STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455489	A. Building B. Wing	04/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Jeffrey Place Healthcare Center	820 Jeffrey Dr Waco, TX 76710

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44526 Based on interview and record review, the facility failed to protect 2 resident (Resident # 3 and Resident #4) of 7 residents reviewed for abuse. Resident # 3 reported that LVN E called her stupid and incompetent. Resident #3 stated this made her upset. Resident # 4 reported that LVN E touched her inappropriate by rubbing her shoulder and thigh. Resident # 4 stated this made her feel uncomfortable. This failure caused these residents to be abused, this failure also places other residents at risk of being abused. Findings included: Resident #3 was [AGE] year-old woman who readmitted to the facility on [DATE]. Resident # 3 admitted the facility with the following diagnosis: bipolar disorder, anxiety disorder, heart failure, cognitive communication deficit diabetic chronic kidney disease. Record review of Resident # 3's quarterly MDS dated [DATE] section GG functioning, reflected Resident # 3 had a BIMS score of 12 which indicated minimal impairment. During an interview on 4/5/2024 at 10:40am with Resident # 3 revealed, she could not remember the exact date of the incident, but stated they had a nurse LVN E who was passing their medications. Resident # 3 stated it was late around 11:30pm and she still had not received her nighttime medications, she stated she went to LVN E and ask when she was going to get her medications. Resident # 3 stated LVN E, was fidgety and sweating, she stated he told her he had already given her medications. Resident # 3 stated she asked LVN E, was he competent to pass medications because of the way he was acting, she stated he said, she was not competent, that's why she was in the facility. Resident # 3 stated he then called her stupid. Resident # 3 stated she was upset and told the Admin. Resident # 4 was a [AGE] year-old woman who admitted to the facility on [DATE]. Resident # 4 was admitted to the facility with the following diagnosis: acute kidney failure, hypertension, obesity, and major depressive disorder. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident # 4 quarterly MDS dated [DATE] section GG functioning, reflected Resident #4 had a BIMS score of 12 which indicates minimal cognitive impairment. During an interview on 4/8/2024 at 11:45am with Resident #4 revealed she was in the shared area near the nurse's station on the night of the incident. Resident # 4 stated LVN E was talking loudly and moving fast, she stated it seemed like something wasn't right with LVN E by the way he was acting. Resident # 4 stated he was talking to her and asking her questions about how she liked her food. She stated LVN E was moving around and started rubbing her neck and shoulder area, she stated LVN E then got down on one knee like he was proposing to her and started rubbing her thigh. Resident # 4 stated it made her feel uncomfortable because he did not have to rub on her to give her medications. Resident #4 stated she did report this to other staff what LVN E had done and how it made her feel. Resident # 4 stated she did not ask to be treated like that nor did she want to the be treated like that by any staff. During an interview on 4/8/2024 at 10:35am with CNA A, revealed she was working the night of the incident March 30, 20224. CNA A stated she was working on the MC unit that night but came out around 8:30 -9:00pm to see why none of the residents on the MC unit had received their medications yet. CNA A stated she witnessed LVN E acting strange, she stated he was moving fast, talking fast, talking loudly and was argumentative with the residents who had asked for their medications. CNA A stated she heard LVN E call Resident # 3 stupid and incompetent. CNA A stated LVN E also got down on one knee and was holding Resident # 4's hand and one hand was on her thigh, she stated she told LVN E at that time that he was inappropriate. CNA A stated one of the nurses who worked that night made the staff leave. During an interview via phone on 4/8/2024 at 9:59am with LVN A, stated she worked the night of March 30, 2024, she stated she worked the 10pm to 6am shift. LVN A stated LVN E appeared to be unhinged, she stated he was argumentative with staff and with the residents that night. Record review of witness statement dated 4/2/2024 completed by LVN K, reflected she worked the night of 3/30/2024. LVN K statement reflected, she overheard LVN E talking loudly while he was passing medications to the residents. The statement reflected initially it sounded like LVN E was joking with the residents, but then LVN E got belligerent with the residents. LVN K statement also reflected LVN E became argumentative and irate with Resident # 