STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455731	A. Building B. Wing	01/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Advanced Health & Rehab Center of Garland	1201 Colonel Drive Garland, TX 75043

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review the facility failed to develop and implement a comprehensive, person-centered care plan for each resident that included describing the services to be furnished to attain or maintain measurable objectives to meet the resident's highest practicable physical, mental, and psychosocial well-being, for one (Resident #1) of 3 residents reviewed for care plans, in that: Resident #1's care plan did not address her behaviors of wandering, intellectual disability, or her most recent elopement incident. This failure could affect residents by placing them at risk of not receiving individualized care and services to meet their needs. Record review of Resident face sheet dated 01/07/2026, reflected she was a 57 years-old, female that was admitted on [DATE]. Resident DX: Schizoaffective Disorder (a serious mental illness (psychosis like hallucinations/delusions) with a mood disorder (major depression or bipolar disorder), featuring periods of psychotic symptoms.) Diabetes Mellitus (changes in blood glucose levels), and Mild intellectual disabilities (deficits in intellectual functioning (like reasoning and problem-solving). Record review of Resident #1 admissions-MDS dated [DATE] by RN-M reflected in Section C-Cognition she had a BIMS score of 07 indicating the resident severely impaired cognitively.Section D for mood 0, D0700 sometimes socially isolates. Section GG Functional Status: Prior Functioning: Everyday Activities indicated Resident #1 required supervision and touching for toileting and bathing, eating, oral hygiene, and personal hygiene. Section I. indicated that the resident received treatment for Diabetes, for a non-pressure ulcer wound infection, DM, Schizophrenia, Asthma, Section Q: no referral to LCA (local contact agency) referral not wanted. Section V. CAA and Care Planning on 11/14/2025: Cognitive Loss/Dementia; 05. ADL Functioning/Rehab potential; Urinary incontinence; Fall protocols; Nutrition/diet; Dehydration; PU; and Psychotropic drug use.Record review of Resident #1 change in condition -MDS dated [DATE] reflected in Section C-Cognition she had a BIMS score of 07 indicating the resident severely impaired cognitively. Section I: reflected Resident #1 received treatment Diabetes Mellitus, Resident received treatment for Multidrug-Resistant Organism (MDRO referring to bacteria or other microbes resistant to multiple antibiotics, making infections difficult to treat.) wound was infected and she required IV. Record review of Resident #1 care plan dated 11/20/2025 reflected Resident has adjustment issues to admission. Learn to recognize/Help the residents identify their stressors. Intervene and remove stressors where possible. Provide the resident with as many situations as possible which give them the control over their environment & care delivery.Resident has a behavior problem as evidenced by schizoaffective disorder, bipolar type.Monitor behavior episodes and attempt to determine underlying cause. Consider location, time of day, person involved, and situations. Document behaviors and interventions in behavior log. Approach resident in a calm manner.Talk while providing cares, allow time for a response, and do not rush. Resident has a diagnosis of Diabetes.Resident takes Psychotropic medications and requires monitoring for changes in medications ordered.Discharge Plans, Resident is in (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the facility for long-term care placement as a result of a continued need for the services of skilled nursing staff as evidenced by an inability to provide selfcare and discharge planning is not needed. Either the family or the resident has requested that questions regarding return to the community only be asked on comprehensive assessments.resident has an ADL Self Care Performance Deficit and is at risk for not activities of daily living (ADLs) having their needs met in a timely manner. Performance Deficit and is at risk for non-skilled activities of daily living (ADLs) having their needs met in a timely manner . Resident #1's care plan did not address her behaviors of wandering, intellectual disability, or her most recent elopement incident 01/05/2026. Record review of Resident #1's care plan conference notes dated 01/09/2026 at 10:00 AM and completed by DON, RN. Resident #1's RP was in