STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375432	A. Building B. Wing	04/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shawnee Colonial Estates Nursing Home	535 West Federal Street Shawnee, OK 74801

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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35389 Based on record review and interview, the facility failed to ensure a NOMNC was provided to a resident discharging from skilled services for 1 (#94) of 3 sampled residents reviewed for beneficiary notification. MDS Coordinator #1 identified 15 residents who were discharged from a Medicare covered Part A stay with benefit days remaining in the past six months (11/18/24 through 04/03/25). Findings: Resident #94 admitted to the facility on [DATE]. A nurse's note, dated 02/25/25, showed Resident #94 discharged home with home health. The SNF beneficiary notification review showed Resident #94's Medicare Part A skilled services episode start date was 12/07/24 and their last covered day of Part A service was 02/24/25. The notification showed the Medicare Part A service termination/discharge was determined voluntarily and the facility/provider initiated the discharge from Medicare Part A services when when benefit days were not exhausted. The notification showed the resident did not receive a NOMNC because Resident #94 did not stay in the facility. On 04/04/25 at 12:58 p.m., MDS coordinator #1 stated they started speaking about discharge with residents, and if they agreed on a discharge date , the MDS coordinator would fill out the NOMNC form and have the resident sign the form. They stated if the resident was unable to sign the form, they would have the family sign. They stated the form was supposed to be provided 48 hours before discharge from skilled services. On 04/04/25 at 1:01 p.m., MDS coordinator #1 stated both the facility and the resident initiated the discharge. They stated the resident wanted to go home. They stated Resident #94 did have benefit days remaining. They stated they got confused on which form they needed to sign and had them sign the SNFmadvance beneficiary notice of non-coverage instead. 49701

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49701 Based on record review and interview, the facility failed to ensure a baseline care plan was completed within 48 hours of admission for 1 (#19) of 17 sampled residents reviewed for completion of baseline care plans. LPN #1 identified 40 residents resided in the facility. Findings: Resident #19 was admitted on [DATE] with diagnoses which included severe protein-calorie malnutrition, repeated falls, and depression. There was no documentation a baseline care plan was completed within 48 hours of admission. On 04/08/25 at 2:17 p.m., the administrator stated they follow the RAI manual regarding care plans. On 04/09/25 at 10:45 a.m., MDS coordinator #1 stated Resident #19 did not have a 48 hour baseline care plan because they were behind on them.

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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 - Some	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** 35389 On 04/08/25 at 3:50 p.m., the Oklahoma State Department of Health was notified and verified the existence of an Immediate Jeopardy situation related to the facility's failure to provide supervision to prevent elopement from the facility. Resident #22 was identified as being at risk for elopement. Resident #22 made it out to the parking lot through the front door within sight of the nurse's station unattended. A visitor notified staff Resident #22 was in the parking lot. On 04/08/25 at 3:55 p.m., the administrator, director of nursing, assistant director of nursing, business office manager, and corporate nurse were notified of the immediate jeopardy and provided the immediate jeopardy template. On 04/09/25 at 11:54 a.m., an amended plan of removal was approved by the Oklahoma State Department of Health. The plan of removal, read in part, A) Immediate interventions initiated for Resident #22 following elopement on 02/03/25: *15 minute checks *Physician notification with medication changes *Pain evaluation *Alternative placement referral. *Interventions successful. Resident #22 has not had further attempts to elope from facility and did not require alternative placement. Once resident #22 was determined to be at risk, [they] was placed on the facility Code White program. Exit seeking behaviors were monitored every shift and continue. Signage placed on facility doors to instruct family members to call for assistance instead of pulling the doors open and to ensure facility residents are not following them outside when they leave. Facility staff received re-education on 11/13/24, 02/01/25, 02/06/25 and a Code [NAME] Drill was performed on 02/10/25. Immediate interventions for Resident #95 on 02/17/25. *1:1 until discharge to memory care facility. B) All facility residents who are at risk for elopement will be considered at risk for this alleged deficient practice. C) A Code [NAME] Drill was held on 04/08/25 with facility staff at 1815. Steps of the mock elopement drill completed per facility protocol and response time was immediate with the resident being found within 3 minutes. