| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 435118 | A. Building<br>B. Wing | 07/24/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Prairie View Healthcare Center | 401 South First Avenue<br>Woonsocket, SD 57385 |

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 0551<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Give the resident's representative the ability to exercise the resident's rights.<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 0551<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on South Dakota Department of Health (SD DOH) facility reported incident (FRI) review, record review, interview, and policy review, the provider failed to ensure the resident representative had been notified of an elopement and change in the resident's status for one of one sampled resident (24) with cognitive impairment. The resident was identified as at risk for elopement and had eloped (left the facility grounds without staff knowledge) on 7/4/25.Findings include:1. Review of the provider's 7/24/25 SD DOH FRI regarding resident 24 revealed:*On 7/4/25 at 6:57 p.m., resident 24 was found to be at the apartment building across the street.*She [resident 24] had signed out of the facility earlier in the day, therefore the incident was not reported.*The resident had a 5/5/25 contract agreement that the resident would not leave the premises of the facility.-This contract had been signed by resident 24 and social services director (SSD) C. It had not been signed by resident 24's resident representative.*The resident had left the facility without staff awareness on 7/4/25, and that event had not been reported to resident 24's representative or SD DOH until 7/24/25. 2. Review of the facilities' sign-out log revealed on 7/4/25, resident 24 signed out at Noon and returned at 1:00 p.m. That was the only time resident 24 signed out that day. 3. Review of resident 24's Guidelines for Outside Activity contract agreement with the facility revealed:*Resident MUST sign herself out and in each time she leaves the building.*Inform Charge Nurse on duty of her going outside & [and] how long she plans to be outside.*Resident will remain on facility property when [she] goes outside: will not go up town to any place of business or location w/o [without] family or facility personnel.*Resident [24] will not go to the apartments to the East or North of the facility.*The contract was signed on 5/5/25 by resident 24 and SSD C. 4. Review of resident 24's electronic medical record revealed:*She was admitted on [DATE].*Her diagnoses included anxiety, nicotine dependence, and dementia (a group of symptoms affecting memory, thinking, and social abilities).*Her 4/19/25 Elopement Risk Evaluation indicated that she was an elopement risk; her wandering placed her at significant risk of getting [in] to an unsafe situation, had a history of leaving the center without notifying staff members, and on 4/19/25 she left [a] supervised area to walk around outsid[e]. *Her 5/19/25 Brief Interview of Mental Status (BIMS) assessment score was 10, which indicated she was moderately cognitively impaired.*A 2/14/25 Durable Power of Attorney (POA) for Health Care was signed by resident 24, designating her daughter and son as her POAs.-Her POAs had been involved in assisting the resident with making decisions and with signing documents since that time.*Resident 24's POAs were listed as her emergency contact persons. 5. Interview on 7/24/25 at 9:25 a.m. and again at 4:38 p.m. with resident 24's son revealed:*His mother was admitted to the facility after a hospitalization and illness several months ago because she required more assistance and supervision than he or his sister could provide to her at home.*He had been notified in April 2025 when his mother had walked away from an outside group activity at the facility, but he had not been notified when she left the faciity on 7/4/25.*On 7/5/25, while at the facility, he was informed that the board had decided that his mother could come and go from the facility, including on overnight visits, if she signed herself out, that the facility did not need to notify him or his sister when she left the facility, and that the facility was not responsible if something happened after she signed herself out of the facility.*He was unsure who the board members were who had made those decisions.*SSD C made a phone call to her supervisor while he was present in the facility on 7/5/25, to confirm the above information he was told, because he was questioning the decision to change her status at that moment, and he continued to be worried for her safety. 6. Interviews on 7/24/25 between 9:45 a.m. and 10:45 a.m. with staff members S and T, who requested anonymity, revealed:*On 7/4/25, around 7:00 p.m., staff members identified they had not seen resident 24 for some time that day and began looking for her.*Resident 24 was allowed to sign herself out to go outside and smoke, but she was not allowed to leave the facility property.*Resident 24 had not signed out that evening and was not found within the facility or outside the facility in the designated smoking area.