STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465059	A. Building B. Wing	06/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission at Richfield Nursing and Rehabilitation	163 East 1000 North Richfield, UT 84701

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 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	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** Based on observation, interview, and record review, the facility did not ensure that residents had the right to be free from abuse, neglect, misappropriation of property, and exploitation. Specifically, for 1 out of 36 sampled residents, a resident required an extensive two-person assist with brief changes and a Certified Nursing Assistant changed the resident's brief alone. Additionally, during the brief change the resident rolled out of bed and sustained a laceration and femur fracture. This resulted in a finding of harm. Resident identifier: 46.Findings included:Resident 46 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included chronic obstructive pulmonary disease, morbid (severe) obesity due to excessive calories, generalized muscle weakness, muscle wasting and atrophy, difficulty in walking, other lack of coordination, and other reduced mobility.A review of the facility's exhibit 358 reported to the State Survey Agency revealed an incident dated 5/8/24, CNA [Certified Nursing Assistant] providing peri [perineal] care when resident rolled herself using her grab bar. The resident rolled out of bed landing on her knees and still holding the grab bar. Staff laid resident down and upon assessment found a laceration to the left knee with apparent adipose tissue exposed. Resident complained of extreme pain to left leg. EMS [Emergency Medical Services] called at 0836 [8:36 AM] and transferred to ER [Emergency Room]. Resident is often a 1 person assist for brief changes.Resident 46's Minimum Data Set (MDS) dated [DATE] revealed that resident 46 was dependent on toileting, dependent on lower body dressing, dependent on personal hygiene, dependent on rolling left and right, dependent on sitting to lying, dependent on lying to sitting, and the resident refused a toilet transfer. Dependent indicated that the helper does all of the effort. The resident does none of the effort to complete the activity or the assistance of 2 or more helpers was required for the resident to complete the activity.Resident 46 had a care plan focus initiated on 6/2/23 with a revision on 6/9/23 which documented that resident 46 had impaired physical mobility. Interventions initiated on 6/2/23 included providing supportive care, assistance with mobility as needed. Document assistance as needed. A care plan focus initiated on 6/2/23 with a revision on 6/9/23 documented that resident 46 was at risk for falls. Interventions included that resident 46 prioritized her safety, independence, and comfort through responsive, proactive support. Staff were to ensure that resident 46's call light was always within reach for prompt assistance and confirm that essential items were accessible before leaving her room. A review of resident 46's progress notes revealed:a. On 4/20/24 at 4:39 PM, a nursing note documented, The resident was very sob [shortness of breath] on Thursday when I was here late. I turned up her O2 [oxygen] to 4 liters and gave her some mucinex.At about 3:30 pm she asked the CNA to get me because she felt like she couldn't catch her breath.The resident weighs 300 pounds and was unable to help with a transfer, she was still in respiratory distress and I did not feel that using the hoyer to lift her would be safe. We tried to roll her in her bed and waited for another CNA to arrive. We decided that the 3 of us were not strong enough to push her on the uneven ground of the parking lot. Dispatch sent an officer to help us but he was also unsure of being about [sic] to get her across the parking lot.b. On 4/23/24 at 12:42 PM, an advanced clinical admission note documented, .Functional : 0 Wheelchair (manual or electric).Able to move all extremities. Upper (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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(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 - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	extremity ROM [range of motion] : No impairment. Lower extremity ROM: No impairment. Gait is unsteady. Balance is poor. Resident prefers self activity. Resident is bedfast all or most of the time. Functional Note: Patient is a 2 person total assist for transfers (with the hoyer), brief changes, upper and lower body dressing; 1 person total assist for putting on footwear, WC [wheelchair] mobility; 1 person setup assist for meals.c. On 5/1/24 at 10:42 PM, a nursing progress note documented, WEEKLY: The resident was readmitted to the facility with RSV [respiratory syncytial