attendance, and other electronically signed disciplines' signatures included: SW, DOR, DM, DON, AD, and the Administrator. The plan reflected met with (Resident #1) (RP) regarding resident care going forward. (RP) stated that she was not qualified to say what should be done and wants the facility to do what we feel is best. (RP) stated that she did not want (Resident #1's) to be locked up like a prisoner. (RP) says if being on an unlocked unit does not work, then we can move (Resident #1's) to memory care. (RP) says that (Resident #1'ss) has issues with regulating her medications and taking them on a consistent basis. (RP) says that there was no wander guard on (Resident #1's) at the last facility. (RP) says that she is willing to accompany (Resident #1's) (RP) to all future appointments.Social services Interdisciplinary Care Plan meeting conducted with SW, DON, Administrator, Activity Director, Dietary Mgr., and resident's family ((RP) via telephone conference) in attendance. Updates provided on the residents' medications.Resident is here for long-term care. (RP) presented concerns regarding resident's placement in the facility and resident safety. states that resident is not believed to be exit seeking and does not have a history of elopement. All concerns raised by the family were addressed by both the DON, SW, and administrator. (Resident #1 will currently remain in long term care outside of memory care per family request. (RP) states they are currently pleased with care at the facility.no change in code status. Resident #1's care plan did not address her behaviors of wandering, intellectual disability, or her most recent elopement incident on 01/05/2026. Record review of consolidated physician's orders, dated 11/11/2025 reflected the following: Senior Psychiatric Care and/or Senior Psychological Care evaluation for treatment. Residents are unable to understand their rights. Record review of Resident #1's dated 11/11/2025 completed by MDSC-W reflected in Section C: C0092. Primary DX of Dementia. Is there evidence that dementia is the primary diagnosis for this individual? No.C0100 Mental illness. Is there evidence or an indicator this is an individual that has a Mental Illness? Yes, C0200. Intellectual Disability.Is their evidence or an indicator this is an individual that has an Intellectual Disability? Yes.C0300. Developmental Disability Is their evidence or indicators that this is an individual that has a Developmental Disability (Related Condition) other than an Intellectual Disability? No. During an interview on 01/09/2026 at 3:30 PM with MDSC, she stated that care plan updates and changes were conducted by the MDS nurses. MDSC said the resident care plan will not reflect the current treatments and care needs if not updated with changes. During an interview on 01/09/2026 at 4:05 PM, the DON stated that it was her expectation for resident care plans to accurately reflect their individual care needs. DON said it was the MDSC along with nursing staff's responsibility to monitor and communicate resident changes to be updated in the care plan. The DON did not address risks to the residents when they were not updated to reflect recent incidents. During an interview on 01/13/2025 at 4:50 PM with a CI, a staff member that wishes to remain anonymous stated that residents' safety and care are paramount for accurate treatment. CI said that the CI stated that Resident #1 had not eloped from the facility. During an interview with the (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	ADM on 11/23/2025 at 1:20 PM who stated it was her expectation that clinical staff follow the procedures for care plan monitoring under the supervision and guidance of the DON. During a second interview on 01/14/2026 6:22 PM with RP to clarify latest information added in the care conference notes on 01/09/2026 at 10:00 AM. Initially the RP did not recall the care plan conference. Then she reported that she received a call from the ADM and SW regarding Resident #1's care needs. The RP said the ADM assured her that Resident #1was being supervised by the staff and doing well in the general population. RP said she was told the staff will continue to monitor Resident #1. The RP said it was her understanding that the facility door alarms would sound off alerting staff that a resident was existing the building. RP said Resident #1 will wander off and should never have been allowed to go to her hospital appointment alone on 01/05/2026. The RP stated that the resident's previous placement was a locked memory unit, and the door alarms would