| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265766 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 02/19/2025 |
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Ellisville Rehabilitation and Nursing | 322 Old State Road<br>Ellisville, MO 63021 |

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

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41061<br><br>Based on interview and record review, facility staff failed to keep a resident free from hazards and provide the necessary monitoring and supervision for a resident when outside of the facility. The facility failed to follow their Elopement/Missing Person policy after one resident (Resident #1) left the facility's premises without the staff's knowledge of the resident's whereabouts or expected time of arrival back to the facility. The facility also failed to assess the risk of leaving the facility without notification to staff due to a possible substance abuse disorder when staff found four shot bottles (miniature bottles of 50 milliliters (ml) alcohol) in the resident's bedroom. The sample size was three. The census was 138.<br><br>Review of the facility's Elopement/Missing Person policy, dated 11/24, showed:<br><br>-Policy: It is the intent of the facility to provide a safe and home-like environment for all residents and to provide adequate supervision and assistance to prevent accidents. It is the responsibility of all staff members to report immediately to the administrator or Director of Nursing (DON) or Nursing Supervisor, and resident attempting to leave the premise or is suspected of not being on the premises without properly checking out in accordance with established policy and procedures;<br><br>-Elopement: means that a disoriented or confused resident or a resident who has been determined to be at risk for elopement, leaves the nursing facility premises without notification to the staff or escort;<br><br>-Missing Resident: is any resident that cannot easily be located or one that fails to return to the nursing facility while out of facility without notifying the facility;<br><br>-Any staff member observing a resident attempting to leave the premises, without proper facility notification or escort, shall attempt to re-direct the resident and prevent such departure;<br><br>-If the resident is thought or found to be missing, the staff person will immediately alert the nursing supervisor or charge nurse;<br><br>-A search will be conducted throughout the nursing unit/neighborhood;<br><br>-If the immediate search is not successful, the Nursing Supervisor, or designee, will notify the DON and the administrator;<br><br>(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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -The administrator, DON or designee will coordinate the search efforts. A missing resident alert will be communicated to staff;<br><br>-Staff will immediately return to their assigned areas and immediately search for the resident.<br><br>-The Administrator, DON, or Nursing Supervisor, or designee, will assign staff to search area within and outside the facility;<br><br>-If the resident is not located within 15 minutes, the Nursing Supervisor/designee, will notify the police department with a description of the resident;<br><br>-The Nursing Supervisor/designee will notify the administrator, and/or on-call facility manager of the event and the status of the search if the person is not on the facility premises;<br><br>-The Nursing Supervisor/designee will notify the attending physician and the resident's responsible of the event and actions being taken;<br><br>-Once the police have arrived and received a briefing from the Nursing Supervisor, the police will assume command of the search and facility staff will assist as requested, and within the resources and capabilities of the facility;<br><br>-Upon return of the resident to the facility, or upon finding the resident, the following steps shall be carried out:<br><br>-The missing person alert announcement will be cancelled, and staff will be notified that the resident has been found;<br><br>-All previously contacted persons and organizations shall be notified of the status of the resident. This includes physician, responsible party;<br><br>-The resident will be evaluated by a licensed nurse and/or physician/practitioner;<br><br>-The resident's medical record will document the details of the event, including evaluation of the resident, treatment/care provided, and monitoring of the resident;<br><br>-The resident's plan of care shall be revised to include interventions to prevent further elopement or the potential for elopement. The plan of care will also be revised to include any treatment resulting from the incident;<br><br>-Following the direction of the administrator or DON, initial notification will be made to required state authorities in accordance with state regulations and guidelines.