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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375253 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 04/18/2025 |
| NAME OF PROVIDER OR SUPPLIER Clinton Therapy & Living Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 2316 Modelle Clinton, OK 73601 | |

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

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
| <p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20960</p> <p>Based on observation, record review, and interview, the facility failed to develop and update a care plan with interventions for wandering and elopement for 1 (#1) of 3 sampled residents reviewed for wandering and elopement.</p> <p>The DON identified two residents with a high risk for wandering and elopement.</p> <p>Findings:</p> <p>Upon entrance to the facility on [DATE] at 8:50 a.m., an elopement book was observed on the nurses station. Resident #1 was identified in the book as a high risk for wandering and elopement.</p> <p>On 04/18/25 at 9:20 a.m., 9:37 a.m., 11:25 a.m., and 2:30 p.m., Resident #1 was observed ambulating through the facility with staff providing one-on-one supervision.</p> <p>The policy titled Safety and Supervision of Residents, revised July 2023, read in part, Our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility wide priorities. Our individualized, resident-centered approach to safety addresses safety and accident hazards for individual residents. The interdisciplinary care team shall analyze information obtained from assessments and observations to identify any specific accident hazards or risks for individual residents. The care team shall target interventions to reduce individual risks related to hazards in the environment, including adequate supervision and assistive devices.</p> <p>An undated admission summary for Resident #1 showed they were admitted to the facility on [DATE] and had diagnoses which included dementia, impulse disorder, schizophrenia, and abnormalities of gait and mobility.</p> <p>Resident #1's wandering risk scale, dated 10/21/24, showed they were a high risk for wandering with a score of 14. A score of 11 and above showed a high risk for wandering.</p> <p>Resident #1's care plan, created on 10/23/24, did not address the high risk for wandering and elopement .</p> <p>(continued on next page)</p> |

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

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Resident #1's Admission Minimum Data Set assessment with an assessment reference date of 10/25/24, showed they had long term and short-term memory problems. The assessment showed Resident #1 wandered and the wandering placed them at risk for getting into potentially dangerous places. The assessment showed Resident #1 had no limitation on their range of motion.</p> <p>Resident #1's care plan was not updated to address their wandering that placed them at risk for danger.</p> <p>An incident progress note, dated 10/31/24 at 9:31 p.m., showed Resident #1 was ambulating up and down the halls attempting to exit seek.</p> <p>Resident #1's wandering risk scale, dated 11/23/24 and 12/12/24, showed they were a high risk for wandering with a score of 16. A score of 11 and above showed a high risk for wandering.</p> <p>Resident #1's care plan was not updated to address the known exit seeking and high risk for wandering and elopement.</p> <p>Resident #1's care plan, updated 01/10/25, showed they had interventions in place of providing diversionary activities for wandering and elopement.</p> <p>Resident #1's wandering risk scale, dated 01/14/25, showed they were a high risk for wandering with a score of 12. A score of 11 and above showed a high risk for wandering.</p> <p>Resident #1's incident progress note, dated 02/16/25 at 5:45 p.m., read in part, Dietary staff reported to this nurse that resident was seen going outside through front door. This nurse and CNA immediately headed outside. Resident noted walking in facility parking lot.</p> <p>Resident #1's wandering risk scale, dated 02/16/25, showed they were a high risk for wandering with a score of 16. A score of 11 and above showed a high risk for wandering.</p> <p>Resident #1's care plan was not updated after they were found outside by the dietary staff on 02/16/25 and to address the high risk for wandering.</p> <p>A care plan revision, dated 04/09/25, read in part, 4/9 wander risk is a 20.Goal Resident eloped 4/9/2025. Interventions have been actively trying to get resident into a locked unit for [their] safety. Identify pattern of wandering is aimless. Intervene as appropriate. May need to redirect resident as needed.Most recent wander score 20 on 4/9/2025. Resident placed one-on-one d/t elopement.</p> <p>On 04/18/25 at 9:55 a.m., Dietary Aide #1 stated they were not aware of any resident leaving the facility without staff knowing. Dietary Aide #1 stated Resident #1 was observed leaving out the front door a few months ago and the nursing staff was alerted. They stated they were not sure where Resident #1 was located when nursing staff went to get them.</p> <p>On 04/18/25 at 1:08 p.m., LPN #3 stated they had worked at the facility for two months and was responsible for the care plans. LPN #3 stated Resident #1 was a high risk for wandering and elopement and the only interventions on the care plan were for diversionary activities and there were no care plan changes until 04/09/25.</p> <p>(continued on next page)</p> |