3 because she was concerned about her medications and his ability to give medication due to how he was acting. LVN K's statement reflected LVN E tried to open the medication cart and when it did not open, he became crazed, the statement reflected LVN E left and went home after this. During an interview at 12:30pm on 4/8/2024 with Admin. revealed, she was contacted the night of March 30, 2024, by one of the nurses. The Admin. stated when she learned of the incident LVN E was sent home that night and suspended pending an investigation. The Admin. stated when she conducted her investigation on March 31,2024 that both Resident # 3 and Resident #4 made an outcry of abuse by LVN E. She stated Resident # 3 stated LVN E called her stupid when she asked him about her medications. The Admin. stated Resident # 4 made an outcry that LVN A had rubbed her neck, shoulder, and her thigh. The Admin. stated after she concluded her investigation that LVN E was terminated from the facility on 4/4/2024 due to inappropriate behaviors which resulted in an abuse allegation. Record review of LVN E suspension documentation dated 3/31/2024, reflected he was suspended pending investigation. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of LVN E termination documentation dated 4/4/2024, reflected LVN E was terminated from the facility. Record review of facility Abuse prevention Program dated 1/9/2023 reflected the following: Our residents have the right the be free from abuse. This includes but not limited to verbal or physical abuse not required to treat the resident's symptoms. Record review of facility Resident Rights policy dated February 2021 reflected the following: Employees shall treat all residents with kindness, respect, and dignity

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F 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Permit a resident to return to the nursing home after hospitalization or therapeutic leave that exceeds bed-hold policy. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44526 Based on interview, and record review the facility failed to permit a resident to return to the facility after being hospitalized or placed on therapeutic leave for 1 (Resident # 2) of 7, residents reviewed for bed hold. Resident # 2 was not permitted to return to the facility after being discharged from the hospital. The facility refused to allow Resident #2 to return to the facility after he was cleared for psychiatric services needed and assessed from a recent fall. Resident # 2 was clear to discharge back to the facility on [DATE]. This failure could place the resident at risk of not getting the care and services required. Findings included: Resident # 2 was a [AGE] year-old male who was admitted to the facility on [DATE] to the secure unit. Resident # 2 had the following diagnosis: progressive Dementia with behavioral disturbance, urinary tract infection, and heart failure. Record review of Resident # 2 MDS admission assessment dated [DATE], Sec, GG cognitive functioning reflected a BIMS score of 06, which indicates severe impairment. Record review of Resident # 2 care plan dated 3/21/2024, reflected behavioral issues identified with the following interventions in place: 1:1 supervision, fix calming tea for resident, approach calm to see what the resident's needs were, and redirect the resident. During an interview on 4/4/2024 at 7:59am with hospital RN case manager, revealed Resident # 2 was cleared for discharge back to the facility on [DATE] by the treating physician. The hospital RN case manager reported they had spoken with the facility staff and advised the facility that psychiatric services were not recommended for Resident #2, and he was cleared to discharge back to the facility, she stated staff refused. During an interview on 4/4/2024 at 1:14pm with the facility Marketing liaison, revealed she previously spoke with the hospital regarding Resident # 2. She reported she advised the hospital of behavioral problems the resident was having at the facility and felt that Resident # 2 needed psychiatric treatment services before he would return to the facility. During an interview on 4/4/2024 at 2:30pm with the DON, revealed the facility requested that the hospital referred Resident # 2 to a psychiatric facility for treatment. The DON stated the facility had received the psychiatric evaluation completed by the hospital, but stated the facility still wanted Resident # 2 referred for psychiatric treatment before he returned to the facility. Record review of facility census report dated 3/29/2024 reflected Resident # 2 was discharged on [DATE] and return expected. (continued on next page)

