidal ideations, and decompensation mental or crisis may be placed on intensive monitoring or one to one or two to one (within eyesight of staff) monitoring at the discretion of the facility staff or the facility supervisor; -The facility staff will document the intensive monitoring in the resident's electronic medical record; -Documentation: -All documentation of intensive monitoring will be done in the electronic medical record under the task. During an interview on [DATE] at 5:36 P.M., the Administrator said she expected for face checks to be done hourly on all residents on all shifts Review of Resident #1's preadmission screening and resident review (PASRR, a federally mandated screening process for individuals with serious mental illness and/or intellectual disability/developmental disability related diagnosis who apply or reside in medicaid certified beds in a nursing facility regardless of payment source), dated [DATE], showed the resident had a history of elopement, hallucinations/delusions, medical treatment and/or monitoring for chronic conditions, behavioral difficulties and/or mental illness symptoms requiring 24 hour monitoring/management, and limited insight and judgement. Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated [DATE], showed the following: -admitted to the facility: [DATE]; -Cognitively intact; -Independent for eating, hygiene, dressing, walking in room and corridor, locomotion on unit; -No physical impairments of either upper and/or lower extremities; -Wandering not exhibited; -Diagnoses of anxiety disorder, depression (other than bipolar), and schizophrenia (a mental disorder that affects a person's ability to think, feel and behave clearly). Review of the resident's elopement assessments showed the following: -On [DATE], elopement evaluation: The resident was an elopement risk; --On [DATE] elopement evaluation: The resident was an elopement risk; -On [DATE], elopement evaluation: The resident was an elopement risk; (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-On [DATE], elopement evaluation: The resident was an elopement risk. Review of the resident's care plan, dated [DATE], showed: -Focus: The resident is at risk of elopement due to he/she has a history of elopement from prior facility; -Goal: The resident will be monitored closely and remain safe through next review; -Interventions: Complete elopement assessments on admission, readmission, and quarterly. Face checks/intensive monitoring will be completed per facility protocol. Resident's photo and information will be kept in elopement book; -Focus: The resident is at risk of elopement related to history of leaving previous facility; -Goal: The resident's safety will be maintained through the review date; -Interventions: Distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television book. Monitor location frequently. Document wandering behavior and attempted diversional interventions in behavior log. Provide structured activities: Toileting, walking inside and outside, reorientation strategies including signs, pictures, and memory boxes. Review of the facility's [DATE] documentation of exit door maintenance checks showed: -Dates of [DATE], [DATE], and [DATE] missing from sheet; -Date of [DATE] showed a line drawn through all the exit doors; -Patio exit door documented as checked [DATE] to [DATE], [DATE] to [DATE], and [DATE] to [DATE]. Review of the facility's [DATE] documentation of exit door checks showed the patio exit door checked [DATE] to [DATE]. Review of the facility's video footage, dated [DATE] at 6:37 A.M., showed Resident #1 standing in the open, fully dressed with a hoodie on. He/She looked around, walked to the patio (exit door), pushed it open then walked out the door. The back side of the resident's body could be observed climbing over the fence. Review of Resident #1's hourly face check documentation completed on [DATE] showed: -Hourly face check completed; resident in the building at the following times: 6:58 A.M. (logged two times), 6:59 A.M. (logged six times), 12:59 P.M., 1:00 P.M., 1:02 P.M., 1:04 P.M., 2:30 P.M., 6:02 P.M., 6:03 P.M., 6:05 P.M., 9:15 P.M., 9:17 P.M., 9:43 P.M.; -No hourly face checks logged from: 7:00 A.M. to 12:00 P.M., 3:30 P.M. to 5:30 P.M., 7:00 P.M. to 8:00 P.M.; (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-No hourly face checks logged over the evening and overnight shifts from: 9:45 P.M. ([DATE]) to 10:00 A.M. ([DATE]). Review of the resident's progress notes, dated [DATE], showed: -At 11:10 A.M., (Late entry); the resident was noticed missing upon rounds by Certified Nurse Aide (CNA) D on A hall. Staff alerted the DON the resident was not in his/her room. Staff began searching and the night shift nurses were contacted to see if the resident was sent out without knowledge. At 8:30 A.M., a code white was called. All staff, department heads, Administrator and DON continued to search every room, closets, and bathrooms. The department heads and staff searched room to room for resident, as well as a ground search. All emergency exits and doors were checked ensuring they were closed completely. After facility search yielded no results, all department heads began searching local areas, local bars, liquor stores, convenient stores, and placed calls to local hospital and shelters. Some department heads stayed behind to review footage for resident. Local authorities contacted at 9:06 AM. A police officer (PO) from the local police department showed up on scene and a missing person's report was filed. DHSS, Physician and psychiatric