<br><br>Review of Resident #1's hospital records, dated 12/19/24, showed:<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -The resident presented from to the emergency room with complaint of generalized weakness. The resident had a significant fall a couple of weeks ago and broke his/her right shoulder and was admitted to a facility for rehabilitation for several weeks. The resident left the facility early and returned to his/her independent living apartment. The resident said for the past couple of days he/she had generalized weakness and multiple ground level falls without head injury. For the past 24 hours, he/she had not been able to get out of bed and Emergency Medical Services (EMS) was called. EMS found the resident covered in his/her own feces and bed-bound.<br><br>Review of the resident's elopement risk assessment, dated 12/27/24, showed the resident was a low risk of elopement.<br><br>Review of the resident's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 12/30/24, showed:<br><br>-admitted on [DATE] from hospital;<br><br>-The resident was able to make him/herself understood and understood others;<br><br>-Severe cognitive impairment;<br><br>-The resident had thoughts he/she would be better off dead, or of hurting him/herself in some way two to six days a week;<br><br>-No behaviors noted;<br><br>-Wheelchair for locomotion;<br><br>-Required set-up assistance with eating;<br><br>-Required moderate assistance for toileting;<br><br>-Required maximal assistance for showering, upper and lower body dressing, putting on and off footwear, personal hygiene, bed mobility and transfers;<br><br>-Dependent for walking 10 feet or more and for picking up objects;<br><br>-Bladder and bowel continence were not rated;<br><br>-Received a mechanically altered diet;<br><br>-Diagnoses included atrial fibrillation (a-fib, irregular heart rhythm), hypertension (high blood pressure), orthostatic hypotension (blood pressure drops when standing up from sitting or lying down), osteoarthritis (OA, chronic degeneration of the joint cartilage), anxiety, depression, emphysema (lung condition that causes shortness of breath), fracture of the right shoulder, sleep apnea (a potentially serious sleep disorder in which breathing repeatedly stops and starts) and stroke.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the resident's progress notes, dated 12/31/24. At 1:52 A.M., showed the resident was rolling down the hall with something black on his/her teeth. The resident said he/she was eating cookies. Therapy found a can of chewing tobacco in the resident's room. It was the second can found in the resident's room since the weekend. The resident's family was called to make aware the facility was a tobacco free facility.<br><br>Review of the resident's care plan note, dated 1/2/25 at 9:25 A.M., showed:<br><br>-The resident's family member (FM) C was in attendance with the resident;<br><br>-The resident saw a neurologist (physician specializing in diagnosing disorders of brain, spinal cord and nervous system) two years ago who stated the resident was suffering from alcoholic dementia;<br><br>-Discharge plan to long term care at the facility.<br><br>Review of the resident's care plan, undated, showed:<br><br>-Problem: Impaired cognitive function or impaired thought processes; Interventions included: Cue, reorient and supervise as needed; Communicate with the resident and family regarding resident's capabilities and needs;<br><br>-Problem: At risk for falls; Interventions included: Educate the resident and family about safety reminders and what to do if a fall occurs; Anticipate and meet the resident's needs;<br><br>-Problem: Mood problem related to admission; Interventions included: Monitor, document and report any risk for harm to self, including impaired judgment or safety awareness and risky actions;<br><br>-Problem: Bladder incontinence; Interventions included provide perineal care (peri-care, washing the front and back of the hips, genitals, anal area and buttocks) with each incontinence episode;<br><br>-There was no documentation showing risk of elopement was care planned with appropriate interventions;<br><br>-There was no documentation showing risk of alcoholic dementia with appropriate interventions;<br><br>-There was no documentation showing the resident was at risk of tobacco and/or alcohol abuse with appropriate interventions.<br><br>Review of the resident's physiatry (physical medicine and rehabilitation) progress note, dated 1/17/25, showed:<br><br>-Chief complaint: Mobility and activities of daily living (ADLs) deficits related to failure to thrive, recent right shoulder fracture and unable to ambulate;<br><br>-The resident was alert and oriented to person and place (A & O X 2);<br><br>-The resident was able to follow one to two step directions with intermittent cueing;<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -Discharge planning included: The resident was discharging from skilled therapies on 1/18/25 after achieving short and long term goals; The resident will remain at the facility for long term care going forth.