sound, and this was not a wander-guard. The surveyor reviewed the previous interview stating that Resident #1 wore a wander guard at her previous placement. The RP stated that Resident #1 was not on a wander guard. Record review of the policy and procedure entitled Comprehensive Person-Centered Care Planning dated 3-2022; 12.2023 read in part .It is the policy of this facility that the interdisciplinary team (IDT) along with the resident, legal representative, and clinical staff develop a comprehensive person-centered care plan includes measurable objectives and timeframes to meet a resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment . to provide effective and person-centered care that meet professional

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	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** Based on interview and record review the facility failed to ensure each resident received adequate supervision and assistive devices to prevent accidents for one of five residents (Resident #1) reviewed for assistive devices and supervision. The facility failed to ensure Resident #1 was provided increased supervision, due to psychiatric issues, Mild intellectual disability, and Diabetes. In addition, she resided on the memory care unit prior to going to the appointment 01/05/2026. Resident #1 was not returned to the memory care unit upon returning from the elopement incident. An Immediate Jeopardy (IJ) situation was identified on 01/08/2026. While the IJ was removed on 01/09/2026, the facility remained out of compliance at a scope of isolated with a potential for more than minimal harm due to the facility's need to evaluate the effectiveness of the corrective systems.This failure could place all residents who requiring supervision in the community due to physical and/or cognitive deficits at risk for emotional decline, physical injury, and diminished quality of life due to a lack of safe accommodations. Resident #1 resided on the memory care unit prior to elopement on 01/05/2026, and on 01/07/2026 she was placed on the main hall after her elopement.Record review of Resident #1's face sheet, dated 01/07/2026, reflected a 57 years-old female who was admitted to the facility on [DATE]. Resident #1 had diagnoses which included: Schizoaffective Disorder (a serious mental illness (psychosis like hallucinations/delusions) with a mood disorder (major depression or bipolar disorder), featuring periods were psychotic symptoms) Diabetes Mellitus (changes in blood glucose levels) and Mild intellectual disabilities (deficits in intellectual functioning (like reasoning and problem-solving).Record review of Resident #1's admission Elopement assessment at admission, dated 11/12/2025 at 3:38 PM, by LVN-A, reflected she had a minimal risk for elopement.Record review of Resident #1's admissions MDS, dated [DATE], reflected a BIMS score of 07, which indicated the resident was severely impaired cognitively. Section D for mood 0, D0700 sometimes socially isolated. Section GG Functional Status: Prior Functioning: Everyday Activities indicated Resident #1 required supervision and touching for toileting and bathing, eating, oral hygiene, and personal hygiene. Section I. indicated the resident received treatment of Diabetes, for a non-pressure ulcer (damaged skin) wound infection, Diabetes Mellitus (unstable Blood sugars), Schizophrenia (chronic brain disorder), (Asthma (chronic lung disease), Section Q: no referral to LCA (local contact agency) referral not wanted. Section V. CAA and Care Planning on 11/14/2025: Cognitive Loss/Dementia; 05. ADL Functioning/Rehab potential; Urinary incontinence; Fall protocols; Nutrition/diet; Dehydration; PU; and Psychotropic drug use. MDS was signed on 11/14/2026 by RN-M. Record review of Resident #1 care plan, dated 11/20/2025, reflected Resident has adjustment issues to admission. Learn to recognize/Help the residents identify their stressors. Intervene and remove stressors where possible. Provide the resident with as many situations as possible which give them the control over their environment & care delivery.Resident has a behavior problem as evidenced by schizoaffective disorder, bipolar type.Monitor behavior episodes and attempt to determine underlying cause. Consider location, time of day, person involved, and situations. Document behaviors and interventions in behavior log. Approach resident in a calm manner.Talk while providing cares, allow time for a response, and do not rush. Resident has a diagnosis of Diabetes.DX of diabetes and at risk of unstable blood sugars