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F 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of hospital medical records dated 4/2/2024 and 4/3/2024 completed by psychiatric physician regarding Resident # 2 reflected the following: Resident #2 was assessed by psychiatric services and no psychiatric services were recommended. The psychiatric assessment record was provided to the facility and the facility refused to accept Resident # 2 back into the facility. Record review of facility bed hold and Return policy dated August 2021 reflected the following: Residents may return to and resume residence in the center after a hospitalization or therapeutic leave as outlined this policy. The resident will be permitted to return to an available bed in the location of the center that he or she previously resided.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44526 Based on observation, interview, and record review the facility failed to ensure adequate supervision and assistive devices to prevent accidents for Resident #1 of 7 residents reviewed for accidents and supervision. The facility failed to ensure Resident # 1 was free from accidents. Resident # 1 eloped from facility on 3/16/2024. Resident # 1 was located two blocks from that facility at a local convenient store that was on busy high traffic road. Resident #1 was found walking in the opposite direction of the facility, disoriented, and confused when facility RN A located her. This failure resulted in an identification of an (IJ) Immediate Jeopardy on 4/5/202 at 11:30am. The IJ Immediate Jeopardy template was provided to the ADM on 4/5/2024 at 11:30am. While the (IJ) Immediate Jeopardy was removed on 4/8/2024 at 12:00pm, the facility remained out of compliance at a scope of isolated and severity level of no actual harm because all staff had not been trained on the elopement process and missing resident procedure. This failure placed all residents at risk for accidents and harm. Findings included: On 4/5/2024 during an observation of the facility front door in the lobby area. The facility door was observed to be an egress door that alarmed after holding for 15 seconds. However, the alarm on the door was observed turned off, so the door opened freely without the alarm sounding. Visitors, staff, and residents were observed going in and out the door without the alarm sounding. During this observation there was no staff assigned to monitor the door for who was leaving or coming in the door. Resident #1 was a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses of Unspecified dementia (progressive or persistent loss of intellectual functioning, with impairment of memory and thinking), unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. During an interview on 4/4/2024 at 12:20pm with Resident #1 revealed that she eloped from the on 3/16/2024. Resident #1 stated she went to the store to get cigarettes. Resident #1 stated she went out the front door of the facility. Resident #1 stated there was no staff at the front desk when she went out the door. Resident # 1 stated she was scared and glad to be alive. Resident # 1 demonstrated how she put her hand up so that the cars would not hit her. Resident # 1 stated she was not going to do that anymore, she showed Surveyor #1 the alarm alert bracelet that had been placed on her ankle. Record review of Resident's #1 quarterly MDS dated [DATE], Section GG functioning reflected Resident #1 had a BIMS score of 2 which indicated severe impairment in cognitive thinking. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #1's care plan reflected prior to 3/20/2024, there was no elopement interventions. On 3/20/2024, after Resident # 1 had eloped from the facility the following care plan and interventions were put into place: Record review of Resident #1 care plan dated 3/20/2024 reflected the care plan had been updated with interventions to address the recent elopement which included the following: roam alert, assess roam alert 1x daily to ensure working properly, elopement assessment will be completed quarterly and with change in condition, document and report any exit seeking behaviors to nursing staff, verify placement of roam alert every shift, and if resident begins to wander provide comfort measures and basic needs for the resident. During an interview on 4/4/2024 at 4:51pm with FM #1, revealed Resident # 1 called her FM to get cigarettes. FM#1 stated she sent FM #2 to the facility to take Resident #1 to the store to purchase some cigarettes, FM#1 stated that was when the facility realized that Resident # 1 had eloped from the facility. FM#1 stated Resident #1 was located at the convenient store across the street walking in the opposite direction of the facility. During an interview on 4/4/2024 via phone at 4:28pm with RN # 1, revealed she was weekend nurse on the day of 3/16/2024. RN #1 stated she was notified by one of the CNA's that Resident # 1 was missing. She stated she and the other staff started searching for Resident # 1 inside and outside the building. RN #1 stated she got in