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Re-education with all staff was provided to include definitions and identifying exit seeking behaviors. CNAs interviewed were well versed with the facility Code [NAME] Program. Door alarms are working properly. D) Residents considered at risk for elopement were reviewed on 04/08/25 with interdisciplinary team to ensure interventions in place continue to be successful. E) Plan of Correction completed on 04/08/25 at 1830. Additional questions from surveyors: 1. What do staff do when visitors are pulling on the door to enter/exit? The door alarm sounding is the initial safety measure. Staff then reset the code and educate visitors to use code provided and to ensure residents do not follow them outside when leaving. A call multiplier was sent to all family contacts. Signage was updated with a Stop sign with instructions on how to enter/exit without pulling on door. This information will be added to the admission packet and orientation packet to ensure continual compliance. 2. With other residents at risk for elopement, what do employees do with exit seeking behaviors and how do staff know what interventions to use and effectiveness. Non-pharmacological resident specific interventions have been identified for both residents and can be found on the TARs, MARs and in POC. Outcome of non pharmacological interventions are documented in the nurses notes. Resident #1 non-pharmacological interventions for target behavior (exit seeking) include 1. Talk about president [name withheld] 2. Offer cup of coffee and active listening 3. Offer favorite snack i.e [that is] oatmeal cream pie 4. Deep breaths 5. Call [family]. Resident #2 non-pharmacological interventions for target behavior (exit seeking) include: 1. Offer favorite snack (any type of cookie) 2. Talk about painting fences 3. Call [family] 4. Coffee time 3. How do employees know what interventions are used and if effective? Target behaviors and Non-pharmacological interventions are monitored every shift. Once a target behavior is identified, non-pharmacological resident specific interventions are available for each resident on the TAR, MAR and in POC. The outcome of utilizing non-pharmacological interventions can be found in the nurses notes and will be reviewed at resident care plan meetings and/or quality assurance meetings to determine if additional plans of action need to be implemented. On 04/09/25 after interviews with facility staff, review of resident elopement wander risk assessments, and in-services, the immediacy was lifted, effective 04/09/25 at 11:00 a.m. The deficient practice remained at a pattern level with potential for more than minimal harm. Based on observation, record review and interview, the facility failed to: a. provide supervision and interventions to prevent elopement for 2 (#22 and #95) of 3 sampled residents reviewed for elopement; b. provide supervision for a resident who wandered and was at risk for elopement for 1 (#20) of 3 sampled residents reviewed for elopement; and (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	c. utilize a mechanical lift as ordered for transfers which resulted in a fall for 1 (#21) of 4 sampled residents reviewed for accident hazards. LPN #1 identified 40 residents resided in the faciilty. The administrator identified two residents at risk for elopement resided in the facility. Findings: On 04/08/25 at 10:27 a.m., the chain link fenced in area on the North side of the building was observed to have the handle closed but without a locking device in place. The gate could be opened. Four of the exit doors had red writing on them that provided instructions to hold the door for 15 seconds to get it to open. A policy titled Emergency Procedure- Missing Resident, revised August 2018, read in part, Residents at risk for wandering and/or elopement will be monitored, and staff will take necessary precautions to ensure their safety. 1. Resident #22 was admitted to the facility on [DATE] with diagnosis which included dementia. A Nurse Note, dated 01/09/25, showed Resident #22 pulled the fire alarm and stated, the alarm said pull, so I pulled it. The note showed Resident #22 also stated the door sign indicates if you hold it down for 15 seconds it will open. The note showed the physician and family were notified of the incident with family stating Resident #22 had never tried to exit seek before. On 01/10/25, the care plan was updated to include wandering and elopement with interventions of Resident #22 to be added to the elopement list for staff to be more aware of their exit seeking, distracting resident, and providing structured activities. A Nurse Note, dated 02/03/25, showed Resident #22 exited North hall entrance, a family member alerted the ADON and they responded immediately by assisting resident back into the facility without further incident. The note showed Resident #22 was noted to be in the parking lot, alarm to North doors noted to be sounding. The note showed Resident #22 was alert to self and noted to have increased confusion of time and place. The note showed Resident #22 stated they were going to other place, but unable to verbalize what place, the resident was assisted back to their room, and attempted to reorient without success. The note showed family called and discussed concerns with exit seeking and elopement, and alternative placement options. The note showed the resident was currently on code white list with 15 minute checks initiated. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	An incident report form, dated 02/03/25, showed Resident #22 was noted to exit North hall entrance. The report showed family members alerted the ADON and DON, they responded immediately assisting the resident back into the facility without further incident. The report showed Resident #22 was noted to be in the parking lot, alarm to North doors noted to be sounding. The report showed Resident #22 was alert to self and had increased confusion of time and place. The report showed Resident #22 stated they were going to other place, but was unable to verbalize what place, the resident was assisted back to their room and attempted to reorient without success. The report showed the DON had visited with family members regarding this behavior, physician had ordered new medications and Resident #22 was to see a counselor. The report showed the DON talked with Resident #22 about any pain they may have been experiencing and Resident #22 denied pain. The report showed Resident #22 remained on 15 minute checks and the DON spoke with the family regarding the interventions the facility had implemented and they let them know if they did not work, Resident #22 might need to find a different placement. The care plan did not have any additional interventions listed after the 01/09/25 incident. On 04/08/25 at 10:19 a.m., the DON stated, We put a stop sign on the door that said please call this number for assistance. staff knows that [Resident #22] is code white, we make a mental note that [Resident #22] is close to the door. Family member of another resident had the alarms going off and when the resident got out they notified staff who was able to easily redirect them back into the building. The alternative placement did not work out due to financial concerns. 2. Resident #95 was admitted to the facility on [DATE] with diagnoses that included general anxiety disorder. An admission Minimum Data Set assessment, with an assessment reference date of 01/24/25, showed Resident #95 had a brief interview for mental status score of 13 indicating Resident #95 was cognitively intact. The assessment showed no wandering behavior and required moderate assistance with walking. Resident #95's Wandering Risk Review, dated 02/01/25, showed they were newly at risk for elopement. An incident report form, dated 02/17/25, showed the ADON heard the center [NAME] door alarm and went to check and saw Resident #95 walking on the sidewalk outside. The report showed Resident #95 left their wheelchair at the door and pressed the bar on the door for 15 seconds and the door opened, and they walked outside. The report showed Resident #95 was looking for their family member. The report showed one on one was implemented immediately, and family stated they thought the code on the door would keep Resident #95 inside. The note showed family advised they wanted the facility to send the medical records to the memory care unit in Shawnee. A Nurse Note, dated 02/17/25, showed the ADON heard the door alarming and upon approach saw Resident #95's wheelchair in front of the door. The note showed Resident #95 was noted to be looking over the fence asking where their house was. The note showed they were easily redirected back inside the building and placed on one on one and the physician and family were notified of the incident. There was no documented care plan regarding elopement. On 04/08/25 at 10:14 a.m., MDS coordinator #1 stated they should have put elopement in the care plan for Resident #95 once it was identified on the elopement risk assessment, but they did not. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 04/08/25 at 10:27 a.m., the DON stated Resident #95 was ambulatory at that time and walked to the middle doorway and pushed the door open and the ADON responded immediately. On 04/08/25 at 1:14 p.m., CNA #3 was able to verbalize their responsibility, if they were to see a resident trying to get out the door, would be to try to stop them, try to redirect them, let them know where they are, keep eyes on them, and tell the nurse about the behavior. CNA #3 stated they were told that when they first started on 03/26/25. CNA #3 stated they have not seen anyone try to get out. On 04/08/25 at 1:19 p.m., CMA #1 stated the last training concerning code white was about a month ago. CMA #1 stated they had mock drills. CMA #3 identified exit seeking behaviors as hanging out by the doors or things they talked about. CMA #3 stated the one they watch the most was Resident #22 because they are always looking for their truck. CMA #1 stated their responsibility was to alert the nurse and try to stop the residents by convincing them to come back in. 3. On 04/07/25 at 10:12 a.m., Resident #20 was observed standing up independently from a recliner in the front living room, used a standard walker, and walked over to the front exit door of the facility. The resident looked out the glass door, but did not touch the door. Resident #20 then turned to the side with their walker. On 04/07/25 at 10:13 a.m., Resident #20 began ambulating away from the front door and towards the hall that ran alongside the dining room. The resident continued down the hall towards the administrator's office. RN #1 stopped the resident and asked them to walk with them towards the nurse's station. The resident followed RN #1. On 04/07/25 at 10:17 a.m., Resident #20 walked towards the front living room again. On 04/07/25 at 10:19 a.m., Resident #20 walked a little closer to the front door, turned around, and began walking towards RN #1. The resident stood next to RN #1. On 04/07/25 at 10:21 a.m, RN #1 and Resident #20 walked down the hall until they arrived at the resident's room. RN #1 explained to Resident #20 they had arrived to their room. CNA #6 entered the room and asked the resident to go to the bathroom. Resident #20 was heard to be saying get out of here to the CNA. CNA #6 opened the door, called for help and two staff members entered the room. The surveyor did not enter the room as Resident #20 was verbally upset. On 04/07/25 at 10:49 a.m., Resident #20 was observed walking with their walker to the common area and ambulated with another resident to the front exit door. Resident #20 did not touch the door. The two residents continued to stand by the door while the other resident remarked about how windy it was outside. On 04/07/25 at 10:54 a.m., both residents remained standing by the front exit door. RN #2 approached Resident #20 and asked if they could shave the resident. RN #2 placed their hand on Resident #20's back and pointed them in the direction of their room. RN #1 stated to Resident #20 lets go down to your room and get you shaved. RN #1 joined RN #2 in Resident #20's room to shave them. Resident #20 had diagnosis which included cognitive communication deficit. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A behavior note, dated 01/07/25, showed Resident #20 had been actively exit seeking for the last 1.5 hours walking nonstop from one end of the North hall to the other. The note showed the resident had been able to set the alarm off on the northwest door twice by pressing it repeatedly. The note showed staff was able to get Resident #20 before the door opened. The note showed the facility notified family and a family member was going to come sit with the resident. An admission elopement/wandering risk assessment, dated 01/07/25, showed Resident #20 was at risk for elopement/wandering as evidenced by exit seeking trying to go to work while approaching exit doors. The assessment showed interventions which included distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, book, the personalization of room with familiar objects and photographs and provide structured activities: toileting, walking inside and outside, and reorientation strategies including signs, pictures and memory boxes. A nurse's note, dated 01/09/25, showed Resident #20 was noted to aimlessly wander throughout the facility. The note showed the resident's family was at their side and voiced concerns about the resident's constant pacing and wandering throughout the facility. An admission resident assessment, dated 01/12/25, showed Resident #20 had severe cognitive impairment (BIMS 00) and did not exhibit wandering behaviors. An alert note, dated 01/20/25, showed Resident #20 was pacing and refused their morning medication. The note showed once the resident's family member arrived, the resident took their medications and the pacing stopped. A nurse's note, dated 01/30/25, showed Resident #20 had increased behaviors when their family member left that afternoon. The note showed the resident was walking towards exit asking to go check on them. The note showed the resident was noted to calm down after staff provided one on one care. A behavior note, dated 02/06/25, showed Resident #20 was combative while staff were attempting to change them. It showed the resident came out of their room, went up and down the hallways, and stated [they] were walking to that door. The note showed the resident walked to the end door, stood there with staff and then turned around and headed back to their room. A behavior note, dated 03/29/25, showed Resident #20 had been anxiously wandering the facility that morning. It showed the resident was down the northeast hall and a CMA tried to give the resident medications which they refused. The note showed Resident #20 pushed the door at the end of the hall open and started to go out. It showed the CMA yelled for help and a CNA went to help. The note showed they got the resident turned around and back up the hallway. The note showed the facility called family to come be with the resident. An alert note, dated 04/09/25 at 7:11 p.m., showed the facility called Resident #20's family and notified them the resident was at the front door when a delivery person pushed the code and came in the door. The note showed Resident #20 tried to get out the front door. The note showed the resident did not get out the door as staff was present at the front door and walked the resident back to the nurses' desk. The note showed staff offered the resident a cookie. The note showed staff were concerned for Resident #20's safety and believed the resident was capable of getting out of the door. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	An alert note, dated 04/09/25 at 7:40 p.m., showed Resident #20 would be one on one while at the facility. On 04/03/25 at 10:37 a.m., family member #1 stated Resident #20 experienced sad and aggressive behaviors at times. They stated the resident was able to get up on their own using their walker. They stated Resident #20 had tried to exit the facility before and wanted to get out. Family Member #1 stated the resident still wanted to work and [NAME]. They stated Resident #20 had been known to push on the door, and staff would come to distract the resident to help them forget why they were trying to get out. Family Member #1 stated Resident #20 had stepped out of the building but not very far off the property. They stated the streets were very busy around the property. On 04/07/25 at 10:43 a.m., CNA #6 stated every one to two hours staff would check on Resident #20. They stated the resident required redirection due to confusion. They stated staff helped the resident shower. They stated the resident had family who came to the facility often. They stated the resident required cueing at times. CNA #6 stated the resident was normally sweet, loving, and laid back. They stated sometimes the resident would get a little upset. They stated the resident did exhibit wandering behaviors and staff would redirect the resident with the television, a snack, or an activity. On 04/07/25 at 10:45 a.m., CNA #6 stated they had not noticed Resident #20 exhibiting exit seeking behaviors. They stated they were not aware of the resident ever eloping from the facility. On 04/08/25 at 12:13 p.m., CNA #2 stated Resident #20 was combative at times and they would get another staff member to assist the resident when this occurred. They stated the resident was able to ambulate independently with their walker. On 04/08/25 at 12:15 p.m., CNA #2 stated there was a time Resident #20 walked out the door at the end of the hall. They stated a CMA saw it occur and ran to catch the resident. CNA #2 stated they did not know if the door was locked or not, but they ran to help as well. They stated the resident was wanting to hit them as they helped them back inside. They stated CNA #1 also helped them get the resident inside. CNA #2 stated Resident #20 wandered the building everyday up and down the hall. They stated they tried to keep the middle doors shut so the resident wouldn't go down there. They stated the doors had a code and would alarm if they were touched/pushed. CNA #2 stated after pushing for 15 seconds, the door would unlock. On 04/08/25 at 12:19 p.m., CNA #2 stated staff would try to entertain Resident #20 with food and the television when they exhibited these behaviors. They stated staff kept an eye on the resident. On 04/08/25 at 12:21 p.m., CNA #2 stated elopement was exiting the building or getting away. On 04/08/25 at 12:22 p.m., CNA #2 stated they did not know if Resident #20 had ever left the facility without staff witnessing. They stated when residents were at risk for elopement staff would keep an eye on them and maybe do every 15 minute checks. On 04/08/25 at 12:46 p.m., CNA #1 stated Resident #20 was able to ambulate with a walker and was very confused. They stated staff checked on the resident every two hours for toileting needs. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 04/08/25 at 12:47 p.m., CNA #1 stated no (opposite sex) could go and assist Resident #20 or they would get mad. They stated the resident could get verbally aggressive at times. On 04/08/25 at 12:48 p.m., CNA #1 stated when behaviors were experienced, staff would try to calm the resident down and sit the resident in the recliner. On 04/08/25 at 12:49 p.m., CNA #1 stated they did not have any idea what the word elopement meant. They stated Resident #20 was walking out the door on the northeast hall. They stated the resident was wandering with their walker, threw the walker, and tried to walk out the door. They stated staff observed this happen. On 04/08/25 at 12:51 p.m., CNA #1 stated they would go next to them, try to calm them down, and take them back to their room. They stated Resident #20 was trying to get home because it was the day their family member was sick and they wanted to go home to see them. On 04/08/25 at 12:52 p.m., CNA #1 stated stated has