*Staff were worried about resident 24's safety because she had not indicated that she was leaving, and it was raining that day.*Resident 24 was found at the apartments next door. Staff encouraged her to return to the facility; however, resident 24 refused to return to the facility.*Resident 24 then went to the shed, behind the facility, and took out her trike [a three-wheeled bicycle] and took off down the street, which was when staff members reported they lost sight of resident 24.*Resident 24 was then seen by one of those staff members about a block away from the facility on that trike.*Charge nurse U had called the supervisors on call that evening while staff members searched for resident 24 and tried to convince the resident to return to |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>(continued on next page) |

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|---|---|
| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on South Dakota Department of Health (SD DOH) facility reported incident (FRI) review, interview, record review, and policy review, the provider failed to report an elopement in the required timeframe to the SD DOH for one of one sampled resident (24) with cognitive impairment and identified at risk for elopement, who had eloped (left the facility grounds without staff knowledge).Findings include:1. Review of the provider's 7/24/25 SD DOH FRI regarding resident 24 revealed:*On 7/4/25 at 6:57 p.m., resident 24 was found to be at the apartment building across the street.*She [resident 24] had signed out of the facility earlier in the day, therefore the incident was not reported.*The resident had a 5/5/25 contract agreement that the resident would not leave the premises of the facility.*The resident had left the facility without staff awareness on 7/4/25, and that event had not been reported to resident 24's representative or SD DOH until 7/24/25.-That was 20 days later. 2. Review of the facilities' sign-out log revealed on 7/4/25, resident 24 signed out at Noon and returned at 1:00 p.m. That was the only time resident 24 signed out that day. 3. Review of resident 24's Guidelines for Outside Activity contract agreement with the facility revealed:*Resident MUST sign herself out and in each time she leaves the building.*Inform Charge Nurse on duty of her going outside & [and] how long she plans to be outside.*Resident will remain on facility property when [she] goes outside: will not go up town to any place of business or location w/o [without] family or facility personnel.*Resident [24] will not go to the apartments to the East or North of the facility.*The contract was signed on 5/5/25 by resident 24 and social services director D. 4. Interviews on 7/24/25 between 9:45 a.m. and 10:45 a.m. with staff members S and T, who requested anonymity, revealed:*On 7/4/25, around 7:00 p.m., staff members identified that they had not seen resident 24 for some time and began looking for her.*Resident 24 was allowed to sign herself out to go outside and smoke, but she was not allowed to leave the facility property.*Resident 24 had not signed out that evening on 7/4/25 and was not found within the facility or outside in the designated smoking area.*Staff were worried about resident 24's safety because she had not indicated that she was leaving, and it was raining that day.*Resident 24 was found at the apartments next door. Staff encouraged her to return to the facility; however, resident 24 refused to return to the facility.*Resident 24 then went to the shed and took out her trike [a three-wheeled bicycle] and took off down the street, which was when staff members reported they lost sight of resident 24.*Resident 24 was then seen by a staff member about a block away from the facility on that trike.*Registered nurse (RN) U had called the supervisors on call that evening while staff members searched for resident 24 and tried to convince resident 24 to return to the facility.*Staff members S and T were told by LPN U that she had been instructed by the supervisors to just let her go, not to report the incident, not to document the incident, and not to mention or talk about the incident again. 5. Interview on 7/24/25 at 2:00 p.m. and again at 2:50 p.m. with director of nursing (DON) B, administrator A, and social services director (SSD) C revealed:*DON B stated that there was no investigation into resident 24's 7/4/25 incident because it had not been considered an elopement at that time.*Administrator A stated that after reviewing additional documentation, it was determined that the incident on 7/4/25 should have been considered an elopement.*Administrator A expected that all elopements would be reported to the state agency immediately and investigated. She expected the results of any investigation related to a resident's elopement to have been documented and reported to the state agency within five working days.*DON B and Administrator A confirmed that there was no documentation of resident 24's 7/4/25 elopement in her electronic medical record, and there was no investigation documentation from that 7/4/25 elopement. 6. Review of resident 24's electronic medical record revealed:*She was admitted on [DATE].