<br><br>Review of the resident's progress notes, showed:<br><br>-On 1/22/25 at 12:48 P.M., the resident's FM C was informed he/she need to retrieve the resident's power wheelchair due to concerns about its unsafe use by the resident. FM C said FM B would come and pick it up to take it home;<br><br>-There was no documentation the family removed the resident's power wheelchair from the facility;<br><br>-On 2/10/25 at 2:53 A.M., the resident was witnessed sliding out of his/her wheelchair onto the floor. The resident was assessed and showed no signs or symptoms of injury;<br><br>-On 2/12/25 at 12:07 A.M., the resident was found with three empty shot bottles of alcohol in his/her bed. The resident went out to an appointment today. The resident was able to talk and did not seem to be intoxicated;<br><br>-On 2/12/25 at 5:52 A.M., the resident was found with a fourth empty shot bottle of alcohol in his/her bed;<br><br>-On 2/12/25 at 9:00 A.M., the resident left the facility without telling staff. A call was made to FM C, who said he/she was not speaking to the resident and would call FM B to see if FM B knew where the resident was located;<br><br>-On 2/12/25 at 6:28 P.M., the resident had not returned from leave of absence (LOA), family, Primary Care Physician (PCP) and administration made aware.<br><br>Review of the resident's unit 24 hour report sheets, showed:<br><br>-On 2/12/25, Licensed Practical Nurse (LPN) A wrote in the day shift column, the resident was on Incident Follow Up (IFU) related to a fall without injury and the resident left at 9:00 A.M., without telling staff, FM C aware, management aware. There was no documentation found in the evening shift column;<br><br>-On 2/13/25, the night nurse wrote possible elopement? in the night shift column. There was no other documentation found in the day or evening shift column.<br><br>Review of the resident's progress notes, showed:<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -On 2/13/25 at 12:36 A.M., the resident had not returned to the facility. A call was placed to the DON to obtain any information regarding resident's LOA status. The call was not answered and a message was left. On 2/13/25, at 12:46 A.M., a call was made to FM B. The call was not answered and a message was left. A call was made to FM C, who did not answer the call and a message was left. A call was made to all floor managers to obtain any information regarding the resident's whereabouts. All staff conducted an internal and external search of the facility for the resident without results. The Administrator was called twice without answer and a message was left. Staff monitored the phone for any return calls, continued to search outside of the building for any sign of the resident and his/her motorized wheelchair. The resident's power cord to the motorized wheelchair was not in his/her room;<br><br>-On 2/13/25 at 10:39 A.M., showed the resident had returned to the facility at 9:20 A.M. The resident reported he/she was at his/her apartment located in a different county and was unable to return to the facility last night due to inclement weather. The resident was assessed and found stable and within his/her normal limits;<br><br>-There was no documentation the family or PCP were updated on the resident's return to the facility;<br><br>-There was no documentation there were any changes made to the resident's plan of care;<br><br>-There was no documentation an elopement risk assessment was completed on the resident after the resident's return on 2/13/25.<br><br>During an interview on 2/14/25 at 9:55 A.M., LPN A said:<br><br>-He/She would know if a resident was an elopement risk if a resident left the unit or facility without notifying staff;<br><br>-He/She would report any residents who showed signs of elopement risk to the Nurse manager (NM), who was expected to assess the resident, call the PCP, implement new orders if given, and update the floor information sheet, available to all staff, to show the resident was an elopement risk;<br><br>-Residents and/or their visitors were expected to sign resident's in and out on the unit's LOA log, available at the nurse's station.<br><br>Review of the resident's floor information sheet, on 2/14/25 at 9:56 A.M., showed:<br><br>-Last updated on 2/9/25;<br><br>-There was no documentation the resident was an elopement risk.<br><br>Review of the resident's unit LOA sign out/in log, on 2/14/25, at 10:03 A.M., showed there was no documentation the resident signed in or out.<br><br>Review of the resident's electronic medical record, showed no documentation found under assessments showing a new elopement assessment was completed after 2/13/25.