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| <p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>On 04/18/25 at 1:21 p.m., the DON stated Resident #1 had been a high risk for elopement since their admission. The DON stated there had been no intervention changes and care plan updates until 04/09/25 because the facility had no care plan coordinator.</p> | | |

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| <p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> | <p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20960</p> <p>On 04/18/25, a past non-compliance Immediate Jeopardy (IJ) situation was determined to exist related to the facility's failure to provide supervision to protect residents with exit seeking behaviors.</p> <p>Resident #1 wandered and had exit seeking behaviors, got out of the facility on 02/16/25 and again on 04/09/25. On 04/09/25 Resident #1 eloped and was located a half mile away from the facility on a four-lane busy road. Resident #1's care plan did not address interventions of exit seeking behaviors on 02/16/25 and was not updated until 04/09/25 with interventions.</p> <p>Based on observation, record review, and interview, the facility failed to provide supervision and interventions to prevent elopement for 1 (#1) of 3 sampled residents reviewed for wandering and elopement.</p> <p>The DON identified two residents with a high risk for wandering and elopement.</p> <p>Findings:</p> <p>Upon entrance to the facility on [DATE] at 8:50 a.m., the front main doors were locked and signs were placed on the door informing anyone leaving to check with the nurse before letting anyone out of the facility. An elopement book was observed at the nurse's station with two residents identified as at risk of elopement.</p> <p>On 04/18/25 at 9:15 a.m. through 10:15 a.m., all exit doors were observed to be secured with a 15 second egress release and a secondary alarm. Staff demonstrated opening the exit doors and the primary alarm and a secondary alarm sounded. The sound was loud enough to be heard at the nurse's station.</p> <p>On 04/18/25 at 9:20 a.m., 9:37 a.m., 11:25 a.m., and 2:30 p.m., Resident #1 was observed ambulating through the facility with staff providing one-on-one supervision.</p> <p>A policy titled Safety and Supervision of Residents, revised July 2023, read in part, Our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility wide priorities. Our individualized, resident-centered approach to safety addresses safety and accident hazards for individual residents. The interdisciplinary care team shall analyze information obtained from assessments and observations to identify any specific accident hazards or risks for individual residents. The care team shall target interventions to reduce individual risks related to hazards in the environment, including adequate supervision and assistive devices.</p> <p>An undated admission summary for Resident #1 showed they were admitted to the facility on [DATE] and had diagnoses which included dementia, impulse disorder, schizophrenia, and abnormalities of gait and mobility.</p> <p>(continued on next page)</p> | | |

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| <p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> | <p>Resident #1's wandering risk scale, dated 10/21/24, showed they were at high risk for wandering with a score of 14. A score of 11 and above showed a high risk for wandering.</p> <p>Resident #1's care plan, created on 10/23/24, did not address the high risk for wandering and elopement.</p> <p>Resident #1's admission Minimum Data Set assessment, with an assessment reference date of 10/25/24, showed they had long term and short-term memory problems. The assessment showed Resident #1 wandered and the resident's wandering placed them at risk for getting into potentially dangerous places. The assessment showed Resident #1 had no limitation on their range of motion.</p> <p>Resident #1's care plan was not updated to address their wandering that placed them at risk for danger.</p> <p>An incident progress note, dated 10/31/24 at 9:31 p.m., showed Resident #1 was ambulating up and down the halls attempting to exit seek.</p> <p>Resident #1's wandering risk scale, dated 11/23/24 and 12/12/24, showed they were at a high risk for wandering with a score of 16. A score of 11 and above showed a high risk for wandering.</p> <p>Resident #1's care plan was not updated to address the known exit seeking and high risk for wandering and elopement.</p> <p>Resident #1's care plan, updated 01/10/25, showed they had interventions in place of providing diversionary activities for wandering and elopement.</p> <p>Resident #1's wandering risk scale, dated 01/14/25, showed they were at high risk for wandering with a score of 12. A score of 11 and above showed a high risk for wandering.</p> <p>Resident #1's incident progress note, dated 02/16/25 at 5:45 p.m., read in part, Dietary staff reported to this nurse that resident was seen going outside through front door. This nurse and CNA immediately headed outside. Resident noted walking in facility parking lot.</p> <p>Resident #1's wandering risk scale, dated 02/16/25, showed they were at high risk for wandering with a score of 16. A score of 11 and above showed a high risk for wandering.</p> <p>Resident #1's care plan was not updated after they were found outside by the dietary staff on 02/16/25 and to address the high risk for wandering.</p> <p>Resident #1's quarterly minimum data set, with an assessment reference date of 03/14/25, showed they had no behaviors of wandering, was severely impaired in cognitive skills for daily decision making with a brief interview for mental status score of 00, and ambulated without any assistive devices.</p> <p>Resident #1's incident progress note, dated 04/09/25 at 11:13 a.m., read in part, Resident was found outside in front of the museum in [name withheld] by a staff member. Resident was returned to building without any issue.</p> <p>(continued on next page)</p> | | |