not received any training for behaviors or residents trying to leave the building without staff present. On 04/08/25 at 12:53 p.m., LPN #1 stated Resident #20 could ambulate with their walker independently. On 04/08/25 at 12:54 p.m., LPN #1 stated Resident #20 exhibited behaviors which included exit seeking, yelling, and hitting. They stated staff tried to talk to the resident, would step back and let them cool off, and if that did not work, they would call family to come sit with the resident. On 04/08/25 at 12:55 p.m., LPN #1 stated elopement was when a resident got out the door and left the building. They stated even if they just got out the door, it was elopement. On 04/08/25 at 12:56 p.m., LPN #1 stated Resident #20 had tried to elope. They stated the resident opened the door and staff was present. They stated they did not know what the facility was doing to prevent it from happening again. On 04/08/25 at 12:57 p.m., LPN #1 stated staff just tried to keep a better eye on residents at risk for elopement. They stated if they were close to the door, LPN #1 would hand out at the nurse's station as they charted to keep an eye on them. On 04/08/25 at 12:58 p.m., LPN #1 stated they placed residents who tried to elope on every 15 minute checks until they had not tried to elope for so many days. LPN #1 stated every 15 minute checks were discontinued on Resident #20 on 02/04/25 and they were not sure when the order was written. The order LPN #1 described related to every 15 minute checks was not observed in Resident #20's clinical record and was not reflected on the resident's January or February 2025 MAR/TAR. On 04/08/25 at 1:17 p.m., the DON stated Resident #20 was pretty independent with occasional incontinent episodes. They stated sometimes the resident forgot to use their walker. They stated the resident had good days and bad days. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375432	A. Building B. Wing	04/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shawnee Colonial Estates Nursing Home	535 West Federal Street Shawnee, OK 74801

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 04/08/25 at 1:19 p.m., the DON stated just the other day, Resident #20 was more confused but most of the time they were easily redirected. They stated they recently discovered the resident preferred female caregivers. They stated staff were educated on using redirection and utilizing non pharmacological interventions for residents with poor recall this morning. On 04/08/25 at 1:20 p.m., the DON stated Resident #20 wandered, but it was not goal driven because the resident did not voice the desire to leave. On 04/08/25 at 1:21 p.m., the ADON stated sometimes Resident #20 would say they were going to work or wanted their family member. The ADON and DON were read the behavior notes dated 01/07/25, 02/06/25, and 03/29/25 and were asked if the notes documented exit seeking behaviors. The DON stated they were not saying the resident was not exit seeking, they were saying can the resident put those two together. The DON stated Resident #20 was on the facility code white and did wander. On 04/08/25 at 1:25 p.m., the DON stated staff would redirect the resident when they exhibited these behaviors by offering coffee. The DON stated the resident's family was heavily involved. On 04/08/25 at 1:26 p.m., the DON stated the interventions should be in the nurses' notes. The ADON stated documentation was also in documentation system the CNAs used and on the TAR. They were asked if it documented what staff did in response to the behavior on the TAR. The ADON stated if there were any behaviors observed, staff would chart in a nurses' note. On 04/08/25 at 1:26 p.m., the DON stated elopement was when residents were exit seeking and got out of the building. They stated residents with elopement risk had the potential to get out of the building. On 04/08/25 at 1:27 p.m., the DON stated Resident #20 had the potential to elope which was the reason they were on the code white. The DON stated when residents were at risk for elopement, staff would try to involve them in activities, offer coffee, and offer snacks. They stated they would be updating interventions staff can do so they can document it. 4. On 04/08/25 from 9:22 a.m. through 9:33 a.m., CNA #2 and CNA #4 were observed transferring Resident #21 from their wheelchair to the bedside commode, then from the bedside commode to the resident's bed utilizing a mechanical lift. On 04/08/25 from 9:53 a.m. through 10:10 a.m., Resident #21 was observed receiving turning assistance in bed, perineal care, and transfer assistance from the bed to the shower chair with a mechanical lift with the assistance of CNA #2, CNA #4, and CNA #5. Resident #21 had diagnoses which included coagulation defect and chronic kidney disease stage 5. A quarterly resident assessment, dated 02/13/25, showed Resident #21's cognition was intact (BIMS 15) and they were dependent on staff for the task of toileting hygiene, lower body dressing, putting on/taking off footwear, roll left and right, sit to lying, lying