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Observation of the resident on 2/14/25 at 10:04 A.M., showed:<br><br>-He/She sat in a motorized wheelchair, eating breakfast which was placed on his/her bedside table in front of him/her;<br><br>-The resident looked unkept with dried unidentified substances on his/her face, unwashed hair, and dry, visibly flaking skin on his/her arms. The resident had an unwashed odor;<br><br>-The resident wore dirty, stained sweatpants and a dirty short sleeved shirt which had both dried food and fresh scrambled egg attached to his/her chest;<br><br>-The resident was barefoot and his/her feet were dark purple with dry, flaky skin;<br><br>-The resident struggled to feed him/herself, using an adaptive fork with a wide handle, spilling scrambled egg down his/her shirt as he/she tried to bring the food to his/her mouth;<br><br>-There were papers and medical documents spread all over the floor in front of the resident's bed and on top of the resident's unmade bed.<br><br>During an interview on 2/14/25 at 10:05 A.M., the resident said:<br><br>-He/She left the facility a few days ago because he/she had a doctor's appointment;<br><br>-He/She arranged transportation by calling his/her insurance, because he/she was allowed a certain amount of rides a year;<br><br>-He/She could not get the transportation service to pick him/her up from the doctor's appointment to return him/her to the facility as he/she was refused service due to the snowy weather;<br><br>-He/She used his/her cell phone to call his/her FM B, who came to pick him/her up and took the resident to his/her senior living apartment, which was approximately twenty-five miles away from the facility;<br><br>-He/She called the transportation service and scheduled a pick up for the next morning for return to the facility;<br><br>-He/She returned to the facility the next morning, he/she was unsure of the time.<br><br>During an interview on 2/14/25 at 10:11 A.M., LPN A said:<br><br>-Nurses were responsible for documenting in a progress note when a resident leaves the facility as an LOA including when the resident left, with who, how transported, contact numbers and expected time of return;<br><br>-Nurses were also expected to write in the 24 hour report sheet when a resident was LOA and expected time of return so the next shift would be aware of residents' whereabouts;<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -Nurses were expected to write a progress note and update the 24 hour sheet showing when a resident returned for continuity of care and to account for all residents;<br><br>-Nurses were expected to round on each resident when they came on shift, after receiving report from off-going nurse, to ensure all residents were accounted for per the census and their needs were met;<br><br>-He/She did not believe any residents, regardless of their cognitive awareness, were appropriate to sign themselves out of the facility or go out on their own because if they were capable of going out into society safely, they would not need care in the facility;<br><br>-He/She would try to call any contact numbers to find the resident's new expected time of return if the resident did not return an hour or so after his/her expected time of return as written when the resident left the facility;<br><br>-Nurses were expected to notify the NM or DON if a resident did not return when expected so they could act quickly to find/locate the resident;<br><br>-The facility was responsible for notifying police and the appropriate State department if a resident was not found within two hours of the facility's awareness the resident's location was unknown;<br><br>-The facility management team was responsible for starting an investigation, interviewing staff and other residents, to gather information such as when was the last time the resident was seen, if anyone knew where the resident was, what the resident was last seen wearing, in order to help the police in their search for the resident;<br><br>-He/She was the nurse assigned to the resident on 2/12/25 during the day shift, from 7:00 A.M. until 3:00 P. M.;<br><br>-He/She received a call from the receptionist at approximately 9:00 A.M., asking if the resident had a doctor's appointment that day because the receptionist just saw the resident leave the facility, get into a medical transport vehicle and drive off;<br><br>-LPN A told the receptionist the resident did not have a doctor's appointment and he/she did not know the resident left the unit or the building;<br><br>-The receptionist told LPN A that he/she did not know where the resident was going when he/she exited the building;<br><br>-LPN A informed the NM that the resident had left the building alone, without informing staff where he/she was going, how to contact the resident, or when the resident was expected to return;<br><br>-The NM instructed the LPN to call any family members to see if they had any information on the resident's location;<br><br>-LPN A called FM C, who answered the phone, claiming