virus] and was placed on droplet precautions upon arrival to our facility. The resident also has chronic afib [atrial fibrillation], COPD [chronic obstructive pulmonary disease], HTN [hypertension], HLD [hyperlipidemia], AKF [acute kidney failure] and morbid obesity. She requires two person extensive assist for transferring with the Hoyer lift. She is incontinent of both bowel and bladder. She wears a brief for protection. She is also a two person extensive assist for all brief changes. She requires extensive, one person assist, with all other ADLs [Activities of Daily Living].d. On 5/8/24 at 9:30 AM, a nursing progress note documented, Resident sustained a witnessed fall around 0830 [8:30 AM] this morning. Resident is alert and oriented and at baseline prior to fall. Staff was assisting with a brief change when the resident rolled herself onto her left side using the grab bar. Resident over turned herself and rolled out of bed. resident landed on her knees and was still holding on to the grab bar. Staff yelled for assistance this nurse responded at that time. Cna and Nurse repositioned the resident to a supine position. Nurse noted a laceration to the left knee with adipose tissue exposed. resident complaining of extreme pain to left leg. resident stated she felt like she was going to pass out. Additional nursing staff responded and EMS called to assist. Resident assisted to gurney via hoyer lift and transferred to emergency department. A review of the facility's exhibit 359 revealed that resident 46 prior to the incident was assessed at her baseline, alert and oriented between 7:00 AM and 8:10 AM. At approximately 8:30 AM CNA 3 assisted resident 46 with a brief change but the resident rolled out of bed while using the grab bar and landed on her knees. Responding staff found resident 46 sitting against the bed and heard resident 46 complain of extreme pain and feeling of light headedness. Nursing staff observed a laceration on resident 46 above the left knee with exposed adipose tissue, bruising on both knees and swelling, alongside a pool of blood on the floor. Staff placed resident 46 in a supine position, obtained a physician's order for transfer, and utilized a Hoyer lift to transfer resident 46 to a gurney for EMS transport to the emergency department. Resident 46 was admitted to the hospital with a femur fracture and a laceration.On 6/10/26 at 3:33 PM, an interview was conducted with the Regional Nurse Consultant (RNC). The RNC stated resident 46's care plan had how she transferred and if resident 46 used grab bars to assist with mobility. The RNC stated that if resident 46 used a Hoyer lift then she would need two people for assistance.On 6/10/26 at 3:51 PM, a follow-up interview was conducted with the RNC. The RNC stated that she was able to get into contact with the previous facility administrator. The previous facility administrator stated that it was the facility policy at the time to not document in resident's care plans what type of assistance was needed for company liability reasons. The RNC stated that she was unable to find any documentation that stated that resident 46 was only a 1 person assist with brief changes.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review it was determined, for 1 of 36 sampled residents, that the facility did not ensure that residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Specifically, a resident's colostomy care was not provided timely and the resident experienced pain, redness, and tearfulness. Resident identifiers: 48.Findings included:Resident 48 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included progressive multiple sclerosis, chronic obstructive pulmonary disease, kidney disease stage 4, chronic pain syndrome, edema and functional quadriplegia. On 6/9/26 a facility reported incident dated 11/11/25 was reviewed and documented that resident 48 claimed her colostomy bag failed and she was left sitting in her bodily fluids for an extended amount of time which caused her discomfort. Staff interviews documented the resident did ask staff for assistance with her colostomy care and had to wait 30 minutes for assistance. The staff reported they were in the hallway when resident 48 called for help but they were taking other residents to the dining room when resident 48 requested assistance. The staff reported they did not go back to check on resident 48 until 30 minutes had passed. The staff reported at that time the resident was crying, expressed pain, and redness was observed in her groin and buttock areas. The finding of the investigation into neglect came back inconclusive. The form documented the investigation conclusion as, It is obvious that there was not any intention of abuse, the resident was not forgotten or left for an incredible amount of time. Communication and lack of understanding of priorities led to this