*Her diagnoses included anxiety, nicotine dependence, and dementia (a group of symptoms affecting memory, thinking, and social abilities).*Her 4/19/25 Elopement Risk Evaluation indicated that she was an elopement risk; her wandering placed her at significant risk of getting [in] to an unsafe situation, had a history of leaving the center without notifying staff members, and on 4/19/25 she left [a] supervised area to walk around outsid[e]. *Her 5/19/25 Brief Interview of Mental Status (BIMS) assessment score was 10, which indicated she was moderately cognitively impaired. 7. Attempts made to contact RN U by phone were unsuccessful, and she was not available for an interview during the survey. 8. Review of the provider's February 2025 Elopement/Wandering policy revealed:*The resident/patient exits the Center without staff knowledge OR the resident/Patient enters an unsafe area without staff knowledge or presence.*A resident is found in the parking lot of the Center by a staff [member] or visitor without staff knowledge or presence. This is elopement |

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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** Based on South Dakota Department of Health (SD DOH) facility reported incident (FRI) review, record review, interview, and policy review, the provider failed to:*Provide adequate supervision for one of one sampled resident (24) during an outside activity by one of one activities assistant L.*Ensure the safety of one of one sampled resident (24) with cognitive impairment, identified at risk for elopement, who had eloped (left the facility grounds without staff knowledge) on 7/4/25. Findings include:1. Review of the 4/19/25 SD DOH FRI regarding resident 24 revealed:<br><br>*On 4/19/25 at 5:32 p.m. the report had been submitted that indicated resident 24 had eloped from the facility at 2:50 p.m. on 4/19/25.<br><br>*The resident had told activities assistant L she wanted to see the kids at the easter egg hunt on the other side of the facility.<br><br>*Resident 24 had walked around to the other side of the facility and was out of staff’s sight.<br><br>*The resident was found by activities director (AD) V walking around the back side of the facility towards an entrance to the facility.<br><br>*The resident refused to be assessed or to have her vitals (blood pressure, temperature, pulse, respirations, and oxygen level) taken after returning to the facility.<br><br>-The resident was assessed an hour later by nursing staff and her vitals were stable.<br><br>*The on-call physician, family, and the local sheriff were notified of the resident’s elopement.<br><br>*Resident 24's care plan indicated she needed to be accompanied by family, a responsible party, or a staff member when leaving the facility.<br><br>2. Review of resident 24's electronic medical record (EMR) revealed she:<br><br>*She was admitted on [DATE].<br><br>*Her diagnoses included anxiety, nicotine dependence, depression, sepsis (serious condition in which the body responds improperly to an infection), dementia (decline in mental ability that interferes with daily life), and behavioral disturbance (disruptive behaviors).<br><br>-A Brief Interview for Mental Status assessment (BIMS) completed on 2/12/25 with a score of 10, indicated she was moderately cognitively impaired.<br><br>*On 2/12/25 she had been assessed and was determined not at risk for elopement.<br><br>*On admission she had a smoking safety evaluation, and determined she could smoke independently.<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 | *She was instructed to only smoke outside in the designated area.<br><br>- When she would go outside to smoke, she was to sign in a book with her name, date, time of leaving and time of returning.<br><br>*Prior to 4/19/25, she did not have a history of wandering, exit-seeking, or elopement.<br><br>3. Interview on 7/22/25 at 10:00 a.m. with resident 24 revealed:<br><br>*She reported on 4/19/25 she had walked around to the other side of the building during an outside activity.<br><br>*She had indicated, she told activities assistant L that she was going to walk around the building.<br><br>*At that time, she was allowed to be outside with staff supervision.<br><br>*After she had returned to the facility, she had indicated to staff that she went for a “walkabout” when she had walked around the building.<br><br>4. Interview on 7/22/25 at 10:12 a.m. with director of nursing (DON) B, regarding resident 24's 4/19/25 elopement revealed:<br><br>*The resident had walked around the facility on 4/19/25 at 2:50 p.m. and she was out of sight of staff for only a short amount of time, about 45 seconds.<br><br>*The resident had returned on her own to the facility without harm.<br><br>* On 4/19/25 resident 24’s care plan had been updated to reflect she was an elopement risk.<br><br>*Resident 24’s care plan indicated all exit seeking behaviors must be documented in resident 24’s EMR.<br><br>*The resident’s care plan indicates an elopement risk will be completed quarterly on her and this was initiated on 4/19/25.