he/she did not know where the resident was because he/she was not on speaking terms with the resident;<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -FM C said he/she would call FM B to see if FM B had any information on the resident's location and he/she would call LPN A back;<br><br>-FM C never called LPN A back to update the nurse with any information;<br><br>-LPN A did not make any other calls, nor did he/she update the NM with the results of the call from FM C;<br><br>-LPN A reported to the on-coming nurse the resident was LOA without informing staff and left the building at approximately 3:15 P.M.;<br><br>-The resident had not returned to the facility before the end of LPN A's shift;<br><br>-The NM did not give LPN A any further instruction, did not ask LPN A to update him on any phone calls the nurse may have made and did not interview LPN A regarding what had happened before LPN A was notified by the receptionist of the resident leaving the facility, what he/she was wearing, etc.<br><br>-The resident was not safe out in the community by him/herself because he/she was a fall risk, was alert and oriented to self, place, time and situation (A & O x 4) sometimes, but had periods of confusion, overestimated his/her abilities and was not able to make safe decisions;<br><br>-LPN A did not know the resident had a cell phone until this morning when the nurse saw the phone in the resident's possession;<br><br>-He/She expected the management team at the facility to notify the police and appropriate State offices when they could not locate the resident so a search would begin for the resident's safety;<br><br>-LPN A was not updated by the NM or any other management team member regarding where the resident was or when he/she returned to the facility;<br><br>-He/She was told in report by the off-going nurse today that the resident returned to the facility on [DATE] at approximately 9:00 A.M.,;<br><br>-LPN A was very afraid for the resident's safety when the nurse left to go home on 2/12/25;<br><br>-The weather on 2/12/25 and 2/13/25 was below freezing and the resident was at risk of hypothermia (dangerous drop in body temperature) if he/she was outside for too long or was not properly dressed for the cold temperatures.<br><br>During an interview on 2/14/25 at 11:04 A.M., Certified Nurse Assistant (CNA) D said:<br><br>-He/She was assigned to care for the resident during the day shift on 2/12/25;<br><br>-On 2/12/25 at around 8:30 A.M., the resident told the CNA he/she had a doctor's appointment that day;<br><br>-CNA D asked LPN A if the resident had a doctor's appointment scheduled on 2/12/25 and LPN A said no;<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -CNA D returned to the resident's room and told the resident he/she did not have a doctor's appointment that day. The resident yelled back you don't know!;<br><br>-CNA D last saw the resident in his/her room around 10:00 A.M.;<br><br>-He/She put the resident's lunch tray in his/her room at 12:30 P.M.;<br><br>-The resident was not in his/her room when the CNA put in the lunch tray in his/her room;<br><br>-CNA D did not inform the nurse the resident was not in his/her room as expected to eat lunch nor did the CNA go and look for the resident;<br><br>-CNA D picked up the resident's lunch tray around 1:00 P.M., and noted the resident was still not in his/her room and did not eat any of the lunch;<br><br>-CNA D told LPN A the resident did not eat any of his/her lunch but did not report he/she had not seen the resident since approximately 10:00 A.M.;<br><br>-He/She can not remember if LPN A said the resident was missing;<br><br>-CNA D did not think the resident was missing or that he/she was an elopement risk as the resident never showed signs of trying to leave the facility;<br><br>-CNA D left the facility at the end of his/her shift at 3:00 P.M.;<br><br>-CNA D did not give report to the on-coming CNA;<br><br>-On 2/13/25, CNA D was assigned to the resident's care when he/she came on shift at 7:00 A.M.;<br><br>-CNA D was told by someone, he/she could not remember who, the resident had not returned to the facility yet;<br><br>-At 7:30 A.M., CNA D went to the resident's room and saw his/her bed had not been slept in the night before because it was still made up;<br><br>-The resident arrived back to the unit sometime later, before breakfast;<br><br>-The resident told CNA D he/she had gone to visit a friend and the friend would not drive the resident back to the facility due to the snow on 2/12/25;<br><br>-The resident told CNA D he/she stayed overnight at his/her apartment;<br><br>-CNA D did not know how the resident got to the apartment or the location of the apartment;<br><br>-CNA D told the NM the conversation he/she had with the resident;<br><br>-He/She expected the NM to start an investigation on where the resident was overnight as soon as the resident returned to the facility and CNA D gave his/her report;<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265766 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 02/19/2025 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER: Ellisville Rehabilitation and Nursing | | STREET ADDRESS, CITY, STATE, ZIP CODE: 322 Old State Road, Ellisville, MO 63021 | |