Nurse Practitioner (NP) were notified. Guardian was notified with no answer, and no available voice mail. The resident's other family member was then called and said he/she was updating the guardian at 9:15 AM. The other family member said he/she had worried the resident was feeling cooped up on B unit (closed unit) and stopped taking him/her out for a while, because he/she would become aggressive with him/her and not want to return to the facility. He/She knew the resident wanted to leave and had said so previously. The family member recently spoke with Social Services Director (SSD) about room moves with Guardian approval, requesting the resident be taken off the locked unit and given a chance in the main area of the facility. The family member did not communicate the resident's anxiety or the resident's statements about wanting to leave the facility until yesterday while speaking to the DON and SSD. Family was aware of the resident's past elopement history at other facilities and his/her assessment scores, but no recent elopement attempts. The family member was educated to report any and all concerns regarding the resident's safety to the facility. The family member said he/she didn't think to tell anyone, because he/she didn't think the resident could get out, but the resident had tried at other facilities before. The resident enjoyed walking in and around the facility as a coping mechanism. DHSS was notified at 10:27 A.M. The Physician was contacted at 9:18 A.M., with no answer (message left). Psychiatric NP was contacted and the Administrator, DON, Regional Director and the local police departments were notified, and another local police department with police report for missing persons filed; -On [DATE] at 11:10 A.M., (Late Entry): Social Services spoke with the resident's family member in regard to their conversation on [DATE] about the resident coming off the locked unit on [DATE]. The family member left Social Worker (SW) a voice message asking for the resident to be moved to the main area of the building. SW had resident moved off the secured/locked unit on [DATE] back to the main area of the building. Also, the family member said the resident told him/her on several occasions that he/she was going to leave the facility, but the family member didn't notify the facility what the resident was saying. Review of the resident's [DATE] Medication Administration Record (MAR), showed from [DATE] to [DATE], the resident did not receive any of his/her medications which included olanzapine (taken for schizophrenia), scheduled daily for 7:00 A.M. and 4:00 P.M., and divalproex Sodium ER tablet (taken for bipolar disorder), scheduled daily for 7:00 A.M., 11:00 A.M., and 4:00 P.M. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the resident's hourly face checks documentation completed on [DATE] showed face checks documented as resident not available beginning at 11:22 A.M. until 1:30 P.M. During interviews on [DATE] at 11:00 A.M. and 11:45 A.M., with the Administrator and the DON, the DON said Resident #1 had eloped and had not returned to the facility. His/Her whereabouts were still unknown. They were still investigating. Yesterday morning, CNA D realized the resident was missing, and he/she informed the DON. Police reports were made to two local police departments. The family had just requested that the resident be taken off the locked unit to give him/her an opportunity to be in the main area of the building. It was unbeknownst to the facility the family had known the resident had been feeling antsy and wanted to leave while he/she was at the facility. The resident's family member didn't want to take the resident home on passes because it was a fight taking him/her back to the facility. Another family member is the resident's Guardian. They tried contacting the Guardian yesterday. The DON called the other family member multiple times yesterday and he/she had updated the Guardian. Review of the resident's progress notes, dated [DATE] at 6:35 P.M., showed around 2:10 P.M., a local area police department contacted the Administrator and said the resident had been found and was being taken to a area local hospital to be assessed. The PO told the DON he/she received a call 1:44 P.M., about an older person at a local gas station telling bystanders he/she wanted to go home but seemed very disoriented and confused. No injuries were noted. The PO said that a call came in around 6:50 A.M., in the morning from a local community member about a man/woman walking with no shoes. SSD and the other department heads went to the hospital to verify the resident's identification and once verified, the Guardian was contacted. DHSS made aware resident was found. Resident was still currently at the hospital. Review of the summary of the facility investigation, dated [DATE], showed: (continued on next page)

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	265534	A. Building B. Wing	06/14/2024