<br><br>5. Interview on 7/24/25 at 9:30 a.m. with certified medication aide (CMA) Q revealed:<br><br>*She referred to a pocket care plan staff used to care for the residents. Those included resident cares and information about them.<br><br>*She had indicated resident 24 was only to be outside with supervision of staff or a responsible person.<br><br>*She had indicated that on 4/19/25 resident 24 had a BIMS score of 10 and needed staff supervision.<br><br>6. Interview on 7/24/25 at 12:24 p.m. with activities director (AD) V revealed:<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 4/19/25 at 2:50 p.m. resident 24 was outside being supervised by activities assistant L.<br><br>*That day the resident had walked around to the other side of the facility and was out of sight of the staff for only a couple minutes .<br><br>*A code white (missing resident) was called to inform all staff of a missing resident for them to start looking for her.<br><br>*Staff then found the resident had been seen by staff walking up the sidewalk next to the building and had come from the opposite side of the facility.<br><br>7. Review of the provider's 7/24/25 SD DOH FRI regarding resident 24 revealed:<br><br>*On 7/4/25 at 6:57 p.m., resident 24 “was found to be at the apartment building across the street. ”<br><br>*”She [resident 24] had signed out of the facility earlier in the day, therefore the incident was not reported.”<br><br>*The resident had a 5/5/25 contract agreement “that the resident would not leave the premises of the facility.”<br><br>*The resident had left the facility without staff awareness on 7/4/25, and that event had not been reported to resident 24’s representative or SD DOH until 7/24/25.<br><br>8. Review of the facilities’ sign-out log revealed on 7/4/25, resident 24 signed out at “Noon” and returned at 1:00 p.m. That was the only time resident 24 signed out that day.<br><br>9. Additional review of resident 24’s electronic medical record revealed:<br><br>*Her 4/19/25 Elopement Risk Evaluation indicated that she was an elopement risk; her wandering placed her at “significant risk of getting [in] to an unsafe<br><br>situation, had a history of leaving the center without notifying staff members, and on 4/19/25 she “left [a] supervised area to walk around outsid[e].”<br><br>*Her 5/19/25 BIMS assessment score was 10, which indicated she was moderately cognitively impaired.<br><br>*There was no documentation of resident 24’s elopement on 7/4/25 as indicated in the 7/24/25 SD DOH FRI.<br><br>*There was no documentation of the resident’s exit-seeking or other behaviors or incidents on 7/4/25.<br><br>*A 7/5/25 BIMS assessment score of 13, which indicated she was cognitively intact.<br><br>-That BIMS assessment was completed the day after resident 24 left the facility without staff knowledge on 7/4/25.<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 | *A 7/20/25 Elopement Risk Evaluation indicated a score of “NA [not applicable]”:<br><br>-Her cognition was impaired with poor decision-making skills.<br><br>-She had a history of wandering.<br><br>-She had a diagnosis of dementia/cognitive impairment.<br><br>-She had a history of leaving the facility without notifying staff.<br><br>-She had a substance use disorder.<br><br>-She had “no reported episodes of wandering in the past 3 months.”<br><br>-Risks included: “Hospitalization, Fall/Injury/Bone Fracture, Being reported as a missing person/elopement.”<br><br>-The resident had been educated on signing out and telling a staff member that she was leaving before she left, and the risks associated with leaving the facility.She acknowledged the risks and understood the process of leaving the facility.<br><br>-She was determined not to be an elopement risk and “allowed to leave facility is signed out/policy [It was unclear what this indicated].”<br><br>10. Review of resident 24’s “5/5/25 Guidelines for Outside Activity” contract agreement with the facility revealed:<br><br>*”Resident MUST sign herself out and in each time she leaves the building.”<br><br>*”Inform Charge Nurse on duty of her going outside & [and] how long she plans to be outside.”<br><br>*”Resident will remain on facility property when [she] goes outside: will not go up town to any place of business or location w/o [without] family or facility personnel.”<br><br>*”Resident [24] will not go to the apartments to the East or North of the facility.”<br><br>*The contract was signed on 5/5/25 by resident 24 and social services director C.<br><br>11. Review of resident 24’s care plan revealed:<br><br>*A 5/28/25 problem area indicated “[Resident 24] is dependent on staff for meeting emotional, intellectual, physical, and social needs r/t [related to] Cognitive deficits, Depression, Mood/Behaviors, [and] Physical Limitations.”<br><br>*A 6/16/25 problem area indicated “[Resident 24] has an alteration in safety r/t: cognitive impairment and<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 | being a risk for elopement off the [facility name] Campus.” That was deleted and revised on 7/5/25 to indicate “Resident [24] is her own responsible party.”