incident with positive learning and understanding gained through this experience. A Minimum Data Set (MDS) dated [DATE] documented resident 48 was dependent on staff for her toileting hygiene needs. Resident 48 was documented as having a Brief Interview of Mental Status (BIMS) score of 14 which determined she was cognitively intact. Resident 48's medical record documented in the Special Instructions section, [resident 48] required total 2-person dependence with ADL's [activities of daily living] [resident 48] transfers by lift. She has a colostomy, urostomy and nephrostomy which requires assistance with emptying and changing from staff .A care plan focus revised on 10/31/25 documented resident 48 utilized ostomies including colostomy, urostomy, and nephrostomy. With a goal initiated on 12/9/24 that resident 48 would be/remain free from ostomy related trauma. With interventions which included, monitor, document and report any pain/discomfort due to ostomy. Report to the nurse and/or medical provider and adjust the plan of care as directed. Monitor, document and report s/sx (sign/symptom) of complications due to ostomy: i.e. (in other words) skin breakdown, change in frequency/consistency of stool, odor, etc. Ostomy care every shift. A physician order dated 10/30/25 documented, colostomy care Q [every] shift. Change colostomy wafer and bag Q 3 days and prn [as needed].Resident 48's November 2025 medication administration record (MAR) documented, resident 48's colostomy was not changed on 11/11/25, the day of the incident, but was recorded as being changed on 11/12/25. Progress notes reviewed and no documentation was found in regard to the colostomy incident. Skin checks were completed daily on 11/11/25, 11/12/25 and 11/13/25 and no skin changes were documented. On 6/10/26 at 12:43 PM, an interview was conducted with Certified Nursing Assistant (CNA) 2 who was involved in the incident and CNA 2 stated resident 48 was compliant with most cares and needed assistance with all cares. CNA 2 stated resident 48 was a 2 person extensive assist with a Hoyer lift used for transfers. CNA 2 stated resident 48's colostomy broke and CNA 2 and an unknown CNA called for assistance from Registered Nurse (RN) 2. CNA 2 stated she had worked at the facility for about 6 months so she was still being trained. CNA 2 stated she could not remember the name of the CNA who was training her. CNA 2 stated the unknown CNA decided to change resident 48's colostomy bag. CNA 2 stated the unknown CNA replaced the entire bag, wafer included. CNA 2 stated the CNAs could burp and empty resident 48's colostomy bag when needed, but it was not common for them to (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	change a colostomy. CNA 2 stated resident 48 did not call her while CNA 2 was out in the hallway because CNA 2 was in the room with resident 48 the entire time. On 6/10/26 at 1:38 PM, an interview was conducted with the Regional Administrator Consultant (RAC) who was involved in the investigation. RAC stated resident 48's colostomy tore open. CNA 2 requested help from the nurse and continued to take other residents to the dining room. After about 30 minutes RN 2 did go check on resident 48 and found her crying and expressed pain. The RAC stated they investigated the situation as abuse with the intent to cause harm and not neglect. The RAC stated he could see how the situation could be neglect or more reasonably a delay in care. The RAC stated they did talk to the staff and the staff believed there were other priorities that took precedence over resident 48's needs. The RAC stated education was provided to all of the staff about resident care.On 6/10/26 at 1:40 PM, an interview was conducted with the Administrator (ADM) who stated one of the reasons they did not deem the incident as neglect was based on the fact that resident 48 expressed she did not want to get anyone in trouble. The ADM stated that even though resident 48 yelled out to the nursing staff for assistance she had the call light within reach and she could have pushed the call light. The ADM stated resident 48 stated that she could have pressed her call light after she had requested assistance verbally and the staff would have been reminded to go to her. The ADM stated the redness was gone by the next day when resident 48 was assessed. The ADM stated making the resident wait a long time for care was not appropriate and we watch call lights closely. The ADM stated they did educate the staff on communication and what resident needs took priority. On 6/10/26 at 2:55 PM, an interview was conducted with the Director of Nursing (DON) who stated CNA 2 relayed the information to the oncoming CNA that was why the oncoming CNA went and cared for resident 48. The DON stated that CNAs did not change resident colostomies, only nursing staff did that. The DON stated there was not another CNA in the room with CNA 2 when the incident took place. The DON stated the resident was alert and oriented and could have pressed her call light if she did not get the care that was needed. The DON stated the staff were expected to provide prompt care to all residents. The DON stated they did colostomy care education to all staff.

