STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525371	A. Building B. Wing	07/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Silver Springs Health Care Center	1300 West Silver Spring Dr Glendale, WI 53209

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 - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure residents right to be free from abuse for 1 of 1 (R5) residents reviewed for abuse.Facility staff witnessed a CNA (Certified Nursing Assistant) verbally abuse R5. The verbal abuse was not immediately reported to the Nursing Home Administrator, and the CNA continued to work the remainder of their shift, putting R5 and other residents at risk for additional abuse.Findings include:The facility's policy titled Abuse/Neglect/Exploitation which was not dated, documents:It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit abuse, neglect, exploitation and misappropriation of resident property.V. Investigation of alleged abuse, neglect and exploitation.A. An immediate investigation is warranted when suspicion of abuse, neglect or exploitation or reports of abuse, neglect or exploitation occur.VI. Protection of a ResidentD. Room or staffing changes, if necessary, to protect the resident(s) from the alleged perpetrator.VII. Reporting/Response1. Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g., law enforcement when applicable) within specific timeframes:a. Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury.b. Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury. R5 admitted to the facility on [DATE] and has diagnoses that include morbid obesity, osteoarthritis, osteomyelitis lower extremity, Diabetes Mellitus type 2, Chronic Obstructive Pulmonary Disease, Major Depressive Disorder and Congestive Heart Failure.R5's BIMS (Brief Interview for Mental Status) dated 5/28/25 documents a score of 10, indicating moderate cognitive impairment. Surveyor reviewed the facility's Misconduct Incident Report which documents that on 6/30/25 the facility social worker received a report from the facility receptionist regarding an incident involving a named CNA (Certified Nursing Assistant). The receptionist stated that on the morning of 6/29/25 at 9:36 AM, she witnessed the CNA walk past R5, who greeted him by saying good morning, how are you. The receptionist alleged that the CNA responded with Shut your ass up, I don't want nothing to do with your ugly ass and then stormed off.The CNA was suspended pending investigation, police were notified, and psych services were offered to R5. The investigation included interview with the receptionist, who confirmed the incident as described above. The facility investigation included a sample of residents assigned to the CNA whom were interviewed to rule out other potential abuse.Surveyor noted the facility's Misconduct Report documents the Social Worker received report of the verbal abuse on 6/30/25, however the witnessed verbal abuse occurred the morning of 6/29/25. On 7/14/25 at 9:45 AM, Surveyor spoke with R5 in his room. R5 reported that R5 remembers the incident. R5 stated (CNA) yelled and swearing at me. Where is he anyway, I haven't seen him. R5 reported he did not know why the CNA yelled and swore at him, stating maybe he was mad at me. R5 reported no adverse outcome following the incident. He stated, I forgot about it. Sometimes people say things when they're made, but don't mean it. I've said things to people I didn't mean when I was mad.On 7/14/25 at 10:30 AM, Surveyor spoke with Director of Social Services-C and asked why the Self Report investigation was started on 6/30/25 when the allegation of verbal abuse occurred the morning of 6/29/25. She reported 6/30/25 was the first she knew about the incident from a note that was placed under her door. She reported the receptionist was brand new and she just wrote the note and slid it under the door. Director of Social Services reported she completed a teachable moment form with the receptionist on 6/30/35 to include abuse training and immediate reporting of abuse. The facility's Misconduct Report documented sampled residents assigned to the CNA were interviewed. Surveyor reviewed the resident interviews. All residents interviewed resided on unit D. The CNA involved in the witnessed verbal abuse allegation on 6/29/25 was assigned to unit B and assisted with unit A. No other residents assigned to the CNA on 6/29/25 were interviewed.The receptionist that witnessed the verbal abuse by the CNA on 6/29/25 did not immediately report the abuse to the Administrator or Social Worker, as the receptionist placed a note under the social worker's door which was found on 6/30/25. The CNA involved in the witnessed verbal abuse continued to work on R5's unit for the remainder of his shift and was not suspended until the following day.On 7/15/25 at 9:20 AM, Nursing Home Administrator (NHA)-A was advised of the above concerns. NHA-A reported that he understood the abuse was not reported immediately and that NHA-A taken over the Relias training with the expectation all staff training to be completed by 7/23/25. No additional information was provided.