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| <p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> | <p>Resident #1's wandering risk scale, dated 04/09/25, showed they were a high risk for wandering with a score of 20. A score of 11 and above showed a high risk for wandering.</p> <p>A care plan revision, dated 04/09/25, read in part, 4/9 wander risk is a 20.Goal Resident eloped 4/9/2025. Interventions have been actively trying to get resident into a locked unit for [name withheld] safety. Identify pattern of wandering is aimless. Intervene as appropriate. May need to redirect resident as needed.Most recent wander score 20 on 4/9/2025. Resident placed one-on-one d/t elopement.</p> <p>A signed statement from the maintenance director, dated 04/09/25, read in part, After the incident had occurred, I checked that all the doors were in proper working condition and checked the batteries on all door alarms that we not connected to the system. All systems were secured and working properly.</p> <p>A review of Resident #1's one-on-one documentation sheets, dated 04/09/25 through 04/18/25, showed they were one-on-one continuously since the elopement on 04/09/25.</p> <p>A review of the in-service documentation showed the facility started in-services related to elopement and securing exit door on 04/09/25 with the last in-service being provided on 04/16/25.</p> <p>A review of the wandering and elopement assessments for all residents showed the facility completed all assessments on 04/09/25.</p> <p>A review of the quality assurance notes showed the facility addressed elopement and exit doors on 04/09/25 and 04/16/25.</p> <p>On 04/18/25 at 9:49 a.m., LPN #1 stated Resident #1 left the facility a week ago. LPN #1 stated prior to that they did not know Resident #1 was at risk for wandering and elopement. LPN #1 stated this was the only time Resident #1 attempted to get out and left the building. LPN #1 stated they had an in-service on elopement, the elopement book, and to make sure all doors were secured, and alarms working. LPN #1 stated Resident #1 was placed with one-on-one supervision since they got out.</p> <p>On 04/18/25 at 9:55 a.m., dietary aide #1 stated they were not aware of any resident leaving the facility without staff knowing. Dietary Aide #1 stated Resident #1 was observed leaving out the front door a few months ago and the nursing staff was alerted. They stated they were not sure where Resident #1 was located when nursing staff went to get them. Dietary Aide #1 stated they had an in-service about a week ago on elopement and to make sure doors were secured, and Resident #1 was placed with staff supervision all the time.</p> <p>On 04/18/25 at 10:00 a.m., housekeeper #1 stated on 04/10/25 they received training on listening for door alarms and observing residents attempting to leave. Housekeeper #1 stated staff were not allowed to let any residents out.</p> <p>On 04/18/25 at 10:05 a.m., CNA #1 stated Resident #1 had been one-on-one for a week and they were provided an in-service on 04/10/25 to make sure all doors were secured. They stated they documented on the form, 1:1 Monitoring for Resident Safety, the whole time they were directly working one-on-one every 15 minutes. CNA #1 stated they were not aware Resident #1 was an elopement risk until they left and was found about a half mile away.</p> <p>(continued on next page)</p> | | |