the car with one of the workers and they drove up the street searching for Resident # 1. RN # 1 stated they located Resident # 1 at the convenient store walking in the opposite direction of the facility. She stated they returned Resident # 1 to the facility. RN # 1 stated a head-to-toe assessment was completed once returned and no injuries were noted. During an interview on 4/4/2024 at 5:02pm with the DON, she stated when Resident # 1 admitted to the facility that it was noted that she had wandering behaviors but had not exhibited any elopement or exit seeking behaviors. During an interview on 4/8/2024 at 10:35am with CNA A, revealed that on March 16, 2024, around 12:00pm she was working when Resident # 1 eloped from the facility. CNA A stated she had seen Resident # 1 earlier when the other residents went outside on a smoke break around 11:30am, but stated she came back in the facility. CNA A stated she thought Resident # 1 was displaying exit seeking behaviors early in the day. CNA A stated Resident # 1 continued to walk back and forth to the front door and stated Resident # 1 then sat down in the front by the front door. CNA A stated Resident #1 waited until there was no staff around and went out the front door. CNA A stated she advised the nurses that Resident # 1 had left the building when the FM showed up and was looking for Resident # 1. CNA A stated Resident #1 had never exhibited those behaviors before and stated she had never attempted to leave the facility, so she was surprised when she found out that Resident #1 had eloped. Record review of facility progress report dated 3/16/2024 at 1:44pm, completed by LVN A reflected, on 3/16/2024 the facility was unable to locate Resident #1 when FM came to facility looking for her. The progress report reflected Resident # 1 was found at the convenient store and returned to the facility around 1:00pm. Record review of facility elopement policy dated 9/1/2023, reflected the following: The facility will ensure that all residents who exhibit wandering behavior and or are at risk for elopement received adequate supervision to prevent accidents and receive care in accordance with their person-centered plan of service. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An (IJ) Immediate Jeopardy was identified on 4/5/2024 at 11:30am., due to the above failures. The ADM was notified on 4/5/2023. The ADM was provided with the (IJ) Immediate Jeopardy template on 4/5/2023 at 11:30am, and a Plan of Removal (POR) was requested. A Plan of Removal was first submitted by the ADM on 4/5/2024 at 1:17pm. The Plan of removal accepted on 4/7/2024 at 1:29pm Plan of Removal Date Initiated: 4/5/2024 and accepted on 4/7/2024 The facility must ensure each resident receives adequate supervision and assistance devices to prevent accidents. This failure placed Resident # 1 in danger and has the potential for other residents at risk of elopement from the facility. With a change in condition the facility could have performed another elopement risk assessment. Residents at risk for elopement could be affected by this deficient practice. Action: Residents residing outside of the secured unit will be educated over signing out prior to leaving the building via a council meeting and/or 1:1(person- to person contact) education. The center will place a sign on the door stating, residents must sign out prior to exiting the doors. The center will add in the admission paperwork, Residents wishing to leave the center must sign out. Person(s) Responsible: Administrator and/or Designee Date: 4/6/2024 by 1PM Action: The facility will place an alarm on the door. All staff will know to respond to the door when it alarms. When the door alarms and staff respond they will check the elopement binder to see if the resident attempting to leave is at risk for elopement and should not leave unattended. Additionally, the staff will check to ensure the resident has signed out to avoid an elopement situation. All of this will be educated on, and all staff will be educated prior to working their next shift. Person(s) Responsible: Administrator and/or Designee (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Date: 4/7/2024 by 12PM Action: The facility will review residents with change in condition in clinical meeting and the IDT (Interdisciplinary Team) and/or Doctor will determine what the change in condition will trigger, such a new elopement risk assessment being completed. If the change in condition occurs over the weekend the nurses will know to notify the MD and Director of Nursing and/or Assistant Director of Nursing immediately so assessments can be completed, and interventions can be put in place. Nurses will know to notify the DON and/or ADON & MD through education. Person(s) Responsible: Director of Nursing and/or Assistant Director of Nursing, and/or Designee Date: 4/6/2024 by 3PM Action: All residents received an elopement assessment. 