STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455802	A. Building B. Wing	11/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Spanish Meadows	440 E Ruben Torres Blvd Brownsville, TX 78520

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 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** 45737 Based on observations, interviews, and record review the facility failed to ensure adequate supervision was provided to prevent accidents for 1 of 5 residents (R #1) reviewed for supervision. The facility failed to ensure R #1 received adequate supervision as R #1 eloped from the facility without anyone's knowledge on 11/21/24 between 2:30AM-3:00AM and was found by RT A when R #1 was reentering the facility. R #1 was out of the facility for approximately 8 minutes before RT A saw him reenter the facility. R#1 sustained an unwitnessed fall while out of the facility that resulted in a closed tripod fracture of left zygomaticomaxillary complex, a fracture of lateral orbital wall, left side, initial encounter for closed fracture, a fracture of left orbital floor, and a closed fracture of the left maxillary sinus. The non-compliance was identified as Past Non-Compliance. The Immediate Jeopardy (IJ) began on 11/21/24 and ended on 11/22/24. The facility corrected the non-compliance before the investigation began. This failure could lead to residents exiting the facility unattended which could result in injuries, hospitalization , or death. The findings included: Record review of R #1's face sheet dated 11/26/24 reflected a [AGE] year-old male, with an original admitted [DATE]. His diagnoses included cognitive communication deficit (difficulty with communication skills that stem from an underlying cognitive impairment), unspecified dementia (lose of cognitive functioning, a group of thinking, and social symptoms that interferes with daily functioning), unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, and Alzheimer's disease (a progressive disease that destroys memory and other important mental functions). Record review of R #1's admission Minimum Data Set (MDS) assessment dated [DATE] reflected R #1 had a BIMS score of 10 indicating moderate cognitive impairment. R#1's MDS reflected he required supervision or touching assistance for bed mobility, transfers, and when walking 50 feet with two turns. (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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of R #1's wandering risk scale signed on 11/21/24 by the ADON with an effective date of 11/20/24 at 10:46AM reflected R #1 was ambulatory, could communicate, could follow instructions, had no history of wandering, had no reported episodes of wandering in the past 3 months, and had medical diagnoses of dementia/cognitive impairment with a BIMS score of 12 or less. R #1's wandering risk scale score was 9, which indicated R #1 was at risk to wander. Record review of R #1's Care Plan initiated 11/20/24 reflected R #1 was at risk of wandering/elopement and included his 11/20/24 wandering risk scale score of 9 and category of At Risk to Wander, no specific initiation date was noted. Some of the interventions included were, staff to assist with re-orientation to room and facility, routine check every 2 hours and to locate the residents where abouts, providing verbal cues and reminding often, hourly checks, assure that staff/receptionist was aware the resident was at risk for elopement, if the resident was walking in a potentially unsafe area or situation, redirect to safer area, leave safe and reassess regularly, encourage activities to divert attention and meet needs for social, cognitive stimulation, and complete elopement risk, if the resident was missing from the facility, follow elopement protocol, and notify the MD and family immediately and document. Interventions did not have a specific initiation date noted. R #1's care plan reflected a focus of, I had a fall on 11/21/24 with no injuries at [SIC] related to (r/t) cognitive impairment, poor balance, and poor safety awareness. I fell outside while I was walking looking for my cousin. No specific initiation date was noted. R #1's interventions included sensor alarm to bed, transfer to emergency room for evaluation and treatment, bed to the lowest positioning, administration of pain medications, encouraging resident to call for assistance, notifying the MD and responsible party (RP) of any falls and injuries, call light within reach, taking vital signs with neuro checks protocol if head injury occurred, monitoring and reporting to the MD for signs and symptoms of pain, bruises, change in mental status, new onset of confusion, sleepiness, inability to maintain posture and agitation, and these