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-On [DATE], Resident #1 was last seen by CNA B at 6:00 A.M. and at 6:33 A.M., by nursing staff in the dining room getting coffee per his/her usual routine. The camera footage showed CNA B completing his/her rounds throughout his/her shift and with the DON during the night of [DATE] beginning at 11 PM leading to [DATE]. After 6:00 A.M., CNAs began rounds on residents and began getting their residents up on their halls. Residents visited the dining area by the nurses station where both Nurse K and DON were sitting and charting on residents' assessments. At 6:29 A.M., the resident walked in the dining area to get water and then returned to get coffee. At 6:35 A.M., CNA C saw the resident in the common area. There were no signs of restlessness or agitation in the residents. At 6:36 A.M., Resident #1 walked and drank his/her morning coffee, and as soon as aides went to their halls, the resident approached the door leading to the patio smoking area, and pushed the door open, where no alarm sounded. The camera footage showed the resident climbed over the chain link fence. On [DATE], CNA D noticed the resident was missing. Staff notified the DON the resident was not in his/her room. Staff began searching and the night shift nurses were contacted to see if the resident was sent out without knowledge. At 8:30 A.M., a code white was called. All staff, department heads, Administrator and DON continued to search every room, closet and bathroom. The department heads and staff searched room to room for resident, as well as an exterior ground search. All emergency exits and doors were checked to ensure they were closed completely. After facility search yielded no results, all department heads began searching local areas, local bars, liquor stores, convenient stores and placed calls to local hospitals and shelters. Some department heads stayed behind to review footage for the resident. Residents and staff were interviewed about any knowledge of the resident's whereabouts, as well as residents' feelings of safety, staff monitoring and if residents felt if they are being treated with dignity and respect. Doors leading to exits with alarms were immediately checked for proper functioning. A one to one monitor was placed on smoking hall patio door and other exits until they were checked to be in good working condition. Alarm boxes were checked for any and all alerts. -On [DATE] around 2:10 P.M., the Administrator was contacted by a local police department stating the resident had been found and was being taken to a local area hospital to be assessed. At 9:18 P.M., the resident returned to the facility via stretcher. Physical and neurological assessments were performed and assessment reported to psychiatric NP. Resident, upon return to facility, was placed back on a locked unit, with Guardian approval of the room move. During an interview on [DATE] at 3:30 P.M., Resident #7 said he/she lived at the facility for five or six years. A code white was called yesterday at the beginning of the first shift. The aides on A Hall were asleep and not on the hall on Sunday [DATE]. The staff don't check on the residents at night. Observation and interview on [DATE] at 4:05 P.M., showed Hall Monitor (HM) G sat at the patio exit door. The patio door was shut. A crack, approximately 2 ,d+[DATE] inches, could be observed at the top and the bottom of the door. When the door was opened the alarm did not sound. HM G said he/she has worked at the facility for about one year and four months. He/She was familiar with Resident #1. Today was HM G's first day back at work since last Thursday [DATE]. When the resident lived on B hall, he/she had never verbalized wanting to leave the facility or showed signs that he/she wanted to leave. He/She only wanted to smoke and drink coffee all day. HM G was watching the door until maintenance fixed the door because they can't leave the door unattended. The door is not always secured (closed) when it is shut. He/she wasn't sure of how long the door had been like that. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 4:18 P.M., the Administrator said the video footage showed Resident #1 left out of the patio exit door at 6:37 A.M. on [DATE]. The patio door does alarm and lock, but if it is not pulled closed, it may stay propped opened. During an interview on [DATE] at 1:25 P.M., CNA C said he/she worked the 11:00 P.M. to the 7:00 A.M. shift. He/She was new to the facility. Saturday night, [DATE] to [DATE] was his/her first shift and Sunday night, [DATE] to [DATE] was his/her second shift (the morning the resident eloped). He/She was with another staff on [DATE] to [DATE] at which time he/she orientated. When he/she went in to work on [DATE] to [DATE], he /she was with another person, but he/she did not orientate. On [DATE]/to [DATE] shift, CNA C last saw the resident at about 6:30 A.M., that morning. The resident was walking with a walker and had a Styrofoam cup saying he/she was wanted some coffee. The resident was walking away from his/her room and toward the dining room area, where the residents watch television. There was nothing out of the ordinary with the resident. CNA C said he/she got off work at 7:00 A.M. on [DATE]. Staff conduct rounds on the residents and document in the computer, but the system wouldn't let him/her in. He/She had tried to get in contact with someone regarding the matter. CNA C did his/her checks like he/she was supposed to. On that Monday night (,d+[DATE]-[DATE]) CNA C said he/she went to work, but did not know where he/she worked at. During an interview on [DATE] at 1:58 P.M., CNA B said he/she had worked at the facility for about three years and was familiar with Resident #1. CNA B worked on the the A hall on the 11:00 P.M.