24 people are at risk for elopement. No new elopement risks that were not previously identified. New admissions will receive an elopement assessment upon admission, quarterly, and as needed. Person(s) Responsible: Director of Nursing, Assistant Director of Nursing, and/or Designee Date: 4/5/2024 by 3PM Action: All residents triggering as an elopement risk will have a care plan and person-centered interventions in place. New admission that are identified as elopement risks in the above assessment will have a person-centered care plan initiated. Person(s) Responsible: Director of Nursing, Assistant Director of Nursing, MDS Coordinator, and/or Designee Date: 4/5/2024 by 3PM Action: All staff will be educated over wandering/elopement/missing resident. Test will be completed for comprehension. All staff will be educated prior to working their next shifts. Person(s) Responsible: Administrator and/or Designee Date: 4/5/2024 by 8PM Action: All doors was checked for functionality on 4/5/2024 with no concerns. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Door functionality was checked weekly and as needed by Maintenance Director and/or Designee. Person(s) Responsible: Maintenance Director and/or Designee Date 4/5/2024 by 3PM Action: Ad hoc QAPI (specifically done for Quality Assurance performance improvement) to review the template and plan to remove the immediacy. Person(s) Responsible: Administrator and/or Designee Date: 4/5/2024 by 3PM Monitoring on 4/8/2024 included the following: 9:10am - Entrance in facility. Observation made on 4/8/2024 at 9:10am- of the entry door, the facility has set up a desk that was always monitored by staff. There was a sign-in and out book for the resident if they are going out for fresh air, there is a separate book for those residents who are signing out leaving the property. Each book has a different sign -in and out sheet for each day. Each day they start a new sign-in and out sheet. Observation made on 4/8/2024 at 9:10am of sign posted on front of facility front door alerting all residents of the sign-in and out process. Observation of table set up at front door with sign-in and out books for fresh air and for leaving the facility property. On 4/8/2024 in an interview at 9:15am with AA who revealed she worked 8am- 5pm Monday through Friday. The AA stated she had been trained on the elopement process, stated the code was Pink if they had a missing resident. Stated she was would her immediate supervisor know, then they would start searching for the resident, notify the family or RP, the DON, administrator, and police. The AA stated she had also been trained on abuse/neglect and stated the administrator was the abuse/neglect coordinator. She stated the protocol to let her know immediately if she is not available the DON, and the next person in charge. Stated she had never seen or suspected abuse/neglect at this facility. On 4/8/2024 in an interview at 9:20am with RN B, revealed she worked the 6am to 2pm shift. RN b stated the facility had implemented the new sign-in and out sheet and the front door was going to be always monitored for now during all shifts. RN B stated she had been trained on abuse/neglect and the process. Stated she had also been trained on the elopement process and that the code was Pink if they had a missing resident. RN B stated all the residents had been in-serviced on the new sign-in and out process and stated some were upset that they had to do it that way now. Record review of the Elopement risk assessments completed from 4/6/2024-4/8/2024 for all residents- 83 assessments completed all residents assessed. Record review of the Competency elopement test dated 4/6/2024 -4/8/2024 completed by - 83 staff that covered the elopement process if a resident was missing the code to call and the steps to take. (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 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Wandering and Elopement policy in-service dated 4/5/24-completed by 100% of staff. Review of Emergency Procedure - Missing resident in-service -dated 4/5/2-24 - completed by 100% of staff. Review of the QAPI - dated 4/5/2024 addressed the elopement process and procedures. Observation made on 4/8/2024 at 11:00am- 1:00pm of alarm alerts going off through the day each time a resident with an alarm alert was within so many feet of the front door. During an interview on 4/8/2024 at 9:59am via phone with LVN A revealed she worked the 10pm- 6am shift. LVN A stated she had been trained on abuse/neglect. She stated the abuse/neglect coordinator was the Admin. and the protocol was to stop the abuse/neglect first ensure the safety of the resident and then make all notifications. LVN A stated she had also been trained on the elopement process and procedures. She stated the code for a missing resident