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

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -CNA D was not interviewed by any of the management team regarding the resident leaving on 2/12/25;<br><br>-CNA D did not receive any direction on any new plan of care for the resident and was not told if the resident was now an elopement risk;<br><br>-He/She did not receive any in-services on the facility's elopement/missing person policy after the incident;<br><br>-He/She could not remember the last in-service he/she received on the facility elopement/missing person policy.<br><br>During an interview on 2/14/25 at 11:25 A.M., LPN A said:<br><br>-He/She was never interviewed by the management team about the resident's incident on 2/12/25;<br><br>-He/She was not told if the resident was now an elopement risk or if there a change in the plan of care;<br><br>-He/She expected the management team to assess the resident's elopement risk, update the resident's care plan with the risk of elopement with appropriate interventions, and update the unit information sheet showing the resident was an elopement risk;<br><br>-He/She did not receive any in-services on the facility's elopement/missing person policy after the resident's incident.<br><br>During an interview on 2/26/25 at 12:00 P.M., LPN B said:<br><br>-He/She worked the 2/12/25 11:00 P.M.-7:00 A.M. shift. When he/she arrived, the off-going nurse told him/her the resident had been gone since 9:00 A.M. They did not know where the resident was;<br><br>-LPN B told the Nursing Supervisor (NS), who didn't seem to know what to do. The NS called the Administrator and DON several times, but got no response. LPN B told the NS he/she needed to call the police and State, but the NS said he/she wanted to wait to hear from management before he/she did anything;<br><br>-This morning, the NM told LPN B the resident is an alcoholic. He/She frequently went out to buy alcohol without telling anyone;<br><br>-LPN B never laid eyes on the resident. Staff searched the building. Staff told LPN B the resident was itty bitty frail and used a motorized wheelchair.<br><br>During an interview on 2/14/25 at 12:05 P.M., the NM said:<br><br>-A resident was considered an elopement when they leave the facility without notifying their nurse where they were going, who they were with, what transportation was utilized, contact numbers, and expected time of return to the facility;<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -A resident was considered missing when they do not return at the expected time from LOA and the facility was not able to make contact with the resident or the responsible party to find out their location and when they planned to make their return to the facility;<br><br>-He expected staff to follow the facility's elopement/missing person policy as soon as a resident was determined an elopement or a missing person;<br><br>-Staff were expected to notify the police and the appropriate State departments when a resident was determined an elopement or missing, so a search could begin as quickly as possible;<br><br>-Residents who were in care of the facility were not safe out in the community by themselves and were at increased risk of injury, harm, or death. If residents were able to make safe decisions out in the community, they would not need to be in the care of the facility;<br><br>-Residents could not sign themselves out LOA because they were not able to function in society safely, otherwise they would not require oversight of the facility;<br><br>-Nursing staff assessed residents for elopement risk when admitted , quarterly and as needed after an attempted or actual elopement;<br><br>-Both he and the charge nurse were responsible for updating the care plan to address elopement risk with appropriate interventions after a resident was deemed an elopement risk;<br><br>-He was the NM over the unit in which the resident resided;<br><br>-On 2/12/25, at approximately 9:00 A.M., he saw there was a medical transport vehicle outside with its wheelchair ramp lowered;<br><br>-The receptionist told him the medical transport was waiting for the resident;<br><br>-He called LPN A to inform him/her the resident's ride was waiting for the resident to come down;<br><br>-The resident told LPN A he/she was leaving to go and see family; LPN A sent the resident down to front of the building after making sure the resident was dressed appropriately for the weather; He could not remember how he knew this information;<br><br>-He did not see the resident exit the building;<br><br>-Shortly after the resident left the building, for some