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure that allegations of verbal abuse and/or misappropriation were immediately reported to the Nursing Home Administrator for 2 of 3 (R2 and R5) residents reviewed for abuse.R2's allegation of misappropriation of money and property was not reported to the Nursing Home Administrator (NHA)-A-or Social worker, resulting in delay of reporting to the State Agency. R5's (witnessed) verbal abuse was not immediately reported to the NHA-A or Social worker.Findings include:The facility's policy titled Abuse/Neglect/Exploitation which was not dated, documents:It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit abuse, neglect, exploitation and misappropriation of resident property.V. Investigation of alleged abuse, neglect and exploitation.A. An immediate investigation is warranted when suspicion of abuse, neglect or exploitation or reports of abuse, neglect or exploitation occur.VI. Protection of a ResidentD. Room or staffing changes, if necessary, to protect the resident(s) from the alleged perpetrator.VII. Reporting/Response1. Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g., law enforcement when applicable) within specific timeframes:a. Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury.b. Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury. R5 admitted to the facility on [DATE] and has diagnoses that include morbid obesity, osteoarthritis, osteomyelitis lower extremity, Diabetes Mellitus type 2, Chronic Obstructive Pulmonary Disease, Major Depressive Disorder and Congestive Heart Failure.R5's BIMS (Brief Interview for Mental Status) dated 5/28/25 documents a score of 10, indicating moderate cognitive impairment. Surveyor review of the facility's Misconduct Report documents on 6/30/25 the facility social worker received a report from the facility receptionist regarding an incident involving a named CNA (Certified Nursing Assistant). The receptionist stated that on the morning of 6/29/25 at 9:36 AM, she witnessed the CNA walk past R5, who greeted him by saying good morning, how are you. The receptionist alleged that the CNA responded with Shut your ass up, I don't want nothing to do with your ugly ass and then stormed off.Surveyor noted the facility's Misconduct Report documents the Social Worker received report of the verbal abuse on 6/30/25, however the witnessed verbal abuse occurred the morning of 6/29/25.On 7/14/25 at 10:30 AM, Surveyor spoke with Director of Social Services-C and asked why the Self Report investigation was started on 6/30/25 when the allegation of verbal abuse occurred the morning of 6/29/25. She reported 6/30/25 was the first she knew about the incident - from a note that was placed under her door. She reported the receptionist was brand new and she just wrote the note and slid it under the door. Director of Social Services reported she completed a teachable moment form with the receptionist on 6/30/35 to include abuse training and the immediate reporting of abuse. The receptionist that witnessed the verbal abuse by the CNA on 6/29/25 did not immediately report the abuse to the NHA-A or Social Worker, she placed a note under the social worker's door which was found on 6/30/25. The CNA involved in the witnessed verbal abuse continued to work on R5's unit for the remainder of his shift and was not suspended until the following day.On 7/15/25 at 9:20 AM, NHA-A was advised of the above concerns. NHA-A reported he understood and has taken over the Relias training with the expectation all staff training to be completed by 7/23/25. No additional information was provided.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not ensure residents received adequate supervision and assistance devices to prevent elopements or accidents for 2 of 4 residents (R1 and R4) reviewed for elopement and falls. *R1 was discovered on the ground outside the facility’s front door on 5/6/2025 at 3:45 AM. R1’s fall was not thoroughly investigated to determine the root cause of the fall and the elopement out of the building was not investigated. On 7/10/2025 at 3:00 AM, R1 was discovered to be missing from the facility. The police found R1 at 4:55 AM on a bench at a street intersection 1.2 miles away from the facility. R1’s elopement was not investigated.The facility’s failure to supervise a resident to prevent elopements in the middle of the night, its failure to ensure the front door alarm was always working, and its failure to do an investigation to determine a root cause of the elopements created a finding of immediate jeopardy that began on 5/6/2025. Surveyor notified Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B of the immediate jeopardy on 7/15/2025 at 2:48 PM. The immediate jeopardy was removed on 7/21/25, however the deficient practice continues at a scope/severity of D (potential for more than minimal harm/isolated) as evidenced by the following example: * R4 fell from bed on 6/28/2025 due to the wheels of the bed not being locked. The care plan intervention of the wheels being locked on the bed was observed not to have been in place during a transfer. Findings include: (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility’s policy and procedure titled “Elopement” with no date documents: “The 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. Policy Explanation and Compliance Guidelines: …2. ‘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. 3. The facility is equipped with door lacks/alarms to help avoid elopements. 4. Alarms are not a replacement for necessary supervision. Staff are to be vigilant in responding to alarms in a timely manner. 5. 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. 6. Monitoring and Managing Residents at Risk for Elopement or Unsafe Wandering a. Residents will be assessed for risk of elopement and unsafe wandering upon admission and throughout their stay by the interdisciplinary care plan team. b. The interdisciplinary team will evaluate the unique factors contributing to risk in order to develop a person-centered care plan. c. 