and abnormal labs. Resident has a venous Stasis Ulcer (slow healing wound on the lower ankle) at risk of decreased circulation, infections, and pain.Resident takes Psychotropic medications and requires monitoring for changes in medications ordered.Discharge Plans, Resident is in the facility for long-term care placement as a result of a continued need for the services of skilled nursing staff as evidenced by an inability to provide selfcare and (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	discharge planning is not needed. Either the family or the resident has requested that questions regarding return to the community only be asked on comprehensive assessments. Record review of Resident #1 change in condition-MDS, dated [DATE], reflected a BIMS score of 07, which indicated the resident was severely impaired cognitively. Section I: reflected Resident #1 received treatment for Diabetes Mellitus. The resident received treatment for Multidrug-Resistant Organism (MDRO referring to bacteria or other microbes resistant to multiple antibiotics, making infections difficult to treat) wound was infected and she required IV. Record review of Resident #1's BIMS assessment, on 01/07/2026 at 9:59 AM, reflected a BIMS score of 13, which indicated the resident was cognitively intact. Record review of Resident #1's elopement assessment, dated 01/07/26 at 11:21 AM, by RNC reflected a minimal risk for elopement. Record review of Resident #1's elopement assessment, dated 01/07/26 at 11:21 AM by the DON, reflected she reflected she had a minimal risk for elopement. Record review of Resident #1's consolidated physician's orders, dated 11/11/2025 reflected the following:Psychiatric Care and/or Psychological Care evaluation for treatment. resident is unable to understand rights.referral for MD-L d/t abnormal vascular findings. assess for pain q shift.Venous wound to left lower leg.Record review of Resident #1's consolidated physician's orders, dated 11/12/2025 reflected an order for Insulin Lispro (1 Unit Dial) Subcutaneous SolutionPen-injector 100 UNIT/ML (Insulin Lispro) Inject as per sliding scale: if 0 - 150 = 0; 151 - 199 = 2; 200 - 249 = 4; 250 - 299 = 6; 300 - 349 = 8, subcutaneously before meals and at bedtime for diabetes for sugar greater than 350 give as ordered and notify MD/NP. Record review of Resident #1's PN nurse assessment notes, by RN-Y, dated 01/05/2026 at 10:43 AM, reflected the following information prior to departing the facility for her appointment. Vitals T-97.8, R-18, BP106/55, SpO2-97, no pain, no symptoms.Resident was alert to person, place, clear speech.Summary: Resident with prior diagnosis of cellulitis (bacterial skin infection) of the left lower limb, now resolved following completion of prescribed antibiotic therapy. Residents report no pain or discomfort. VSS. Will continue routine skin assessments, reinforce safety with mobility, and monitor any recurrence of symptoms. Record review of Resident #1's Progress Notes (MD/PN), dated 01/07/2026 at 2:05 PM, by the NP, History of present illness: Patient is being seen today to follow up on her status. Patients had an appointment earlier this week with a vascular surgeon. She is scheduled for a procedure (possible stent placement) on the 15th. At the time of this visit, the patient was tired. She recently bathed and is resting comfortably in bed. No signs of distress are noted. Patients continue with leg wounds that are slow to heal due to her vascular issues. She denies pain at this time. No shortness of breath or coughing is noted. Per staff with no further issues, continue to monitor. Respiratory: Clear to auscultation throughout without evidence of wheezing, Chronic or labored respirations. CV (cardiovascular): S1/S2 (abnormal heart sound), regular rate, regular rhythm without [NAME], rubs, or heaves. [NAME]. +4 Edema noted: Soft, non-tender, non-distance. Bowel sounds present and normal Musculo: No swelling, tenderness. Skin: chronic Wound noted to left lower leg Neuro: A&Ox2. Psychiatric: Patient is calm at this time.Record review of Resident #1's PN, dated 01/07/2026 at 7:12 AM, by LVN L reflected Note Text: At about 0712 this morning, this (LVN L) received patient from (Hospital) accompanied by the Administrator. She was awake and alert, respirations even and unlabored, no cough/congestion noted. Head to Toe skin assessment was initiated and completed. Upon assessment, no new skin changes were noted, but the venous wound of the left lower leg remains, wound care provided by the wound care nurse. V/S at this time were 116/73,98,20,97.8,18,97%, NP