interventions did not have a specific initiation date noted. Record review of R #1's progress notes documented on 11/20/24 reflected R #1 seemed confused, disoriented, and unaware of where he was. Record review of R#1's change in condition dated 11/21/24 at 2:59am stated R #1 had an unwitnessed fall with documentation of an abrasion/skin tear discoloration to left elbow, abrasion/skin tear to back of left hand, abrasions to front of left knee, left cheek discoloration/abrasion, left eyebrow contusion (bruise), abrasion, discoloration, and left eye discoloration. Record review of R# 1's progress notes dated 11/21/24 at 3:00am written by LVN B reflected R #1 had an unwitnessed fall and was noted outside in back of the facility next to the dumpster. R #1 was found with abrasions to the left knee, left elbow, left cheek, nodule to left brow, discoloration under left eye with swelling, discoloration noted to left eye and left arm, with resident stating that his foot got caught (dragged) and he lost his balance falling. Progress note stated R #1 was confused and forgetful at times and was looking for his cousin's house. Notifications were made to the MD, the DON, the on call manager, and R #1's family. R #1 was sent to the hospital. Record review of the hospital visit summary for R #1 stated patient arrived to hospital on 11/21/24 and had a diagnosis of, closed tripod fracture of left zygomaticomaxillary complex, fracture of lateral orbital wall, left side, initial encounter for closed fracture, fracture of left orbital floor, and closed fracture of the left maxillary sinus. (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 on 11/22/24 at 1:54pm and 2:31pm of the facility video surveillance footage reflected R #1 exited the double fire door exit at the end of his hall and was noted entering the service hall approximately 8 minutes later when found by RT A. Time stamped date and time on videos reviewed were not accurate. Record review of R #1's progress note dated 11/21/24 at 4:26pm by the Social Worker reflected R #1's photo and face sheet had been added to the elopement binder in anticipation of his return to the facility. Record review of R #1's progress notes dated 11/21/24 at 9:00pm reflected R #1 returned to facility from the hospital and was unaware he had been at the hospital for a fall. Report received from the emergency room to the facility nurse communicated R #1 had a left eye blow out orbital fracture. Record review of R #'1's progress notes dated 11/22/24 at 1:57pm by the Social Worker reflected the facility had a care meeting with R #1's family on 11/22/24. R #1's family was explained 3 options, 1.) R #1 could stay at facility and would continue to be monitored 2.) R #1 can be referred to a facility that has a wander guard system in place or 3.) R #1 could be referred to a facility that had a secured unit. Family for R #1 stated they preferred for R #1 to be referred to another facility. Record review of R# 1's progress noted dated 11/22/24 at 2:24pm by the Social Worker reflected she had reached out to 6 facilities to gather information regarding, VA contracts, wander guard systems, secure units, and male beds. Record Review of TULIP (HHSC online incident reporting application) on 11/22/24 at 12:00pm revealed a self-report was submitted by the facility and received on 11/21/24 at 10:29AM. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview with the DON on 11/22/24 at 1:09pm the DON stated R #1 admitted to the facility on [DATE] and had only been in the facility about a day. He stated he was not aware that R #1 was a wanderer until time went on and they noticed R #1 would walk out of his room and wandered the hallway but was not exit seeking. The DON stated R #1's nurse at the time of R #1's exit from the facility on 11/21/24 was LVN B. He stated the last person to round on R #1 was CNA D at around 2am. The DON stated they reviewed surveillance footage and saw that R #1 exited through the 31-40 hallway door and entered the facility through the service door in the back hallway. The DON stated a respiratory therapist was in the service hall and saw R #1 in the service hall at around 2:30am/3:00am. The DON stated staff completed a head to toe and noted skin tears and open areas to his left, arm, forehead, and left side of his face. The DON stated R #1's family was notified and wanted him sent out for evaluation. The DON stated at the hospital he was treated for a facial maxillary fracture. The DON stated prior to R #1 exiting the facility on 11/21/24, the only assessments completed on R #1 were their regular admission packet and nursing assessments. The DON stated a wandering assessment was completed on R #1 the day of the incident, after the