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| <p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> | <p>On 04/18/25 at 11:57 a.m. CNA #2 stated they knew Resident #1 was an elopement risk when their employment started over two months ago and everyone knew they were. CNA#2 stated Resident #1 got out of the building recently even when they always kept a close eye on them. CNA #2 stated a close eye meant you could see their location every two hours. CNA#2 stated they were working the day of the elopement and Resident #1 was found on a busy road with a lot of traffic. CNA #2 stated they did not know the resident was missing until they were returned to the facility and Resident #1 was placed on direct supervision all day long. CNA #2 stated they were assisting another resident when Resident #1 left and they were not sure how long they were gone. CNA#2 stated they had an in-service over elopement, making sure doors were secure, and how to ensure the alarms were set right on the exit doors.</p> <p>On 04/18/25 at 12:05 p.m., CNA #3 identified Resident #1 as an elopement risk and they did not know how long they had been at risk. CNA #3 stated they did not know how Resident #1 got out and was not aware until they were returned. CNA#3 stated they did not hear any alarms go off and was not sure how they exited the building. CNA #3 stated they had been in-serviced on elopement, Resident #1 being one-on-one, the elopement book, and how to check and make sure the alarms were working correctly. CNA #3 stated Resident #1 was located at the museum on a very busy road.</p> <p>On 04/18/25 at 12:13 p.m., CMA #1 stated Resident #1 was at risk for elopement and was on one-on-one supervision. CMA #1 stated Resident #1 was not an exit seeker prior to the incident on 04/09/25. Certified Medication Aide #1 stated Resident #1 was placed in the elopement book and they received an in-service on elopement and exit doors.</p> <p>On 04/18/25 at 12:24 p.m., CNA #4 stated they had worked at the facility for six months and Resident #1 was not at risk for wandering and elopement when they started. CNA #4 stated they had been in-serviced on elopement, the elopement book, and Resident #1 being placed on one-on-one supervision. CNA#4 stated they did not know how Resident #1 got out of the facility, but thought it was because the alarms were not working right.</p> <p>On 04/18/25 at 12:35 p.m., LPN #2 stated they were the charge nurse assigned to Resident #1's hall when they eloped. LPN #2 stated they were not aware of Resident #1 missing until they were located outside the museum, about a half mile away, on a route with a lot of traffic. LPN #2 stated the alarms were malfunctioning, and they did not go off, and did not know where Resident #1 exited the facility from. LPN #2 stated they had been trained on elopement and checking and setting the alarms correctly on the doors. LPN #2 then stated Resident #1 was placed on direct one-on-one supervision.</p> <p>On 04/18/25 at 12:45 p.m., maintenance supervisor stated Resident #1 got out of the facility and they thought the lock was not reset on the doors. The maintenance supervisor stated they checked all doors when Resident #1 had returned and found all alarms to be working and the doors secured. The maintenance supervisor stated they checked all exit doors six times a day during rounds to ensure alarms were set and doors were secured.</p> <p>On 04/18/25 at 1:05 p.m., CNA #5 stated Resident #1 wandered a lot and they never received any training on the wandering until the elopement on 04/09/25. CNA #5 stated they received training on checking the doors and making sure they knew who was in the elopement book.</p> <p>(continued on next page)</p> | | |

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| <p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> | <p>On 04/18/25 at 1:08 p.m., LPN #3 stated they had worked at the facility for two months and was responsible for the care plans. LPN #3 stated Resident #1 was a high risk for wandering and elopement and the only interventions on the care plan were for diversionary activities and there were no care plan changes until 04/09/25.</p> <p>On 04/18/25 at 1:21 p.m., the DON stated Resident #1 had been at a high risk for elopement since their admission. The DON stated there had been no intervention changes and care plan updates until 04/09/25 because the facility had no care plan coordinator. The DON stated Resident #1 was found by the dietary manager on 04/09/25 near the museum located about a half mile from the facility. The DON stated no one knew for 20 minutes Resident #1 was gone and the alarms did not sound on the doors. The DON stated every day in standup elopement was discussed because of Resident #1.</p> <p>On 04/18/25 at 2:15 p.m., the administrator stated no one knew how Resident #1 got out of the facility and it was anticipated they were gone 20 to 30 minutes. The administrator stated Resident #1 was located about a half mile away near the museum located on a very busy road. The administrator stated Resident #1 wandered and got out of the building once into the parking lot when dietary staff watched them go out in February. The administrator stated they in-serviced all staff, started monitoring the doors, and Resident #1 was placed one-on-one starting on 04/09/25.</p> |