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. d. Adequate supervision will be provided to help prevent accidents or elopements. e. Charge nurses and unit managers will monitor the implementation of interventions, response to interventions, and document accordingly. f. The effectiveness of interventions will be evaluated, and changes will be made as needed. Any changes or new interventions will be communicated to relevant staff. 7. Procedure for Locating Missing Resident a. Any staff member becoming aware of a missing resident will alert personnel using facility approved protocol (e.g., internal alert code). b. The designated facility staff will look for the resident. c. If the resident is not located in the building or on the grounds, Administrator or designee will notify the police department and serve as the designated liaison between the facility and the police department. The administrator or designee should also notify the company’s corporate office. d. DON or designee shall notify the physician and family member or legal representative. e. Police will be given a description and information about the resident, include any photos. f. All parties will be notified of the outcome once the resident is located. g. Appropriate reporting requirements to the State Survey agency shall be conducted. 8. Procedure Post-Elopement a. A nurse will perform a physical assessment, document, and report findings to physician. b. Any new physician orders will be implemented and communicated to the family/authorized representative. c. A social service designee will re-assess the resident and make any referrals for counseling or psychological/psychiatric consults. d. The resident and family/authorized representative will be included in the plan of care. e. Staff may be educated on the reasons for elopement ad possible strategies for avoiding such behavior. f. When repeated elopement attempts occur, after the facility has exhausted possible care approaches, the resident may be referred for alternate placement in an appropriate facility. g. Documentation in the medical record will include: finding from nursing and social service assessments, physician/family notification, care plan discussions, and consultant notes as applicable.” 1.) R1 was admitted to the facility on [DATE] with diagnoses of cerebrovascular disease, moyamoya disease (a rare progressive cerebrovascular disorder characterized by the narrowing or blockage of the internal carotid arteries and the formation of abnormal blood vessels at the base of the brain leading to reduced blood flow to the brain causing strokes, transient ischemic attacks, and other neurological symptoms), and vascular dementia. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R1’s admission Minimum Data Set (MDS) assessment dated [DATE] documented R1 was cognitively intact with a Brief Interview for Mental Status (BIMS) score of 15. R1’s Elopement Risk assessment dated [DATE] documented R1 was a risk of elopement with a score of 1 (1 or higher was at risk for elopement) due to R1 being admitted to the facility within the last 30 days and not accepting of the situation. R1 did not have a history of wandering or elopement from home per the risk assessment. Surveyor noted no Elopement Care Plan was initiated for R1 with this assessment. R1’s Physical Functioning Deficit Care Plan was initiated on 4/22/2025 and documented R1 needed transfer and walking assistance with distance supervision on 4/28/2025. R1’s At Risk for Falls Care Plan was initiated on 4/28/2025 with the interventions:-Call light and personal items available and in easy reach.-Clear and monitor environmental obstacles (tubing, cords, etc.). -Footwear to prevent slipping.-Keep bed locked. R1’s progress noted dated 5/6/2025 at 6:36 AM written by an RN (Registered Nurse) documented: At approximately 3:45 AM, the RN was informed by the pharmacy delivery driver that R1 was sitting down outside. The RN observed R1 sitting upright at the front outside the building. R1 stated R1 had been feeling a little tipsy because R1 had drank some alcohol and fell on their “butt”. R1 stated R1 was okay. The RN assessed R1; R1 was alert and oriented with some confusion. R1 sustained an abrasion to the right thumb. Staff members assisted R1 up from the floor and ambulated to R1’s room with assistance of staff. The RN searched R1’s room and did not find any alcohol. The Nurse Practitioner (NP) was notified and instructed staff to continue with neurological checks. R1’s POA was called and updated. The RN completed a Post Fall Evaluation documenting the cause of the fall to be wandering. R1’s progress note dated 5/6/2025 at 1:19 PM and written by Director of Social Services (DSS)-C documents: DSS-C was alerted of R1’s fall early that morning as a result of alcohol intoxication. The psych NP was notified, and a psych referral was made. DSS-C documented DSS-C spoke with R1 regarding behavioral expectations while in the facility and R1 expressed understanding regarding the risk associated with alcohol use.Surveyor was provided the Risk Management tool used by the facility for incidents/events. The documentation on the tool was the same as documented by the RN in the progress notes on 5/6/2025. According to timeanddate.com, the temperature in Glendale, Wisconsin at 3:55 AM was 45 degrees with no wind, humidity 93%. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on 7/15/2025 at 8:51 AM, Licensed Practical Nurse Unit Manager (LPNUM)-H stated LPNUM-H was not employed at the facility at the time of the fall or elopement on 5/6/2025 but would review R1’s medical record to see if any more information was documented at that time. LPNUM-H provided a statement by the RN as part of the Risk Management tool dated 5/6/2025. The statement documented: “Resident came out of room, staff redirected (R1) back to (R1’s) room Resident stated ‘I slept all day, I want to move around’ Resident tried to go outside, staff brought (R1) back in, informed Resident it was too early to go outside. Door Bell was not working”. LPNUM-H stated from reading that statement, it could not be determined when R1 was trying to leave the building, if it was before R1 was found outside or after the incident of the fall outside. LPNUM-H stated the statement was unclear if the alarms when leaving the building were not working or if the doorbell to come back in was not working and would have meant R1 was locked out of the building. LPNUM-H stated the investigation into the fall and the elopement did not create a clear picture of what happened at that time with R1. LPNUM-H provided Surveyor with the Risk Management interdisciplinary team (IDT) meeting documentation. On 5/13/2025, the IDT determined the cause of the fall to be walking outside on uneven surfaces without the walker after drinking alcohol. R1 was found sitting on R1’s bottom outside. R1 reported that R1 was drinking and feeling tipsy. R1’s vital signs were stable, denied any pain, denied hitting the head, and neurological checks were initiated. Surveyor noted the IDT did not meet until 5/13/2025, seven days after the fall and elopement. R1’s At Risk for Falls Care Plan was revised on 5/12/2025 with the interventions:-Offer ADOA (Alcohol and Other Drug Abuse).-Refer to Psych. Surveyor noted the investigation of the fall and elopement did not include where R1 obtained the alcohol or if other physical disease processes were a factor. Surveyor noted the investigation did not include if the alarm system was working, when R1 was last seen to know how long R1 had been outside of the building, or any other behaviors R1 was exhibiting prior to leaving the facility. No elopement or wandering care plan was initiated at that time. On 5/8/2025, R1 was seen by the Psych (psychiatric) NP. The Psych NP documented staff reported that R1 fell that week due to being intoxicated. No additional alcohol use was reported after that incident. R1 did not have a history of alcohol use. R1’s Medication Administration Record (MAR) had an order to monitor R1’s behaviors and document those behaviors on every shift. Nurses documented R1 had wandering behaviors on 5/24/2025 AM shift, 6/6/2025 PM shift, and 6/7/2025 AM shift. No elopement or wandering care plan was initiated at that time. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 6/12/2025, R1 was seen by the Psych NP. The Psych NP documented staff reported that R1 was having increased confusion, restlessness, and agitation this week, which started when R1 got a new roommate. Staff report that R1 was difficult to redirect currently. The Psych NP documented the Psych NP called and spoke with R1’s POA to discuss medication options for R1’s agitation. The Psych NP recommended an increase in R1’s antipsychotic medication dose, but R1’s POA refused the dose increase stating R1 “is only agitated because something is wrong, and this place needs to fix why (R1) is agitated.”Nurses documented on R1’s MAR R1 had wandering behaviors on 6/13/2025 AM and PM shift. On 6/18/2025 at 7:59 PM in the progress notes, DSS-C documented DSS-C met with R1’s POA and discussed R1 likes to take short walks in the community. R1’s POA indicated R1’s POA was okay with R1 signing themselves out and going on a walk unsupervised. DSS-C advised against this and discussed the risk vs benefit. R1’s POA expressed understanding. DSS-C offered an intervention that R1 could request staff to accompany on short walks, time permitting, otherwise POA advised the POA can be called to come in and accompany R1 when R1 would like to go out for a walk. R1’s At Risk for Elopement Care Plan was initiated on 6/18/2025 related to attempts to leave living center to go on short walks. The following interventions were initiated at that time:-Assess for risk of elopement per living center policy.-Assess for secure unit.-Evaluate effect of cognitive impairment upon resident’s ability to understand changes in surroundings.-Redirect patients from doors.-Take picture of patient upon admission for identification for updating elopement book. R1’s Behavior Care Plan was initiated on 6/18/2025 with behaviors that include going for short walks near the facility “WITHOUT” notifying staff and R1’s POA has given permission for R1 to take short walks unsupervised however staff encourages R1 to request an escort for safety. The following interventions were initiated at that time:-Attempt interventions before my behaviors begin.-Help R1 maintain their favorite place to sit.-If R1 seems restless, please offer to escort R1 on a short walk in the community/or call POA to escort R1 on a walk.-Make sure R1 is not in pain or uncomfortable.