incident. The DON stated the doors R #1 exited from had a continuous alarm that went off when the doors were opened. The DON stated through their investigation they gathered the nurses did not hear any alarm go off. The DON stated the following day they checked the doors and stated they were up and running with nothing identified not working. The DON stated he thought the staff followed all the procedures that they needed to at that time and did not think there was any failure by staff. The DON stated in response to the incident when R #1 exited the building they identified 4 other residents at risk for wandering, which were placed on hourly checks along with R #1 who was placed on 15-minute visual checks. The DON stated they had added keypad locks to the service entry doors and were doing hourly monitoring on the fire exits to ensure all fire exits were activated. The DON stated additionally in R #1's hall they had added an additional chime door alarm to both the service hall door and the double fire door exit on that hall. The DON stated they had also added a chime alarm to the front entry door and had added a staff member to be in the service hall between the hours of 7pm and 7am. The DON stated he had provided in services to staff. The DON provided copy of in services and topics covered and resident/door monitoring. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview with LVN B on 11/22/24 at 4:32pm, she stated she was R #1's nurse from 10:00pm on 11/20/24 until 6am on 11/21/24. LVN B stated R #1 was a brand-new admission and had been completing his first 24 hours in the building. LVN B stated R #1 was wandering but was not exit seeking. LVN B stated R #1 was confused looking for his cousin and was wandering the halls and rooms and was reoriented by staff to go back to his room. LVN B stated this had been constant since he was admitted . LVN B stated because R #1 was not exit seeking and they did not have any specific timeline/monitoring in place before the incident, when he exited the building, aside from random check ins with him and when they saw him in the hallway. LVN B stated R #1 was last rounded by CNA D when he was asked to take R #1 back to his room to get dressed because R #1 was getting undressed and wandering the hall. LVN B stated R #1 needed to use the restroom and CNA D took him to the toilet and exited the room to give R #1 privacy because he was able to go to the restroom on his own. LVN B stated R #1 went out through the double doors or the loading dock doors and stated she was not sure but knows that one of the respiratory therapists saw R #1 outside. LVN B stated R #1 was taken to his room where she asked what happened, and completed a head-to-toe assessment, took vitals, contacted the DON, the responsible party for R #1, on call manager, and the MD. LVN B stated R #1 stated his foot got caught on something and he tripped and fell and then got up and continued walking looking for his cousin's house. LVN B stated R #1 was not very reliable. LVN B stated when she assessed R #1, he had multiple abrasions to his left knee, elbow, hand, cheek, and eyebrow along with a nodule and contusion to left eyebrow and underneath left eye and left arm. She stated she could not identify if it was new or not because R #1 admitted with some bruising from the hospital admission. LVN B stated she explained injuries, his head injury, and that R #1 was on blood thinners to the MD and he ordered to send R #1 out. LVN B stated when R #1 returned from the hospital he had an orbital fracture. LVN B stated when R #1 was found she and LVN C went to test the door alarm in R #1's hall and noted there was no alarm that sounded. LVN B stated the alarm was deactivated and it was indicated by no alarm sounding and the light being off on the panel at the nurse's station. LVN B stated she was not aware of any issues with the door alarms recently. She stated there was construction going on at the facility and was not familiar with who deactivated the alarm or reactivated it. She stated she was not told that the construction crew had left. LVN B stated when the exit doors needed to be used the nurses had to be notified and had to be told when they were done using the exit doors because they were responsible for activating the door alarm. LVN B stated she did not see any fault on the nurse but stated they were ultimately responsible for the residents. LVN B stated in response to the incident when R #1 exited the building they had added a staff member to be sitting at the back doors to monitor the service hallway. R #1 was placed on 15-minute visual checks, and they were having to check the doors and alarms hourly. LVN B stated they also added chirping alarms to