to sitting on the side of the bed, chair/bed-to-chair transfer, toilet transfer, and tub/shower transfer. A physician order, dated 02/13/25, read in part NWB RLE (utilize Hoyer [mechanical] lift for transfers). (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A physician order, dated 02/14/25, read in part, use Hoyer [mechanical] lift for all transfers every shift for NWB status to RLE. An incident report, dated 03/27/25, showed a CNA had summoned the nurse to Resident #21's room. The report showed the resident had to be lowered to the floor while dressing the resident after a shower. The report showed upon entering the room, the resident was noted to be sitting on the floor in front of the shower chair. The report showed CNA staff reported they were standing Resident #21 up to dress them and the resident's legs buckled, causing them to lower the resident to the floor. The report showed no injury was noted and the intervention was to dress the resident in bed rather than standing the resident from a chair to dress. On 04/03/25 at 11:12 a.m., Resident #21 stated they fell last week when transferring to the shower chair. They stated they did not have skid socks on and slide to the ground. They stated two staff were with them when they fell . Resident #21 stated they were supposed to use a full body lift, but the lift was either occupied or the battery was dead. They stated staff were transferring them from the shower chair to the wheelchair when the resident slid. Resident #21 stated two staff members physically lifted them with their arms. They stated the staff members were new. Resident #21 stated when they first started sliding, they instructed staff to let them down easy. They stated they were non weight bearing due to a wound on their right foot. They stated they had to have bone in their heel removed. On 04/08/25 at 10:14 a.m., CNA #2 stated Resident #21 required a mechanical lift for transfers. On 04/08/25 at 10:17 a.m., CNA #2 stated staff had transferred the resident before without a lift. CNA #2 stated the resident had a wound on their right foot and was non weight bearing. They stated the DON, ADON, or therapy determined when a lift was needed for transfers. On 04/08/25 at 10:18 a.m., CNA #2 stated Resident #21 had experienced a fall not very long ago. They stated it was in the resident's room and a CNA and an agency CNA assisted the resident to the floor. CNA #2 stated they did not know the details of the fall. On 04/08/25 at 10:20 a.m., CNA #2 stated if a lift was not available, they would speak to the DON, ADON, and therapy to see what they needed to do if the resident was wanting to get up. They stated if the lift was not charged, they would wait for it to be charged. They stated the facility did not have a system in place to charge the batteries and it had been a problem before. On 04/08/25 at 10:25 a.m., CNA #4 stated Resident #21 was a maximum assistance by two staff members right now. They stated the resident had a wound on their heel and was non weight bearing. They stated a mechanical lift had to be used for all transfers. On 04/08/25 at 10:27 a.m., CNA #4 stated to their knowledge staff were not transferring Resident #21 without using the lift. They sated if staff transferred the resident without a lift, they would be putting weight on that heel. On 04/08/25 at 10:27 a.m., CNA #4 stated the DON, ADON, and therapy usually would look at a resident to determine when a lift was needed for transfers. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 04/08/25 at 10:28 a.m., CNA #4 stated Resident #21 had experienced a fall not long ago. They stated staff were transferring the resident from the shower chair to the bed using a gait belt. They stated it was an assisted fall, the resident's feet gave out, and staff lowered them to the floor. They stated staff were inserviced that they had to use what was in their plan of care. They stated Resident #21 did not have any injuries from the fall. They stated staff would charge the lift batteries after every two to three transfers. On 04/08/25 at 10:32 a.m., CNA #4 stated if the lift was unavailable or not functioning properly, they would let the resident know it would be a few minutes and they would be back as soon as possible. They stated the facility had two lifts. On 04/10/25 at 10:07 a.m., LPN #2 stated Resident #21 was 100 percent reliant on staff for transfers. They stated the resident required a mechanical lift because they were non weight bearing on their right leg. They stated there was a wound to their right heel. On 04/10/25 at 10:09 a.m., LPN #2 stated Resident #21 sometimes thinks they can do more than they can. They stated the resident was at risk for falls because their leg would buckle and they didn't have enough strength. They stated the resident was especially a fall risk now because they were not non weight bearing to the right leg. On 04/10/25 at 10:11 a.m., LPN #2 stated Resident #21 had an order to continue non weight bearing to right foot that was dated 03/06/25. They stated there was also an order [TRUNCATED]