-Offer R1 something likes as a diversion. On 6/18/2025 at 5:30 PM until 6/21/2025 at 11:45 AM, facility staff were documenting 15-minute checks on R1. On 6/18/2025, R1’s Elopement Risk Profile page was placed in the Wandering/Elopement binder indicating R1 was at risk for elopement. The profile page documented R1’s identifying information as well as the presence of dementia and impulsivity. The profile page documented R1’s favorite spot outside was under a bridge across from a grocery store approximately 0.3 miles from the facility. No documentation was found preceding the elopement and wandering behavior care plans being initiated, the reason R1 was placed on 15-minute checks, or the reason R1 had a profile page in the Wandering/Elopement binder. No documentation was found indicating R1 had been leaving the building or wanting to take walks. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 6/19/2025, R1 was seen by the Psych NP. The Psych NP documented staff reported that R1 was having continued restlessness and agitation. R1 was moved to a different room this week, but the agitation continued. R1 was very difficult to redirect. R1 was pacing the unit and was up by the nurses’ station frequently. R1’s POA was at the facility and the Psych NP along with the unit nurse tried to talk to R1’s POA about R1’s agitation. The Psych NP recommended a few medication options, as R1 was reporting feelings of nervousness and restlessness. R1’s POA refused to increase R1’s current antipsychotic dose or to start any new medications stating R1 “is not that bad”, and R1 “doesn’t need more medications”. Nursing staff documented on R1’s MAR R1 had wandering behaviors on 6/19/2025 PM shift, 6/23/2025 AM shift, 6/24/2025 AM shift, and 7/9/2025 night shift. On 7/10/2025 at 8:30 AM in the progress notes, RN-I documented RN-I noticed R1 was not in R1’s room at 3:00 AM. Everywhere was checked and R1 was not found in the building or its environment. 911 was called and police officers showed up and helped with the search. A police officer brought R1 back to the facility at 4:55 AM stating R1 was found at an intersection sitting on a bench. (The exact location was documented in the progress note.) Director of Nursing (DON)-B was notified of the incident as well as the Unit Managers. Surveyor noted the intersection R1 was found sitting on a bench was 1.2 miles from the facility. The facility is located on a heavily trafficked 4-lane divided road with a grassy median with center turn lanes and sidewalks. The speed limit of the street is 30 miles per hour. R1 would have crossed multiple intersections including an on/off ramp intersection and under/overpasses. According to timeanddate.com, the temperature in Glendale, Wisconsin at 4:15 AM was 59 degrees, humidity 100%. There was no wind. Surveyor noted R1’s medical record did not have any documentation after the progress note on 7/10/2025 at 8:30 AM. R1 did not have any vital signs taken upon return to the facility. No head-to toe-assessment was completed to check for injuries. No follow up documentation was found regarding behaviors or aftereffects of being out of the facility for greater than two hours in the middle of the night. R1’s Care Plan was not revised. In an interview on 7/14/2025 at 10:34 AM, Surveyor asked Receptionist-G if the facility had a book or binder of residents at risk for elopement. Receptionist-G stated yes, it is right here at the front desk and provided the binder to Surveyor. Surveyor noted the Elopement Policy was at the front of the binder and three residents had an Elopement Risk Profile page. R1 was not included in the Wander/Elopement binder at the front desk. Surveyor asked Receptionist-G if the residents in the binder were the residents that had a Wanderguard in place. Receptionist-G stated no, the binder has all residents that may get out. Receptionist-G stated DSS-C is the one that updates the binder; all the residents with a Wanderguard on are on the C Unit. Surveyor asked Receptionist-G what doors are equipped with alarms. Receptionist-G stated all the doors have alarms and the front door gets locked at 8:00 PM. Surveyor asked Receptionist-G if there was a sign-out book for residents leaving the building. Receptionist-G stated yes and showed the book to Surveyor. Receptionist-G stated residents do not have to sign out in the book if they are just going for a walk. Receptionist-G provided the names of four residents that do sign out in the book when they are going to leave the building to go to the grocery store. R1 was not a resident that Receptionist-G named. (continued on next page)

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	525371	A. Building B. Wing	07/28/2025

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Surveyor asked Receptionist-G if R1 was a resident that was at risk for eloping or leaving the building without anyone knowing. Receptionist-G stated there are no problems with R1; R1 will sit outside the front door and if R1 starts to get up to go somewhere, Receptionist-G will point at R1 through the window to tell R1 “no” and then R1 comes in or sits back down. Receptionist-G stated sometimes she has to go to the front door so R1 can hear Receptionist-G, but R1 has never caused a problem. Surveyor noted the reception desk is adjacent to a glass wall so the bench outside the front door is easily visible. Surveyor asked Receptionist-G if R1 had ever gotten out of the building and far away. Receptionist-G stated she was not aware of any elopements. In an interview on 7/14/2025 at 1:07 PM, Surveyor asked DON-B for the investigations the facility did on R1’s elopements. DON-B stated there are no investigations. Surveyor asked DON-B how many times had R1 eloped. DON-B thought R1 