the service hall door and back double doors. LVN B stated not monitoring residents who were at risk for elopement and not monitoring door alarms to ensure they were functioning and activated could negatively impact residents because they could leave the building and get lost, have an accident, or get injured. During an interview with the ADON on 11/22/24 at 7:45pm she stated she completed wandering/elopement assessments on all residents and had identified 4 residents at risks (R #1, R #2, R #3, and R #5). These residents were updated in the wandering/elopement binders located at the nurses stations and the front desk and were being monitored hourly. The ADON stated she added R #4 to the list to be cautious because although he was not a wandering risk, he did enjoy walking around the outside of facility. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview with LVN C on 11/25/24 at 10:30pm, she stated she was not R #1's nurse but did work from 10:00pm on 11/20/24 until 6am on 11/21/24. LVN C stated R #1 would wander in the hall and staff would redirect him back to his room but never stated he wanted to leave and never tried to leave. LVN C stated R #1 was last rounded by an aide at around 2:30am who took him to the restroom. LVN C stated at that time, R #1 was just mumbling to himself and talking about Vietnam. LVN C stated after the camera footage was reviewed, they identified that R #1 exited through the back doors in his hall. LVN C stated the respiratory therapist found R #1 between 2:00am-3:00am. LVN C stated R #1 didn't say why he left but did state that he tripped and fell on the cement and that was how he got the scrapes on his knee, elbow, wrist, and around and under his eye. LVN C stated R #1 was assessed, the MD was notified, and R #1 was sent out. LVN C stated she knew they did a CT scan at the hospital and thought everything had been found to be okay. LVN B stated when R #1 was found she and LVN C went to test the door alarm in R #1's hall and noted there was no alarm that sounded. LVN C stated her and LVN B tested the door alarm on R#1's hall and realized that it was not on because no alarm sounded, and the light was off on the panel. LVN C stated they reset the door alarm and activated it. LVN C stated she was not aware of any issues with the door alarms recently. She stated there was construction going on in the back all week at the facility, so the alarms were turned off. LVN C stated the nurses were responsible for making sure the alarms were on and stated the construction workers should have told them when they left, so the nurses could have turned the alarms back on. LVN C stated anyone needing to use the exit doors should notify the nurses and should let them know when they were done. LVN C stated it was miscommunication because the construction crew never told them they left, so the nurses never turned the alarm back on. LVN C stated she did not know who deactivated the door alarm and stated the facility failed to ensure the fire door alarm was activated in the 31-40 hall. LVN C was aware of how to check that the door alarms were activated. LVN C stated this was her first night back since the incident. She stated she had been trained over door alarm activation, both at the start of her shift and previously over the phone by the DON, who also went over added door alarms, a new worker that would be in in the back hall monitoring, and R #1's nurses monitoring him every 15 minutes. LVN C stated not monitoring residents who were at risk for elopement and not monitoring door alarms to ensure they were functioning and activated could negatively impact residents because they could leave or get injured without their knowledge. During an interview with RT A on 11/26/24 at 12:39am, he stated he worked from 10pm on 11/20/22 to 6am on 11/21/24. RT A stated R #1 was last rounded at around 2am and 4am, when an aide and nurse took R #1 to the restroom, and the nurse walked away but the aide stayed in the hallway. RT A stated at that time R #1 was fine. RT A stated about 30 minutes later he went to heat up his coffee in the back hall between 2AM and 4AM when he saw R #1 enter the service hall and appeared dirty and with some blood on the side of his head. RT A stated he asked R #1 who seemed confused what had happened, and R #1 stated he had tried to go down the stairs and he tripped, he fell on his side, he got an abrasion to one side of his temple, and a scrape on one knee and shoulder. RT A stated R #1 was assessed and LVN B took over. RT A stated he was not aware of R #1 wandering. RT A stated he did not hear any alarm between 2:30am and 3:00am. RT A stated there had not been any issues with the door alarm and stated they were good at checking the doors to be locked with activated alarms. RT A stated not monitoring residents who were at risk for elopement and not monitoring door alarms to ensure they were functioning and activated could negatively impact residents because they could leave the facility if the alarm was not activated and could get an injury from a fall or even worse. RT A stated the residents would be placed in jeopardy if they left the facility. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview with CNA D on 11/26/24 at 1:54am, he stated he worked from 10:00pm on 11/20/24 until 6am on 11/21/24. CNA D stated he rounded on R #1 at around 2am when R #1 was talking about random things, praying, and walking around his room. CNA D stated R #1 was taken to the restroom and then taken to bed. CNA D exited the room and went to work with another resident. CNA D stated he had not heard R #1 state that he wanted to leave the facility and he had only seen R #1 up in his room. CNA D stated he was not sure how R #1 got outside, and he understood he went through the emergency doors. CNA D stated he did not hear any alarms between 2:30am and 3AM. CNA D stated he did not know if there were any issues with the activation of the door alarms recently. CNA D stated the nurses were responsible for turning the alarm off and on. CNA D stated he did not know who deactivated the alarm the night R #1 exited the building. CNA D stated he did not know if staff failed to ensure the fire door alarm was activated for hall 31-40 on 11/21/24 between 2:30am-3:00am. CNA D stated after the incident the nurses now had to sign off when checking the doors. CNA D stated not monitoring residents who were at risk for elopement and not monitoring door alarms to ensure they were functioning and activated could negatively impact residents because they can get out. During a follow up interview on 11/26/24 at 5:42pm the DON stated the nurses, LVN B and LVN C were responsible for ensuring the door alarms were activated. The DON stated they should have been monitoring/checking if the door alarm was activated on 11/21/24 but was not able to say why they had not. The DON stated both LVN B and LVN C were aware of the procedures for the door alarms and had both been trained prior to the incident with R #1 but was unsure by who or when. The DON stated not monitoring residents who were at risk for elopement and not monitoring door alarms to ensure they were functioning and activated could negatively impact residents by having a similar situation occur with doors left unarmed and unattended and residents could wander out through the exit without staff being aware. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a follow up interview with the ADON on 11/26/24 at 6:50pm, she stated LVN B was R #1's nurse and CNA D was R #1's CNA from 10:00pm on 11/20/24 until 6am on 11/21/24. The ADON stated she was not sure who rounded on R #1 last, as the DON had conducted those interviews. The ADON stated R #1 was a brand-new patient and had not had a history of wandering and had not stated he wanted to leave the facility. The ADON stated she was told R #1 went through the fire exit doors to get outside and she was not aware of any staff hearing an alarm on 11/21/24 between 2:30am and 3:00am. The ADON stated a respiratory therapist found R #1 when he walked back into the facility service hall. The ADON stated that as per staff, R #1 voiced he was looking for his cousin. The ADON stated staff were not aware that R #1 had exited the facility. The ADON stated R #1 was assessed, and the MD was notified and gave orders to send R #1 out to the hospital. The ADON stated R #1 had minor bruising and skin tears. The ADON stated the hospital finding was a facial fracture. The ADON stated she was not aware of any recent issues with the fire door alarm activation. The ADON stated in order to activate the door alarm the light would have to be on and the alarm should sound when the door was opened. The ADON stated to deactivate the alarm you would need to go back physically and press the button on the panel and reset it to turn off the alarm. The ADON stated the nurses were responsible for ensuring the door alarms were activated. The ADON stated the nursing staff, LVN B and LVN C were responsible for monitoring the door alarms to ensure they were activated on 11/21/24 and should have been but she did not know why they did not. The ADON stated prior to the incident with R #1 staff had just been verbally trained on how to monitor the door alarms to ensure they were activated. The ADON stated in response to the incident the facility implemented 15 minutes checks for R #1, 1-hour checks for any at risk residents, hourly door checks, in-services over elopement