<br><br>*A 6/16/25 goal for the above problem area was to “Prevent [resident 24] from risk, including exposure to dangerous environmental factors, increased risk of falls or accidents, and potential for exploitation or abuse.”<br><br>*A 6/6/25 intervention indicated “[Resident 24] will be accompanied by family, responsible party, or center staff member when leaving the center. Or approved outings by daughter POA [Power of Attorney]. ” That was deleted and revised on 7/5/25 to indicate “[Resident 24 will be compliant with facility sign [sign] out/sign in process. These are approved outings by [her] daughter POA.”<br><br>*A 6/16/25 intervention indicated ”If [resident 24] exhibits behavior leaving campus, the episodes are documented in [resident 24’s] medical record.<br><br>Documentation includes interventions used and their effectiveness.” That was deleted and revised on 7/5/25 to indicate “If [resident 24] exhibits behaviors of not signing B/4 [before] leaving then [the] facility & [and] signing in after returning, the episodes are documented in [resident 24’s] medical record. Documentation includes interventions used and their effectiveness.”<br><br>*Resident 24’s care plan had been revised on 7/5/25 the day after she left the facility without staff<br><br>knowledge.<br><br>12. Review of resident 24’s “7/6/25 Guidelines for Outside Activity” contract agreement with the facility revealed:<br><br>*”Resident MUST sign herself out and in each time she leaves the building.”<br><br>*”Inform Charge Nurse on duty of her going outside & [and] how long she plans to be outside.”<br><br>*”Resident will notify staff on duty, sign out & [and]<br><br>back in when [she] goes uptown to any place of business or location on her three wheeled bicycle.”<br><br>*The contract was signed on 7/5/25 by resident 24 and social services director C.<br><br>*The contract was signed two days after resident 24 had left the facility without staff knowledge on 7/4/25.<br><br>13. Interviews on 7/24/25 between 9:45 a.m. and 10:45<br><br>a.m. with staff members S and T, who requested anonymity, revealed:<br><br>(continued on next page) |

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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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | *On Friday, 7/4/25, around 7:00 p.m., staff members identified they had not seen resident 24 for some time that day and began looking for her.<br><br>*Resident 24 was allowed to sign herself out to go outside and smoke, but she was not allowed to leave the facility property.<br><br>*Resident 24 had not signed out that evening and was not found within the facility or outside in the designated smoking area.<br><br>*Staff were worried about resident 24’s safety because she had not indicated that she was leaving, and it was raining that day.<br><br>*Resident 24 was found at the apartments next door to the facility. Staff encouraged her to return to the facility; however, resident 24 refused to return to the facility.<br><br>*Resident 24 then went to the shed behind the facility and took out her “trike” [a three-wheeled bicycle] and “took off down<br><br>the street,” which was when staff members reported they lost sight of resident 24.<br><br>*Resident 24 was then seen by one of those staff members about a block away from the facility on that trike.<br><br>*The charge nurse had called the supervisors on call that evening while they searched for resident 24 and tried to convince the resident to return to the facility.<br><br>*Staff members S and T were told by the charge nurse, “Just let her go,” not to report the incident, not to document the incident, and not to mention or talk about the incident again.<br><br>*Staff members S and T knew resident 24 was allowed to “sign out” to smoke independently in the designated smoking area, but she was not to leave the facility property that day unsupervised because it was part of a posted outside activity agreement for resident 24, and the resident had not been care planned to leave the facility independently.<br><br>14. Interview on 7/24/25 at 9:25 a.m. and again at 4:38 p.m. with resident 24’s son revealed:<br><br>*His mother was admitted to the facility after a hospitalization and illness several months ago because she required more assistance and supervision than he or his sister could provide for her at home.<br><br>*He had been notified in April 2025 when his mother had walked away from an outside group activity at the facility, but he had not been notified when she left the faciity on 7/4/25.<br><br>*On 7/5/25, while at the facility, he was informed that the “board” had decided that his mother could “come and go” from the facility, including on overnight visits, if she signed herself out, that the facility did not need to notify him or his sister when she left the facility, and that the facility was not responsible if something happened after she signed herself out of the *He was unsure who the “board” members were who had made those decisions.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 435118 | A. Building<br>B. Wing | 07/24/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Prairie View Healthcare Center | 401 South First Avenue<br>Woonsocket, SD 57385 |