was aware. Shower was given and she tolerated it well, tolerated all meals and all due medication, needs attended to safety-maintained call light placed within reach, staff will continue to provide care.type 2 diabetes mellitus with unspecified complications Chronic/stable (unexpected duration) (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Most recent blood sugar was 119 mg/dL Continue insulin lispro via sliding scale Admit labs drawn on (11/18/2025) show an HA1c (blood test that shows the test measuring average blood sugar glucose)levels. of 5.5% Continue to monitor. chronic venous hypertension (idiopathic) (high pressure in leg veins) with ulcer of left lower extremity Chronic/ongoing Non healing wound present. Will have a vascular (blood vessel disease) procedure on 1/15 Continue to monitor. Record review of Resident #1's (PD) report completed by [NAME]-W at 01/05/2026 at 7:11 PM, reflected Missing persons from hospital. (Resident #1), reported by ADM and (DON) Incident Supplement (# number), incident record (#) On Monday (01/05/2026), at approximately 6:54 P.M. [NAME] were dispatched on a missing person at (Address).[NAME] F arrived on scene and spoke to (ADM name).(ADM) stated that a patient (B/F) from the (facility name) was transported by the facility to (hospital location) for a regular vascular appointment. The driver dropped (Resident #1) off at the door then left, when the driver returned, he could not locate (Resident #1) .(ADM) stated that they attempted to locate (Resident #1) but were unsuccessful. (ADM) stated that she called (PD) who told her to contact (PD).(DON) is a nurse at the facility and gave the following medical information.(Resident #1) suffers from type 2 diabetes (irregular sugar levels) and would need to eat or receive insulin (hormone that regulates blood sugar) every 6 to 8 hours to maintain healthy levels. (DON) stated that if (Resident #1) insulin dropped low she would enter a coma (deep unconsciousness) state.(Resident #1) also suffers from schizoaffective disorder, bipolar disorder, major depressive disorder and mild intellectual disability.(Resident #1) is approximately (height/weight) It is unknown what (Resident #1) was last wearing. (Resident #1) has no access to money, credit cards, or a cellphone.[NAME]-F NCIC check with (County) and (Resident #1) is not incarcerated. ([NAME]-F called (hospital) and (Resident #1) is not a patient there.Body camera footage is available.[NAME]-F narrative reflected the following.'01/05/2026 8:15 PM on Monday (01/052026), at approximately 6:54 P.M. (Police) were dispatched on a missing person at (facility address, city, and county) .01/05/2026 9:30 pm.' On 01/05/2026, Lt. spoke with (ADM) by phone. (ADM) informed Lt. that missing person (Resident #1) was taken to (MD-L) vascular office located at (address, city, sate) this morning for a checkup and was taken into a medical room and while waiting to be seen by the doctor, (Resident #1) decided to leave the location against the medical staff's advice. (ADM) stated she was informed of this by the medical staff at (MD-L) office and that this occurred between 12 noon and 1 p.m. The phone number to MD-L phone numbers, at the time of this supplement, (MD-L) office was closed. (ADM) also stated that she has been in contact with (Resident #1) RP: however, she has not heard from (Resident #1) and stated that (Resident #1) usually ends up in jail or the hospital because of her psychological history. At 9:47 AM, (MD-L) office provided the demographics, NE, office administrator. Appointments as at 10:00 AM as a new patient. Arrived at 9:56 AM (during vitals). No one came with the resident. Resident was scheduled for 12/15/2026. New patient. Procedure: office visit, ultra-sound of her leg.After the ultrasound, resident said she did not want to wait for results. In the exam room, she asked for a soda. (Resident #1) stated that she did not want to wait. Then she walked out the door. This was at 11:00 AM. The staff walked out to search. Contact campus security for hospitals. Report filed with TS-L reported to (PD). She had transportation to the office, and they were contacted. He called the facility to report that the resident was missing. After 3 hours of searching the officers were unable to find the resident. (PD) came and searched for 3 more hours and did not find her. Called the facility 3 times to see if the resident was back. Between 11:00 AM and 5:09 PM call. (DON) called the next day and stated the resident was missing and they needed the information from her visits.They (MD-L) were notified on 01/08/2026 was notified that the resident had been located on a bus. VS-N stated that while in the clinic she left to go to the rest room (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	several times. Driver (named). Aides for the facility arrived to search for the resident. Time is unknown. After an hour, the staff came.