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F 0689 Level of Harm - Actual harm 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 record review and interview, it was determined that for 2 out of 36 sampled residents, the facility failed to ensure each resident's environment remained as free of accident hazards as was possible; and that each resident received adequate supervision and assistance devices to prevent accidents. Specifically, a resident required an extensive two-person assist with brief changes and a Certified Nursing Assistant changed the resident's brief alone. Additionally, during the brief change the resident rolled out of bed and sustained a laceration and femur fracture. This resulted in a finding of harm for this resident. In addition, one resident removed his wander guard for a fourth time and eloped. Resident identifiers: 13 and 46.Findings included:HARM: 1. Resident 46 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included chronic obstructive pulmonary disease, morbid (severe) obesity due to excessive calories, generalized muscle weakness, muscle wasting and atrophy, difficulty in walking, other lack of coordination, and other reduced mobility.A review of the facility's exhibit 358 reported to the State Survey Agency revealed an incident dated 5/8/24, CNA [Certified Nursing Assistant] providing peri [perineal] care when resident rolled herself using her grab bar. The resident rolled out of bed landing on her knees and still holding the grab bar. Staff laid resident down and upon assessment found a laceration to the left knee with apparent adipose tissue exposed. Resident complained of extreme pain to left leg. EMS [Emergency Medical Services] called at 0836 [8:36 AM] and transferred to ER [Emergency Room]. Resident is often a 1 person assist for brief changes.Resident 46's Minimum Data Set (MDS) dated [DATE] revealed that resident 46 was dependent on toileting, dependent on lower body dressing, dependent on personal hygiene, dependent on rolling left and right, dependent on sitting to lying, dependent on lying to sitting, and the resident refused a toilet transfer. Dependent indicated that the helper does all of the effort. The resident does none of the effort to complete the activity or the assistance of 2 or more helpers was required for the resident to complete the activity.Resident 46 had a care plan focus initiated on 6/2/23 with a revision on 6/9/23 which documented that resident 46 had impaired physical mobility. Interventions initiated on 6/2/23 included providing supportive care, assistance with mobility as needed. Document assistance as needed. A care plan focus initiated on 6/2/23 with a revision on 6/9/23 documented that resident 46 was at risk for falls. Interventions included that resident 46 prioritized her safety, independence, and comfort through responsive, proactive support. Staff were to ensure that resident 46's call light was always within reach for prompt assistance and confirm that essential items were accessible before leaving her room. A review of resident 46's progress notes revealed:a. On 4/20/24 at 4:39 PM, a nursing note documented, The resident was very sob [shortness of breath] on Thursday when I was here late. I turned up her O2 [oxygen] to 4 liters and gave her some mucinex.At about 3:30 pm she asked the CNA to get me because she felt like she couldn't catch her breath.The resident weighs 300 pounds and was unable to help with a transfer, she was still in respiratory distress and I did not feel that using the hoyer to lift her would be safe. We tried to roll her in her bed and waited for another CNA to arrive. We decided that the 3 of us were not strong enough to push her on the uneven ground of the parking lot. Dispatch sent an officer to help us but he was also unsure of being about [sic] to get her across the parking lot.b. On 4/23/24 at 12:42 PM, an advanced clinical admission note documented, .Functional : 0 Wheelchair (manual or electric).Able to move all extremities. Upper extremity ROM [range of motion] : No impairment. Lower extremity ROM: No impairment. Gait is unsteady. Balance is poor. Resident prefers self activity. Resident is bedfast all or most of the time. Functional Note: Patient is a 2 person total assist for transfers (with the hoyer), brief changes, upper and lower body dressing; 1 person total assist for putting on footwear, WC [wheelchair] mobility; 1 person setup assist for meals.c. On 5/1/24 at 10:42 PM, a nursing progress note documented, WEEKLY: The resident was readmitted to the facility with RSV [respiratory (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	syncytial virus] and was placed on droplet precautions upon arrival to our facility. The resident also has chronic afib [atrial fibrillation], COPD [chronic obstructive pulmonary disease], HTN [hypertension], HLD [hyperlipidemia], AKF [acute kidney failure] and morbid obesity. She requires two person extensive assist for transferring with the Hoyer lift. She is incontinent of both bowel and bladder. She wears a brief for protection. She is also a two person extensive assist for all brief changes. She requires extensive, one person assist, with all other ADLs [Activities of Daily Living].d. On 5/8/24 at 9:30 AM, a nursing progress note documented, Resident sustained a witnessed fall around 0830 [8:30 AM] this morning. Resident is alert and oriented and at baseline prior to fall. Staff was assisting with a brief change when the resident rolled herself onto her left side using the grab bar. Resident over turned herself and rolled out of bed. resident landed on her knees and was still holding on to the grab bar. Staff yelled for assistance this nurse responded at that time. Cna and Nurse repositioned the resident to a supine position. Nurse noted a laceration to the left knee with adipose tissue exposed. resident complaining of extreme pain to left leg. resident stated she felt like she was going to pass out. Additional nursing staff responded and EMS called to assist. Resident assisted to gurney via hoyer lift and transferred to emergency department. A review of the facility's exhibit 359 revealed that resident 46 prior to the incident was assessed at her baseline, alert and oriented between 7:00 AM and 8:10 AM. At approximately 8:30 AM CNA 3 assisted resident 46 with a brief change but the resident rolled out of bed while using the grab bar and landed on her knees. Responding staff found resident 46 sitting against the bed and heard resident 46 complain of extreme pain and feeling of light headedness. Nursing staff observed a laceration on resident 46 above the left knee with exposed adipose tissue, bruising on both knees and swelling, alongside a pool of blood on the floor. Staff placed resident 46 in a supine position, obtained a physician's order for transfer, and utilized a Hoyer lift to transfer resident 46 to a gurney for EMS transport to the emergency department. Resident 46 was admitted to the hospital with a femur fracture and a laceration.On 6/10/26 at 3:33 PM, an interview was conducted with the Regional Nurse Consultant (RNC). The RNC stated resident 46's care plan had how she transferred and if resident 46 used grab bars to assist with mobility. The RNC stated that if resident 46 used a Hoyer lift then she would need two people for assistance.On 6/10/26 at 3:51 PM, a follow-up interview was conducted with the RNC. The RNC stated that she was able to get into contact with the previous facility administrator. The previous facility administrator stated that it was the facility policy at the time to not document in resident's care plans what type of assistance was needed for company liability reasons. The RNC stated that she was unable to find any documentation that stated that resident 46 was only a 1 person assist with brief changes. POTENTIAL FOR HARM: 2. A facility reported incident dated 2/9/26 at 6:56 PM indicated that the facility reported that on 2/9/26 at 5:45 PM Registered Nurse (RN) 3 was unable to locate resident 13 for his evening medications. It indicated Certified Nurse Assistant (CNA) 3 reported being with resident 13 in the dining room until 5:30 PM when he left after he finished dinner. It further indicated that staff began to look for resident 13 and he was found off of the premises at 6:07 PM.Resident 13 was admitted to the facility on [DATE] with diagnoses which included dementia, type 2 diabetes mellitus, anxiety disorder, muscle weakness, and insomnia.A Minimum Data Set (MDS) assessment dated [DATE] indicated a Brief Interview for Mental Status (BIMS) score of 5, which indicated severe cognitive impairment.A Nursing Progress Note dated 12/28/25 at 6:37 PM indicated, Resident has made multiple attempts to leave the facility grounds. He has set off multiple alarms on the locked doors. On call suggested a wander guard.It will be checked for placement once a shift and then another order for every Sunday to ensure it's working. Resident is continent [sic] with this option as he gets confused and can't remember where he's going and this will help keep him safe. He will be on alert charting for three days.A Nursing Progress Note dated 12/29/25 at 10:49 AM indicated, resident has been placed on alert charting. He had cut his wander guard off this morning when I checked for placement. I educated the patient that this needs to stay on to keep him safe. He