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 | *Social services director (SSD) C made a phone call to her supervisor while he was present at the facility on 7/5/25, to confirm the above information he was told, because he was questioning the decision to “change her status at that moment,” and he continued to be worried for her safety.<br><br>15. Interview and review of resident 24’s occupational therapy records on 7/24/25 at 3:58 p.m. with director of rehabilitation R regarding resident 24’s participation in therapy revealed:<br><br>*Resident 24 received occupational therapy services from 6/5/25 through 7/23/25.<br><br>*Her occupational therapy evaluation included assessing her safety with the use of an adult tricycle on facility grounds and in the community.<br><br>*On 7/23/25, resident 24 was discharged from occupational therapy with the recommendation “not realistic for off campus due to safety concerns of use with traffic. Can use on campus.”<br><br>*The occupational therapy assistant who completed the safety assessment was on leave and unavailable for interview.<br><br>16. Interview on 7/24/25 at 2:00 p.m. and again at 2:50 p.m. with director of nursing (DON) B, administrator A, and social services director (SSD) C revealed:<br><br>*DON B stated there was no documentation or investigation of resident 24’s 7/4/25 “incident” because it had not been considered an elopement.<br><br>*Administrator A stated after reviewing additional documentation, it was determined that the “incident” on 7/4/25 should have been considered an elopement as the resident had left the facility without the staff’s knowledge or supervision.<br><br>*Administrator A had not been aware of the ”Guidelines for Outside Activity” contracts that had been made with resident 24 on 5/5/25 before the incident on 7/4/25 and again on 7/6/25 after the incident occurred on 7/4/25.<br><br>*Administrator A was surprised that resident 24 had a BIMS assessment score of 10 before the incident on 7/4/25 and had been reassessed to have a BIMS of 13 “magically” on 7/5/25.<br><br>*SSD C confirmed she had completed resident 24’s 7/5/25 BIMS assessment, had updated the outside activity contract, and updated resident 24’s care plan to reflect the new agreement.<br><br>*SSD C stated that resident 24’s family had not been involved in the development of the contract but had agreed with it on 7/5/25.<br><br>-Those documents had been updated after the incident on 7/4/25.<br><br>*Administrator A expected that all elopements would be reported to the state agency and investigated for potential abuse, neglect, or additional interventions. She expected the results of any investigation related to a resident's elopement to have been documented and reported to the state agency.<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 | *DON B and Administrator A confirmed there was no documentation of resident 24’s 7/4/25 elopement in her electronic medical record, and there was no investigation documentation from that 7/4/25 elopement.<br><br>*DON B was unaware of occupational therapy’s 7/23/25 discharge recommendation that resident 24 was assessed as unsafe for off-campus use of her trike due to safety concerns.<br><br>17. Review of the provider’s February 2025 Elopement/Wandering policy revealed:<br><br>*”The Center evaluates residents for wandering and/or exit seeking behavior and implements appropriate interventions as indicated via the evaluation process.”<br><br>*”The resident/patient exits the Center without staff knowledge OR the resident/Patient enters an unsafe area without staff knowledge or presence.”<br><br>*”A resident is found in the parking lot of the Center by a staff [member] or visitor without staff knowledge or presence. This is elopement.”<br><br>*”A resident exits the front door without staff knowledge or presence. This is elopement.”<br><br>“Residents deemed at risk to elope…are accompanied by family, responsible party, or a center staff member when leaving the center for appointments… are ai eyesight when on center sponsored outings. If staff are unable to keep the resident in line of sight, the resident is accompanied by a staff member assuring resident safety.”<br><br>*” Recurrent evaluations are completed quarterly for those at risk to elope… with [a] change in condition and following elopement events. The care plan is reviewed and updated as appropriate.”<br><br>*”If [a] resident exhibits exit seeking behavior, the episodes are documented in the resident's medical record. Documentation includes interventions used and their effectiveness.”<br><br>Review of the provider’s June 2020 Facility admission Agreement packet revealed:<br><br>“Your stay begins with a complete assessment of cognitive and physical health so that your care team may provide you with comprehensive attention specific to the care you need.”<br><br>*”Care plans are individualized for every patient based on their diagnosis and needs. The goal is to maximize each patient’s functional abilities…your needs and the risks associated with them change over time, and we review your plan of care regularly to make sure it continues to meet your needs. ” |