had eloped twice stating after the first elopement there was a discussion with R1’s POA and the POA said it was okay for R1 to go for a walk by themselves. Surveyor noted the discussion with R1’s POA was on 6/18/2025 where there was no documentation of an elopement or R1 taking walks out in the community. On 7/14/2025 at 1:23 PM, Surveyor observed the front desk with no staff and no staff was in view of the front door. Surveyor noted one resident outside the building in an electric wheelchair by the bench located by the front door. On 7/14/2025 at 2:03 PM, Surveyor observed R1 awake, lying in bed. Surveyor asked R1 if R1 likes to go for walks. R1 stated yes, he goes after breakfast and before dinner, and sometimes after dinner. Surveyor asked R1 if R1 ever goes for a walk at night. R1 denied ever going for a walk at night. R1 stated there is a log to sign out but you do not have to sign out, you can just go. Surveyor again asked R1 about leaving the building in the middle of the night. R1 stated R1 had never left in the middle of the night. In an interview on 7/14/2025 at 3:25 PM, Surveyor asked Nursing Home Administrator (NHA)-A and DON-B how the alarming system works for the front door. NHA-A stated the door is locked at 8:00 PM and you must punch a code to get out, otherwise the alarm goes off, and to get in, you have to ring the doorbell. In an interview on 7/14/2025 at 3:38 PM, Surveyor asked LPN-F about R1’s behaviors. LPN-F stated R1 wanders but is easily redirected. LPN-F stated R1 wanders aimlessly; R1 will be sitting in the back hallway and then goes to R1’s room, then goes to the front, back and forth. LPN-F stated R1 does not hurt anyone with the wandering. Surveyor asked LPN-F if R1 had ever gotten out of the building. LPN-F stated R1 had gotten out to the street one time. LPN-F was not sure how far R1 got. LPN-F stated R1 had never gotten out of the building when LPN-F was working. LPN-F stated LPN-F tries to put eyes on R1 every 30 minutes. On 7/15/2025 at 8:32 AM, Surveyor asked Receptionist-G for the Wander/Elopement binder. Receptionist-G stated the binder is kept at the nurses’ station. The binder that was at the reception desk the day before was no longer at the reception desk. Surveyor found 4 separate Wander/Elopement binders, three located at the main nurses’ station and one located on the C Unit. A total of 8 residents were in the binders including R1. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on 7/15/2025 at 8:40 AM, LPN-F stated the elopement binder for the hall LPN-F was working was at the nurses’ station. LPN-F was not sure where the other three hallway binders were kept. In an interview on 7/15/2025 at 8:51 AM, Surveyor asked LPNUM-H about the circumstances of R1’s elopement on 7/10/2025. LPNUM-H reviewed the charting in R1’s medical record from the progress note on 7/10/2025. LPNUM-H stated on nightly rounds on 7/10/2025, R1 was not in their room. The whole building was searched and 911 was called. R1 was brought back to the building at 4:55 AM by the police. R1 was sitting on a bench. LPNUM-H stated R1 does not have a Wanderguard and when they see R1 leave, they ask R1 to sign out. LPNUM-H stated R1’s care plan says R1 likes to leave the building and R1’s POA has given permission for R1 to go on walks unsupervised. Surveyor asked LPNUM-H if R1 was safe to go for an unsupervised walk at 3:00 AM. LPNUM-H stated there are not enough staff on the night shift to take R1 for a walk at 3:00 AM. LPNUM-H stated R1 was not safe to go for a walk in the middle of the night. Surveyor asked LPNUM-H if there was an investigation into the elopement. LPNUM-H stated the nurse on staff would notify the DON of an event like that. LPNUM-H could not find anything in R1’s medical record to indicate that R1’s elopement was investigated. Surveyor shared the concern with LPNUM-H that Surveyor was unable to find any documentation after R1 returned to the facility that a skin check was done or vital signs taken to assess for injury. LPNUM-H agreed there were no assessments in R1’s medical record after R1 returned on 7/10/2025. LPNUM-H stated it would make sense to do a complete assessment to make sure R1 was not injured; it may not be a change in condition but vital signs and a skin check for injuries should have been completed. In a phone interview on 7/15/2025 at 9:35 AM, Surveyor asked RN-I to review the events of R1’s elopement on 7/10/2025. RN-I stated RN-I checks every resident when RN-I comes on duty at 10:30 PM. RN-I stated RN-I saw R1 at 11:00 PM and checks on R1 every time RN-I walks down the hall. RN-I stated another resident requested a pain medication and when RN-I went past R1’s room, R1 was not there. RN-I stated RN-I checked the bathroom and when R1 was not there, RN-I called the Certified Nursing Assistant (CNA) to help look for R1. RN-I stated residents are checked every two hours on night shift and the CNA saw R1 at Midnight and 1:00 AM. RN-I stated at 3:00 AM, R1 was not seen. RN-I stated they looked outside because on a previous day, R1 had wanted to go outside to go to their car. RN-I stated that was at 2:00 AM on a previous day, but since R1 had said that, RN-I thought to look outside. RN-I stated they looked out the front door, the side door, the parking lot in back and the bus stop. RN-I stated then they called 911. Surveyor asked RN-I if RN-I did an assessment of R1 when R1 was returned to the facility. RN-I asked R1 if R1 was okay and R1 said yes. RN-I said R1 did not have any issues so RN-I thought R1 was okay. Surveyor asked RN-I if R1 had gotten outside in the past. RN-I stated R1 could be easily redirected and was not aware of R1 getting out of the facility before. Surveyor asked RN-I if RN-I had to make up a report or anything for an investigation. RN-I stated RN-I talked to the DON and the Unit Manager that day. Surveyor asked RN-I if the door had alarmed. RN-I stated no alarm had gone off to alert them that R1 was outside. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In a phone interview on 7/15/2025 at 9:51 AM, Surveyor asked R1’s POA if R1’s POA had a conversation with DSS-C about R1 going for walks unsupervised. R1’s POA stated yes, R1’s POA had a conversation and did say it was okay for R1 to go on walks by themselves. Surveyor asked R1’s POA if R1’s POA was aware of R1 leaving the facility in the middle of the night. R1’s POA stated yes, they informed R1’s POA of R1 leaving and R1’s POA was not okay with R1 going for a walk alone in the middle of the night. R1’s POA stated R1 should not go for a walk at 2 in the morning and R1’s POA was going to talk to the facility staff about that. In an interview on 7/15/2025 at 10:06 AM, Surveyor shared the concerns with DSS-C that R1’s fall on 5/6/2025 was not investigated as to how or why R1 was outside at 3:45 AM, there was no documentation preceding 6/18/2025 when R1’s care plan was updated with wandering/eloping behaviors and 15-minute checks were initiated, and when R1 eloped on 7/10/2025, there is no investigation into the elopement such as working alarms on the door and the care plan was not revised to increase supervision. DSS-C stated the changes in R1’s care plan and the 15-minute checks had something to do with a care conference but could not recall the exact events. DSS-C stated DSS-C would look into DSS-C’s soft files and get back to Surveyor. On 7/15/2025 at 10:22 AM, Surveyor shared the concerns with NHA-A and DON-B R1’s elopements on 5/6/2025 and 7/10/2025 were not investigated, R1’s care plans were not revised after the elopements, and R1’s medical record lacked documentation of behaviors of wandering other than a checkmark on the MAR indicating wandering was occurring. R1’s wandering and elopement care plans were initiated on 6/18/2025 with no documentation as to the preceding events that indicated R1 needed these to be in place and R1 was put on 15-minute checks at that time as well with no indication of why. When R1 returned to the facility on 7/10/2025 after being gone for at least two hours in the middle of the night, and found 1.2 miles away, no assessments were done to determine if R1 had any injuries or psychological effects of the event. Surveyor shared the concern that even though R1’s POA stated it was okay for R1 to go on walks in the community unattended, that would not include walks in the middle of the night; the fact that the police were called to assist in finding R1 shows that walking in the middle of the night is not a safe activity. Surveyor shared the concern that there was no investigation into the elopements and there was no assessment of the alarm system to see if it was functioning to prevent other residents from eloping as well. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on 7/15/2025 at 10:46 AM, Surveyor asked Director of Maintenance (DM)-K how long DM-K had been employed at the facility. DM-K stated DM-K had worked at the facility for about one month. Surveyor asked DM-K if there have been any problems with the alarm system on the front door or any alarmed door. DM-K stated when DM-K first started working the door alarms were working. DM-K stated the side door is always alarmed but the front door is open at 7:00 AM and automatically locked at 8:00 PM and when it is locked, the alarm is activated. DM-K stated every morning, DM-K does rounds and checks on all the doors and alarms. DM-K stated on 7/10/2025 in the morning, the power box was unplugged. DM-K was not sure if it got bumped or something, but DM-K plugged it back in and knows it was working after it was plugged back in. DM-K showed Surveyor the plug at the front door. The doorway has double glass doors with a small space leading to a second set of outer double glass doors. The alarm is only for the inner double glass doors and the power plug referenced before is to the upper right corner of the inner glass doors within reach of adult-sized people. DM-K showed Surveyor where a screw normally holds the plug in place, but the screw was missing. DM-K was not sure how long the screw had been missing allowing the plug to become unplugged. DM-K stated sometimes storms will knock out the power because it is an old building. Surveyor asked DM-K in the last month how many times the alarms system had been affected by a power outage. DM-K stated twice. Surveyor asked DM-K how the door is secured when the alarm system is not functioning. DM-K stated the doors have to be manually locked, but then they cannot be opened in case of a fire. DM-K stated the alarm system was not working on Monday, 7/14/2025 when DM-K came to work and checked it in the morning. DM-K was not sure what the problem was so had someone who specializes in alarm systems come in to do repairs. Surveyor had noted someone working on the front doors the prior day. DM-K stated the alarm was working on Thursday 7/10/2025 after DM-K had plugged it back in. DM-K stated DM-K did not work on Friday, Saturday, or Sunday so did not know when the alarm system had stopped working. DM-K stated currently the door alarm is not working because parts had to be ordered. &nb