(Driver) told, the facility he saw the resident getting on the bus. Record review of the facility's provider investigation, dated 01/07/2026, reflected On 1/5/2026, (Resident #1) had a scheduled physician appointment at MD-L. At approximately 3:00 pm, office staff from MD-L contacted the facility and reported that (Resident #1) left the appointment Against Medical Advice (AMA) and could not be located. Staff from MD-L office later stated that (Resident #1) had been placed in a waiting room while awaiting test results, and when staff returned, she was no longer present. Facility staff immediately began attempts to locate (Resident #1). The (PD) was notified at approximately 6:00 p.m. on 01/5/2026, followed by notification to (Public Transportation) Police at 6:45 p.m. The Responsible Party (RP) was notified immediately and remained in constant communication with the Administrator throughout the incident. Facility staff conducted an active search of (address of appointments, utilizing both vehicle and foot patrols, for approximately six hours. On 01/07/2026 at approximately 3:30 a.m., (Resident #1) was located on a train by (Public Transportation) Police. The Administrator was notified and subsequently transported (Resident #1) from (Hospital) back to the facility. (Resident #1) signed hospital discharge paperwork prior to returning. Upon return, the Administrator interviewed (Resident #1) regarding her whereabouts. (Resident #1) stated, I just went to (city) and got me a piece of chicken and a soda. When asked how she traveled, she stated, By the train, I know how to get around there. (Resident #1) returned safely to the facility and remains in the facility at this time with no injuries or trending concerns observed. A head-to-toe assessment was completed by RN-O; Head-to-toe assessment completed with no injuries or adverse findings. Resident #1 requires no level of supervision, independently ambulatory, interview able, and compacity to make informed decisions. The resident was alert and oriented with X 3, schizoaffective disorder, bipolar. Facility investigation confirmed findings of missing person. Staff in-service initiated on 01/05/2026 at 1:00 PM. Post investigation actions from the provider included Safe Surveys completed with no trending concerns. Abuse and Neglect in-service completed.Missing person in-service completed. Interviews Completed. Record review of the facility's investigation safe surveys reflected Does staff treat you with dignity and respect? If not, tell me some examples of where the staff did not treat you with dignity and respect. 2. Have you ever been treated roughly by staff? 3. Do you ever feel afraid because of the way you or some other resident is treated? 4. as staff ever yelled or rude to you? If the answer is yes, ask who, when, what was said or what happened? 5. Do you feel safe and free of harm? 6. Are you aware of any threats of safety towards you or any other residents? and 7. Have you felt unsafe? The review determined that the reviewed residents had no concerns. Record review of ADM interview with Resident #1 on 01/07/2026 time unknown reflected Administrator asked (Resident #1) where she went on 1/5/2026, she stated I just went downtown and got me some food and a soda. Administrator asked how she got around, (Resident #1) stated I rode the train wherever I needed to go. (Resident #1)it's fine, I know that area pretty well. This resident then proceeded to state it's okay you didn't do anything wrong; you're doing the right thing. Record review of Resident #1's assessment on 01/07/2026 at 7:00 AM by LVN O. Head to toe assessment completed. No adverse findings. Record review of PD's follow up report, dated 01/06/2026 at 1:43 P.M., by MPD-I reflected on 01/6/2026, (MPD-I) confirmed that (Resident #1) is entered on NCIC/TCIC as a missing person. (MPD-I) contacted reporting party (ADM) who stated she has not seen or heard from (Resident #1) since approximately 1:00 P.M. on 01/05/2026.(ADM) provided the contact information for (Resident #1) (RP), (phone number). (MPD-I) reported that (Resident #1) will either end up being incarcerated or hospitalized . (MPD-I) contacted (hospital name) and confirmed that Resident #1 is not currently a patient and (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 Note: The nursing home is disputing this citation.	