reason, he became concerned about the resident and where he/she went as the NM remembered there was no doctor appointment set up for the resident and it didn't make sense for the resident to go and see family as they were not on good terms;<br><br>-He instructed LPN A to call the resident's FM B to find out if FM B knew the location of the resident;<br><br>-He did not follow up with LPN A to see if he/she made contact with FM B;<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -He did not follow up with LPN A to see if he/she had any knowledge of the resident's location before LPN A left the facility at the end of day shift, approximately 3:00 P.M.;<br><br>-He left the building at the end of his shift between 3:00 P.M. and 4:00 P.M. without knowing where the resident was or expected time of the resident's return;<br><br>-He did not alert the Administrator or the DON the resident left the building without staff's knowledge of his/her destination, transportation method, contact numbers or expected time of return;<br><br>-He did not give the on-coming nurse any instruction regarding the missing resident;<br><br>-He assumed the resident was with FM B;<br><br>-He arrived back to the facility the next morning, on 2/13/25 at approximately 7:30 A.M., and was told by the night nurse the resident had not returned to the facility;<br><br>-He then was alarmed and called the resident's FM C, who did not answer;<br><br>-He called FM B, who answered the phone who told the NM the resident was with a friend but didn't know who the friend was or where the resident was located;<br><br>-The NM called the resident's cell phone number and the resident answered, saying he/she was not able to return to the facility the night before due to the snowy weather but was getting picked up by medical transport at 8:00 A.M. to return to the facility. He/She was at his/her apartment safe but alone;<br><br>-The NM was not aware the resident had an apartment;<br><br>-The resident arrived back to the facility on [DATE] at approximately 9:00 A.M.;<br><br>-The NM assessed the resident head to toe for any injury or change of condition and found the resident was stable and performing within his/her normal limits;<br><br>-The resident said he/she left the facility, on 2/12/25, to check on his/her apartment;<br><br>-The NM notified the DON of the resident's safe return;<br><br>-The DON had texted him on 2/13/25 at 4:27 A.M., that the resident had not returned to the facility. The NM did not read the text until he arrived at the facility the next morning;<br><br>-He did not make any change to the resident's care plan;<br><br>-He did not know if the PCP was made of aware of the resident's incident and if there were any changes to the plan of care;<br><br>-He did not provide any education on the facility's elopement/missing person policy to the nursing staff;<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -He was responsible for following the facility's elopement and missing person policy as soon as he confirmed the facility did not know where the resident was on 2/12/25 at approximately 10:30 A.M., and should have notified the police and appropriate state agencies;<br><br>-He should have started an investigation immediately, interviewing staff, as every moment was key when trying to find a resident;<br><br>-The longer residents were out in the community alone, their risk for injury, harm to self or by others, or possible death increased.<br><br>During an interview on 2/14/25 at 2:50 P.M., the DON said:<br><br>-Elopement was when a resident exited the building without anyone knowing they left, where they were going, or who was with them, contact information or expected time of return;<br><br>-She expected staff to follow the facility elopement/missing person policy as soon as they found out the resident left without leaving any information;<br><br>-She expected staff to notify the administrative team immediately if a resident was LOA without a known location;<br><br>-She expected nursing staff to call the police if the resident was not located within two hours of first knowing the resident had left the building;<br><br>-She expected nursing staff to notify the PCP of the missing resident after the police were notified;<br><br>-She was not sure of the timeline of when to call State, maybe two hours after known missing, within those two hours, the facility was making calls, to try to locate the resident;<br><br>-She expected nursing staff to document the elopement, showing what happened, when resident left, who called family, list of contacts, everything they did and what they found out;<br><br>-She expected nursing staff to question the resident once they returned to the facility, to find out where they were, conduct a head to toe assessment and check to see if the resident had any change of condition, contact the PCP, family, police and state agencies. Nursing staff were expected to docum |