- 7:00 A.M. shift on [DATE] to [DATE]. CNA B said the resident had left on [DATE] at about 6:30 A.M. He/She last saw the resident at 6:00 A.M. on [DATE]. The resident had come from out of his/her room and was walking down the hallway as CNA B was doing his/her rounds. He/She does his/her rounds every hour, but they could be done every two hours. Rounds are documented in the electronic medical record. CNA B documented the rounds in real (actual) time. Staff have to actually put eyes on the resident during rounds. The resident was asleep when CNA B reported to work at 11:00 P.M. The resident slept the entire time. It was a normal night. The resident was in his/her room during every round, with the exception of the 6:00 A.M. round, when the resident left his/her room. The resident woke up to get his/her coffee. The resident used a walker, so CNA B didn't have any indications the resident wanted to leave. The resident is alert and oriented. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 2:37 P.M., CNA A said he/she had worked at the facility for about one year and a couple of months. He/She was familiar with Resident #1 and was one of the resident's regular CNAs. Resident #1 just moved from the B Hall to his/her assignment on the A hall. During the short time on A hall, the resident never gave any indication that he/she would leave. He/She was naturally a wanderer and walked the halls a lot. He/She would also go to the dining room and sit outside of the dining room and drink coffee. Prior to this, CNA A last worked with the resident on Friday [DATE] on the ,d+[DATE] shift. The resident gave CNA A no indication on Friday ([DATE]) that he/she was going to leave. The CNAs do rounds every hour and the nurses do rounds every 30 minutes, so technically rounds are done every 30 minutes. When rounds are done, staff document them in the computer. CNA A takes a laptop around with him/her and walks and charts at the same time. The resident left Monday [DATE] at early morning. On Monday [DATE], CNA A didn't see the resident at all. CNA A did document in the electronic medical record that he/she saw the resident, but he/she realized he/she made a mistake. He/She really saw another resident on B hall. He/She tried to document as much as possible as he/she goes, because it does get hectic when you trying to document at the end. The resident did the same thing every day and was never in his/her room. The resident would get up to get his/her coffee and then roamed the halls. Since the resident was never in his/her room, when CNA A got in on [DATE], he/she thought the resident was already walking around getting his/her coffee. CNA A saw another resident, Resident #8, sitting in the dining area and thought he/she was Resident #1. CNA A worked a double on [DATE]. He/she worked the ,d+[DATE] shift and ,d+[DATE] shift. CNA A documented the entire day and evening that he/she had seen Resident #1. CNA A knew that he/she messed up. Prior to this, CNA A was not aware of anything wrong with the smoking patio door. During an interview on [DATE] at approximately 3:15 P.M., CNA D said he/she started at the facility in February of 2024. He/She worked the 7:00 A.M. to 3:00 P.M. shift. He/She was not too familiar with the resident because he/she was new to the A Hall. The resident was not on CNA D's assignment. The last time he/she saw the resident was Sunday ([DATE]) right before lunch, about 11:15 A.M. The resident is alert and totally independent. He walked on his/her own. CNA D worked Monday ([DATE]), but the resident was not on his/her assignment. He/She discovered the resident was gone on Tuesday [DATE] at about 8:05 A.M., right before the 8:15 A.M. smoke break. CNA D and Certified Medication Technician (CMT) H were walking down the hallway and noticed the resident's bed was untouched. That wasn't normal, so CNA D went to check the dining room to see if the resident was in there. CNA D didn't see the resident in there, so he/she checked the resident's bathroom and didn't see him/her. CNA D asked the DON if the resident was in the hospital. That's when they all started looking for him/her. The DON called a code white. The resident had eloped. The staff searched everywhere. They went to the metro station, the gas station, and he/she thinks someone went to the apartments too (adjacent to the facility). CNA D would normally just see the resident when he/she would leave out of his/her room to go and get his/her coffee. The staff do rounds every hour. CNA D does face checks every hour, but he/she couldn't speak for anyone else. He/she documents in the electronic medical record in real time. It is possible to go back and document later. With the face checks you have to document if in the building, or if you didn't see them, there are other options like resident out for appointments, resident outside privileges/Leave of absence (LOA) or resident at the hospital. CNA D was not aware of anything wrong with the patio door. It doesn't shut all the way and you have to push it hard for it to open. On the outside, it is kind of hard to open, but you won't be able to get out without putting a code in. The resident didn't put a code in to get out so CNA D's only speculation was that the door wasn't closed all the way. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Heritage Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4401 North Hanley Road Saint Louis, MO 63134	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 2:56 P.M., CMT H said he/she has worked for the facility for about twelve and half years, normally on the 7:00 A.M. to 3:00 P.M. shift. He/She was familiar with Resident #1. The resident had not received any medication on [DATE]. He/She looked for the resident thinking he/she hadn't taken his/her medications. The resident's roommate told him/her the resident was in the bathroom. This had happened at about 10:00 A.M. on [DATE]. He/She then had gotten called to another hall. He/She had gotten tied up on another hall and had forgotten about it. CMT H left at 3:00 P.M. It hadn't dawned on him/her that he/she still had not seen the resident. CMT H left a memo for the oncoming CMT, advising that he/she had not seen the resident. CMT H said he/she left on the memo that he/she thought the resident was on LOA with his/her family member because one of his/her family members goes and gets the resident. He/She didn't see the resident at all on [DATE]. CMT H said typically when he/she arrived to work, he/she tried to get a report. He/She would ask about people deceased , hospitalization s, LOAs, or so forth. CMT H asked the nurse and he/she wasn't aware of anything. During an interview on [DATE] at 3:10 P.M., Resident #6, said he/she was roommates with Resident #1. Resident #6 really didn't know that much about Resident #1. Resident #1 left a couple of days ago. Resident #6 was unsure of the last time he/she saw Resident #1 prior to him/her leaving. They had been roommates for maybe a day or two. Resident #1 hadn't mentioned anything about wanting to leave the facility. During an interview on [DATE] at 2:27 P.M., the DON said Resident #1 had been found. The police were taking him/her to a local area hospital. Once the resident was checked over, he/she would return to the facility. During observation and interview on [DATE] at 11:18 A.M., Resident #1 said he/she did not feel like talking and declined speaking with the surveyor. During an interview on [DATE] at 11:35 A.M., with Maintenance Assistants (MA) I and MA J, MA I said on Monday [DATE], he/she noticed the patio door was hard to catch. He/She called the Maintenance Director (MD) and he contacted an area lock company on Monday [DATE]. The lock company came out to the facility on [DATE] and [DATE]. They looked at the door and said they had to come back. A little metal box was needed which would make the lock catch when the door was shut. Right now, the door is locked, but if the door was not slammed, it would not lock like it was supposed to. With the elopement incident, the last person who went out the door didn't make sure the door was secure. You have to make it connect with the box so that it connects with the magnet. During an interview on [DATE] at 4:24 P.M., the MD said MA I called him on Monday, [DATE] a little after 7:00 A.M., and told him he/she had to slam the smoking patio door to get it to shut. MD went in to work about 9 AM. He called a local lock company. That is when the MD became aware of the problem with the door. They routinely checked the patio smoking door. There had not been any problems with the smoking patio door prior to this. They checked all the exit doors daily. The lock company was called on [DATE] but they couldn't come out to the facility until today ([DATE]). That is why they have a staff person by the door around the clock. All the exit doors have alarms on them, so if residents try to bust through them, the alarms will sound. If the door was opened without a code, it would alarm. The resident didn't put a code in. When MA I arrived at work, he/she discovered the door was messed up. The issue with the door was that the door had to be pulled really hard to shut it completely. Door alarm drills were done monthly. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265534	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/14/2024
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 2:13 P.M., the resident's Guardian said the resident had eloped from the facility on [DATE]. The resident was tired of being at the facility. The resident had told a family member this before. There were no indication given to the Guardian the resident was going to leave. The resident had gone to the hospital and was released yesterday. The resident is not able to take care of him/herself. The resident needs around the clock care. It was not safe for the resident to be out by him/herself. The resident had been at other facilities in the past. He/She had left four or five times prior from other facilities. The Guardian did not know if the facility was aware of this or not. The Guardian was not aware the resident had been recently moved off the locked unit. The facility had placed him/her on the locked unit for supposedly 90 days. The resident's 90 days were up, so the resident was upset he/she had to stay on locked unit. The Guardian thought his/her other family member had said something to the facility about the resident moving off the locked unit. During an interview on [DATE] at 4:44 P.M., the DON said they were aware on admission that Resident #1 did have elopement attempts at other facilities, but the resident had been doing well at this facility. The DON got to the facility in February 2024, so she is still getting to know the residents. The resident has an elopement history and had been on the behavioral unit. It was very normal for him/her to walk up and down the halls with his/her coffee. The resident's family member asked the Social Worker for the resident to come off the locked unit because he/she felt the resident was getting a little more antsy and needed more freedom, and being on the behavioral unit was causing him/her anxiety. The DON worked overnight from [DATE] to [DATE]. No alarms sounded. The resident was doing his/her usual morning walks in the dining room. The resident had gotten coffee and water. She wasn't working the resident's hall but was rounding the entire building with CNA B. There was nothing outside the resident's normal that morning. The resident was normally quiet. Re [TRUNCATED]