was code Pink LVN A stated once the code Pink was called then a head count would be completed, and the search would be started by all staff. During an interview on 4/8/2024 at 10:31am with LVN C revealed she worked the 6am-2pm shift. LVN C stated she had been trained on abuse/neglect and the elopement process and procedure. She stated the abuse/neglect coordinator was the Admin. and the protocol was to stop the abuse/neglect first ensure the safety of the resident and then make all notifications. She stated the code for a missing resident was code Pink LVN C stated once the code Pink was called they would start search inside and outside the building and if the resident was still not able to be located then they would contact the police. During an interview on 4/8/2024 at 11:00am with the Maintenance supervisor, who stated he checked all exit doors to ensure working properly. He stated he was educated on the elopement process and that the elopement code was Pink. The Maintenance supervisor stated the abuse/neglect coordinator was the Admin. and he needed to report immediately if he saw or suspected abuse/neglect, he stated he had never seen or suspected abuse/ neglect at this facility. During an interview on 4/8/2024 at-11:10am with CNA D and CNA E revealed they both worked the 6am-2pm shift. CNA D and CNA E both stated they were trained on abuse/neglect and the elopement process and procedures. They stated the code when there was a missing resident was code Pink. They reported the process was to notify the nurse immediately, call the code Pink and everyone would start searching inside and outside the building looking for the missing resident. CNA D and CNA E reported that the abuse/neglect coordinator was the Admin., and the protocol was to report immediately to management if they saw or suspected abuse/neglect. They both stated that they had never seen or suspected abuse/neglect at this facility. During an interview on 4/8/2024 at 11:05am with Resident # 30 revealed he was educated on the sign-in and out process and stated he was started following the process. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455489	A. Building B. Wing	04/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Jeffrey Place Healthcare Center	820 Jeffrey Dr Waco, TX 76710

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 4/8/2024 at 11:20am with the DON revealed she and other designated staff completed elopement assessments on all residents. She stated all staff were trained on the elopement process and emergency process. Stated any agency staff will be in-serviced before starting their shift by herself or someone from nursing would in-service. The DON stated only facility staff were working at facility at this time. The DON stated the sign-out book was placed at the front door and the front door would be monitored 24/7 (24 hours 7 days a week) and the sign-in and out sheet would be changed daily. She stated all exit doors were checked to ensure they were functioning properly. The DON stated all residents were educated on the sign-in and out procedure moving forward. During an interview on 4/8/2024 at11:30am with Admin revealed, all staff were in-serviced over the elopement process and emergency procedures. She stated it was her expectation that staff follow all the steps when they had a missing resident. The Admin. stated all the residents were educated on the sign-in and out procedure, she stated a lot of the residents were upset that they had to do it this way. The admin stated it was her expectation that staff stop any abuse/ notify her or the DON immediately and ensure that the resident was safe. The Admin. stated they added the sign-in and out process to the admission packet for any new residents. During an interview on 4/8/2024 at 11:45am with the following residents who were on a smoke break outside included: Resident # 3, Resident # 8, Resident #9, and Resident # 10 who all stated they were educated on the sign-in and out policy. It was said they were required to sign-out when going out for fresh air on the front porch. They also stated that they had to check with a nurse prior to signing -out if they were going to the store or leaving the facility for any reason. Review of facility elopement policy undated reflected the following: The facility will ensure that residents who exhibit wandering behavior and /or are at risk for elopement receive adequate supervision to prevent accidents and receive care in accordance with their person-centered plan of care. On 4/8/2023 at 12:00pm., the ADM was informed the (IJ)immediate Jeopardy was removed. While the (IJ) Immediate Jeopardy was removed on 4/8/2024 at 12:00pm, the facility remained out of compliance at a scope of isolated and severity level of no actual harm because all staff had been trained on the elopement process and missing resident procedure.