agreed and stated he would keep it on. He has not tried to exit the facility today or even ask to walk (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	outside today.The care plan was not updated with revised interventions after this incident.A Nursing Progress Note dated 1/4/26 at 9:02 AM indicated, when nurse checked for his wander guard, it was not on his ankle. nurse found it on his nightstand next to a pair of scissors. replaced the band on his left ankle. scissors were removed from the room.The care plan was not updated with revised interventions after this incident.An Administration Note dated 2/1/26 at 11:46 AM indicated, Check to ensure wander guard is working by taking resident to the door and ensure the alarm turns on one time a day every Sun [Sunday] for wander guard working Wander guard not on either leg. It should be noted that there was no other information found in the medical record regarding the wander guard not found on resident 13's leg.The care plan was not updated with revised interventions after this incident.A Nursing Progress Note dated 2/9/26 at 7:26 PM indicated, At approx [approximately] 1750 [5:50 PM], nurse was delivering HS [hour of sleep] meds [medications] to resident in the dining room, as he was eating dinner in there tonight. Nurse did not see him in the dining room, went to residents bedroom to check there, was not there. nurse immediately notifed [sic] other floorstaff [sic] that he was not in his usual places. All floor staff available began to look for resident, inside and outside. Nurse got in car and began to drive the main street searching for him. [Administrator] notified of possible elopement at 1800 [6:00 PM]. while driving the main street headed south, nurse received a call from another staff nurse at 1801 [6:01 PM] stating that she received a call from a clinic nurse asking if she knew him. It was [resident 13]. Clinic had notified police. police and floor nurse arrived at the same time to the clinic regarding the resident. Police asked nurse to identify resident via name. Nurse loaded resident into personal car and drove him back to the facility, arriving at 1810 [6:10 PM]. assessment done, no injury noted. no wander guard in place. Facility locked down until more wander guards are received.An Administration Note dated 2/10/26 at 4:23 AM indicated, .wander guard was cut off by resident will monitor till get new wanderguard.On 6/9/26 at 1:57 PM, an interview was conducted with Registered Nurse (RN) 3 who stated that in February, resident 13 had been eating dinner in the dining room that was served at 5:00 PM and that she was giving night medications sometime before 6:00 PM. RN 3 stated when she went to give him his medications in the dining room he was not in there so she went to his room and he was not there either. RN 3 stated she alerted all floor staff, including housekeeping and kitchen staff, to search in-house and all the grounds. RN 3 stated they did not find him so she got in her car and went on the mainstreet to look for him. RN 3 stated that while she was out looking, a health clinic staff member called the facility and asked facility staff if they were missing a resident. RN 3 stated the facility then called her and told her that resident 13 was found at another health clinic so she went there and arrived at the same time a police officer got there. RN 3 stated she had to identify resident 13 and then she was able to bring him back to the facility. RN 3 stated the clinic he was found at was about a block from the facility and that he would have had to cross the main street to get to the clinic. RN 3 stated she assessed him when they returned to the facility and found no wander guard on him. RN 3 stated she found the wander guard in his room and that it had been cut off with some scissors so she removed the scissors and any other items he could have used to cut it off with. RN 3 stated that they immediately locked all of the doors of the facility. RN 3 stated that prior to this elopement, resident 13 would try to elope a couple times a week by exit seeking and attempting to go out the facility doors. RN 3 stated that if a resident was attempting to elope, they would only document it if the attempts to redirect did not change the behavior.On 6/10/26 at 3:01 PM an interview was conducted with the Director of Nursing (DON) who stated that resident 13 had a wander guard ordered and placed after his first elopement on 12/28/25. The DON stated additional interventions that were placed at that time included being put on alert charting that monitored if he was having exit-seeking behaviors and frequent safety checks, which included being checked on every 30 minutes by the nurses and CNAs, but that there was no documentation for that. The DON stated the facility was not locked at that time until after his second elopement on 2/9/26.