has not been admitted . (MPD-I) also checked (AIS) and there was no record of (Resident #1). RP notifiedMD notifiedPD report 2026E001710,Public Transportation police notifiedSafe surveys initiated Record review of the missing person Locator worksheet reflected in part.Whenever a staff member discovers a patient missing or hears an alarm that may indicate a patient has left the center, the staff member immediately notifies the Charge Nurse who initiates an initial internal or simultaneous external search of the immediate area to locate the patient. (Page overhead code for missing patient -Silver).2. The administrator or the charge nurse acts as search coordinator and coordinates and documents all search efforts. If an alarm has sounded or patient cannot be located an immediate face-to-face head count of all patients in the center is conducted The search coordinator organizes a thorough building search includes all rooms (locked and unlocked), bathrooms, closets, stairwells, elevators, storage spaces, walk-ins in the dietary department, maintenance, laundry, therapy, and roof areas. Potential hiding areas, e.g behind curtains, furniture, under beds, and behind doors or equipment are searched .4. The search coordinator, after confirming that a patient is missing, via the head count, immediately notifies the administrator and director of nursing, as well as all other department heads.The search coordinator interviews staff to determine where and when patient was last seen, customary routine, recent mood or behavioral disturbances, attire and physical condition. Identify environmental circumstances fire drill, change of shift, visitors departing, activity group departing, etc. Check working condition of alarm system.The search coordinator interviews staff to determine where and when patient was last seen, customary routine, recent mood or behavioral disturbances, attire and physical condition. Identify environmental circumstances fire drill, change of shift, visitors departing, activity group departing, etc. Check working condition of alarm system. Record review of the facilities policy titled Missing Resident Policy, dated 10/24/2022 Revised: 8/15/23reflected in part.This facility ensures 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 addressing the unique factors contributing to wandering or elopement risk.Definitions:Wandering is random or repetitive locomotion that may be goal-directed (e.g., the person appears to be searching for something such as an exit) or non-goal directed or aimless.Elopement occurs when a resident leaves the premises or a safe area without authorization (i.e., an order for discharge or leave of absence) and/or any necessary supervision to do so. Policy Explanation and Compliance Guidelines: 1. The facility is equipped with door locks/alarms to help avoid elopements .2. Staff are to be vigilant in responding to alarms in a timely manner .3. The facility shall establish and utilize a systematic approach to monitoring and managing residents at risk for elopement or unsafe wandering, including identification and assessment of risk, evaluation and analysis of hazards and risks, implementing interventions to reduce hazards and risks, and monitoring for effectiveness and modifying interventions when necessary .Monitoring and Managing Residents at Risk for Elopement or Unsafe Wandering .1. Residents will be assessed for risk of elopement and unsafe wandering upon admission, quarterly and as needed throughout their stay by the interdisciplinary care plan team 2. The interdisciplinary team will evaluate the unique factors contributing to risk in order to develop a person-centered care plan .3. Interventions to increase staff awareness of the resident's risk, modify the resident's behavior, or to minimize risks associated with hazards will be added to the resident's care plan and communicated to appropriate staff .4. Supervision will be provided to help prevent accidents or elopements .5. Charge nurses and unit managers will monitor the implementation of interventions, response to interventions, document and report to Administrator/Director of Nurses accordingly .6. The effectiveness of interventions will be evaluated, and changes will be made as (continued on next page)

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	455731	A. Building B. Wing	01/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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