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. (continued on next page)

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Based on interview and record review, the facility did not ensure nurse staff postings were accurate. This deficient practice has the potential to affect all 93 residents residing in the facility.Review of the daily nursing schedule and required nurse staff postings revealed inaccuracies with the total number of licensed and non licensed staff working and the number of nursing staff posted on the nurse staffing posting for 20 of 30 days reviewed.Findings include:On 7/28/25, at 8:47 a.m., Surveyor received and reviewed the nursing daily schedules and nurse staff postings from 6/29/25 to 7/28/25. During the review, Surveyor noted the following:The nurse staff postings has a category for Actual Hours. This section was not completed on any of the nurse staff posting forms reviewed for Certified Nursing Assistants (CNA), Medication Technicians, Licensed Practical Nurses (LPN) and Registered Nurses (RN).Sunday, 6/29/25, the nurse staff posting for the day shift documents 4 Licensed Practical Nurses (LPNs) and the daily nursing schedule has 3 LPNs working. The night shift documents 2 LPN and Registered Nurse (RN) is blank. The daily nursing schedule has 1 LPN and 1 RN working.Monday, 6/30/25, the nurse staff posting for the day shift documents 9 CNAs, Med Tech is blank and 4 LPNs. The daily nursing schedule has 8 CNAs, 1 Med Tech, and 3 LPNs working. The nurse staff posting for the evening shift has 8 CNAs, Med Tech is blank, and 2 LPNs. The daily nursing schedule has 7 CNAs, 1 Med Tech, and 1 LPN working. The nurse staff posting for the night shift has 2 LPNs and RN is blank. The daily nursing schedule has 1 LPN and 1 RN working.Wednesday, 7/2/25, the nurse staff posting for the evening shift documents 8 CNAs, Med Tech is blank and 2 LPNs. The daily nursing schedule for the evening shift has 9 CNAs, 1 Med Tech, and 1 LPN working. The nurse staff posting for the night shift has 4 CNAs and the daily nursing schedule has 5 CNAs working.Thursday, 7/3/25, the nurse staff posting for the day shift documents 9 CNAs, 1 Med Tech, and 2 LPNs. The daily nursing schedule for the day shift has 8 CNAs, 0 Med Techs, and 3 LPNs working. The nurse staff posting for the evening shift has 8 CNAs, Med Tech is blank, and 2 LPNs. The daily nursing schedule for the evening shift has 7 CNAs, 1 Med Tech and 1 LPN working. The nurse staff posting for the night shift has 4 CNAs and the daily nursing schedule has 3 CNAs working.Friday, 7/4/25, the nurse staff posting for the evening shift documents 7 CNAs and 1 Med Tech. The daily nursing schedule for the evening shift has 6 CNAs and 0 Med Techs working.Saturday, 7/5/25, the nurse staff posting for the evening shift documents 7 CNAs and the daily nursing schedule has 6 CNAs working. The nurse staff posting for the night shift documents 4 CNAs and the daily nursing schedule has 5 CNAs working.Sunday, 7/6/25, the nurse staff posting for the night shift documents 1 LPN and 1 RN. The daily nursing schedule for the night shift has 2 LPNs and 0 RN working. Tuesday, 7/8/25, the nurse staff posting for the day shift documents 8 CNAs and the daily nursing schedule has 9 CNAs working. The nurse staff posting for the evening shift documents 7 CNAs and the daily nursing schedule has 8 CNAs working.Thursday, 7/10/25, the nurse staff posting for the day shift documents 9 CNAs, 4 LPNs and is blank for RN. The daily nursing schedule for the day shift has 8 CNAs, 3 LPNs, and 1 RN working. The nurse staff posting for the evening shift documents 8 CNAs and the daily nursing schedule has 7 CNAs working.Friday, 7/11/25, the nurse staff posting for the day shift documents 9 CNAs and the daily nursing schedule has 8 CNAs working. The nurse staff posting for the evening shift documents 8 CNAs and the daily nursing schedule has 7 CNAs working.Saturday, 7/12/25, the nurse staff posting for the night shift documents 3 CNAs and the daily nursing schedule has 4 CNAs working.Monday, 7/14/25, the nurse staff posting for the evening shift documents 1 Med Tech, 2 LPN and 1 RN. The daily nursing schedule has 2 Med Techs, 0 LPN, and 2 RNs working.Tuesday, 7/15/25, the nurse staff posting for the day shift is blank for Med Tech and 4 LPNs. The daily nursing schedule for the day shift has 1 Med Tech and 3 LPNs working. The nurse staff posting for the evening shift documents 7 CNAs and the daily nursing schedule has 6 CNAs working.Friday, 7/18/25, the nurse staff posting for the evening shift documents 7 CNAs, 2 Med Techs and 1 LPN. The daily nursing schedule for the evening shift has 8 CNAs, 0 Med Techs, and 3 LPNs working. The nurse staff posting for the night shift has 2 Med Techs and the daily nursing schedule does not have any Med Techs working.Sunday, 7/20/25, the nurse staff posting for the day shift documents 1 Med Tech and 3 LPNs. The daily nursing schedule for the day shift has 0 Med Tech and 4 LPNs working. The nurse staff posting for the evening shift documents 1 Med Tech and is blank for LPN. The daily nursing schedule for the evening shift has 2 Med Techs and 1 LPN working.Monday, 7/21/25, the nurse staff posting for the evening shift documents 1 Med Tech and is blank for LPN. The daily nursing schedule for the evening shift has 2 Med Techs and 1 LPN working.Tuesday, 7/22/25, the nurse staff posting for the day shift documents 1 Med