policy, wander/elopement binder, and assessing 100% of residents for wandering risk. The ADON stated they also added a bed alarm to R #1's bed, in-serviced staff on deactivation and activation of the fire door alarms and who was responsible, added chime alarms on service doors, added keypad lock to service doors, and placed a staff member in the service hall from 7pm -7am. The ADON stated the failure was staff did not make sure the alarm was on. The ADON stated not monitoring residents who were at risk for elopement and not monitoring door alarms to ensure they were functioning and activated could negatively impact residents because they could exit the building without staff being aware and could cause a serious injury. Record review of R #1's physician order dated 11/21/24 at 10:49pm reflected R #1 was placed on hourly checks. Record review of R #1's November medication administration record (MAR) reflected R # 1 was being checked hourly. Record review of additional sampled residents R #2, R #3, R #4, and R #5 reflected wandering assessments had been completed on 01/21/24 with R #2, R #3, and R #5 identified as at risk for wandering and were placed on hourly checks. Record review of R #2, R #3, and R #5's November medication administration record (MAR) reflected they were being checked hourly. Record review of R #1's physician order dated 11/22/24 at 1:53pm reflected R #1 had a sensor pad added to bed due to poor safety awareness and history of falls. Observation on 11/22/24 at 1:32pm confirmed a keypad lock had been added to the service hall door located in R #1's hall in addition to a chime alarm present on both the service hall door and the double fire exit doors. (continued on next page)

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Observation and test of north side doors on 11/22/24 at 3:10pm confirmed 3 of 3 doors had working alarms that sounded when opened and continued when closed until staff pressed button on panel. Observation and test of north side doors on 11/22/24 at 3:15pm confirmed 3 of 3 doors had working alarms that sounded when opened and continued when closed until staff pressed button on panel. Observation of R #1 on 11/22/24 at 5:43pm confirmed he had a bed sensor pad that would trigger sound notification when resident would move off it. Observation and record review on 11/22/24 at 7:35pm of wander/elopement binders located at the nurses' station and front desk reflected they had been updated to include residents identified at risk for wandering/elopement. Face sheets and pictures of at-risk residents were noted in binders. Record review of R #1's 15-minute checks reflected staff started monitoring him at 9:15PM on 11/21/24 and had completed all checks up until current time of 5:15pm on 11/26/24, when copies of 15-minute checks were submitted to Surveyor E. Record review of north and south side hourly door checks reflected staff started hourly checks on 11/22/24 at 7:00AM and had completed all checks up until current time of 5:15pm on 11/26/24 when copies of the hourly door checks were submitted to Surveyor E. Record review of in-service dated 11/21/24 reflected staff from all departments were in-serviced over hourly checks for fire exit doors activation, 15-minute interval checks for R #1 and hourly checks for any resident at risk for wandering, wandering/elopement binder placement, and policy and procedures for elopement and wandering. 18 staff members from various shifts included 5 LVNs, 4 CNAs', 2 respiratory therapists, 1 therapy staff, 1 housekeeping staff, 1 dietary staff, and 4 leadership staff including the Maintenance Director, DON, ADON and Administrator were interviewed between 11/22/24 and 11/26/24 and recalled and understood the recent Inservice/training. During an interview on 11/26/24 at 7:53pm with the Regional Nurse she stated there was only 9 full time staff members that had not been trained and had not yet worked since the incident. The Regional Nurse stated they were going to be working on calling them. Record review of the wandering and elopement policy with a revised date of March 2019 stated, The facility will identify residents who are at risk of unsafe wandering and strive to prevent harm while maintaining the least restrictive environment for residents. Record review of the exit and means of egress policy dated January 2019 stated under the section, Policy Interpretation and Implementation the following verbiage, 7. Exit doors will remain unlocked at all times. Residents are never denied access to unlocked exits. During an interview with the Administrator on 11/26/24 at 7:33pm he stated the closest policy they had related to door alarms was the Exits or Means of Egress policy that was provided.